East and North Hertfordshire NHS Trust
Trust Board - Public Meeting

Boardroom / MS Teams

7 July 2021 10:15 - 7 July 2021 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	10:15
2	Apologies for absence:		
3	Declaration of Interests	All	
4	Questions from the Public At the start of each meeting the Board provides members of the public the opportunity to ask questions and/or make statements that relate to the work of the Trust. Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Trust Secretary can be contacted by email, 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 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. Minutes of Public Trust Board Meeting 05.05.21.... 7	Chair	10:20
6	Patient Story For discussion	Chief Nurse	10:25
7	Chief Executive's Report For discussion 7. CE Board Report - June 2021.pdf 17 7. CE Board Report - IPR Summary June 2021.pdf 19	Chief Executive	10:40

#	Description		Owner	Time
8	Integrated Performance Report For discussion 8. IPR Month 2.pdf	21	Chief Executive	
9	System Collaboration Update For discussion 9. System Collaboration Update.pdf 9. Appendix 1 System Collaboration Report.pdf 9. Appendix 2 ICS Design Framework Paper.pdf 9. Appendix 3 MH and LD draft MOU.pdf	59 63 65 73	CEO / Chair / Director of Strategy	10:55
10	Operational and People Recovery For discussion 10. Operational and People Recovery.pdf	83	Chief Operating Officer and Chief People Officer	11:10
11	Trust Objectives 2021/22 For approval 11. Trust Objectives 2021-22.pdf	95	Director of Strategy	11:25
12	Board Assurance Framework For discussion 12. Board Assurance Framework.pdf	99	Associate Director of Governance	11:35
13	Nursing Establishment Review For approval 13. Nursing Establishment Review.pdf	129	Chief Nurse	11:40
14	Quality Account For information 14. Quality Account 2020-21.pdf	151	Chief Nurse	11:45
15	Learning from Deaths Report For discussion 15. Learning from Deaths Report.pdf	259	Deputy Medical Director	11:50

#	Description	Owner	Time
16	Nursing and Midwifery Strategy Annual Review For discussion 16. Nursing, Midwifery and Allied Health Profession... 285	Chief Nurse	12:00
17	Safeguarding Annual Report For approval Note: Website version to follow 17. Safeguarding Annual Report.pdf -	Director of Nursing	
18	Health and Safety Annual Report For approval Note: Website version to follow 18. Health and Safety Annual Report.pdf -	Director of Estates and Facilities	
19	R&D Annual Report For discussion 19. ENHT Research Annual Report 2020-21.pdf 323	Deputy Medical Director	
20	Sub-Committee Reports		12:20
20.1	Finance, Performance and People Committee Report to Board For information 20.1 a) FPPC Board Report 26 May 2021.pdf 339 20.1 b) FPPC Board Report 30 June 2021.pdf 343	Chair of FPPC	
20.2	Strategy Committee Report to Board For information 20.2 Strategy Committee Report 22 June 2021.pdf 347	Chair of Strategy Committee	
20.3	Quality and Safety Committee Reports to Board (to follow) For information 20.3 a) QSC Board Report 25 May.pdf 351 20.3 b) QSC Board Report 29 June.pdf 355	Chair of QSC	

#	Description	Owner	Time
20.3.1	**IPC Report** For information [P] 20.3.1 IPC Report.pdf 359	Chief Nurse	
20.4	**Audit Committee Report to Board** For information [P] 20.4 AC Report to Board 4 June 2021.pdf 381	Chair of Audit Committee	
20.5	**Charity Trustee Committee Report to Board** For information [P] 20.5 CTC Report to Board 7 June 2021.pdf 385	Chair of CTC	
20.6	**Equality and Inclusion Committee** For information [P] 20.6 EIC Report to Board 18 May 2021.pdf 389	Chair of EIC	
20.6.1	**Appendix A - Equality and Inclusion Committee Terms of Reference** For approval [P] 20.6.1 Appendix A - EIC Terms of Reference - July... 393	Chief People Officer and Chair of EIC	
21	**Actions Log** For information [P] 21. Public Trust Board Actions Log.pdf 397	Trust Secretary	
22	**Annual Cycle** For information [P] 22. Board Annual Cycle 2021-22.pdf 399	Trust Secretary	
23	**Data Pack** For information [P] 23. Data Pack.pdf 403		
24	**Date of next meeting** 1 September 2021		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 5 May 2021 at 10.00am at the Lister Hospital, Stevenage & via Microsoft Teams Video Conferencing

Present:	Mrs Ellen Schroder	Non-Executive Director (Trust Chair)
	Mrs Karen McConnell	Non-Executive Director
	Dr Peter Carter	Non-Executive Director (via conference call)
	Mr Jonathan Silver	Non-Executive Director
	Dr David Buckle	Non-Executive Director (Associate) (via conference-call)
	Ms Val Moore	Non-Executive Director (via conference call)
	Mr Bob Niven	Non-Executive Director (via conference call)
	Mr Biraj Parmar	Non-Executive Director
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance and Deputy Chief Executive
	Dr Michael Chilvers	Medical Director (via conference call)
	Mrs Rachael Corser	Chief Nurse (via conference call)
	Mrs Julie Smith	Chief Operating Officer (via conference call)
From the Trust:	Mrs Sarah Brierley	Director of Strategy (via conference call)
	Mr Tom Pounds	Interim Chief People Officer (via conference call)
	Mr Joseph Maggs	Trust Secretary (via conference call)
	Ms Jude Archer	Associate Director of Governance (via conference call)
	Mr Mark Stanton	Chief Information Officer (via conference call)
Also in attendance (via conference call):		
	Catherin Boaden	Due to join ENHT in June
	Deborah Price	
	Eilidh Murray	Head of Communications (ENHT)
	Steve Palmer	Healthwatch Herts
	Jenny Newsom	
	Nicole Goetze	Member of public
	Linda Sheridan	Chair of Herts Community Trust
	Rose Bedford	Consultant Midwife (ENHT)

21/025 CHAIRS OPENING REMARKS

21/025.1 Mrs Schroder welcomed everyone to the meeting. She also welcomed Biraj Parmar to his first meeting as Associate Non-Executive Director and congratulated Tom Pounds on his recent appointment to the role of Chief People Officer.

21/026 APOLOGIES FOR ABSENCE

21/026.1 There were no apologies for absence.

21/027 DECLARATIONS OF INTEREST

21/027.1 The Director of Strategy declared that she was undertaking a joint

role as Director of Strategy for both East and North Hertfordshire NHS Trust and Hertfordshire Community NHS Trust.

21/028 QUESTIONS FROM THE PUBLIC

21/028.1 There were no questions submitted from members of the public.

21/029 MINUTES OF PREVIOUS MEETINGS

21/029.1 The minutes of the previous meeting were approved as an accurate record of the meeting.

21/030 PATIENT STORY

21/006.1 The Consultant Midwife introduced the patient story which was in the form of a video recording. The recording related to Ms A. whom had given birth at Lister hospital and spoke about her experiences. She reported that there had been some complications associated with the birth but thanks to the expertise of staff, the outcome was ultimately a positive one and she was pleased to report that she now had a happy and healthy child. She was very grateful to the Trust's maternity team for the caring service they had provided and explained that she was intending to pursue a career as a midwife as a result of her experience.

21/006.2 Mrs Schroder thanked Ms A. for taking the time to submit the video recounting her experiences and she was pleased with the service the Trust had provided. She added that whilst it was important for the Board to hear from patients' experiences where improvement was needed, it was also pleasing to hear one of the many examples of good service provided by Trust staff.

21/031 CHIEF EXECUTIVE'S REPORT

21/031.1 The Chief Executive highlighted the following points from his report:

- The number of Covid patients the Trust was seeing had reduced considerably
- ED attendances were now returning to a more normal level
- The Trust was undertaking work to restore services and increase activity levels in other areas, in order to as a minimum meet the targets that had been set nationally.
- The Trust's 2021 AGM would take place in the same format as last year, with an online event on 30 June.
- The Trust was in the process of establishing an Equality and Inclusion Committee, to be chaired by Biraj Parmar. The new committee would be a formal subcommittee of the Board and the terms of reference would be considered for approval at the next meeting.

The Chief Executive's summary of the Integrated Performance Report is detailed below.

21/032 INTEGRATED PERFORMANCE REPORT

21/032.1 The Chief Executive presented a summary of some of the key aspects of the M12 Integrated Performance Report:

- Albeit in the context of an unusual financial framework, the

Trust had finished the year in a positive position financially with a surplus of £2.5m.

- The Trust had continued to maintain a good performance in terms of the key mortality metrics. The impact of the Covid period on mortality would continue to be monitored as more data became available.
- As the pandemic eased, performance against the A&E target had improved (the Trust's performance was 85.2% compared with a national position of 86.1%)
- The Trust's performance against cancer waiting time targets had remained resilient, which reflected the Trust's actions to prioritise cancer related activity during the challenges of Covid.
- It was recognised that there had been growth in terms of the number of patients waiting longer for treatment and the Trust was working hard to rapidly restore the level of planned activity.

21/032.2 Mrs Schroder emphasised the scale of capital investment in facilities that had taken place across the year. She also commented that the excellent mortality performance and historically low vacancy rates were noteworthy.

21/032.3 Mr Niven asked about the possibility of experiencing a surge in patient demand, Covid or otherwise, later in the year. The Chief Executive advised that modelling over the Covid period had posed challenges but the Trust would be prepared for the possibility of further surges.

21/032.4 Mr Niven also noted that next week was the NHS's annual Equality, Diversity and Human Rights Week and suggested that this could be a good opportunity to publicise the role of the new Equality and Inclusion Committee.

21/032.5 Ms Moore noted that the number of complaints had been increasing and asked if there were any particular themes the Board ought to be aware of. The Chief Executive commented he was encouraged that people felt able to raise complaints and additionally some increase in complaints was unfortunately expected given the abnormal period patients had experienced. The Chief Nurse agreed with these points and noted that the complexity of complaints was also increasing. She advised that the complaints team was being strengthened in terms of capacity and reassured the Board that making improvements in this area remained a focus for the Trust.

21/032.6 Mrs Schroder asked about the profile of staff sickness in March. The Chief People Officer advised that the profile had changed from January and February when Covid accounted for a much greater proportion of staff sickness rates. Shielding staff had now been brought back into the Trust as appropriate, following the official pausing of the national guidance regarding shielding.

21/033 SYSTEM COLLABORATION UPDATE

21/033.1 The Board received an update regarding system collaboration. The Director of Strategy explained that the strategic context had developed considerably over the last 18 months and the paper

detailed the different areas that the Trust was currently collaborating on. She also highlighted the work that the Chief Operating Officer and Chief Nurse were involved in that was looking at how the Trust might adopt some of the models of care that were put in place during the pandemic, in particular virtual models of care.

21/033.2 Mrs Schroder welcomed the paper and the oversight of both horizontal and vertical collaboration.

21/033.3 Mrs McConnell asked how the Board could receive assurance on the collaborations that are proving most effective to identify the areas where additional emphasis would be beneficial. The Director of Strategy said this would be the next area of focus and the Trust's strategy refresh would also support this.

21/033.4 Mr Niven added that it would be useful for the Board to be clear on the outcomes that it was looking for from the collaborative projects. He also asked about the balance between old ways of working and new. The Director of Strategy responded that proactive consideration of the possibility of an external approach for work that would previously been done internally was a key step. One of the challenges was the number and range of forums being put in place to support the collaborative working, but this was not unique to this area.

21/033.5 The Chief Operating Officer commented that effective partnership working would be essential as community and other colleagues could support the resolution of issues that the Trust may not be able to overcome on its own.

21/033.6 The Chief Executive offered the view that collaborative working with partners was not new and the relationships with those partners had been key during the Covid pandemic. The difference was the framework in which the work was being undertaken and directed and it was important that this would build on the forums and relationships that were already in place.

21/033.7 Mrs Schroder concluded that this was a topic the Board was likely to spend an increasing amount of time on, as well as at its subcommittees. The governance of patient pathways was also an element that would need to be sufficiently covered.

21/034 OPERATING PRIORITIES, PLANNING RESPONSE AND PEOPLE RECOVERY

21/034.1 The Chief Operating Officer presented a paper detailing the operating priorities and planning response for 2021/22. The Trust's operating priorities for 2021/22 were:

A. Maintain provision of urgent and emergency services – ED capital build
B. Recover cancer and planned care services – meeting/exceeding targets
C. Respond to Covid demand – use of 'flatpack' method
D. Staff recovery; well-being; recruitment and retention
E. Bed plan aligned with demand
F. Capital refurbishment tower infrastructure and environment
G. Winter plan

H. Develop integrated pathway solutions across the system

21/034.2 The Chief Operating Officer confirmed that the Trust's priorities were designed to fit with the national planning guidelines and its own people recovery work. She provided an overview of the detail behind the priorities. Bed modelling had been undertaken to underpin the priorities in terms of activity and included plans for bed alternative initiatives.

21/034.3 It was highlighted that a priority for 21/22 would be ward refurbishment which had been factored into the bed plan.

21/034.4 The Trust was working with ICP colleagues to respond to the planning priorities, with final submission due by 3 June. The draft submission had been made. Key themes of the guidance included staff wellbeing, health inequalities and system working.

21/034.5 The Chief People Officer followed with a presentation regarding recovery of the Trust's people. The paper included the background to the position, reiterating the emphasis that the Trust Board has placed on providing the best possible support for Trust staff since the start of the pandemic. In response, a 'care support pyramid' had been developed which demonstrated the strategic approach to health and wellbeing. The pyramid covered the following from bottom to top:

- Hygiene factors
- Health leadership
- Self-care
- Referral and interventions
- Specialist care referrals

21/034.6 The Chief People Officer described to the Board the types of support available to staff under each category. This included work to develop leadership capabilities and the implementation of a series of debriefing sessions. He also noted the approach in terms of supporting annual leave uptake and managing the vacancy rate to support any further pressures.

21/034.7 Ms Moore asked about opportunities for integrated pathways to help with addressing falls. The Chief Operating Officer and Chief Nurse agreed there would be challenges and opportunities arising from a greater ambulatory care approach. The impacts would be closely monitored.

21/034.8 Ms Moore asked about uptake of the vaccine among BAME staff groups. The Chief People Officer explained the Trust had experienced a similar uptake as had been the case nationally. Lower uptake among certain staff groups was an issue the Trust would continue to work on. Mr Parmar encouraged the Trust to embrace the national and local resources available in relation to vaccine uptake.

21/034.9 In response to a question from Mr Silver, the Chief Operating Officer provided an update on plans to improve the discharge process. A deep dive was also scheduled for FPPC.

21/034.10 Mr Silver also asked about the balance between medical and surgical wards. The Chief Operating Officer advised this had been

considered in the modelling and work to improve length of stay would also help to reduce outliers.

21/034.11 Mrs McConnell asked about the development of the programme to support patients on the waiting list. The Chief Operating Officer confirmed this was being explored and there was the potential for greater working with system partners, including primary care, in this area. She also confirmed that the waiting lists would be risk stratified based on clinical need.

21/034.12 Regarding the workforce, Dr Carter commented that from his recent observations, staff morale seemed high.

21/034.13 Mrs Schroder said she was hopeful that greater numbers of staff would take advantage of the support that was available but asked the Chief People Officer to ensure this was closely monitored. The Chief People Officer agreed there were elements that could be facilitated more effectively and the programme would adapt based on the learning as it progressed. Mr Niven suggested diversity of background of the facilitators may also help attract different staff groups to attend the sessions.

21/034.14 Mr Niven asked what indicators were available to the Board to monitor success in terms of staff support. The Chief People Officer explained there were a few indicators available, a key one being the sickness absence rate which was the lowest in the region for March.

21/035 BOARD ASSURANCE FRAMEWORK AND RISK MANAGEMENT STRATEGY REVIEW

21/035.1 The Board received the latest edition of the BAF. The process of reviewing and updating the priorities for 2021/22 was now underway and was due to be completed by the time of the next meeting. The items discussed by the Board continued to align with the risks articulated on the BAF.

21/035.2 The BAF had been reviewed by the internal auditors who had concluded a view of substantial assurance. Their feedback would also be taken into consideration in relation to the annual review. The impact of the introduction of the Equality and Inclusion Committee would also be reflected.

21/035.3 The risk relating to pandemics had now been reduced from a score of 20 to 15. This was to reflect the effective ongoing management of the pandemic that was now in place.

21/035.4 Two risks had remained at 20 throughout the last year; both of these risks were being reviewed going into 2021/22. Mrs Schroder welcomed the progress in reducing a number of the BAF risks and agreed that it was appropriate to review the scoring of the two risks currently rated at 20.

21/035.5 Regarding the review of the Risk Management Strategy, it was noted that a light touch review had taken place on this occasion with the intention being to undertake a more thorough review next year once the Trust's strategy refresh had concluded. Nonetheless, the review had taken into account new structures and other good practice

updates that had emerged.

21/035.6 The Board endorsed the revised strategy.

21/036 LEARNING FROM DEATHS REPORT

21/036.1 The Medical Director presented the latest Learning from Deaths Report. The main mortality metrics (HSMR, SHMI and crude mortality) were continued to paint a broadly positive picture. The Medical Director explained that mortality metrics provided an indication of the overall level of care.

21/036.2 The Medical Director highlighted certain specialities that were being more closely monitored in relation to mortality data.

21/036.3 The report also provided some initial data related to Covid patient deaths up to the point of the report. As at the time of the report, the Trust had sadly recorded 509 patient deaths. It was expected that further data from CHKS in relation to wave 2 would be available in the next update.

21/036.4 The Trust's non-Covid mortality deaths appeared to be broadly in line with the national picture.

21/036.5 It was reported that the Trust had restarted the mortality review process following a pause due to the Covid pandemic.

21/036.6 Dr Buckle agreed that low mortality rates were an indicator of good clinical care. He asked how the Medical Director would ensure that the Trust would maintain the good position. The Medical Director responded that positively engaged staff was the crucial first step, supported by an effective programme to identify areas for improvement.

21/036.7 The Medical Director also informed the Board of analysis and learning arising in relation to outcomes for patients with Learning Disabilities.

21/037 IPC REPORT

21/037.1 The Chief Nurse presented the latest IPC report. There were currently no ongoing Covid outbreaks, the last of which had concluded in March. The report detailed that one case of hospital acquired Covid had been reported for March.

21/037.2 Regarding other IPC metrics, it was confirmed that there had been 0 cases of MRSA recorded last year and there remained a focus on improving SSI rates, with a deep dive planned for a future QSC meeting.

21/037.3 Mrs Schroder congratulated the IPC team on their work over the course of an extremely challenging year.

21/037.4 Dr Carter added that the Trust's recent IPC focus day had been very impressive.

21/038 ANNUAL REPORT AND ACCOUNTS – PROPOSAL FOR APPROVAL PROCESS

21/038.1 The Trust Board approved the formal delegation of approval of the Trust's Annual Report and Accounts for 2020/21 to the Audit Committee.

SUBCOMMITTEE REPORTS:

21/039 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

21/039.1 The Board received and noted the summary reports from the last two meetings of the Finance, Performance and People Committee, held on 31 March and 28 April 2021.

21/039.2 Referring to the meetings, Mrs McConnell highlighted the presentations received from the Chief Operating Officer's team regarding cancer performance and sustainability, SDEC front door ambulatory solutions, theatres and outpatient transformation. She also highlighted the role the FPPC had played in ensuring the additional capital available to the Trust during 2020/21 had been spent effectively.

21/040 STRATEGY COMMITTEE REPORT TO BOARD

21/040.1 The Board received and noted the summary report from the Strategy Committee meeting held on 20 April 2021.

21/041 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

21/042.1 The Board received and noted the summary reports from the last two meetings of the Quality and Safety Committee, held on 30 March and 27 April 2021.

21/042 AUDIT COMMITTEE REPORT TO BOARD

21/042.1 The Board received and noted the summary report of the last meeting of the Audit Committee held on 24 March 2021.

21/043 CHARITY TRUSTEE COMMITTEE REPORT

21/043.1 The Board received and noted the summary report of the last meeting of the Charity Trustee Committee held on 8 March 2021.

21/043.2 Mr Niven highlighted the applications for charitable funding that had been considered by the Committee, including in relation to thank you initiatives and events for staff. He also highlighted the significant amount received by the Charity in donations and gifts in kind over 2020/21.

21/044 ACTION LOGS

21/044.1 The Board noted the latest version of the Actions Log.

21/044.2 The Trust Secretary informed the Board that in accordance with the Trust's Standing Orders an urgent decision had been taken since the

previous meeting to award the contract for domestic services.

21/045 ANNUAL CYCLE

21/045.1 The Board noted the latest version of the Annual Cycle.

21/046 DATA PACK

21/046.1 The Board noted the content of the Data Pack.

21/047 DATE OF NEXT MEETING

21/047.1 The next meeting of the Trust Board will be on 7 July 2021.

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Ellen Schroder
Trust Chair

July 2021

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

July 2021

Covid-19 Update

The Covid-19 pandemic NHS alert level was reduced to level 3 in May recognising that the epidemic remains 'in general circulation'. The NHS incident level was changed to level 3 in March meaning that the NHS response to the pandemic is co-ordinated at a regional level by NHS England rather than a national level. We continue to monitor and review all national guidance and directives regarding the pandemic and take action as necessary. The Trust currently has 3 Covid-19 positive patients (and a further 5 with suspected Covid-19).

We are continuing to support our staff through the pandemic. We have a comprehensive staff wellbeing programme in place with multiple strands of support available. In addition, all staff have access to twice-weekly Lateral Flow Testing (LFT) and staff at Mount Vernon undertake weekly PCR tests. This enables the Trust to detect asymptomatic positive staff and to mitigate further spread of Covid-19.

We have carried out people and place based risk assessments and put in place measures to mitigate the risks including social distancing and amended visiting arrangements. In addition we have a set of 'flat-pack' Covid-19 escalation plans ready for use if required. Triggers have been identified for 'unpacking' these plans should surge capacity be required in response to future waves of Covid-19. The plans relate to critical care capacity, Covid-19 ward capacity and the redeployment of staff. We are working closely with system partners to ensure a joined up response.

Service Restoration

Our recovery programme continues to progress well for both elective and non-elective activity. Covid-19 has, unfortunately, led to an increase in both waiting times and the number of people waiting but we are working hard to increase our capacity in response. There is a balanced risk stratified approach to patient prioritisation that considers both the clinical priority and the length of time the patient has waited. We are taking a collaborative approach to recovery, working closely with system partners in a number of different ways including through the Planned Care Recovery Board for Herts and West Essex.

East and North Herts provided high quality responsive cancer services to those who need them. As a result we have, over the last year, seen an improvement in our performance. 86% of people waited no more than 62 days from receipt of referral from their GP to the start of treatment and 97% of suspected cancer referrals were seen within 2 weeks. That said, we are not complacent, and are continuing to focus on earlier diagnosis, better patient outcomes and further improvements in performance.

We recognise the great importance of supporting our staff to recover and have put in a range of support measures including free complimentary therapies for staff. Feedback has been extremely positive with staff reporting reduced stress as a direct result. In addition we are running Schwartz Rounds, a multidisciplinary forum designed for staff to come together once

a month to discuss and reflect on the emotional and social challenges associated with working in healthcare. Schwartz Rounds provide a confidential space to reflect and share experiences.

AGM

Once again, the Trust held a virtual AGM week – a week of webinars for staff, stakeholders, members, and the public – with the formal AGM held on 30 June.

Almost 400 have watched the formal AGM, and almost 300 people have watched the other 5 webinars. Initial analysis of the data suggests that a bigger proportion of our audience was made up of members of the public than last year, and feedback has been very positive about the week.

This week, beginning 5 July, is the Trust's thank you week – hopefully going some way to show gratitude to our staff for their hard work, compassion and commitment over the last 18 months. The week includes tea and cake on 5 July for the NHS birthday, a livestreamed memorial event, food and ice cream vans at all of our sites, and a wellbeing day at the Lister.

East and North Hertfordshire NHS
NHS Trust

IPR Chief Executives Summary

Sustainable Services

- At month 2 the Trust reports a small surplus of £0.2m
- Performance against elective performance target which is incentivised by the Elective Recovery Fund has been strong.
- Improved recruitment and reduced turnover will necessitate careful management of future recruitment and temporary staff resource.

Effective Services

- The Trust's HSMR remains in the best performing quartile and Trust's SHIMI is lower than expected.
- CHKS analysis shows that the Trust's Covid 19 mortality is centrally placed in comparison to both peers and the national position.

Responsive Services

- The Trust's performance against the cancers standards remains strong, with 6 out of 8 national targets being achieved.
- The number of patients waiting over 52 weeks has reduced to 2,791, with patients continuing to be treated in accordance with national guidance on prioritisation.
- Stroke performance remains challenged and is being monitored by the FPPC.
- A&E performance slightly improved to 84% despite an 8% increase in attendances.

Well Led

- The Trust's overall vacancy rate remains low at 5.7% and 2.7% for nursing.
- The increased availability of substantive staff has helped reduce temporary staffing hours worked.
- Statutory and mandatory compliance has dropped slightly to 84.4%. The introduction of the ENH academy is designed to improve compliance.

- A staff vaccination rate of 89% has helped keep Covid 19 absence low.

Safe & Caring Services

There are 32 open serious incident (SI) investigations, with 9 new SIs declared this month.

Clustering learning from our serious incidents has commenced, with the rapid post incident 'round table' learning review in place. The process for ensuring all hospital onset Covid infections are reported and investigated has commenced and will contribute to the increase in numbers of SIs reported this month and the coming months.

There has been a positive improvement in the sample size of sepsis audits as we are collecting more data on more patients. For inpatients a slight improvement towards our trajectory of 95% against all of the sepsis six bundle aspects. The two areas for improvement and focus are prompting taking lactate and blood cultures.

Focus for sepsis improvement in ED are on urine output and fluid balance.

The number of Covid infections remains low in month with no hospital onset Covid reported. The number of c-difficile infections has reduced in May with a total year to date being eight.

East and North Hertfordshire NHS Trust

Agenda Item: 8

TRUST BOARD – 7 JULY 2021
Integrated Performance Report – Month 2

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report Month 2 to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: QSC and FPPC, 29 and 30 June 2021		
Director: All Directors	**Presented by:** Chief Executive	**Author:** All Directors / Head of Information and Business Intelligence

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

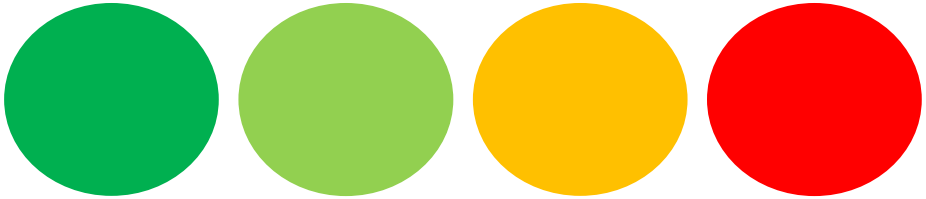
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 02 | 2021-22



Data correct as at 25/06/2021

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	Monthly	Apr-21	Local	1.9	0.4	
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)	Dec-20 - May-21	National	0	2	58 days since last Never Event (at 25-Jun)
Safe	Patient Safety Alerts not completed by deadline	Monthly	May-21	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	May-21	National	0	no submission	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	May-21	Local	95.0%	96.8%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	May-21	Local	90.0%	90.1%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	May-21	Local	93.0%	83.3%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	May-21	Local	93.0%	97.3%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	May-21	Local	93.0%	98.2%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	May-21	Local	93.0%	92.3%	
Safe	Emergency c-section rate	Monthly	Apr-21	Local	15%	14.5%	
Organisational health	CQC inpatient survey	Annual	2019	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q3 2019-20	National	95%	88.1%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	May-21	NHSI	52	8	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Jun 20 - May 21	National	21.40	23.50	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Jun 20 - May 21	National	0.75	0.00	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	Monthly (12-month rolling)	Jun 20 - May 21	National	9.20	9.12	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Monthly (12-month rolling)	Jun 20 - May 21	National	10.10	11.50	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Apr 20 - Mar 21	National	100	82.6	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Jan 20 - Dec-20	National	100	86.7	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	Sep 20 - Feb-21	National	16.98%	18.00%	

Finance

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

Operational performance

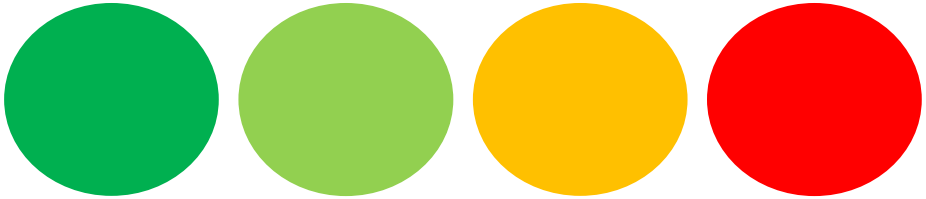
A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	May-21	National	95%	82.79%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	May-21	National	92%	59.43%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Apr-21	National	85%	87.36%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Apr-21	National	90%	64.29%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	May-21	National	1%	30.52%	
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%	in progress	
	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	Apr-21	Local	3.8%	4.23%	
Organisational health	Staff turnover	Monthly	Apr-21	Local	12.0%	12.2%	
Organisational health	Proportion of temporary staff	Monthly	Apr-21	Local	-	11.1%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2019	National	63.3%	58.1%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2019	National	20.9%	22.5%	
Organisational health	NHS Staff Survey Teamwork	Annual	2019	National	65.5%	66.2%	
Organisational health	NHS Staff Survey Inclusion	Annual	2019	National	87.8%	86.7%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2019	National	7.4%	0.0%	

Quality & Safety

Month 02 | 2021-22



Key Issues

Serious Incidents

- There are 32 open serious incident (SI) investigations, with 9 new SIs declared this month.

Infection Control

- The number of covid infections remains low in month with no hospital onset covid reported.
- The number of c-difficile infections has reduced in May with a total year to date being eight.

Sepsis screening

- Four out of six sepsis bundle measures are showing improvement whilst blood cultures and intravenous antibiotics have deteriorated in month.
- ED overall sepsis compliance is showing normal variation.

Venous Thrombo-embolis

- Step one VTE risk assessment is at 80% and step two (within 48 hours of admission) is at 45%.

Complaints

- The number of new complaints opened in month shows normal variation, with the trust achieving the target of acknowledging complaints within three days.
- The final response to complaints has deteriorated in month.

Executive Response

Serious Incidents

- Clustering learning from our serious incidents has commenced, with the rapid post incident 'round table' learning review in place.
- The process for ensuring all hospital onset covid infections are reported and investigated has commenced and will contribute to the increase in numbers of SIs reported this month and the coming months.

Infection Control

- The numbers of c-difficile cases has increased.
- Local reviews are underway to ensure prompt identification of any potential key learning.
- The new cleaning standards are being worked through with our new cleaning partner, Mitie.

Sepsis

- There has been a positive improvement in the sample size of sepsis audits as we are collecting more data on more patients.
- For inpatients a slight improvement towards our trajectory of 95% against all of the sepsis six bundle aspects.
- The two areas for improvement and focus are prompting taking lactate and blood cultures.
- Focus for sepsis improvement in ED are on urine output and fluid balance.

VTE

- VTE risk assessment has been focused on a junior doctor and clinical director training programme.
- Digital and Nervecentre flags are being scoped to assist in the tracking of real time VTE compliance.

Complaints

- There is a trajectory in place with the divisional and corporate teams to ensure final response to complaints remains a priority.

Quality and Safety

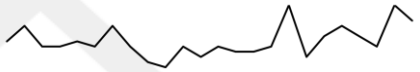
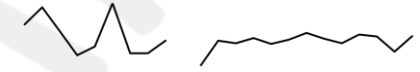
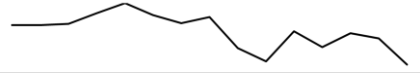
East and North Hertfordshire NHS Trust

Summary

Please refer to the full Quality and Safety Report for M02 2021-22 for full details and narrative about these outliers and other Quality and Safety metrics.

Key

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

Domain	Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Safe Services	SIs	Serious incidents	May-21	5	9	▼		9 SIs in-month, higher than the 2019-20 monthly average (5)
	IPC	Hospital-acquired c.difficile	May-21	n/a	3	◀▶		3 hospital-acquired c.diff. in-month
	Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	May-21	95%	72%	▲		Trust performance (72%) below national target (95%)
		Inpatients Sepsis Six bundle compliance	May-21	95%	38%	▲		Trust performance (38%) below national target (95%)
		ED attendances receiving IVABs within 1-hour of red flag	May-21	95%	76%	◀▶		Trust performance (76%) below national target (95%)
		ED attendance Sepsis Six bundle compliance	May-21	95%	34%	◀▶		Trust performance (34%) below national target (95%)
	VTE	VTE risk assessment stage 1 completed	May-21	85%	79.6%	▼		Trust performance (79.6%) below national target (95%)
		VTE risk assessment for stage 2, 3 and / or 4	May-21	85%	45.6%	▼		Trust performance (45.6%) below national target (95%)
		TED stockings correctly prescribed and documentation of fitted	May-21	85%	58.2%	▼		Trust performance (58.2%) below national target (95%)

Quality and Safety

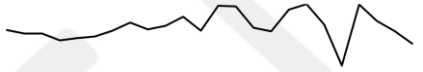
Summary

East and North Hertfordshire NHS Trust

Please refer to the full Quality and Safety Report for M02 2021-22 for full details and narrative about these outliers and other Quality and Safety metrics.

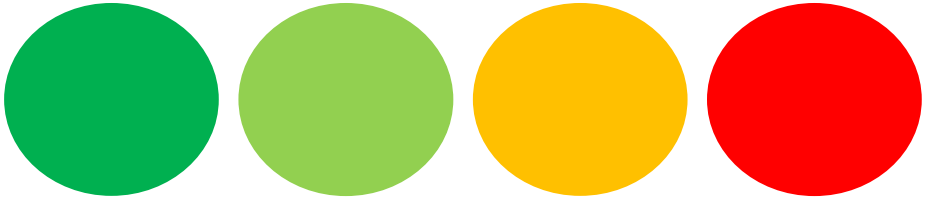
Key

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

Domain	Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Caring Services	FFT	Maternity FFT - Antenatal Positive recommendations	May-21	93%	83.3%	◀▶		Trust performance (83.3%) below Trust target (93%)
		Maternity FFT - Community Positive recommendations	May-21	93%	92.3%	◀▶		Trust performance (92.3%) below Trust target (93%)
		Outpatients FFT Positive recommendations	May-21	95%	94.1%	▼		Trust performance (94.1%) below Trust target (95%)
	Complaints	Proportion of complaints acknowledged within 3 working days	May-21	75%	89%	▼		Low special cause variation in-month
		Proportion of complaints responded to within agreed timeframe	May-21	80%	45%	▼		Trust performance (45%) below Trust target (80%); Low special cause variation

Effective Services

Month 02 | 2021-22



Key Issues

Crude Mortality
- The in-month crude mortality rate increased from 10.10 deaths per 1,000 admissions in April, to 11.84 in May.
- The rolling 12-months crude mortality rate has decreased to 14.62 deaths per 1,000 admissions in the 12 months to May, and is lower than the most recently available national rate of 17.74 deaths per 1,000 admissions (Apr -21 to Mar-21).

Hospital-Standardised Mortality Ratio
- The in-month HSMR has decreased from 88.22 in February to 84.94 in March.
- The rolling 12-months HSMR has decreased from 83.00 in the 12 months to February, to 82.59 in the 12 months to March.
- The Trust remains within the best performing quartile of Trusts for HSMR.
- HSMR is usually available 2 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to January continued to decrease to 86.70.
- This has remained in the 'lower than expected, Band 3' category.

Re-admissions
- The re-admission rate for 12 months to March has increased to 9.1% from 9.0% in the 12 months to February.

COVID-19
- To date CHKS analysis of our COVID-19 mortality has shown the Trust to be centrally placed in comparison to national and our PMO peer group.
- Most of the probable/definite hospital acquired COVID-19 cases which sadly resulted in a death where COVID-19 was on part I of the death certificate have now been reviewed and passed to the SI Panel for consideration. Outputs are awaited.
- In addition to routine reviews 2 areas have been identified for further assurance and learning on the back of the COVID -19 pandemic: (1) Review of COVID-19 patients who died on re-admission within 28 days; Shared with December Mortality Surveillance Committee, with agreement to review a 2nd wave batch of deaths. (2) Deaths in the Community (COVID -19/non COVID-19) within 28 days of discharge - initial findings did not indicate inappropriate discharges. June 2021 Mortality Surveillance Committee discussion of the latest coding review outputs for both cohorts of patients identified subsets of deaths where it was felt further learning may be identified via additional clinical review. Outputs will be report ed in due course.

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.
- We have accepted that the number of mortality reviews completed for 2020-21 deaths would be lower due to the pandemic. The final completion rate for 2020-21 deaths reviewed by 30 April 2021 was 54% (837 reviews).
- Work to integrate our mortality review process into the new Datix iCloud platform when this is implemented into the Trust continues.

Executive Response

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

Executive Response (continued)

Crude Mortality (continued)
- This measure is available the day after the month end. It is the factor with the most significant impact on HSMR.
- The general improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with Sepsis, Stroke, etc. together with a continued drive to improve the quality of our coding.
- Our crude mortality has steadily improved over recent years. In the second half of 2019 our rolling 12 month crude mortality rate was consistently better than the national average. While our in-month rate increased significantly in April 2020 at the start of the peak COVID-19 period, this steadily decreased returning to levels similar to pre-COVID-19 period, until January 2021, when it peaked again. While recent months have seen a steady increase in our rolling 12 month rate, it has remained below the national rate for the corresponding month.

Hospital Standardised Mortality Ratio (HSMR)
- Our current HSMR of 82.59 (rolling 12 months to February 2021) positions us in the best performing quartile of Trusts nationally (18/123 trusts). We remain focussed on driving further improvement.
- Following a number of outlier alerts within the Cardiology basket of diagnosis groups, a subsequent specialty review, outputs were presented to the Mortality Surveillance Committee in June. As a result a 6 month collaborative quality initiative has been agreed between coding/cardiology to ensure correct identification of MI deaths, with a re-audit and report.
- The NHFD has advised that we are a 3SD outlier for #NOF mortality for the Jan-Dec 2020 year. A detailed review has commenced and findings will be reported in due course.

Summary Hospital-level Mortality Indicator (SHMI)
- Following significant improvements in SHMI, there has now been a sustained period of stability. The latest figure of 86.7 (12 months to January 2021) sees the Trust positioned within the 'lower than expected' band 3 category. Our position relative to our national peers currently stands at 11th out of all acute non-specialist trusts (123).
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital.
- The fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, provides some assurance that our response to COVID-19 has not generally resulted in a disproportionate increase in deaths within 30 days of discharge.

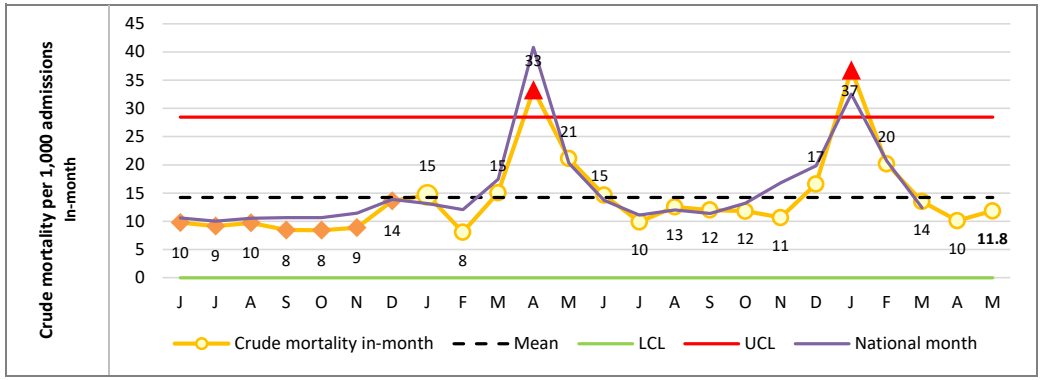
Re-admissions
- The Trust's re-admission rate has generally been consistent with the national performance. Significant dips in readmissions were seen in March and October 2020 while July and August saw the Trust's rate rise slightly above the national picture. Recent months have seen performance return to those seen pre-COVID-19, with the Trust tracking just below the national average. The significant changes in overall admissions and the change in case mix during this period make interpretation of this data challenging but the Trust's position will continue to be monitored.

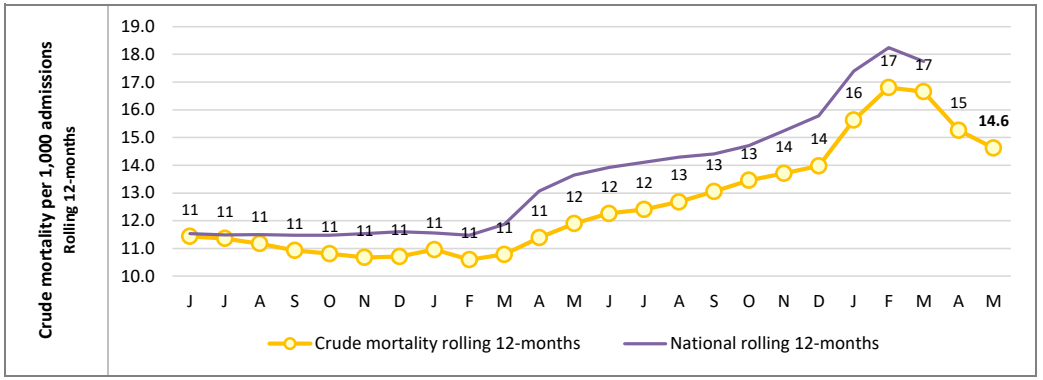
Learning from Deaths
- In addition to the outcomes of cases escalated to specialties being considered by the Mortality Surveillance Committee, the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with interested working groups such as Deteriorating Patient, End of Life and Seven Day Services Steering Group.
- While still firmly on the agenda, work with Business Informatics and the Head of Coding to gather appropriate data and set up reports to monitor, provide assurance regarding mortality data has slowed due to competing pressures. A dashboard on QlikView is now under development.

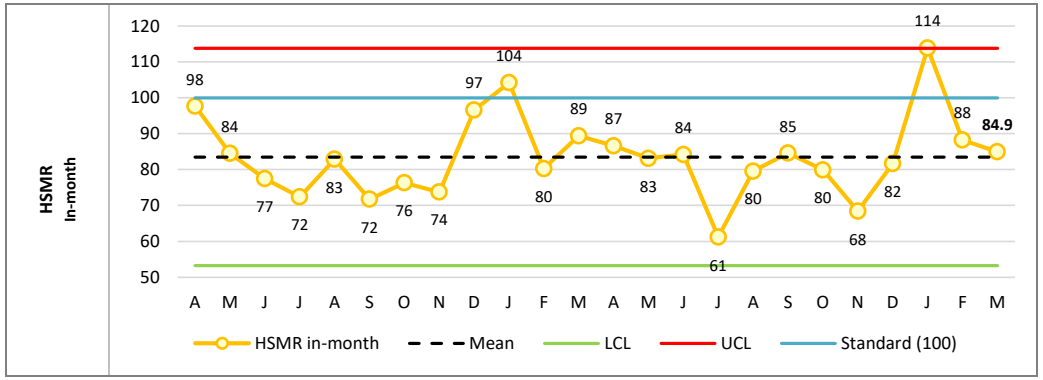
Specialist Palliative Care
- This data refers solely to patients under the care/review of the Palliative Care Team. Other data is available for deaths that are not known to the PCT. However, it resides in an access database and we are currently working through some data quality issues.

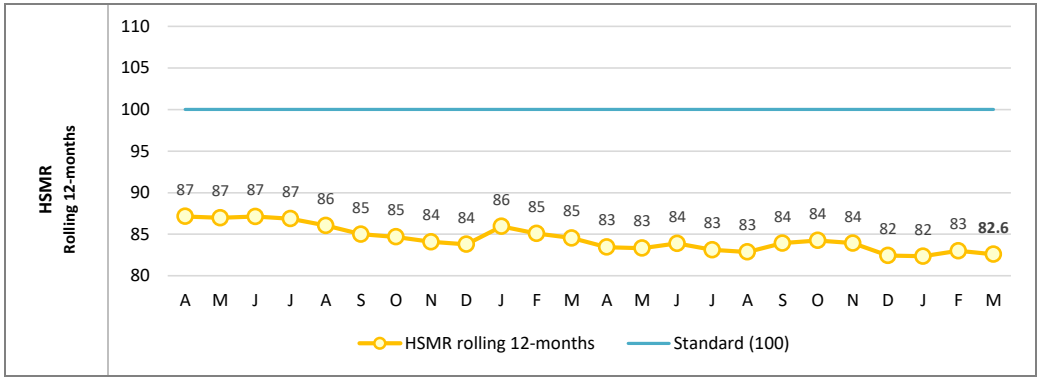
Effective Services

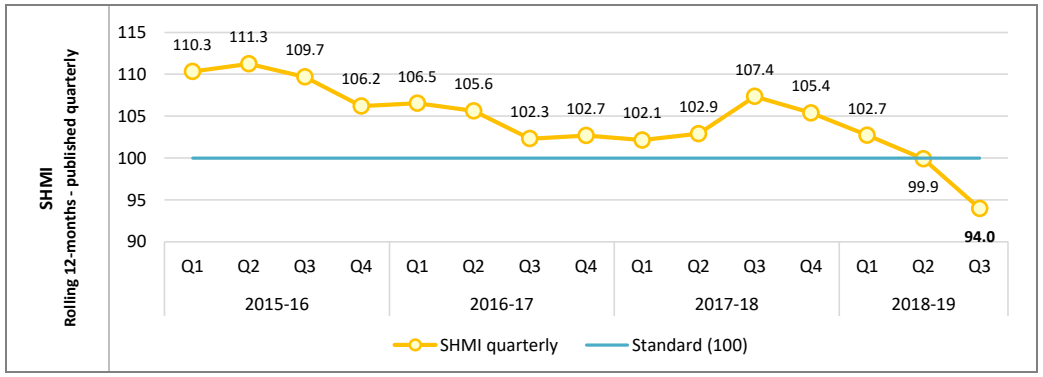
East and North Hertfordshire NHS Trust

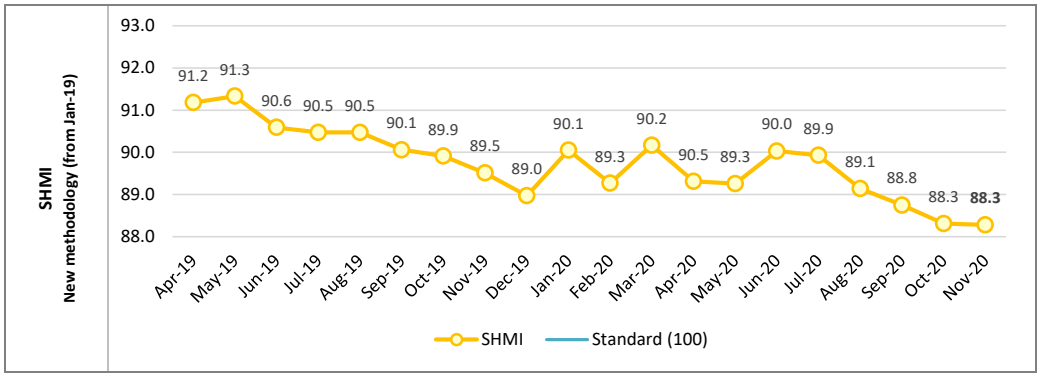


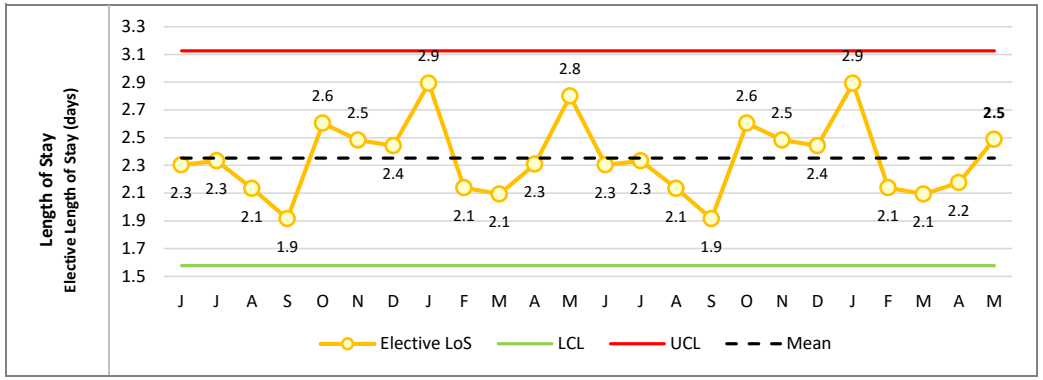


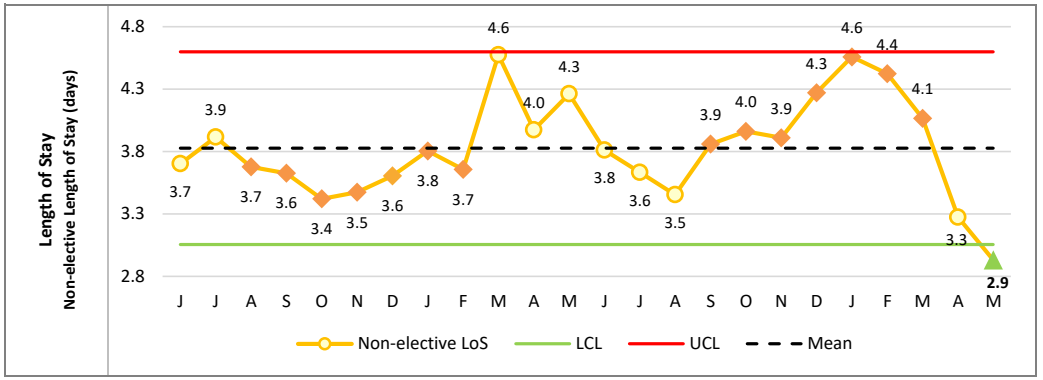


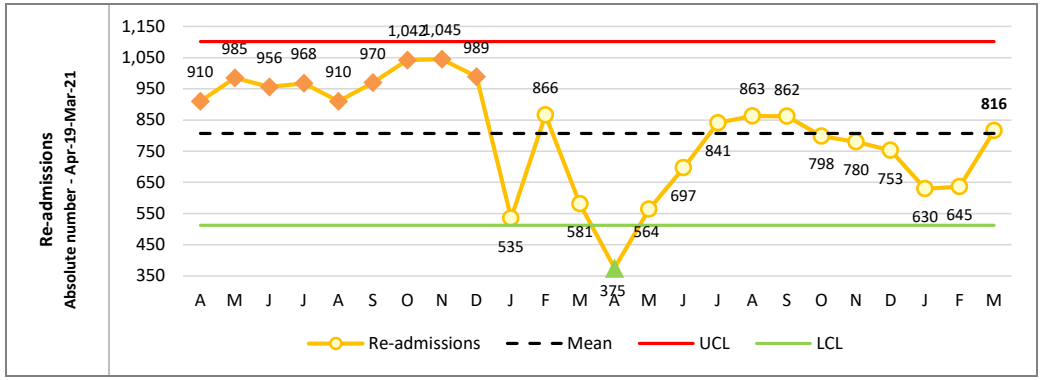


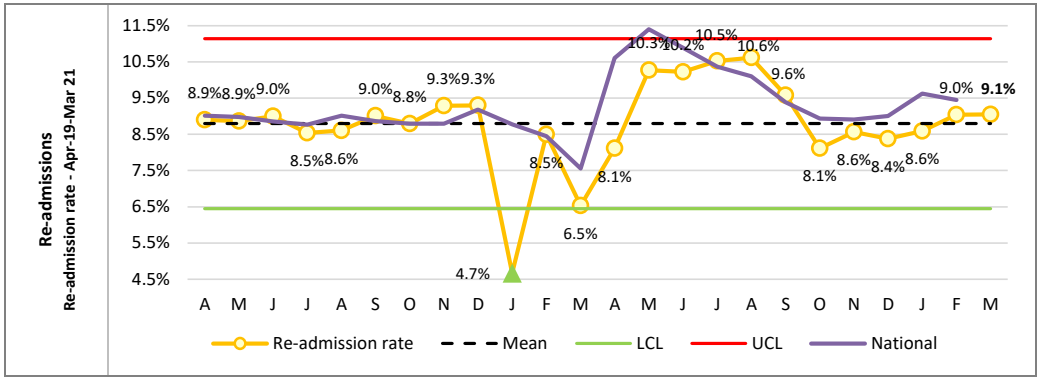


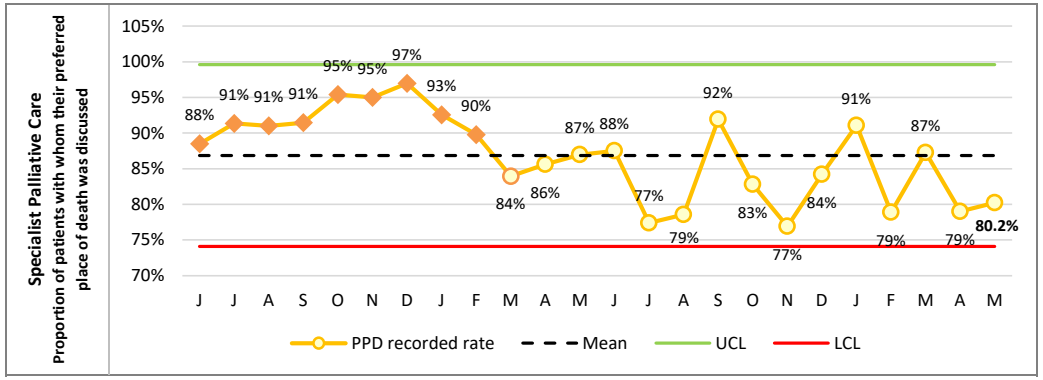


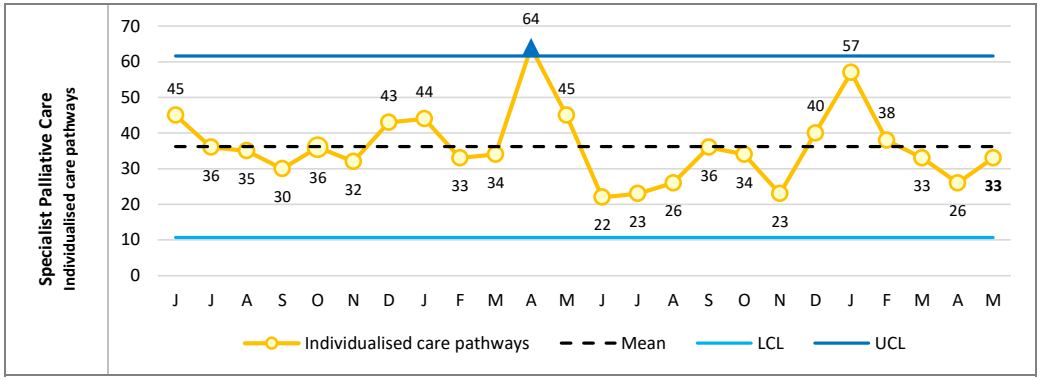

Length of Stay
Elective Length of Stay (days)
Elective LoS
LCL
UCL
Mean


Length of Stay
Non-elective Length of Stay (days)
Non-elective LoS
LCL
UCL
Mean


Re-admissions
Absolute number - Apr-19-Mar-21
Re-admissions
Mean
UCL
LCL

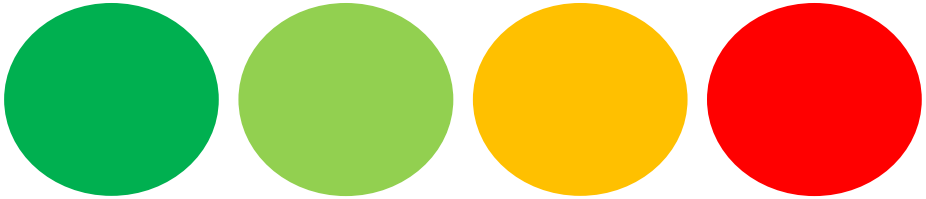

Re-admissions
Re-admission rate - Apr-19-Mar 21
Re-admission rate
Mean
LCL
UCL
National


Specialist Palliative Care
Proportion of patients with whom their preferred place of death was discussed
PPD recorded rate
Mean
UCL
LCL


Specialist Palliative Care
Individualised care pathways
Individualised care pathways
Mean
LCL
UCL

Responsive Services

Month 02 | 2021-22



Key Issues

A&E
- Performance for the month of May was 84.06%.
- There were zero 12-hour trolley waits reported in May.

Cancer Waiting Times
- The Trust achieved 6 out of the 8 national targets for cancer performance in April.
- The Trust 62-day performance for April was 91.12%.
- There were 4 pathways over 104 days for the 62-day standard and 4 pathways over 104 days for 62-day screening. Longest wait is 6.5 days for 62-day standard.
- Good progress continues on the speciality cancer action plans, all plans being reviewed and updated weekly.
- Robust weekly cancer PTL management is in place.

RTT
- Incomplete performance for April was 64.06%. This is an increase from the 59.43% reported in April.
- The May backlog was 18,006, a decrease of 2,426 from 20,432 in April.
- There were 2,791 52-week breaches reported in the May incomplete position, a decrease of 193 from the 2,984 reported in April.
- There were 53 patients waiting over 104 weeks: in March. The longest week wait is 1 patient at 196 weeks.

Diagnostics
- DM01 performance for May was 30.58% against the national standard of 1% and the April position of 30.52%.
- Latest National performance for April was 24.03%.

Stroke
- Stroke performance for May is 43.5%.
- Thrombolysis performance is at 3.2% in May.
- Door-to-needle performance decreased in May 0%, below the Trust target of 70% - based on 2 patients, both of which were due to clinical need and not eligible to administer treatment.
- CT 1-hour to scanning improved to 58.1% in May which is above the Trust target of 50%.

Executive Response

A&E
- A&E Performance slightly improved compared to the previous month despite an 8% increase in NEL attendances. Non admitted per formance remained above 90% however, admitted performance showed limited improvement. Time to triage showed a decline due to volumes of patients. However, we did increase access to Direct Assessment and Rapid Treatment by a senior clinical decision maker which is why despite delays at triage, assessments by senior clinical decision makers earlier maintained our non-admitted performance. Admitted performance failed to demonstrate improvement and remained at around 53%. The main contributory factor was staff escalation capacity due to staffing limitations. The conversion rate of attendance to admission remained relatively static.
- Although there was an increase in ambulance handovers above 30 minutes there was significant improvement on delays above 60 m inutes. This is despite increase of 6.5% in ambulance arrivals to ED.
- Key actions have and continue to be taken to respond to the increased pressure at the front door. The ED department have des igned a new streaming and redirection model, which has been used on 3 days throughout June between 12noon and 1700hrs. The model has pro ved successful and redirected up to 30% of activity to UTC, SDEC or the patients GP with a booked appointment. The ED leadership team are now developing a proposal to maintain this model consistently. The model is similar to what the new triage and streaming hub off ers from December 2021. As part of the UEC capital transformation project. Other improvements include the development of internal prof essional standards which are currently in the early draft stage. It is expected they will be signed off and implemented by early July.

Cancer Performance (April)
- In April 21, the Trust achieved 6 of the 8 national targets and 0 out of 3 -28-day FDS standards for Cancer performance: 2ww GP Referrals, 2ww Breast Symptoms, 31-day First Treatment, 31-day Subsequent for Radiotherapy and Chemotherapy, and 62-day urgent referral to treatment.

Executive Response (continued)

Cancer Performance (April) - continued
- 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 April 2021 the Trust performance was 96.8%.
- In April 2021, the Trust wide average days wait for first appointment is at 10 days and the majority of patients were seen between 8 and 12 days.
- The Trust has consistently delivered against the Breast Symptomatic national standard which requires 93% of patients referred to have attended the 1st Outpatient appointment within 14 days. For April2021, the Trust performance was 95.1%.
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy but not for the subsequent Surgery. For April2021 the Trust Chemotherapy performance was 100%, the Trust Radiotherapy performance was 99.3% and the Trust subsequent Surgery performance was 84.4%.
- The Trust performance for 31-day to first definitive treatment was 99.5%. The standard requires 96% of patients to receive treatment within 31 days of diagnosis.
- In April 2021, the Trust performance for the Faster Diagnosis is 74.2% for the 2ww patients, 74.2% for Breast Symptomatic and 25.8% for screening patients.
- Reported 62-day performance for April 2021 was pre-sharing 87.5% and post-sharing 91.1%.
- Cancer performance is available one month in arrears.

RTT
- In May performance improved but remains significantly below the required performance standard of 92%. The number of patients greater than 104 weeks has increased, however the number of patients over 52-weeks has decreased along with the overall PTL size.
- Treatment priority given to patient classified under the Royal College of Surgeons Guidelines (P1 – P6), then long waiters taking into consideration of patient's needs, such as Learning Disabilities. 98.4% of admitted patients are risk stratified against the Royal College guidelines.
- 17 theatres are operational on the Lister site, use of the private sector continues.
- Elective/Day case activity is at 87.5% 2019/20 levels.
- Outpatient activity is at 110% of 2019/20 levels.
- PTL management continues, reviewing and managing patients on our treatment lists.
- Recovery continues with the Trust exceeding the percentage required against the 2019/20 levels.
- Validation of waiting lists continues, with the correction of patient pathway if identified.

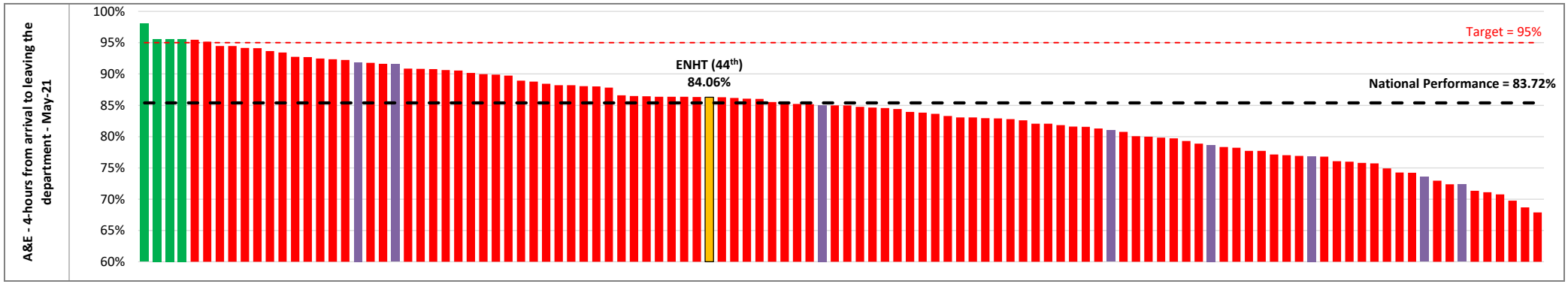
Diagnostics
- Performance improved in May, with the number of patients waiting over 6 and 13 weeks reducing.
- Diagnostics recovery is delivering 91.8% of 2019/20 activity
- Referrals/Demand remained as expected.
- Diagnostics relating to cancer remained consistent, with prioritisation of these patients, turnaround remains good.

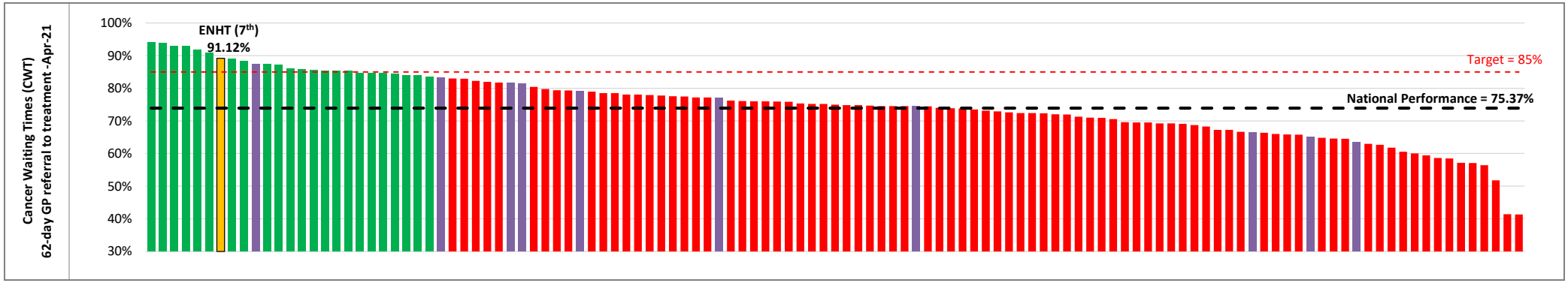
Stroke
- 4-hour performance is underperforming against the 63% target - May performance was 43.5%.
- Concerns are ongoing with the requirements of Stroke beds needing to be used for Medical patients to support Trust position and to ensure safety. This reduces the available capacity for Stroke bed and adherence to 4hr performance, impacting available bed capacity for the month of May, which resulted in 21% of the overall breach reasons.
- Impact on bed capacity to support IPC pathway, resulted in 15% of overall breaches.
- High number of breaches due to patient related and clinical need total of 10 (29%)- which would appear to collate with the current and ongoing pressure within ED demand.
- SNNAP rating performance reduction. Main contributing factors are: OT/PT non-compliance of establishment in-line with National Specification. A business case has been provided for approval to support levels to be compliant and therefore provide the necessary delivery of care in accordance with the SNNAP requirement.
- Door to Needle performance within 1hr is 0%. Impact is due to 2 x Clinical Need. We have raised the reporting issue within the Stroke Programme board, as the patient aren't clinical stable to administer the treatment, so 0% is reflective and reduce clinical risk.
- Thrombolysed rate is 3.2%, based on 2 pts in discharging month.
- In-month performance (on admission date) 4 patients of which 25% within 60mins.
- CT performance for 1hr improvement in performance at 58.1%.

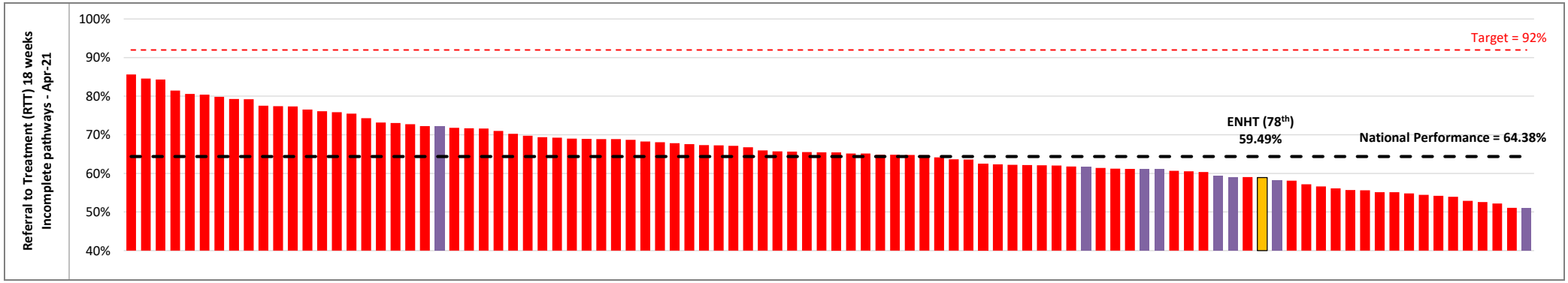
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



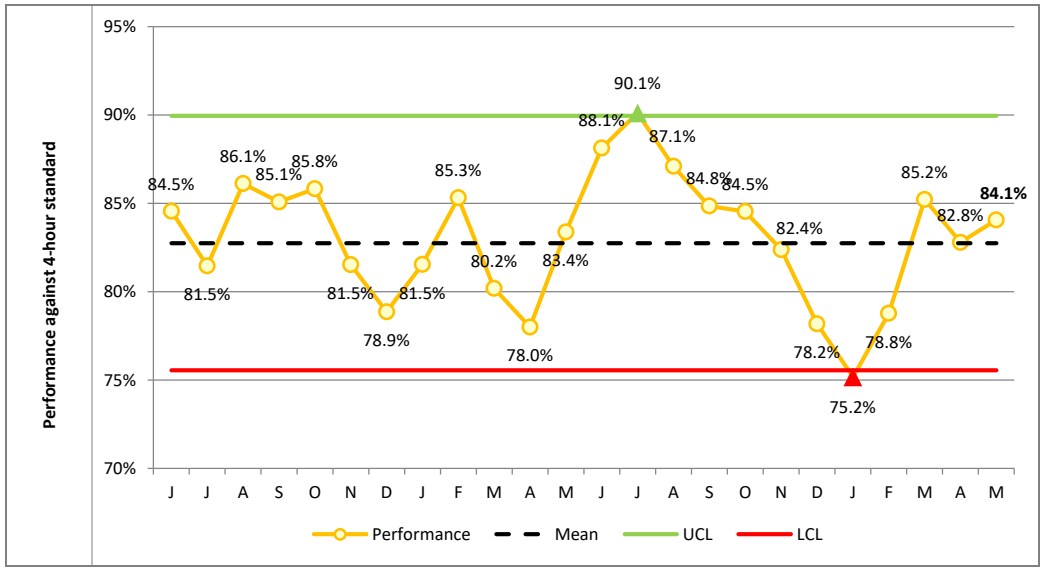




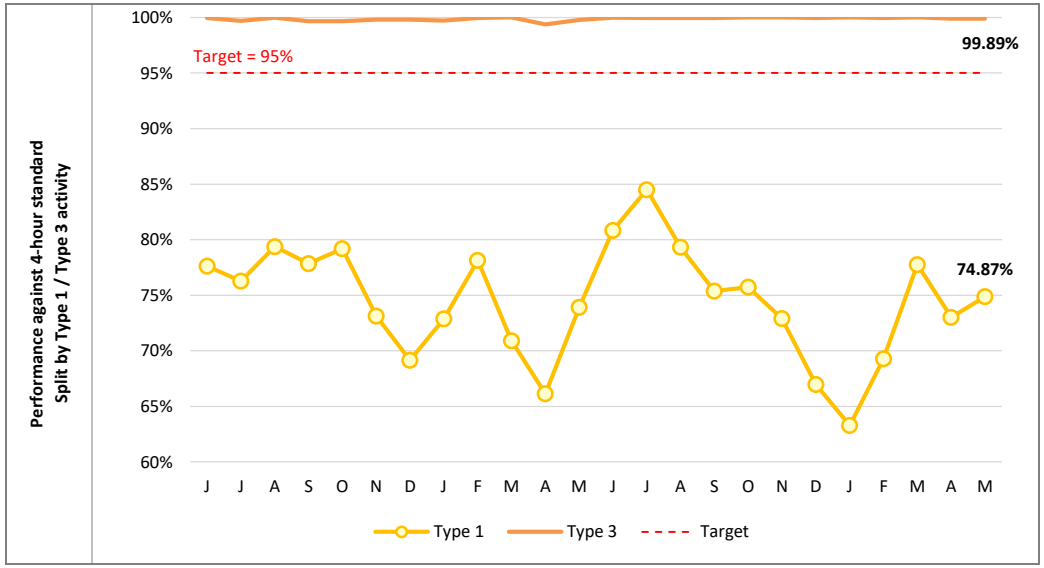
Responsive Services

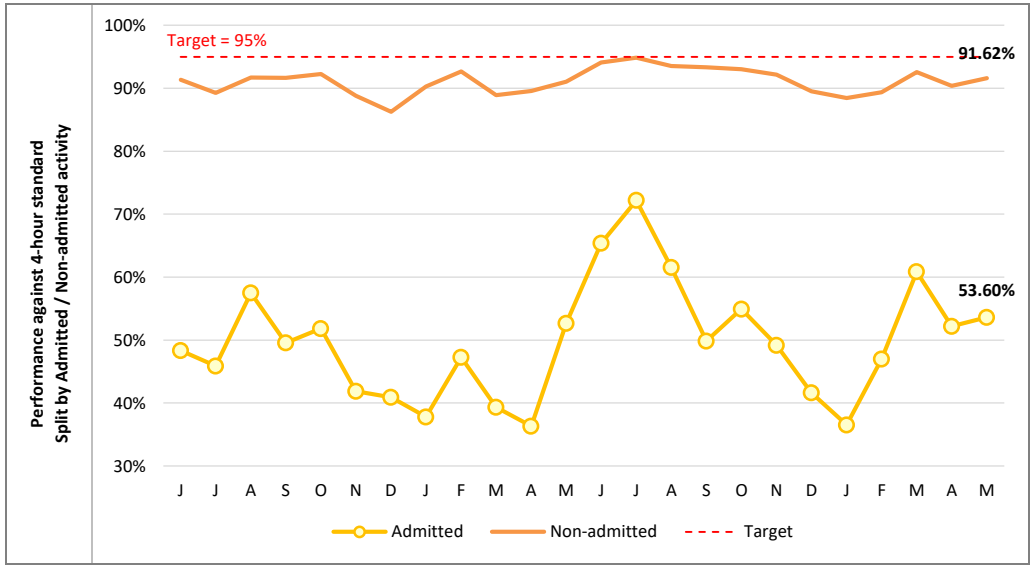
Emergency Department Performance

East and North Hertfordshire NHS Trust



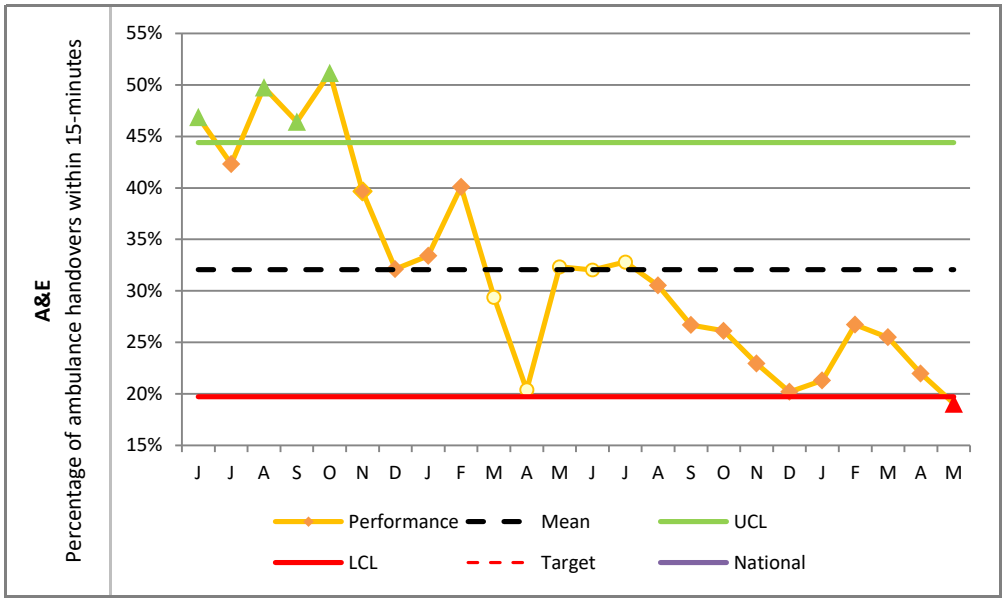
Domain	Metric	Target	Apr-21	May-21	Change	Trend
Other Emergency Department measures	Ambulance handovers (Arrival to Handover) Proportion within 15 minutes	-	22%	19%	▼	
	Ambulance handover breaches 30 minutes	334	380	341	▼	
	Ambulance handover breaches 60-minutes	73	117	81	▼	
	Attendance to admission conversion rate	-	33.6%	33.4%	▼	
	Time to initial assessment 95th centile	15	tbc	tbc	◀▶	
	Time to treatment Median	60	tbc	tbc	◀▶	
	Left department before being seen for treatment	5%	1.37%	1.15%	▼	
	Unplanned re-attendance rate	5%	5.88%	6.35%	▲	

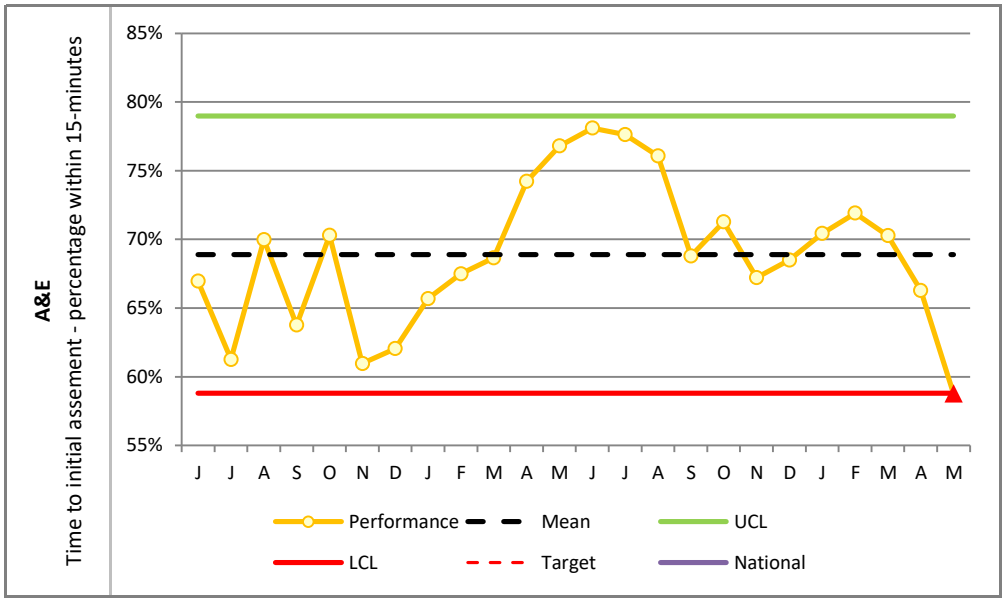


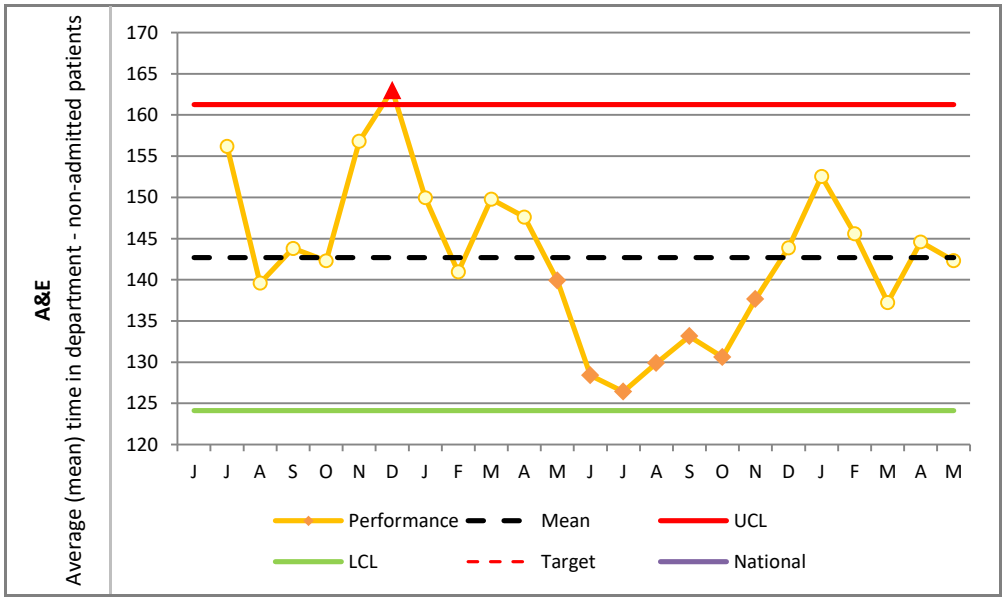


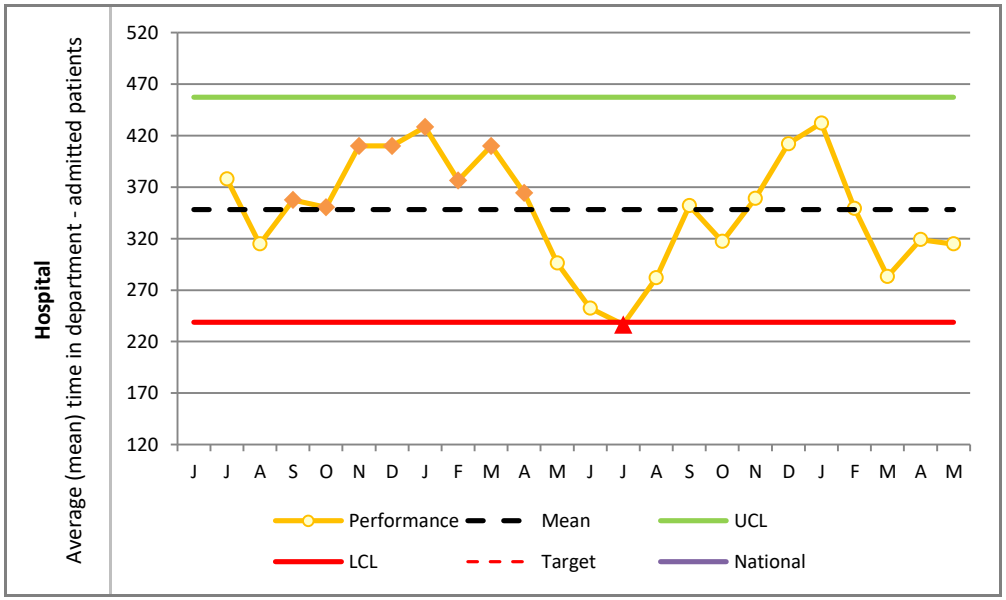
Responsive Services

New Emergency Department Standards

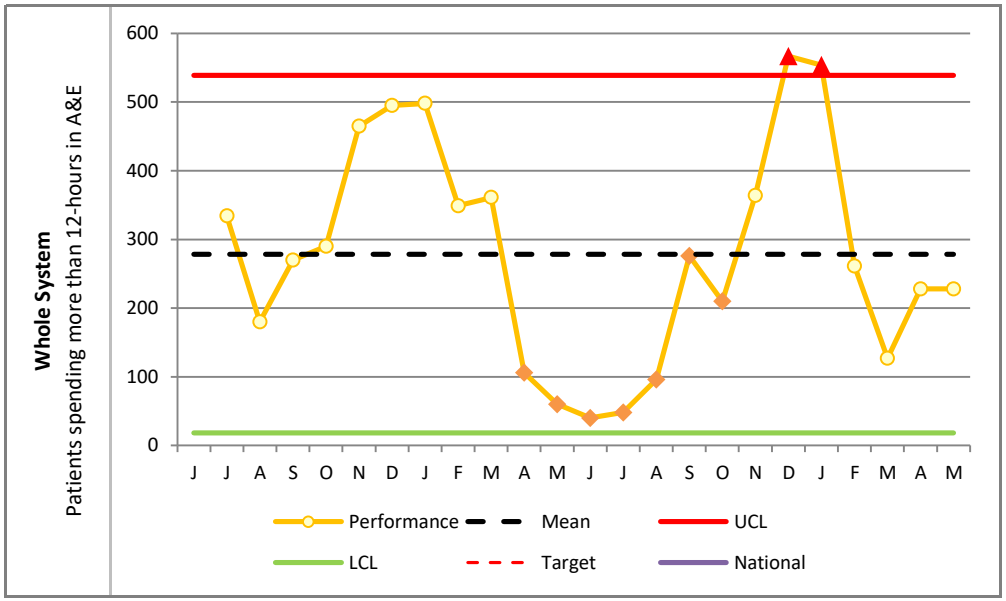


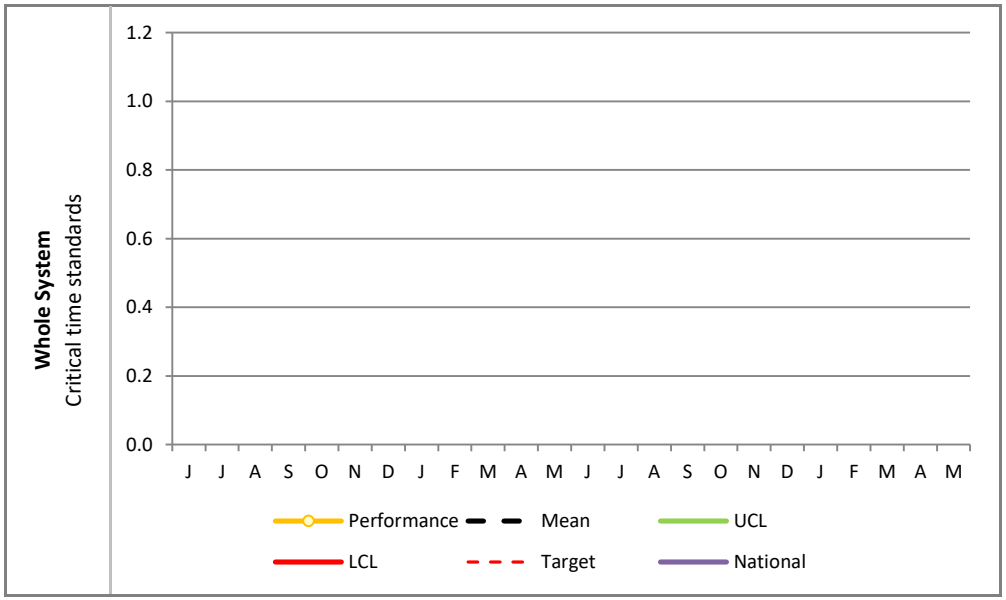






New Emergency Department Standards





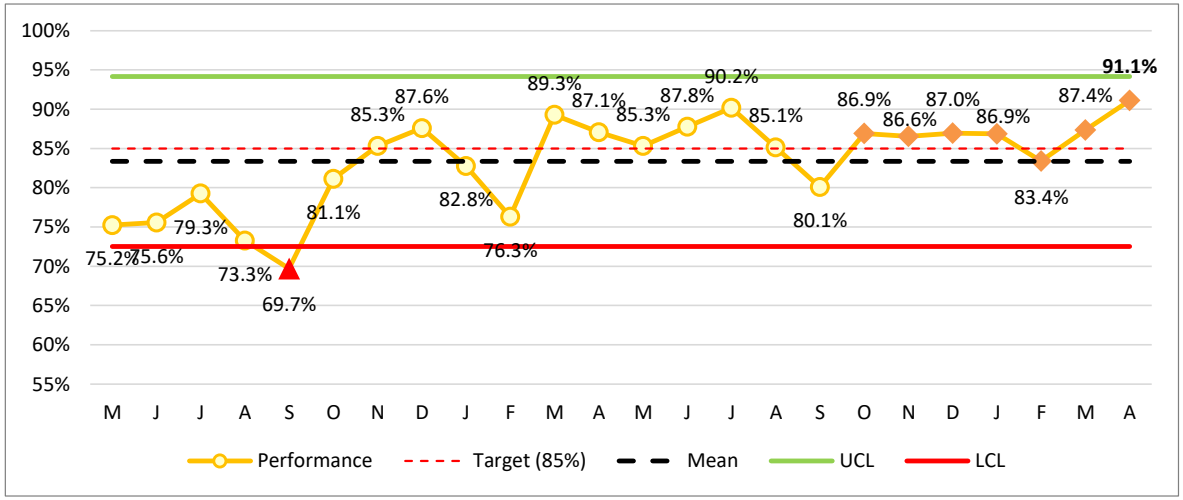
Responsive Services

Cancer Waiting Times

East and North Hertfordshire NHS Trust

12-months' performance - all standards	Standard	Target	2020-21												2021-22
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Apr-21
	Two week waits Suspected cancer	93%	97.72%	99.35%	99.32%	92.80%	95.84%	97.25%	96.74%	97.36%	98.12%	96.17%	98.00%	99.13%	97.26%	96.84%
	Two week waits Breast symptomatic	93%	79.31%	100.00%	98.59%	97.98%	98.67%	99.00%	96.36%	97.64%	93.33%	93.40%	100.00%	100.00%	97.08%	95.10%
	31-day First definitive treatment	96%	98.60%	98.50%	98.63%	94.59%	98.22%	98.48%	98.28%	98.68%	99.57%	99.05%	97.84%	96.97%	98.11%	99.51%
	31-day subsequent treatment Anti-cancer drugs	98%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	100.00%	100.00%	99.42%	100.00%	99.86%	100.00%
	31-day subsequent treatment Radiotherapy	94%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	98.90%	99.63%	98.76%	98.51%	99.35%	98.87%	99.29%
	31-day subsequent treatment Surgery	94%	94.44%	96.15%	100.00%	95.00%	96.15%	90.00%	95.12%	95.45%	100.00%	75.00%	92.11%	87.76%	92.68%	84.44%
	62-day GP referral to treatment	85%	87.08%	85.31%	87.78%	90.16%	85.15%	80.10%	86.92%	86.55%	86.96%	86.87%	83.41%	87.36%	86.13%	91.12%
	62-day Specialist screening service	90%	38.46%	0.00%	NIL	20.00%	0.00%	80.00%	100.00%	100.00%	84.62%	80.00%	75.00%	64.29%	69.34%	81.48%

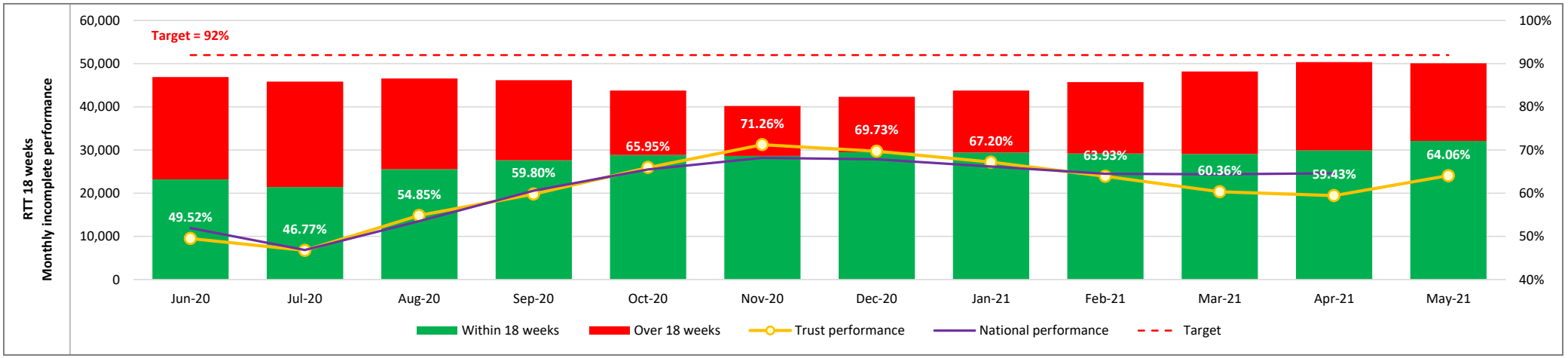
62-day GP referral to treatment Apr-21	Tumour Site	OK	Breach	Total	Perf.	104+ day waits
	Breast	29.5	0.0	29.5	100.00%	-
	Gynaecology	3.5	1.0	4.5	77.78%	-
	Haematology	4.0	1.5	5.5	72.73%	-
	Head and Neck	5.0	0.0	5.0	100.00%	-
	Lower GI	5.0	5.5	10.5	47.62%	-
	Lung	6.0	0.0	6.0	100.00%	-
	Other	2.0	0.0	2.0	100.00%	-
	Skin	25.0	1.0	26.0	96.15%	-
	Testicular	1.0	0.0	1.0	100.00%	-
	Upper GI	3.0	0.0	3.0	100.00%	-
	Urology	13.5	0.5	14.0	96.43%	-
	Total	**97.5**	**9.5**	**107.0**	91.12%	-



Responsive Services

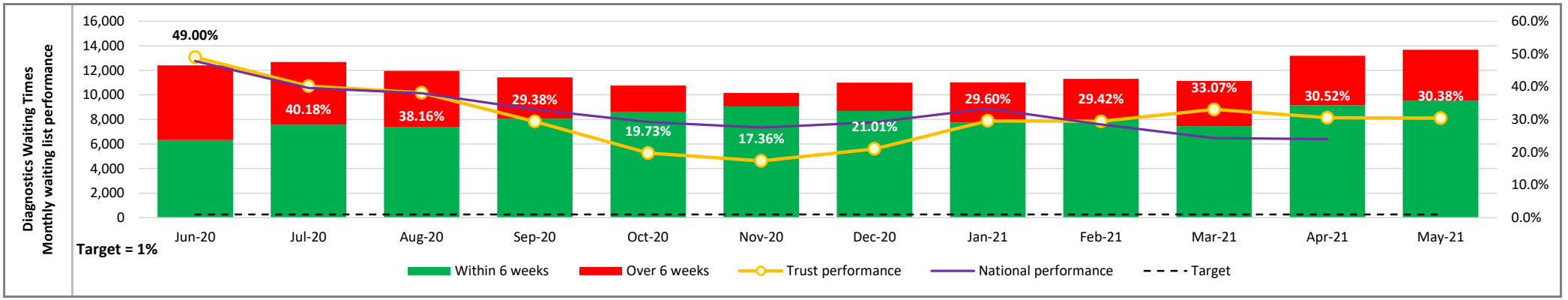
RTT 18 weeks

East and North Hertfordshire NHS Trust



RTT 18 weeks
In-month performance by Specialty - May-21

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 52 weeks	Over 104 weeks	
General Surgery	154	49.35%	0	528	34.28%	0	1,829	1,486	3,315	55.17%	160	0	656
Urology	95	69.47%	0	900	45.67%	0	1,407	794	2,201	63.93%	207	0	707
Trauma & Orthopaedics	46	26.09%	0	1,000	30.30%	5	2,011	2,307	4,318	46.57%	716	12	746
Ear, Nose & Throat (ENT)	95	50.53%	0	1,038	30.54%	0	2,148	1,218	3,366	63.81%	72	0	865
Ophthalmology	112	22.32%	0	1,174	36.54%	3	2,633	2,410	5,043	52.21%	164	0	1,095
Oral Surgery	22	31.82%	0	440	33.41%	0	1,517	1,185	2,702	56.14%	356	4	498
Plastic Surgery	84	59.52%	0	1,420	46.62%	1	1,007	299	1,306	77.11%	54	0	932
Cardiothoracic Surgery	0	-	0	14	35.71%	0	11	0	11	100.00%	0	0	6
General Medicine	1	100.00%	0	152	50.00%	0	171	17	188	90.96%	0	0	188
Gastroenterology	75	78.67%	0	432	32.87%	0	2,504	1,856	4,360	57.43%	425	0	880
Cardiology	15	86.67%	0	952	40.44%	0	1,451	412	1,863	77.89%	7	0	522
Dermatology	1	100.00%	0	390	35.64%	0	463	177	640	72.34%	0	0	209
Thoracic Medicine	14	71.43%	0	450	35.11%	1	699	239	938	74.52%	3	0	265
Neurology	0	-	0	344	47.67%	0	370	13	383	96.61%	2	0	197
Rheumatology	1	100.00%	0	288	27.78%	0	883	200	1,083	81.53%	9	0	284
Geriatric Medicine	0	-	0	82	23.17%	0	177	52	229	77.29%	0	0	71
Gynaecology	47	53.19%	0	742	33.56%	0	3,397	1,304	4,701	72.26%	44	1	926
Other	74	62.16%	1	2,021	80.06%	0	9,419	4,037	13,456	70.00%	572	36	3,935
Total	**836**	**52.63%**	**1**	**7,194**	**76.24%**	**10**	**32,097**	**18,006**	**50,103**	**64.06%**	**2,791**	**53**	**12,982**



Diagnostics Waiting Times
In-month performance by Modality - May-21

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	1,453	649	2,102	30.88%	0	1,840	129	4	**1,973**
	Computed Tomography	1,411	634	2,045	31.00%	87	3,330	413	1,594	**5,337**
	Non-obstetric ultrasound	4,630	1,085	5,715	18.99%	24	5,606	294	29	**5,929**
	DEXA Scan	523	519	1,042	49.81%	96	188	19	0	**207**
Physiological Measurement	Audiology - audiology assessments	43	7	50	14.00%	1	24	0	0	**24**
	Cardiology - echocardiography	825	51	876	5.82%	7	1	0	0	**1**
	Neurophysiology - peripheral neurophysiology	61	0	61	0.00%	0	78	0	0	**78**
	Respiratory physiology - sleep studies	57	0	57	0.00%	0	58	0	0	**58**
	Urodynamics - pressures & flows	62	44	106	41.51%	11	28	0	0	**28**
Endoscopy	Colonoscopy	219	563	782	71.99%	372	258	0	0	**258**
	Flexi sigmoidoscopy	72	240	312	76.92%	145	73	0	0	**73**
	Cystoscopy	15	2	17	11.76%	2	37	0	0	**37**
	Gastroscopy	151	361	512	70.51%	249	212	0	0	**212**
Total		**9,522**	**4,155**	**13,677**	**30.38%**	**994**	**11,733**	**855**	**1,627**	**14,215**

Responsive Services

Stroke Performance

East and North Hertfordshire NHS Trust

Domain	Metric	2021-22 Target	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend
Stroke	Trust SSNAP grade	A	B	C	C	C	C	C	C	tbc	tbc	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	100.0%	88.9%	100.0%	100.0%	80.0%	87.5%	71.4%	100.0%	100.0%	85.7%	88.9%	87.5%	
	4-hours direct to Stroke unit from ED Actual	63%	66.7%	67.9%	69.9%	50.7%	54.0%	56.5%	52.0%	48.3%	28.1%	49.3%	61.0%	43.5%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	63%	68.8%	69.1%	69.9%	54.5%	55.3%	56.9%	52.1%	50.9%	29.5%	48.5%	66.7%	45.0%	
	Number of confirmed Strokes in-month on SSNAP	-	71	58	73	75	53	71	83	64	66	70	63	62	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	92.6%	91.1%	89.0%	89.0%	86.5%	84.3%	87.7%	88.5%	92.3%	97.1%	93.4%	93.5%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	61.4%	46.6%	56.2%	45.3%	45.3%	71.8%	55.4%	57.8%	47.0%	52.9%	55.6%	58.1%	
	Scanned within 12-hours - all Strokes	100%	95.7%	100.0%	94.5%	96.0%	92.5%	100.0%	100.0%	98.3%	97.0%	95.7%	98.2%	91.9%	
	% of all stroke patients who receive thrombolysis	11%	11.4%	15.5%	9.6%	5.3%	5.7%	23.2%	11.0%	11.3%	10.6%	5.7%	11.3%	3.2%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	70%	37.5%	44.4%	28.6%	25.0%	0.0%	62.5%	77.8%	71.4%	85.7%	25.0%	14.3%	0.0%	
	Discharged with JCP	80%	93.3%	97.2%	93.3%	92.3%	79.4%	93.3%	92.6%	94.7%	85.0%	91.3%	75.8%	91.9%	
	Discharged with ESD	40%	52.1%	56.1%	56.3%	64.9%	40.0%	49.0%	69.2%	76.7%	80.0%	62.5%	56.8%	73.0%	

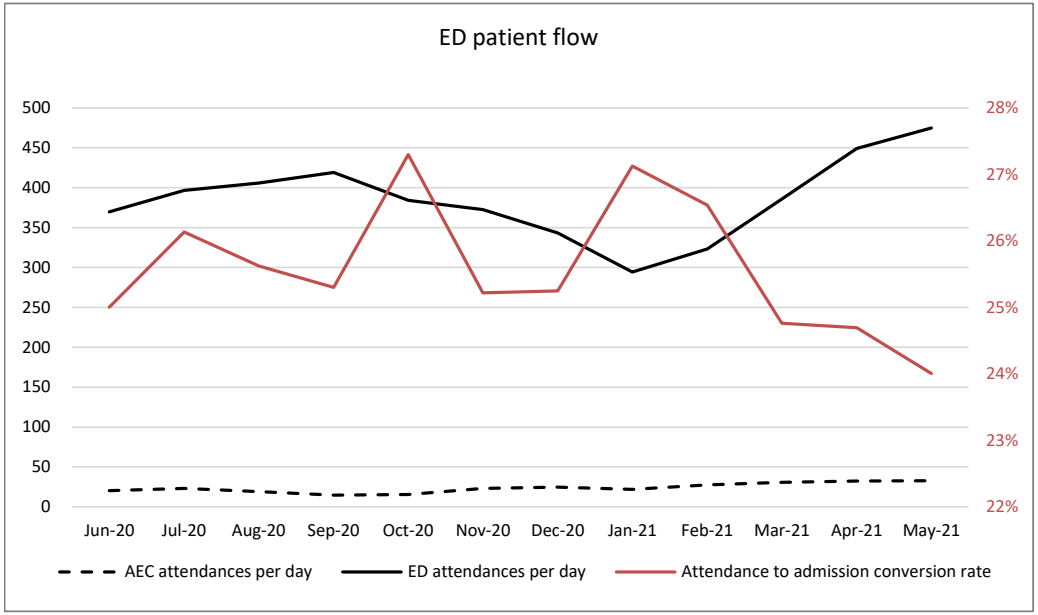
Breaches May-21	Breach reasons:			Breach Reasons: 34
		• Challenging Diagnosis/Complex Patients = 2 • Late referral = 3 • Share Care Transfers = 0	• Bed Capacity = 7 • Inpatient Stroke = 2 • Patient Related / Clinical Need = 10 • COVID POC = 5	

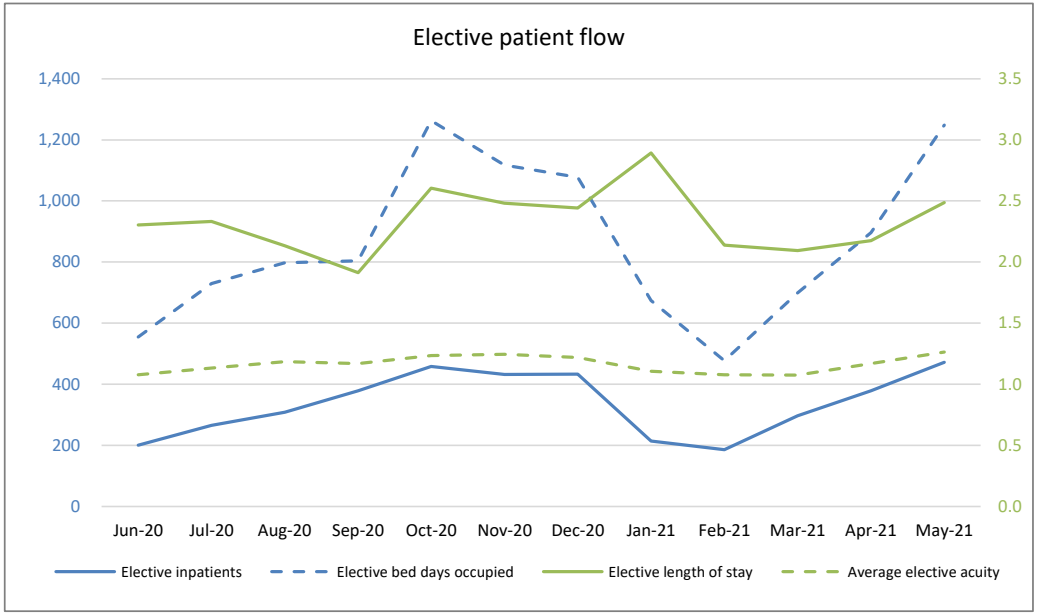
Responsive Services

East and North Hertfordshire NHS Trust

Patient Flow

Domain	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	11,091	12,289	12,578	12,580	11,904	11,173	10,639	9,119	9,044	11,955	13,470	14,720	
	Attendance to admission conversion rate	25.0%	26.1%	25.6%	25.3%	27.3%	25.2%	25.2%	27.1%	26.5%	24.8%	24.7%	24.0%	
	ED attendances per day	370	396	406	419	384	372	343	294	323	386	449	475	
	AEC attendances per day	20	23	19	14	15	23	24	22	27	31	32	33	
	4-hour target performance %	88.1%	90.1%	87.1%	84.8%	84.5%	82.4%	78.2%	75.2%	78.8%	85.2%	82.8%	84.1%	
	Time to initial assessment 95th centile	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	
	Ambulance handover breaches 30-minutes	76	242	285	317	350	507	634	467	327	274	380	341	

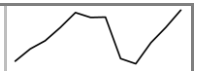
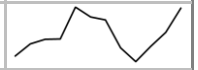
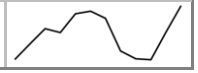
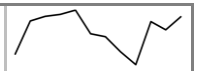
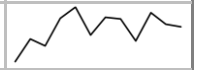
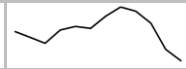
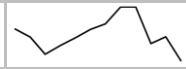
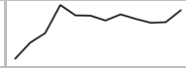
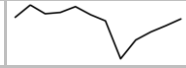
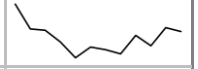
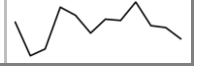




Responsive Services

Patient Flow

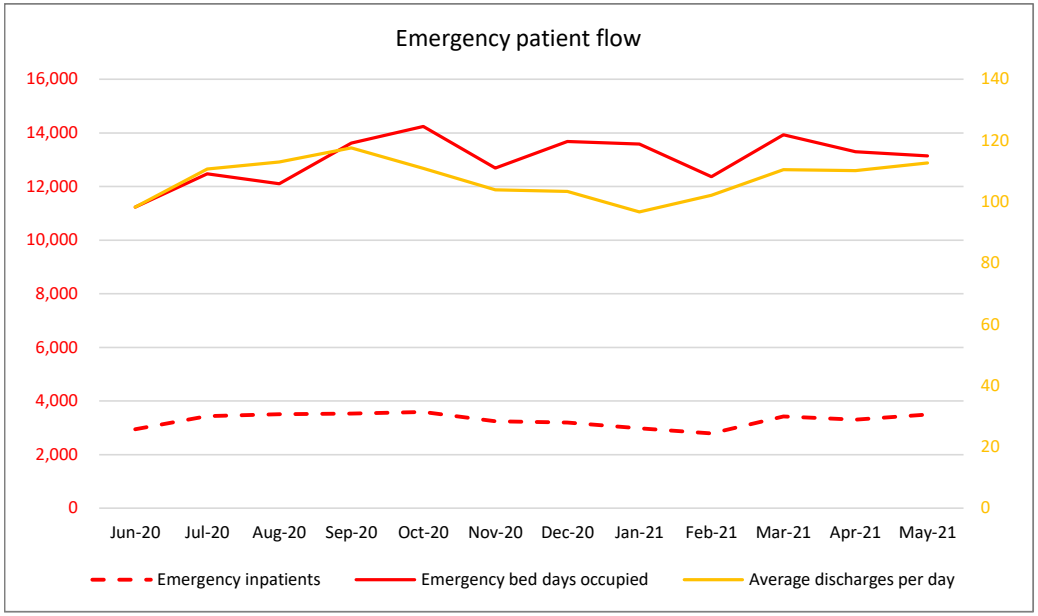
East and North Hertfordshire NHS Trust

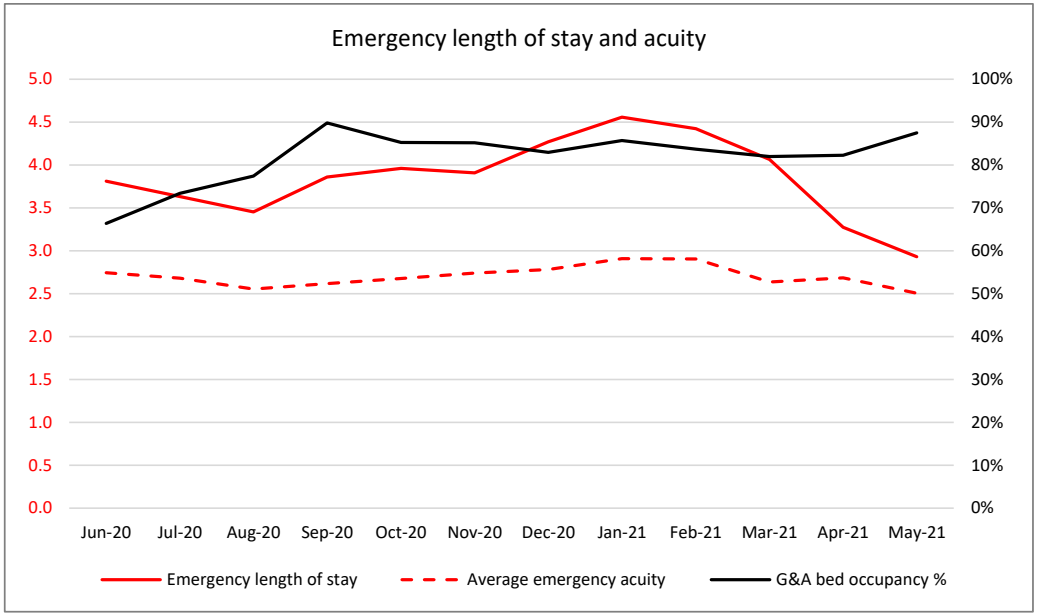
Domain	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend
Elective Inpatient Flow Indicators	Elective inpatients	200	265	308	378	458	432	433	214	186	297	378	472	
	Elective bed days occupied	555	730	798	804	1,263	1,117	1,077	674	477	699	896	1,248	
	Elective length of stay	2.3	2.3	2.1	1.9	2.6	2.5	2.4	2.9	2.1	2.1	2.2	2.5	
	Daycase rate %	86.6%	86.8%	85.3%	87.1%	87.7%	87.7%	87.0%	89.2%	89.6%	89.1%	87.9%	87.0%	
	Average elective acuity	1.08	1.13	1.18	1.17	1.24	1.24	1.22	1.11	1.08	1.07	1.17	1.26	
Emergency Flow Indicators	Emergency inpatients	2,947	3,433	3,503	3,529	3,595	3,246	3,202	2,981	2,794	3,425	3,303	3,494	
	Average discharges per day	98	111	113	118	111	104	103	97	102	110	110	113	
	Emergency bed days occupied	11,232	12,471	12,102	13,622	14,242	12,692	13,676	13,588	12,361	13,926	13,290	13,139	
	Emergency length of stay	3.8	3.6	3.5	3.9	4.0	3.9	4.3	4.6	4.4	4.1	3.3	2.9	
	Average emergency acuity	2.7	2.7	2.6	2.6	2.7	2.7	2.8	2.9	2.9	2.6	2.7	2.5	
	G&A bed occupancy %	66%	73%	77%	90%	85%	85%	83%	86%	84%	82%	82%	88%	
	Patients discharged via Discharge Lounge	488	564	509	518	554	504	465	234	348	398	436	478	
	Discharges before midday	13.7%	11.8%	11.7%	10.8%	9.6%	10.4%	10.2%	9.9%	11.3%	10.5%	11.9%	11.6%	
	Weekend discharges	12.9%	13.9%	15.8%	14.7%	16.8%	15.0%	13.9%	16.3%	13.0%	14.3%	16.1%	17.3%	
	Proportion of beds occupied by patients with length of stay over 14 days	17.5%	15.1%	15.9%	19.0%	18.4%	17.9%	19.3%	19.4%	20.4%	18.2%	16.6%	15.9%	
	Proportion of beds occupied by patients with length of stay over 21 days	9.3%	6.9%	7.4%	10.4%	9.8%	8.5%	9.5%	9.4%	10.8%	9.1%	8.9%	8.1%	

Responsive Services

East and North Hertfordshire NHS Trust

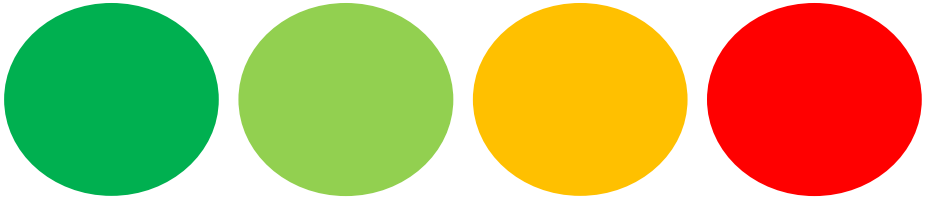
Patient Flow





Well-led Services

Month 02 | 2021-22



Key Issues

Work
- Overall vacancy rate increased to 5.7% due to an increase of 16 WTE in overall establishment as well as fewer numbers of new starters in month. Nursing vacancy rate remains low at 2.7%.
- Agency spend increased by £119k in M2, which was consistent with the upward trend of the agency demand increasing (15%), the largest increase was for Admin & Clerical staff-group much of which related to one-off payments.
- Overall temporary staffing hours worked reduced by 5.5% due to increased availability of substantive staff.
- Numbers of staff taking Annual Leave in rostered areas has increased by 2% in M2 to 12.4%, although this is still in line with the national tolerance thresholds of 10% to 14%.

Grow
- Statutory and mandatory training compliance dropped slightly to 84.4% and the number of staff with 100% compliance has dipped from 50% to 38.1%. This is due to the needed refresh in audiences for certain courses, which has been identified during the implementation of ENH Academy. The new system will support the Trust in meeting its statutory and mandatory requirements.
- The Appraisal rate is improving in line with the trajectory going from 58.3 to 62.7%.
- Recovery work to increase statutory and mandatory training compliance continues. This is creating pressure on space requirement which is an issue being discussed within the space utilisation group.
- Continued professional development, (CPD), funding from heath education England, (HEE), announced for our registrants of £690k.

Thrive
- Turnover increased slightly to 12.2%. Despite the increase, the Trust remains on target and nursing turnover is considerably below target at 10%.
- The main reasons for leaving were work/life balance and relocation. Work within the divisions' staff voice forums will investigate this further to assess any trends and interventions that can be put in place.
- Model employer target has reduced in quarter 4 with a reported shortfall at band 9 and VSM.
- The average duration of disciplinary cases has reduced by 105 days due to one extremely long standing case being closed.

Care
- Sickness absence rate has increased to 4.2% compared to 4.1% last month. This was due to a slight increase in long term absence, however short term absence remains lower than expected.
- Over the month 1702 days were lost to mental health related reasons , which is 62 days higher than the same month last year.
- Absence due to COVID-19 continues to be low helped by the 89% vaccination rate.

Executive Response

Work
- A group consisting of Workforce, Operational and Finance colleagues has been reviewing 6 areas as part of a pilot for reviewing the paybill using specific workforce and Finance metrics, a detailed recommendation paper will be presented at June's FPPC.
- There are 213 new starters in our pipeline of which 37 of which are Doctors and 80 are qualified nursing staff.
- A values based screening tool continues to progress well, this will support our increased focus on values and behaviours from new starters into the organisation. Launch date is expected to be in the next 4-6 weeks.
- The Trust is now 82% compliant against NHSE/I levels of attainment with a rostering system, in addition 92% of junior doctors and 46% of consultants are live on eRoster with the remaining implementation of new areas progressing well.
- Work has begun on project mapping the new Job Planning software, a programme of work which will run over the next 18-24 months in reviewing all current job plans (367), updating where required and building team job plans onto the new software in conjunction with the Medical Directors Office.
- A Resourcing pipeline report is being developed onto QlikView which contains filtered content available for managers to use instead of a manual excel report, this will work alongside the Workforce information on establishments.
- The new people team page on the KC will be launched on 1st July, work has been underway to review and update content in line with our People Strategy and ensure ease of access around people services is available to staff and managers.

Executive Response

Work (cont'd)
- Data Alignment steering group has recommenced to support the journey of 'one source of the truth' between Finance and Workforce systems, this is line with our People Operations team objective of delivering the brilliant basics across 21/22.

Grow
- The launch of ENH Academy in May has provided a more user friendly and accessible platform for staff to complete a suite of training including statutory and mandatory training.
- We are supporting subject matter experts from across the organisation to produce new education material to be added to the ENH Academy.
- The 'Grow together' module for performance and talent conversations has launched on ENH Academy. This provides a better user experience and negates the need for managers to record on ESR.
- The new grow together cycle has been publicised ensuring career conversations and objective setting happens for all staff at the start of the year, enabling positive talent discussions in the second part of the year. Identifying a window will increase compliance rates for appraisals and the expectation is that the trust is back on target by the end of August.
- A refresh of skills that are essential for roles continues to be developed with our teams and subject matter experts to ensure that this learning is accessible, relevant and user friendly for our people.
- CPD funding from HEE confirmed £690k to support the training needs analysis. First iteration of the plan is to be submitted to HEE 12th July 2021.
- International nursing training continues at pace to hit Trust and NHS England and Improvement targets with first time pass rates sitting above 85%.

Thrive
- The Head of People Culture commenced in post on 1.7.2021. They are undertaking a diagnostic of our current position to inform the activity plan for the next 6 months. The findings, plan and initial outcomes will be shared with the FPPC and EIC in relation to their respective agendas.
- The Trust is working with each of the service lines to review a range of cultural indicators including staff survey results as part of the development of the new integrated strategic business plan. This includes circulated staff survey results heat map by service line (and Q1 Pulse survey to share), to be discussed at service line meetings. Themes for focus include Equality, Diversity and Inclusion; Safe Environment; and Health and Wellbeing.
- Compassionate conversation training is being rolled out across the Trust, targeting around 150 participants. To date 141 staff have attended.
- Accelerated model employer targets are planned in conjunction with the integrated business planning programme to ensure delivery of a representative workforce.
- The ERAS team is now fully established with new team members taking case work, it is expected that case duration will shorten, except for those that are still awaiting external parties to conclude their interventions.
- A week of thanks is planned w/c 07th July 2021 to reflect on staff contribution during the pandemic including a memorial service for the patients and staff lost as a result
- To support women against violence the Trust has applied for accreditation to the white ribbon scheme which recognises organisations reducing violence against its staff
- Windrush day was celebrated and recognised by the Trust with numerous speakers attending a network led event to share stories about Windrush relatives and subsequent generations.

Care
- Reflection opportunities have been widely promoted as a measure to proactively prevent mental health problems and address issues such as stress and burnout. Reflection develops self-awareness, improves energy levels, empathy and wellbeing. Twice weekly Reflective Spaces have been available face to face at Lister & Mount Vernon and remotely. Teams have also been able to request a facilitated reflection session in their department. This offer has been taken up by one of the renal satellite units, resulting in very positive feedback.
- Monthly Schwartz rounds continue, further encouragement has been given to teams to participate either face to face or remotely.
- The trust has continued to provide free complimentary therapies for staff. Feedback has been extremely positive with staff reporting reduced stress as a direct result. It is expected that treatments will be offered to over 1000 people. Details of uptake and will be shared at next month's report.
- The Trust now has four staff trained as mental health first aid instructors. These are delivering remote training for mental health first aiders across the organisation, with the aim of having 200 trained MHFA within the trust.
- It is recognised that mental health related issues continue to affect absence. Promotion of the Here For You service is continuing to support staff who may need additional therapeutic intervention.

Well-led Services

Staff and Workforce Development

East and North Hertfordshire NHS Trust

Domain	Metric	Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend
Work	Vacancy Rate	6%	5.9%	5.5%	4.9%	5.7%	5.7%	5.7%	5.7%	5.3%	5.7%	4.3%	2.6%	5.0%	5.7%	
	Time to hire (weeks)	10	12.9	13.0	13.0	13.0	12.0	12.0	13.0	9.0	11.0	10.0	10.0	11.0	11.0	
	Recruitment experience	4	4.5	4.5	4.5	4.6	4.3	4.4	4.7	4.5	4.6	4.5	4.4	4.7	4.7	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	1.30		1.40			1.40			2.00			tbc		
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	1.24		0.84			0.57			0.70			tbc		
	Agency Spend (% of WTE)	4%	3.2%	2.7%	3.6%	3.0%	3.3%	4.3%	3.5%	3.4%	3.2%	3.3%	3.5%	2.9%	3.3%	
	Bank Spend (% of WTE)	10%	8.2%	8.0%	9.6%	9.2%	7.9%	9.7%	9.9%	10.5%	11.6%	8.6%	10.4%	8.4%	8.1%	
	% of staff on eRoster	> 90%	62.0%	63.0%	63.0%	63.0%	64.0%	64.0%	65.0%	65.0%	64.0%	65.0%	66.0%	66.0%	67.0%	
	% of fully approved rosters in advance of 8 weeks	60%	33.6%	31.8%	21.3%	16.7%	25.0%	22.4%	22.1%	22.5%	22.7%	15.5%	22.8%	11.6%	21.8%	
	% of actual clinical unavalibility vs % of budgeted clinical unavailability (headroom) - Nursing & Midwifery ONLY	< 21%	36.2%	31.6%	27.3%	26.6%	26.3%	23.2%	26.6%	27.0%	32.5%	31.2%	31.9%	32.2%	23.2%	
	Pulse survey Flexibility	55%	55.5%		59.5%			56.0%			60.0%			tbc		
Grow	Statutory & mandatory training compliance rate	90%	79.6%	77.5%	81.8%	81.6%	84.6%	85.1%	86.5%	86.9%	85.9%	84.8%	84.4%	85.8%	84.4%	
	Appraisal rate	90%	71.5%	70.2%	66.8%	62.5%	61.0%	60.2%	59.7%	59.8%	57.0%	57.3%	58.5%	58.3%	62.7%	
	Pulse survey Training and development opportunities	55%	48.1%		53.0%			54.0%			52.1%			tbc		
	Pulse survey Talent management	55%	53.1%		47.1%			55.0%			51.3%			tbc		
	Likelihood of training and development opportunities (BAME)	1	tbc		tbc			tbc			tbc			tbc		
	Likelihood of training and development opportunities (Disability)	1	tbc		tbc			tbc			tbc			tbc		
	LMCPD places filled	800 (cum)	0	0	0	0	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	tbc	

Well-led Services

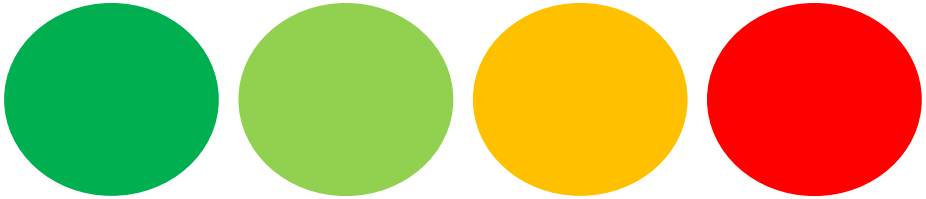
Staff and Workforce Development

East and North Hertfordshire NHS Trust

Domain	Metric	Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend
Thrive	Pulse survey My leader	75%	77.9%		81.4%			87.0%			79.8%			tbc		
	Pulse survey Harnessing individuality	60%	60.8%		59.8%			59.0%			57.7%			tbc		
	Pulse Survey Not experiencing discrimination	95%	71.0%		72.2%			90.5%			68.4%			tbc		
	Turnover Rate	12.2%	12.8%	12.6%	12.9%	12.8%	12.9%	12.5%	12.3%	12.0%	11.9%	11.8%	11.2%	12.0%	12.2%	
	Model employer targets (% achieved)	100%	83%		66%			83%			67%			tbc		
	Average length of suspension (days)	20	70	0	0	0	0	29	60	22.5	33	43	37	59	57.2	
	Average length of Disciplinary (excluding suspensions) (days)	60	304	183	111	102.5	158	154	87	74.3	96	102	148	168	63	
	Average length of Grievance (including dignity at work) (days)	60	199	0	0	28	2	20	46	22	114	86	91	82	80	
Care	Pulse survey Well-being	70%	67.0%		74.8%			51.0%			68.6%			tbc		
	Pulse survey Reasonable adjustments	50%	67.5%		67.4%			74.0%			60.4%			tbc		
	Staff FFT Recommend as a place to work	60%	47.7%		51.1%			61.0%			47.8%			tbc		
	Staff FFT Recommend as a place of care	70%	69%		76.0%			71.0%			70.3%			tbc		
	Sickness Rate	3.8%	5.51%	3.96%	3.72%	3.72%	4.07%	3.92%	4.23%	4.69%	6.69%	5.17%	3.84%	4.14%	4.23%	
	Sickness FTE Days Lost	6,777	9,504	6,649	6,543	6,490	6,861	6,863	7,183	8,270	11,825	8,357	7,005	7,265	7,633	
	Mental health related absence (days lost)	1,650	1,640	1,794	1,889	1,643	1,799	1,981	1,725	1,716	1,743	1,691	1,684	1,798	1,702	
	MSK related absence (days lost)	1,285	1,216	1,152	1,407	1,580	1,431	1,478	1,580	1,554	1,347	1,315	1,165	1,120	1,170	

Sustainable Services

Month 02 | 2021-22

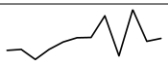
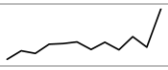
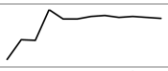
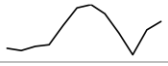


Key Issues	Executive Response
• NHSE has confirmed that the financial framework for 21/22 will be separate and distinct for both halves of the financial year. At present only funding arrangements for the first six months (H1) have been specified at this point, with arrangements for the second half of the year set to be confirmed at a later point. • The funding settlements for individual NHS organisations during H1 have been confirmed as being based upon a rollover of block, top up and other COVID-19 monies received as key components of financial plans for the second half of 20/21. These allocations included approved distributions of System COVID-19 and growth funds which have provided ENHT with coverage for a range of unavoidable costs resulting from the pandemic and also resources to enable the recovery of elective services. • In April 2021 the Finance Committee considered and approved a balanced budget for H1. This was prepared on the basis of the funding settlement outlined above and in alignment with Trust and national business planning guidelines and priorities. The Trust's financial plan is one component of an overarching balanced system wide financial plan that was submitted to NHSE. Final confirmation of that system wide plan and its constituent parts remains pending. Bi weekly ICS Directors of Finance meetings remain in place for the system to ensure that in year delivery across partner organisations is co-ordinated to ensure that collective financial balance is achieved. • During H1 21/22 the delivery of improved levels of elective activity is incentivised through the implementation of the Elective Recovery Fund (ERF). This will enable providers to earn additional non recurrent funds should activity achievement exceed specified thresholds. The Trust operational and Finance & Information teams have worked across March and April to agree and implement delivery plans that will deliver stepped increases in elective activity levels. In addition the Trust is presently leading work across the ICS to construct a financial and activity monitoring mechanism to allow the system to track delivery and achievement on a monthly basis. • ERF performance during the first two months of 21/22 has been strong, although final performance is subject to both validation by DH / NHSE against aggregate system targets as well as gateway criteria. • At Month 2 the Trust reports a small surplus of £0.2m. • The management of the Trust pay bill during H1 will require careful and focused management. A combination of improved recruitment and reduced turnover has seen the number of permanent staff employed by the Trust increase by 351 contracted WTE's since April 2020. As a consequence, vacancy rates across most staff groups and departments have fallen to an all-time low. In response the Trust will need to carefully and flexibly manage the deployment of new staff, the approval of the use of temporary staffing resources and also the pace of future domestic and international recruitment to ensure that it is able to manage its workforce within the boundaries of its approved pay budget.	• The Trust maintains robust mechanisms and systems for monitoring financial performance and maintaining good governance. In addition to its formal Committee structure, the Director of Finance also chairs monthly finance boards which each of the Divisions. Attendance and participation at each of these sessions has been high and they have proved effective in identifying and managing planned delivery and the agreement of remedial action where appropriate. In addition monthly Delivery Oversight Group (DOG) meetings focusing upon finance and workforce issues have been highly effective in promoting mature engagement and discussion of policy and planning issues. • Finance & Information colleagues continue to work alongside Divisional colleagues to support the agreement of the final Trust bed plan for 21/22 and the staffing and establishment resources that are associated with this plan. This remains a significant priority given the materiality of the issue. • In order to monitor and drive the delivery of improved elective activity during H1 the Trust has set up a weekly Demand and Capacity review session. This is chaired by the Managing Director of Planned Services supported by senior corporate officers. The session reviews progress at a service line level, discussing opportunities for improvement or how obstacles to achievement can be addressed. A monthly Executive level review of activity performance is chaired by the Director of Finance. It is expected that in the coming month a regular reporting and discussion mechanism to understand and drive system level ERF performance will be agreed. • As a component part of the new 'ENHT Academy' learning management system the Finance and Information team have refreshed and significantly expanded the range of business skills training materials that are available to budget holders and managers to assist in the discharge of their responsibilities. This suite of materials will continue to be monitored, expanded and enhanced to support both individual and collective training needs and also improved business decision making across the Trust. • Finance and Corporate teams continue to work to develop and enhance business partnering models to support divisional teams. • The availability of accurate and timely business intelligence and modelling has been key in supporting the Trusts agile and flexible response to the rapidly changing environment. It is important therefore that the Trust continues to expand the scope and sophistication of its BI universe at pace to support the need to supply relevant, timely and accurate data to clinicians and managers to enable more effective decision making and plan delivery. This will remain an important component in the Trust's recovery process. • A key priority for the Trust's Finance and Information Team in 21/22 is the development of an effective suite of Population Health Management (PHM) Data products. This specific project co-ordinated by the AD for Planning will be crucial in terms of assisting the Trust and system partners in understanding the patient needs and outcome and provide a framework to set out opportunities for transformation and change. An internal steering group to co-ordinate PHM activities has been set up and project updates and briefing will be provided to Committees on a regular basis. • The Trust continues to work with place based partners to explore new models of service collaboration moving forward. A number of specific areas of project work have been agreed to test the effectiveness of these models.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

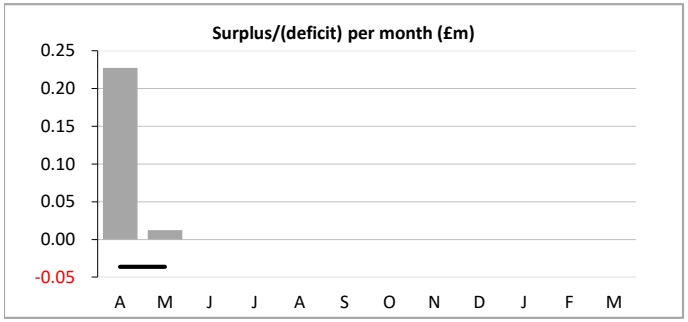
Domain	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	36.2	36.2	35.9	36.2	36.4	36.5	36.5	37.1	36.0	37.3	36.4	36.5		72.5	72.9	0.4
	Other Income Earned	2.2	2.5	2.5	2.8	2.9	3.1	2.6	2.9	2.9	10.0	2.6	4.9		6.3	7.6	1.3
	Pay Costs	24.9	25.4	25.5	26.8	26.6	26.6	27.2	27.1	26.6	31.6	26.5	26.8		54.5	53.3	-1.1
	Non Pay Costs inc Financing	15.2	16.2	15.9	17.0	17.0	17.2	16.4	17.2	16.3	17.9	16.6	21.2		33.0	37.8	4.8
	Underlying Surplus / (Deficit)	-1.8	-3.0	-3.0	-4.8	-4.3	-4.3	-4.4	-4.3	-4.0	-2.1	-4.1	-6.6		-8.7	-10.7	-2.0
	Top up payments	1.8	3.0	3.0	4.8	4.2	4.2	4.4	4.4	4.3	4.4	4.3	4.3		8.6	8.6	0.0
	Retained Surplus / Deficit	-0.00	-0.00	-0.00	-0.00	-0.10	-0.02	-0.03	0.13	0.31	2.24	0.23	-2.31		-0.07	-2.08	-2.0
Paybill Metrics	Substantive Pay Costs	22.3	22.1	22.3	23.8	22.8	22.8	23.2	22.0	23.4	27.8	23.4	23.5		50.8	46.9	-3.9
	Premium Pay Costs Overtime & WLI	0.0	0.0	0.1	0.1	0.2	0.3	0.3	0.3	0.1	0.0	0.2	0.2		0.5	0.4	-0.1
	Premium Pay Costs Bank Costs	2.0	2.4	2.3	2.1	2.6	2.6	2.8	3.7	2.3	3.0	2.2	2.2		2.4	4.4	2.0
	Premium Pay Costs Agency Costs	0.7	0.9	0.8	0.9	1.1	0.9	0.9	1.2	0.8	0.8	0.8	0.9		0.8	1.7	0.9
	Premium Pay Costs As % of Paybill	10.7%	13.0%	12.4%	11.1%	14.3%	14.4%	14.7%	18.9%	12.2%	11.9%	11.7%	12.4%		6.7%	12.1%	5.4%

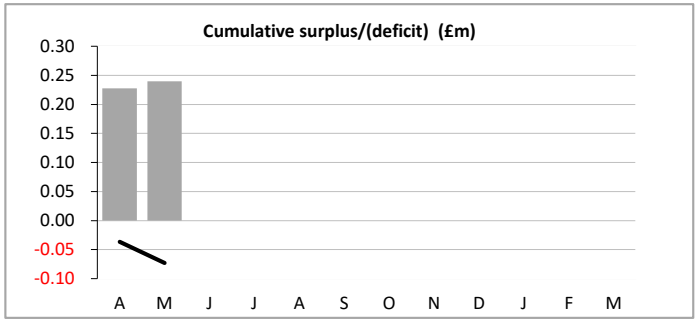
Sustainable Services

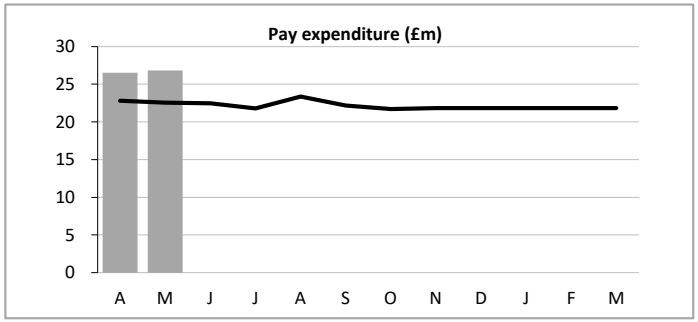
Finance Plan Performance

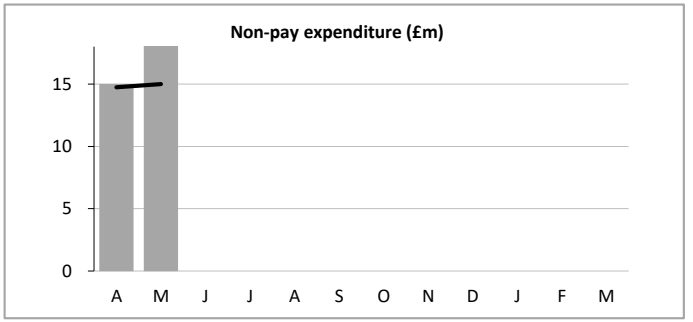
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	———	1	N/A	
	Liquid Ratio (Days)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	———	1	N/A	
	I&E Margin	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	———	1	N/A	
	Distance from Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	———	1	N/A	
	Agency Spend vs. Ceiling	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	———	1	N/A	
	Overall Finance Metric	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	———	1	N/A	









Sustainable Services

SLA Contracts - Income Performance

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	2,372	2,659	287	4,743	5,113	370
	Daycases	3,121	2,795	-326	6,242	5,149	-1,093
	Inpatient Elective	1,942	6,272	4,330	3,885	7,683	3,799
	Inpatient Non Elective	9,813	8,463	-1,350	19,627	17,064	-2,562
	Maternity	2,582	2,444	-138	5,164	4,949	-215
	Other	2,892	3,325	433	5,784	6,366	582
	Outpatient First	2,188	1,899	-288	4,375	3,779	-596
	Outpatient Follow Ups	2,452	2,975	523	4,905	6,059	1,154
	Outpatient Procedures	1,165	1,110	-56	2,330	2,296	-35
	NHSE Block Impact	0	1,095	1,095	0	2,958	2,958
	Other SLAs	65	65	0	130	130	0
	Block	847	847	0	1,694	1,694	0
	Drugs & Devices	3,950	3,918	-32	7,901	8,409	508
	Chemotherapy Delivery	611	605	-5	1,221	1,241	20
	Radiotherapy	1,226	1,063	-163	2,452	2,068	-384
	Renal Dialysis	1,194	1,165	-29	2,388	2,317	-71
	Total	36,420	40,700	4,280	73	77	4

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	21,742	21,742	-0	43,484	43,484	-0
	Specialist Commissioning	8,329	8,458	129	16,658	17,098	440
	Bedfordshire CCG	2,826	2,812	-14	5,652	5,624	-28
	Herts Valleys CCG	1,411	1,411	-0	2,822	2,822	-0
	Cancer Drugs Fund	590	773	183	1,180	1,647	467
	Luton CCG	0	0	0	0	0	0
	PH - Screening	381	171	-209	761	345	-417
	Other	1,141	5,333	4,192	2,282	6,256	3,973
	Total	36,420	40,700	4,280	72,840	77,275	4,435
By Division	Cancer Services	6,982	7,204	221	13,965	14,862	897
	Unplanned Care	19,059	17,656	-1,402	38,117	35,269	-2,849
	Planned Care	11,374	10,747	-626	22,747	20,636	-2,112
	Other	-995	5,093	6,088	-1,989	6,509	8,498
	Total	36,420	40,700	4,280	72,840	77,275	4,435

Sustainable Services

Activity and Productivity

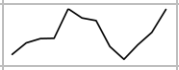
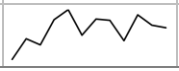
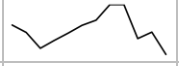
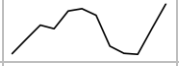
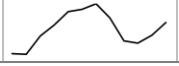
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	10,251	11,423	11,873	12,080	11,432	10,984	10,632	8,951	8,840	11,769	13,380	14,556		26,775	27,936	1,161
	Chemotherapy Atts	2,192	2,354	2,147	2,343	2,313	2,315	2,689	2,232	2,268	2,759	2,452	2,315		4,539	4,767	228
	Critical Care (Adult) - OBD's	488	512	737	467	631	649	870	1,170	1,117	731	574	612		1,234	1,186	-48
	Critical Care (Paeds) - OBD's	434	546	494	358	580	584	339	268	372	492	466	702		1,110	1,168	58
	Daycases	1,551	2,051	2,174	2,848	3,447	3,205	2,949	1,920	1,926	2,730	2,827	3,169		7,914	5,996	-1,918
	Elective Inpatients	241	313	374	420	485	450	441	233	223	334	388	475		1,123	863	-260
	Emergency Inpatients	3,554	4,149	4,097	3,974	4,074	3,933	3,936	3,652	3,556	4,371	3,303	3,494		8,561	6,797	-1,764
	Home Dialysis	139	150	193	165	165	163	155	148	139	176	168	167		331	335	4
	Hospital Dialysis	7,576	7,755	7,078	7,160	7,522	6,977	7,521	7,215	6,673	7,557	6,255	6,321		12,887	12,576	-311
	Maternity Births	445	443	433	418	436	408	368	437	350	448	410	406		884	816	-68
	Maternity Bookings	498	550	467	480	535	490	609	546	533	583	526	517		1,001	1,043	42
	Outpatient First	5,631	5,703	5,659	6,282	6,175	6,496	5,698	3,145	3,018	4,334	4,452	5,012		18,001	9,464	-8,537
	Outpatient Follow Up	9,311	11,385	11,948	14,965	15,126	14,801	13,378	5,977	6,012	7,277	9,075	10,035		34,858	19,110	-15,748
	Outpatient procedures	3,128	4,065	4,629	6,010	6,804	7,008	6,570	4,788	4,859	5,680	6,739	6,435		14,831	13,174	-1,657
	Radiotherapy Fractions	4,297	4,027	3,520	3,991	3,459	3,503	4,321	3,583	3,585	4,233	3,688	3,975		9,896	7,663	-2,233

Sustainable Services

Activity and Productivity

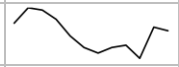
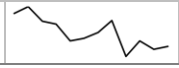
East and North Hertfordshire NHS Trust

Domain	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	81	103	127	149	179	174	161	108	107	133	169	192		220	167	-53
	Emergency Spells per Day	94	107	109	113	112	103	99	92	96	106	105	109		140	111	-29
	ED Attendances per Day	342	368	383	403	369	366	343	289	316	380	446	470		439	458	19
	Outpatient Atts per Working Day	821	920	1,112	1,239	1,278	1,348	1,221	696	694	752	1,067	1,131		1,651	1,018	-633
	Elective Bed Days Used	555	730	798	804	1,263	1,117	1,077	674	477	699	896	1,248		845	2,144	1,299
	Emergency Bed Days Used	11,232	12,471	12,102	13,622	14,242	12,692	13,676	13,588	12,361	13,926	13,290	13,139		32,191	26,429	-5,762
Efficiency	Admission Rate from A&E	25%	26%	26%	25%	27%	25%	25%	27%	27%	25%	25%	24%		23.3%	24.3%	1.0%
	Emergency - Length of Stay	3.8	3.6	3.5	3.9	4.0	3.9	4.3	4.6	4.4	4.1	4.0	3.8		4.0	3.9	-0.1
	Emergency - Casemix Value	2,744	2,683	2,556	2,620	2,678	2,740	2,783	2,909	2,907	2,635	2,686	2,507		2,321	2,596	276
	Elective - Length of Stay	2.3	2.3	2.1	1.9	2.6	2.5	2.4	2.9	2.1	2.1	2.3	2.6		2.6	2.5	-0.1
	Elective - Casemix Value	1,077	1,131	1,184	1,170	1,235	1,244	1,219	1,105	1,078	1,075	1,170	1,263		1,117	1,216	99
	Elective Surgical DC Rate %	86.6%	86.8%	85.3%	87.1%	87.7%	87.7%	87.0%	89.2%	89.6%	89.1%	87.9%	87.0%		85%	87%	2.4%
	Outpatient DNA Rate % - 1st	6.5%	7.9%	6.7%	6.0%	6.7%	7.8%	6.5%	8.3%	7.1%	7.0%	6.4%	4.9%		6.4%	4.8%	-1.6%
	Outpatient DNA Rate % - FUP	6.5%	7.9%	6.7%	6.0%	6.7%	7.8%	6.5%	8.3%	7.1%	7.0%	7.0%	5.5%		7.1%	5.5%	-1.6%
	Outpatient Cancel Rate % - Patient	4.0%	3.9%	5.6%	6.6%	7.8%	8.0%	8.6%	7.2%	5.1%	4.9%	5.6%	6.8%		5.6%	6.2%	0.6%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	33.1%	22.5%	13.1%	11.8%	8.8%	8.3%	7.4%	11.8%	11.4%	8.9%	9.5%	8.9%		11.1%	6.4%	-4.7%
	Outpatients - 1st to FUP Ratio	1.7	2.0	2.1	2.4	2.4	2.3	2.3	1.9	2.0	1.7	2.0	2.0		1.9	2.0	0.1
	Theatres - Ave Cases Per Hour	1.5	1.9	2.0	2.0	2.3	2.2	2.3	1.7	1.9	2.2	2.4	2.5		2.9	2.4	-0.4
	Theatres - Utilisation of Sessions	74%	75%	75%	78%	82%	82%	82%	80%	85%	90%	85%	84%		85%	84%	-1%
	Theatres - Ave Late Start (mins)	22	24	24	22	19	17	16	17	17	15	21	20		27	21	-6.2
	Theatres - Ave Early Finishes (mins)	65	71	58	56	41	43	48	59	27	41	33	36		39	35	-4.8

Sustainable Services

Productivity and Efficiency of Services - 2019-20 YTD vs. 2020-21 YTD

NHS East and North Hertfordshire NHS Trust

Activity Measures	2020-21 YTD	2021-22 YTD	Change
Emergency Department Attendances	15,811	27,936	12,125
Emergency Department Ave Daily Atts	259	458	199
Admission Rate from ED %	23.2%	24.3%	1%
Non Elective Inpatient Spells	4,524	6,797	2,273
Ave Daily Non Elective Spells	74	111	37
Daycase Spells	1,979	5,996	4,017
Elective Inpatient Spells	331	863	532
Ave Daily Planned Spells	38	112	75
Day Case Rate	86%	87%	2%
Adult & Paeds Critical Care Bed Days	2,385	2,354	-31
Outpatient First Attendances	8,994	9,464	470
Outpatient Follow Up Attendances	13,012	19,110	6,098
Outpatient First to Follow Up Ratio	1.4	2.0	0.6
Outpatient Procedures	3,762	13,174	9,412
Ave Daily Outpatient Attendances	422	684	262

Workforce Measures	2020-21 YTD	2021-22 YTD	Change
Average Monthly WTE's Utilised	5,964	6,257	293
Average YTD Pay Cost per WTE	8,700	8,522	-2.0%
Staff Turnover	12.9%	12.1%	-0.8%
Vacancy WTE's	744	761	17
Vacancy Rate	12.0%	11.7%	-0.3%
Sickness Days Lost	21,506	14,898	-6,608
Sickness Rate	6.4%	4.2%	-2.2%
Agency Spend- £m's	1.8	1.7	-0.1
Temp Spend as % of Pay Costs	3.4%	3.1%	-0.2%
Ave Monthlty Consultant WTE's Worked	339.0	348.9	9.9
Consultant : Junior Training Doctor Ratio	1 : 1.7	1 : 1.6	-0.0
Ave Monthly Nursing & CSW WTE's Worked	2,453.8	2,657.2	203.4
Qual ; Unqualified Staff Ratio	26 : 10	26 : 10	0.0
Ave Monthly A&C and Senior Managers WTE's	1,323	1,362	38
A&C and Senior Managers % of Total WTE's	22.2%	21.8%	-0.4%

Sustainable Services

Productivity and Efficiency of Services - 2019-20 YTD vs. 2020-21 YTD

NHS East and North Hertfordshire NHS Trust

Capacity Measures	2020-21 YTD	2021-22 YTD	Change
Non Elective LoS	4.2	3.9	-0.3
Elective LoS	2.9	2.5	-0.4
Occupied Bed Days	35,005	28,573	-6,432
Adult Critical Care Bed Days	1,428	1,186	-242
Paediatric Critical Care Bed Days	957	1,168	211
Outpatient DNA Rate	7%	6%	-1.0%
Outpatient Utilisation Rate	44%	25%	-19.5%
Total Cancellations	25,452	16,024	-9,428
Theatres - Ave Cases per Hour	0.0	2.4	2.4
Theatres - Ave Session Utilisation	0%	84%	84.2%
Theatres - Ave Late Start (mins)	0	21	21
Theatres - Ave Early Finishes (mins)	0.0	34.6	35
Radiology Examinations	398,101	398,101	0
Drug Expenditure (excl HCD & ENH Pharma) - £000s	1,260	2,042	782
High Cost Drug Expenditure - £000s	6,022	8,348	2,326

Finance & Quality Measures	2020-21 YTD	2021-22 YTD	Change
Profitability - £000s	-54	180	233.9
Monthly SLA Income £000s	36,183	36,446	263
Monthly Clinical Income per Consultant WTE	£106,733	£104,446	-£2,286
High Cost Drug Spend per Consultant WTE	£17,762	£23,923	£6,160
Average Income per Elective Spell	£1,152	£1,216	£64
Average Income per Non Elective Spell	£2,912	£2,596	-£316
Average Income per ED attendance	£174	£183	£9
Average Income per Outpatient Attendance	£131	£139	£8
Ave NEL Coding Depth per Spell	7.6	7.9	0.3
Procedures Not Carried Out	382	283	-99
Best Practice HRGs (% of all Spells)	5.0%	3.0%	-2.0%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Feb-21	10,757	8,615	-2,142
Non-elective re-admissions within 30 days % Rolling 12-months to Feb-21	8.34%	9.23%	0.88%
SLA Contract Fines - £000's	0	0	0

East and North Hertfordshire NHS Trust

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 7th JULY 2021
Collaboration Update

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

The purpose of this paper is to provide the Board with an update on Trust collaboration in the development of the ICS, ICPs and transformation of services to improve the care and health of the population that we serve in support of the Trust's strategic objectives, in the context of emerging national legislation and guidance.

The Trust is increasingly engaging in building and developing relationships with a range of partners in order to continue to develop the effectiveness, quality and sustainability of services that the Trust and its partners provide. The increased national focus on collaboration as a key organising principle of the NHS and the ongoing development and strengthening of clinical (and triumvirate) leadership within the organisation is informing the development of refreshed clinical service strategies by providing a platform encompassing Trust-wide and clinically-led identification of collaboration opportunities and needs.

Board is asked to note the paper and to consider approval of the draft MH&LD MOU.

Action required: For discussion

Previously considered by:
Strategy Committee 22nd June 2021

Director:	**Presented by:**	**Author:**
Director of Strategy	**Director of Strategy**	**Director of Strategy**

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)
006/20

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

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

TRUST BOARD – 7 JULY 2021
COLLABORATION UPDATE

1. Purpose

The purpose of this paper is to provide the Board with an update on Trust collaboration in the development of the ICS, ICPs and transformation of services to improve the care and health of the population that we serve in support of the Trust's strategic objectives, in the context of emerging national legislation and guidance.

2. Background

This paper builds on updates previously provided to the Board and Strategy Committee.

The recent White Paper, "Integration and Innovation: working together to improve health and social care for all" (DHSC, February 2021) builds on the strategic direction of travel initially set out in the NHS Long Term Plan. The government intends to introduce a new duty to promote collaboration across the healthcare, public health and social care system. Whilst providers are expected to remain statutory organisations, this proposal will place a mandated duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. Providers will be expected to belong to at least one provider collaborative in order to support delivery and resilience of some services across a wider geography.

The Trust is an active member of both the East and North Hertfordshire (geographical) ICP, the Hertfordshire and West Essex ICS and has bi-lateral relationships with a range of providers.

3. Current position

The Trust has been expanding the scope of potential provider collaboration in the context of both improved relationships between providers and the impetus given to collaboration by the White Paper and Operating Plan. At its recent meeting, the Strategy Committee received a detailed overview of current provider collaboration activity. The Trust recognises the value of this and is working to identify appropriate capacity to support and drive this work, both in the context of recovery and resilience of services in response to the impact of the COVID pandemic and in the longer term opportunities to collectively identify, understand and reduce health and care inequalities.

At this early stage of development, work is being driven by areas of operational and clinical need (eg to support the Trust's capacity plans, service sustainability or quality improvement). The development of a vascular surgery network with an arterial hub at Lister is one example of ICS-wide provider collaboration, led by the Trust, designed to enhance patient outcomes, efficiency and service sustainability. The development of a virtual ward in east and north Hertfordshire is another example of ICP (place) collaborative work designed to reduce hospital lengths of stay and improve patient experiences through receiving sub-acute care in their home environment.

4. ICS update

The ICS is continuing to work with acute providers in relation to service recovery and transformation whilst also working to prepare for and execute the anticipated transformation from three CCGs, to a new Statutory ICS from April 2022. The local ICS provider landscape across which we operate is attached as Appendix 1.

NHS England has published the ICS Design Framework guidance (16 June 2021; see Appendix 2 for an overview) which outlines the following areas in more detail:

- Anticipated functions of the ICS Partnership and ICS body
- Likely governance arrangements for the ICS body
- Good practice for ICSs
- Key features of the financial framework
- The roadmap to implement new arrangements for the ICS body.

There is a high degree of flexibility for ICPs to develop their arrangements to best meet local needs - the guidance provides the design framework for systems; with significant flexibility for local determination of system governance arrangements. The timescales for transition from CCG to ICS are challenging within which to effect significant change in the commissioning and governance of health and care . Therefore, the Trust will need to understand and engage with the ICS's and ICPs' local proposals in the context of both the best interests of effective ICP and system working and consideration of its own statutory responsibilities and strategic aims.

5. ICP updates

5.1 Mental Health and Learning Disability (MH&LD) Collaborative MOU

The Trust continues to engage with partners through the Mental Health and Learning Disabilities (MH&LD) Collaborative which has recently commissioned work to forecast the impact of the pandemic on future demand for mental health services in Hertfordshire and, as with physical health, this indicates a significant increase in expected need. This work is to be further considered by the ICS.

In common with many other hospitals, the Trust has seen a sustained increase in the numbers and acuity of patients with acute mental health needs attending the Lister Emergency Department, including children and young people requiring specialist mental health care. The Trust has also been working with Hertfordshire Partnership NHS Trust to enhance training, pathways and support for these patients whilst they are in the Trust.

With the publication of the White Paper "Integration and Innovation: working together to improve health and social care for all" the MH&LD Collaborative now needs to build on the work already done to jointly "develop a joint proposal for the structure and activities of a Collaborative" for presentation to the Hertfordshire and West Essex ICS. A draft

Memorandum of Understanding (MOU) (Appendix 3) has been developed through discussion and feedback at the Collaborative Directors' Group that describes what further work needs to be completed. The MH&LD Collaborative has asked partners to approve this draft MoU. The Strategy Committee has considered this in advance of the Board and noted the need to ensure that the scope of the collaborative does not detract from the ability of the ENH ICP to develop a holistic and joined –up approach population-based approach to both physical and mental health.

5.2 East and North Hertfordshire ICP

We have continued to work with partners on a number of priority transformation areas to enhance system flow and resilience, drawing on population health data to inform identification of the following priorities; heart failure, respiratory, pre and post operative care to reduce overnight hospital stays , falls and infection. The virtual ward model is being further developed to play a key role in the development of a hospital at home model for the ENH system. A Health Inequalities sub-group, chaired by a PCN clinical director, has been set up to advice the group on this important area and ensure a clear focus on understanding and reducing health inequalities. In recognition of the value in consolidating relationships across partners, an initial programme of informal summer events has been agreed , to be followed by further ICP-wide OD work to complement transformation across partner organisations.

ICP partners have also been progressing the agreement of a Memorandum of Understanding for the partnership and agreed the outline scope of a partnership strategy which is now under development. A draft maturity assessment has been developed and, to support further ICP development, the Partnership Board has agreed to jointly fund a small partnership development team to provide additional capacity in support of the work that the development director is undertaking on behalf of partners.

6. Recommendation

The Board is asked to:

- note this update
- Consider approving the draft MH&LD MOU (Appendix 3) whilst formally noting the Trust's view that the scope of the collaborative should not adversely impact the scope of the geographical (ENH) ICP in its ability to adopt and drive a holistic approach to population health, connecting both physical and mental health and LD needs together.

Our Provider Landscape

Appendix 1

Royal Papworth

Bedford hospital

Luton & Dunstable hospital

Watford hospital

MVCC

Cambridge University Hospitals

Lister

QEII

Hertford County

Princess Alexandra Hospital

HUC

UCLH

HPFT – mental health & LD

HCT – ENH adult community services, HV CYP services

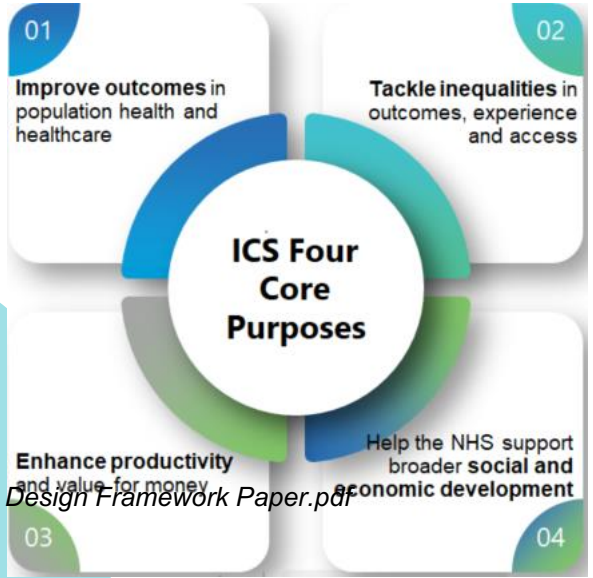
ICS: Design Framework

Beena Jhoree
Head of Contracts
21.06.2021

ICS NHS Body

Key features

- **Statutory organisation**
- Will **absorb all CCG functions** duties, assets, liabilities, commissioning and contract responsibilities.
- Will have **delegated functions from NHSE/I**
- **Common framework** for effective leadership and governance
- **Shared corporate accountability** for functions and duties.
- **Unitary body** focused on ICS four core purposes
- Build on existing **quality oversight arrangements** and resource quality governance arrangements.
- Should be **constituted to deliver ICS four core purposes.**



NHS The Princess Alexandra Hospital NHS Trust

NHS Hertfordshire Community NHS Trust

NHS West Hertfordshire Hospitals NHS Trust

NHS East and North Hertfordshire NHS Trust

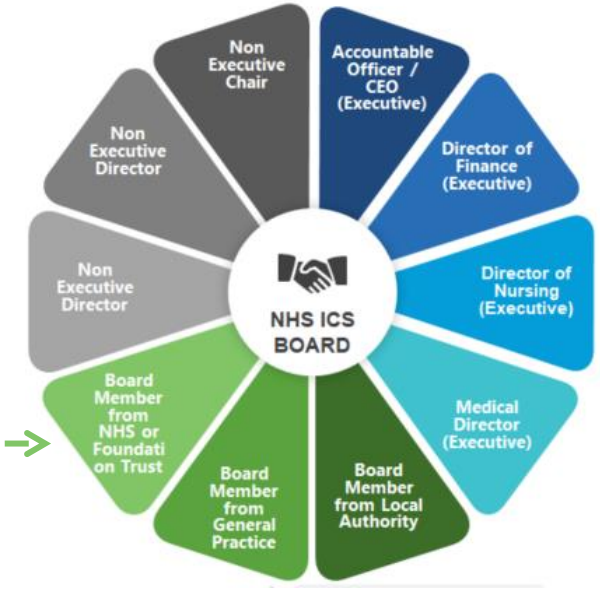
NHS Hertfordshire Partnership University NHS Foundation Trust

Board member from NHS / Foundation Trust is

- **not a delegate** for the sector
- Often be a **CEO / Executive** and
- **Must act in the interest of the ICS body** and wider system, not employing provider

ICS NHS body responsibilities

- Develop plan to meet health needs of population & have regard to Partnership's strategy
- Allocating resources (revenue and capital) to deliver plan across the system
- Establishing joint working arrangements to embed collaboration
- Establish governance arrangements for collective accountability
- Arrange provision of health services
- Lead implementation of the People Plan
- Lead system-wide action on data and digital
- Understand local priorities, track delivery of plans, monitor and address variation and drive continuous improvement
- Drive joint work on estates, procurement, supply chain and commercial strategies
- Lead system-wide action on data and digital
- Plan, respond and lead on recovery from incidents
- Functions NHSE/I delegate



NHS ICS Board is the senior decision making body of the NHS ICS Body. All members are expected to be full members.

Model of distributed clinical and professional leadership should be developed and signed off.

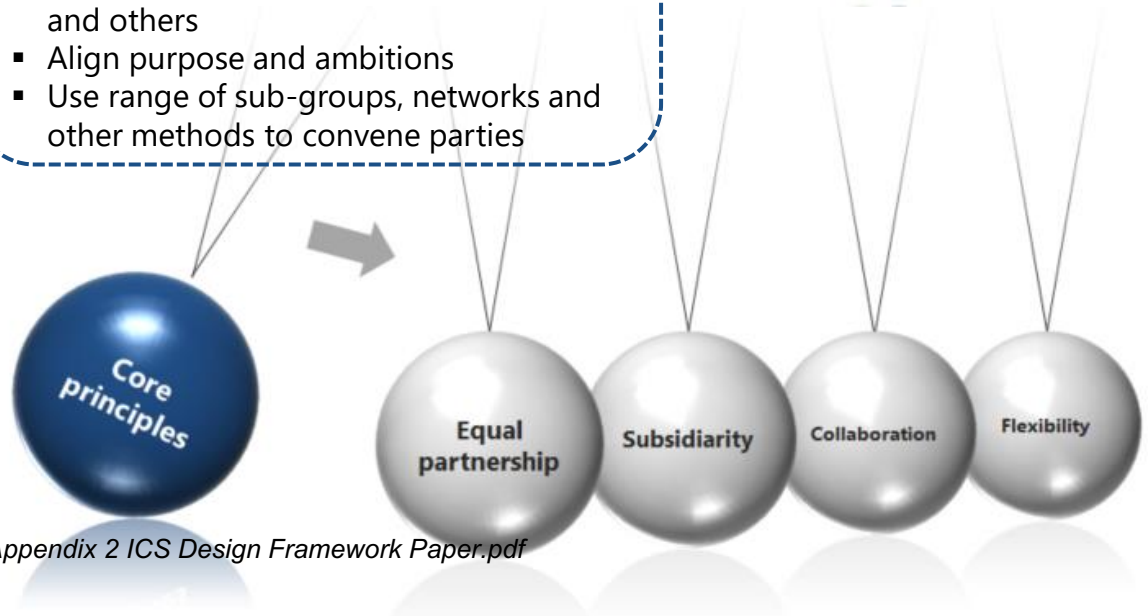
ICS Partnership

Established by

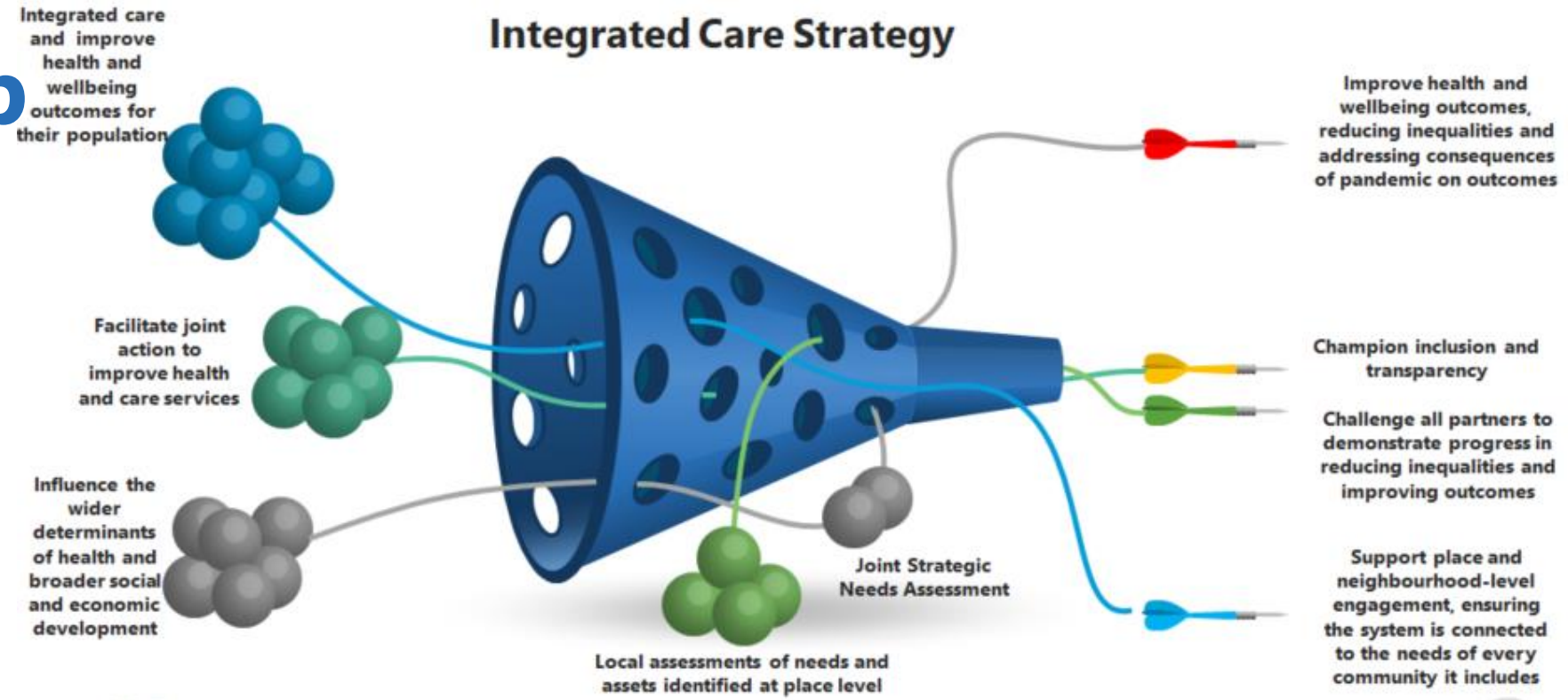
NHS + Local Authorities

And includes wider membership from across the local organisations and community.

- Partnership to operate as a forum (committee and not corporate body)
- Partnership chair can be same or different to NHS Body
- Bring together local government, NHS and others
- Align purpose and ambitions
- Use range of sub-groups, networks and other methods to convene parties



9. Appendix 2 ICS Design Framework Paper.pdf



ICS partnership responsibilities

- Distributed leadership model
- Nurturing the culture and behaviours of a system
- Support legal duties of statutory bodies
- Agree arrangements for transparency
- Operate a collective model of accountability
- Co-operate
- Agree arrangements for transparency and local accountability, including meeting in public
- Principle of subsidiarity
- Improve outcomes for people
- Champion co-production and inclusiveness
- Create a learning system, share evidence and insight

Providers

ICS NHS body and partnership decision-making

- Must harness expertise, energy and ambition from organisations responsible for delivering integrated care.
- Expected legal duty of engagement with people and communities with priority to engage with groups affected by inequalities.

Primary Care Networks	Place based Partnerships	VCSE Sector	NHS & Foundation Trusts	Provider Collaboratives	Supra- ICS Arrangements
▪ To be included at all levels of ICS. ▪ Needs of local population at neighbourhood level to be considered at place and system level. ▪ PCNs to support delivery of care at place level. ▪ Develop integrated MDT's across NHS, LA's and VCSE's.	▪ ICS to define place based including geographical size. ▪ Must represent local communities and allow joined up decision making. ▪ To resource PCNs where work is to drive improvement or provide representation at place.	▪ ICS to develop formal agreements to integrate VCSE in system level decision making by April 2022.	▪ To transform and deliver services. ▪ Agree best to use resources to improve population health. ▪ Delegation of commissioning function and responsibilities. ▪ Performance to be measured against contribution to ICS objectives (financial balance)	▪ Provider Trusts expected to part of at least one Provider Collaborative by April 2022. ▪ Integral to transform services with shared ownership of objectives and plans. ▪ Governance subject to local determination. ▪ ICS to contract with PC (e.g. Lead Provider)	▪ Some ICS services (mental health) will need to work across systems. ▪ This could be a PC or similar arrangement which can work within and across systems. ▪ There will need to be shared plans. ▪ Governance will be co-designed by ICSs / NHSE/I

Governance

Oversight

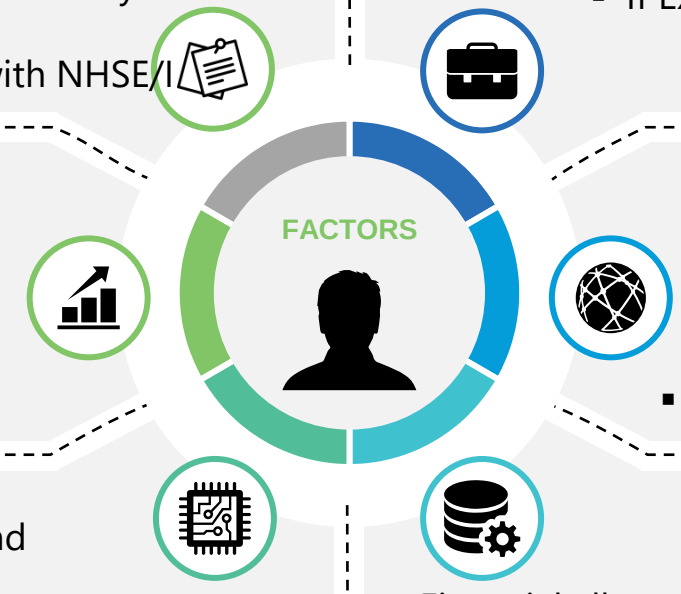
- NHSE / I oversight to be built on System Oversight Framework.
- ICS to have formal local role in wider system to lead on and support on oversight for individual organisations within the system to identify and tackle risk.
- ICS NHS bodies oversight and accountability will be with NHSE/I

Accountability

- ICS NHS Body & Statutory organisations to be held to account by NHSE/I.
- Formal regulatory action remains responsibility of NHSE/I.
- Executives within organisations responsible to their own Boards for performance.
- If Executive sits on NHS ICS Body then also responsible for their performance.

Data & Digital

- ICS to have smart digital and data foundations in place by April 2022.
- New Framework with 7 success measures and expectations including investment in infrastructure and implementation of shared care records.



People and culture

- Requirement to deliver against NHS People Plan with One Workforce approach.
- Clear governance arrangements for agreeing and driving local priorities.
- Leadership to drive culture and behaviours and align functions. .

Mechanisms to support collaboration

- System financial envelopes with aligned payment and incentive approach
- Change in organisational oversight to System Oversight Framework.

Regulatory (anticipated duties on NHS organiations)

- Common duty to have regard to the three standards of the triple NHS Aims (improve population health, quality of care and use of resources) in wider decisions
- Duty to ensure system financial balance supported with review of provider license.
- Power to ensure organisation capital spend in line with system capital plan

Finance and funding flows

- Financial allocations to be made to ICS based on population need (and on similar basis as CCG allocations).
- May also include primary care, spec comm, transformation and investment in data and digital funding.
- ICS can set delegated budgets for place-based partnerships based on principle of equal access for equal and requirement to reduce health inequalities
- Must meet national commitments and funding guarantees (i.e. mental health, community and primary care)

9. Appendix 2 ICS Design Framework Paper.pdf

Transition to Statutory ICS (Timeline)

Backlog
Ready to Do
In-Progress
Done

Boards | Jump to...

Preparation (by end of Q1)

Update system development plans (SDP's) against key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements.

Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, and any changes to ICS boundaries and the need to transform functions to support recovery and deliver across the ICS.

Implementation (by end of Q2)

Ensure people currently in ICS chair, ICS lead or accountable officer roles are well supported and consulted with appropriately.

Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHS E/I.

Confirm appointments to ICS chair and chief executive. Subject to NHS Bill, these roles will be confirmed as designate.

Draft proposed new ICS NHS Body MoU arrangements for 2022/23, including ICS operating model and governance arrangements.

Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint.

Begin due diligence planning.

Implementation (by end of Q3)

Ensure people in impacted roles are well supported and consulted with appropriately.

Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level role in the NHS ICS Body, using local filling of post processes.

Confirm designate appointment to ICS NHS Body finance director, medical director and director of nursing roles and other board and senior level roles.

ICS NHS bodies and ICS partnerships to be ready to operate in shadow form.

Engagement on local ICS constitution and governance arrangements by NHS ICS bodies and ICS partnerships

Transition (by end of Q4)

Ensure people in affected roles are consulted and supported.

Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes..

Confirm designate appointments to any remaining senior ICS roles so that as much of the ICS NHS executive board and other senior leadership is ready.

Complete due diligence and preparation for staff and property transfers from CCGs and other NHS staff transfers to new ICS NHS Body in line with NHSE/I guidance.

Commence engagement and consultation on the transfer with trade unions.

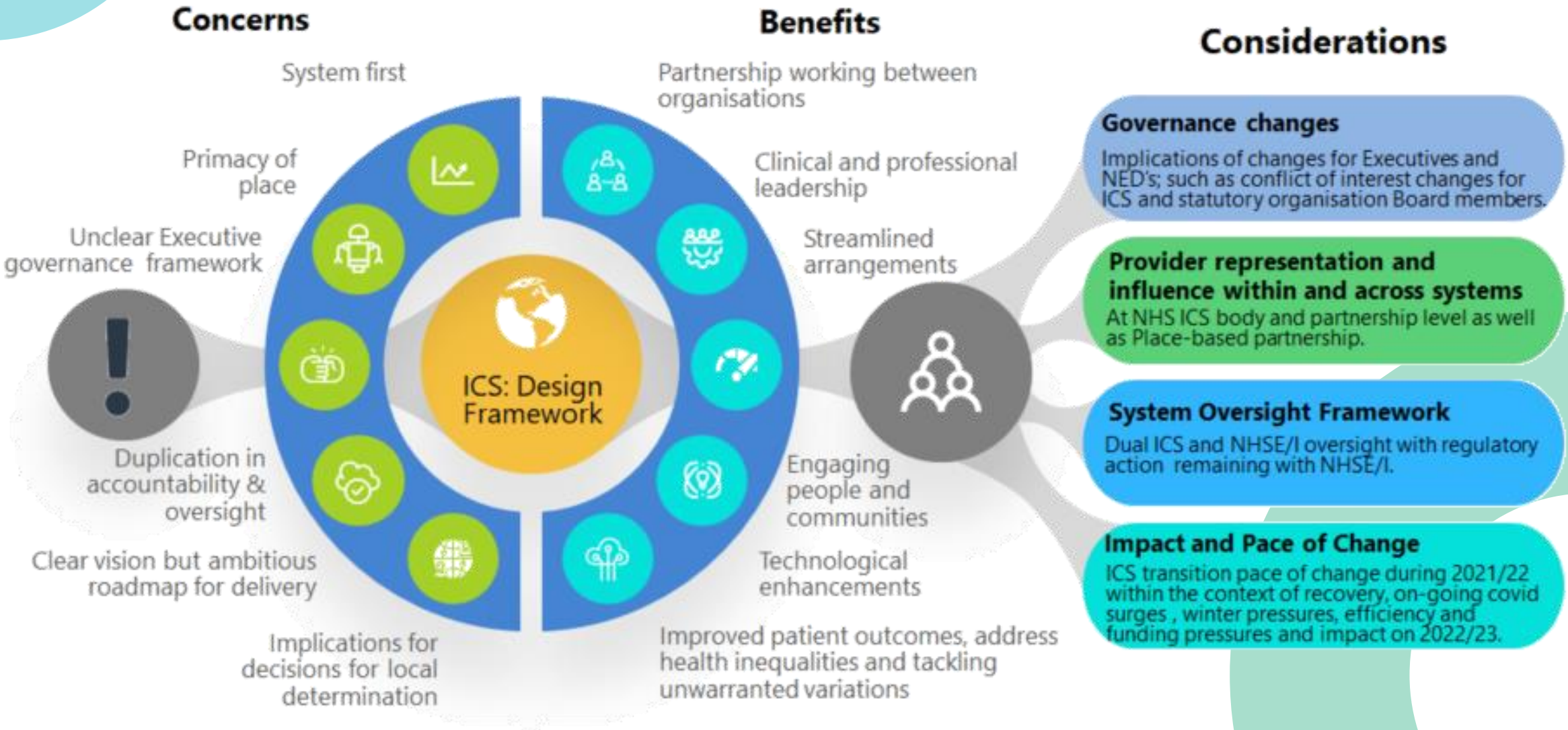
Complete preparations to shift NHSE/I direct commissioning functions to ICS NHS body, where this is agreed from 1st April 2022.

Ensure the revised digital, data and financial systems are in place ready for 'go live'.

Submit the ICS NHS body constitution for approval and agree the 2022/23 ICS MoU with NHSE/I , setting out key elements of how the new ICS NHS body and ICS partnership will operate in the future, in accordance with NHSE/I guidance.

+ Add another card

Considerations



9. Appendix 2 ICS Design Framework Paper.pdf

Mental Health & Learning Disability Collaborative

MH LD Collaborative Partnership Board

Meeting Date:	18th June 2021	**Agenda Item:**
Subject:	Memorandum of Understanding	**For Publication:**
Author:	Kate Linhart, Head of Mental Health and Learning Disabilities Collaborative Development	
Presented by:	Kate Linhart, Head of Mental Health and Learning Disabilities Collaborative Development	
Approved by:	Karen Taylor, Executive Director of Strategy and Integration	

Purpose of the report:

To propose a Memorandum of Understanding (MOU) to be considered for approval by the Collaborative members.

Action required:

The Board is asked to review the attached draft MOU and consider that it be adopted as a final version for signature by the partner organisations and if the there are any changes required, to approve subject to the required changes being made.

Summary and recommendations to the Board:

With the publication of the White Paper "Integration and Innovation: working together to improve health and social care for all" the MHLD Collaborative now needs to build on the work already done to jointly "develop a joint proposal for the structure and activities of a Collaborative" for presentation to the Herts & West Essex ICS (HWE ICP).

A draft Memorandum of Understanding has been developed, through discussion and feedback from the Collaborative Directors Group, that describes what further work needs to be completed, "The objectives", to create this proposal and is now being presented for Final Agreement

The MOU commits the Collaborative members to continue "to work collaboratively to develop a joint proposal for the structure and activities of a Collaborative" for presentation to the HWE ICS.

The MOU reconfirms the Collaborative Vision and our Aims and Guiding Principles, however, its main focus is on defining the joint work that will need to be completed to make the proposal. It also sets an aspiration, to be kept under review, of when the Collaborative will complete the work.

The MOU is not a legally binding agreement but it does more formally commit all members to completing this work.

Recommendation's

The Board is asked to review the attached draft MOU and recommend to the partner organisations that it be adopted as a final version for signature by the partner organisations

If the there are any changes required that prevent such a recommendation to approve subject to the required changes being made.

December 2020

MEMORANDUM OF UNDERSTANDING

ESTABLISHMENT OF AN INTEGRATED CARE PARTNERSHIP FOR MENTAL HEALTH AND LEARNING DISABILITY IN HERTFORDSHIRE

Between

XXXXXXXXXXX

and

XXXXXXXXXXXXXXXX

and

XXXXXXXXXXXXXXXXXXX

and

HERTFORDHSIRE PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

2021

1.0 Parties to the Agreement

THIS AGREEMENT is made and entered into on the 1st October 2020

BETWEEN:

1) **AAAAAAAAA**
2) **BBBBBBBBB**
3) CCCCCCCC
4) DDDDDDDDD
5) **NNNNNNNNN**

Together known as the "**Parties**" and individually as a "**Party**"

2.0 Purpose

The Parties have agreed to work collaboratively to develop a joint proposal for the structure and activities of a Collaborative that will take responsibility for meeting the mental health and learning disability needs of those ordinarily living in Hertfordshire and or registered with a Hertfordshire GP.

With its focus on mental health and learning disability / autism needs, it will work with others across the local system to:

- Improve population health and healthcare
- Tackle unequal outcomes and access, particularly those experienced by people with mental health or learning disability needs
- Enhancing productivity and value for money and helping the NHS to support broader social and economic development, through its employment, training, procurement and volunteering activities, and as a major estate owner

The shared aspiration is for this proposal to be formalised, following the governance processes of the member organisations, in a "Collaborative Agreement" at a Collaborative Board by 30 Sept 21. However, given final legislation and guidance will shape this work, this aspiration will be kept under review.

3.0 Vision

Supporting people living with a mental illness and / or a learning disability in Hertfordshire to live longer, happier and healthier lives

4.0 Aims / Guiding Principles of the Integrated Care Partnership

- A strong mental health and learning disabilities voice across and for the system
- A focus on addressing inequalities in healthcare; preventing people from becoming unwell and the promotion of positive health and wellbeing
- Safe, high quality mental health and learning disabilities support and services across Hertfordshire
- Integration of mental health and physical health support and services

5.0 Agreement

In order to achieve these aims the Parties have agreed to:

- Work together with key stakeholders to develop a new approach to the commissioning and provision of integrated care that will improve outcomes for communities in Hertfordshire
- Jointly meet on a regular basis to progress the aims.
- Keep action, issue and risk logs to identify progress and manage potential blockages at the earliest opportunity
- Actively promote the benefits of working together internally, to stakeholders and contacts;
- Actively participate and resource participation in the design and preparation of the proposed "Collaborative Agreement"
- Implement a management escalation process, as needed, to an appropriate and nominated senior manager, for the purposes of joint strategic and/or management decision-making, issue clarification or dispute resolution;
- Make best endeavours to secure the mutual understanding and agreement of the other Party prior to making any significant representations or submissions to the contracting authority in relation to the agreed activities, that may have a reputational, operational or financial impact for any party;

6.0 Contractual arrangements

The final contractual arrangements between the ICS and the members of the Collaborative will be developed by the work under this MOU and agreed through the Collaborative Board and the governance processes of the member organisations, before formally being proposed to the ICS NHS Body.

7.0 Key Objectives

Working together as described in section 5.0 we will develop a joint proposal for the structure and activities of a Mental Health and Learning Disabilities Collaborative, and a proposed Collaborative Agreement.

This joint work will:

- Establish the future approach to commissioning including the core activities and how these are shared between the ICS NHS Body and the Collaborative partners
- Define the scope (who services are provided to and what services are provided) of the services commissioned and provided by the Collaborative
- Describe how the geographical and mental health / learning disability Collaborative will work together to ensure integrated care
- Develop appropriate governance structures in line with the Vision and Principles of the Collaborative and in line with the scope and commissioning agreed through the work described in this MOU
- Define the Collaborative's approach to ensuring a co-production approach to services development such that the voice of the service user is heard
- Recommend a revised approach to the existing Section 75 Agreements to ensure the continuation of the associated benefits as the CCGs are subsumed by the ICS NHS Body.

- Define the supporting contractual arrangements between the parties and the ICS NHS body to take effect from April 2022 that, taken together with the proposed Collaborative Agreement, allow the parties, collectively, to make decisions and provide services that improve the mental health and learning disability outcomes for our local populations.
- Identify key risks to the parties (financial and non-financial) and mitigations associated with the proposed arrangements
- Provide a transition plan that will progressively establish these agreements in practice from Oct 21 such that the Collaborative is able to take formal responsibility from 1 April
- Ensure that all relevant agreements are approved through the relevant Party's governance processes and formally signed off
- Agree Information Sharing requirements and sign off a mutually agreeable Information Sharing Agreement (ISA)

8.0 Accountability

The accountability of each party both separately and collectively will be established through achievement of the objectives described in section 7 above.

9.0 Governance Arrangements relating to this MOU

The already established "Directors Group" will oversee this work and ensure adequate resources are made available to allow the work described to be progressed to the required timetable.

The Directors Group will report on progress to the Collaborative Board.

10.0 Financial Arrangements relating to this MOU

10.1 Each Party is responsible for their own costs. However, there may be agreement to provide financial resource to the partnership to support costs of development e.g. jointly seconded posts, project management etc. All costs will be agreed in advance and in writing.

11.0 Disputes / Reconciliation

11.1 In the event of the Parties not working to the agreed terms of this MOU, in the first instance, the Parties should work together to resolve any problems that arise through – dialogue and review will be the first step.

11.2 If local actions of this sort do not resolve the problem(s) then other steps may be taken to bring the matter to a satisfactory conclusion, initially by escalation through to the Collaborative Board and ultimately through a Chief Executive to Chief Executive discussion.

12. Evaluation and Review

This MOU will continue until the Parties have agreed to a formal Collaboration Agreement.

13. Status of the MoU

With the exception of Paragraphs 14 and 15 (inclusive), this MoU is not intended by any Party to be legally binding.

No Party has the authority to commit any other Party to any act, responsibility or liability under the terms of this MoU.

Nothing in this MoU is intended to create, or be deemed to create, a relationship of agency or partnership, joint venture, or the relationship of employer and employee, between the Parties, or constitute any Party being the agent of any other Party.

The MoU is a clear intention of the Parties joint commitment to work together to deliver the Objectives as evidenced by the signatories below.

14. Confidentiality and Data Protection

For the purposes of this Paragraph the following definitions shall apply:

"**"Confidential Information"**

means all information in whatever form (including without limitation in written, oral, visual or electronic form, or on tape or disk) directly or indirectly relating to the Partnering Proposal being considered by the Parties (including all such information that is provided by either Party to the other Party in respect of its business and operations) that is disclosed whether before or after the date of this MoU in connection with the Partnering Proposal being considered by the Parties;"

"Data Protection Legislation"

the Data Protection Act 1998, the Data Protection Directive (95/46/EC), the General Regulation (Regulation (EU) 2016/679) (when in force) and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner.

14.1 Save as required to be disclosed by law, each Party agrees that it shall keep:

14.1.1 the Confidential Information secret; and

14.1.2 the existence, terms and content of this MoU and the terms of each final document in relation to the Partnering Proposal including the Partnering Documentation confidential

subject to Paragraph 14.2.

14.2 The obligations in Paragraph 14.1 shall continue without limit in point of time save that they shall cease to apply to any information coming into the public domain otherwise than by breach of those obligations.

14.3 No Party shall advertise or make any public announcement regarding the Partnering Proposal without the prior written consent of the other Parties.

14.4 All Parties shall comply with Data Protection Legislation and must ensure that all personal data processed by its staff on behalf of and/or in the course of this MoU, is processed in accordance with the provisions and principles of the Data Protection Legislation.

14.5 Notwithstanding anything in this MoU to the contrary, in the event that any Party receives a request for information under the FOIA, the receiving Party shall be entitled to disclose all information and documentation (in whatever form) as necessary to respond to that request in accordance with the FOIA, save that in relation to any such information that is Exempted Information, the receiving Party shall use reasonable endeavours to consult the other Parties as soon as reasonably

practicable and shall not disclose the information requested, if in the receiving Party's opinion (having taken into account the views of the other Parties) that an exemption is, or may be applicable in accordance with the relevant section of the FOIA in the circumstances.

15. Business as usual

15.1. The Parties agree to co-operate with each other and work through the Governance Arrangements in a constructive, open manner in order to progress the Partnering Proposal.

15.2. The Parties will co-operate with, and work in a constructive, open manner with each other in relation to any negotiation of documentation which may occur in the period from the date of this MoU until completion of the Partnering Proposal.

15.4. In doing so each Party acknowledges and agrees that it will use its best endeavours to:

15.4.1 operate in its usual way and not discontinue or cease to operate all or a material part of its business;

15.4.2 not acquire or dispose of, or agree to acquire or dispose of, any material asset except in the usual and ordinary course of its business or assume or incur a material liability, obligation or expense (actual or contingent) except in the usual and ordinary course of its business and on usual terms;

15.4.3 not deliberately do (or not do) any act or thing which is likely to materially adversely affect its reputation or the relationship of it with patients, interest groups, commissioners, consultants, professional advisers, regulators, trade unions, suppliers, the DH and/or employees.

Signed:

Name:

Date:

On behalf of: xxxxxxxxxxxxx xxxxxxxxxxxxxxx xxxxxxxxxxx

Signed:

Name:

Date:

On behalf of: xxxxxxxxxxxxx xxxxxxxxxxxxxxx xxxxxxxxxxx

Signed:

Name:

Date:

On behalf of: xxxxxxxxxxxxx xxxxxxxxxxxxxxx xxxxxxxxxxx

Signed:

Name:

Date:

On behalf of: xxxxxxxxxxxxx xxxxxxxxxxxxxxx xxxxxxxxxxx

Signed:

Name:

Date:

On behalf of: xxxxxxxxxxxxx xxxxxxxxxxxxxxx xxxxxxxxxxx

East and North Hertfordshire NHS Trust

Agenda Item: 10

TRUST BOARD – 7 JULY 2021
Operational and People Recovery

Purpose of report and executive summary (250 words max): The report provides an update on the Trust's work in relation to the operational and people recovery programmes.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chief Operating Officer and Chief People Officer	**Presented by:** Chief Operating Officer and Chief People Officer	**Author:** Chief Operating Officer and Chief People 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) Operational, People, Pandemic
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

ENHT Elective COVID Recovery

Recovery

East and North Hertfordshire NHS Trust

As we continue to recover we must do so in a way that addresses our key priorities.

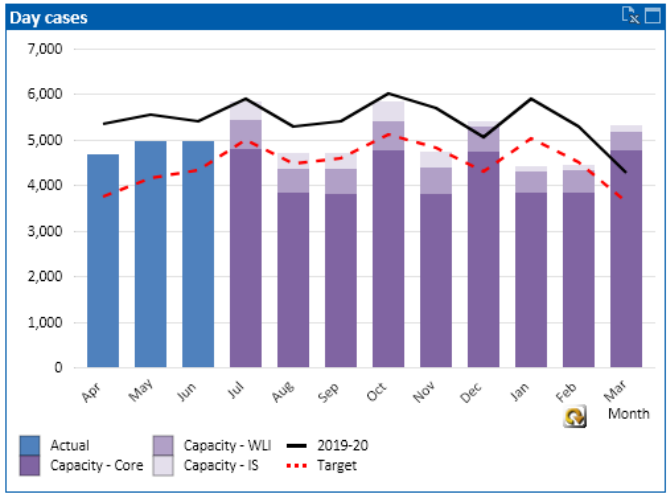
Recovery (activity) performance and plan

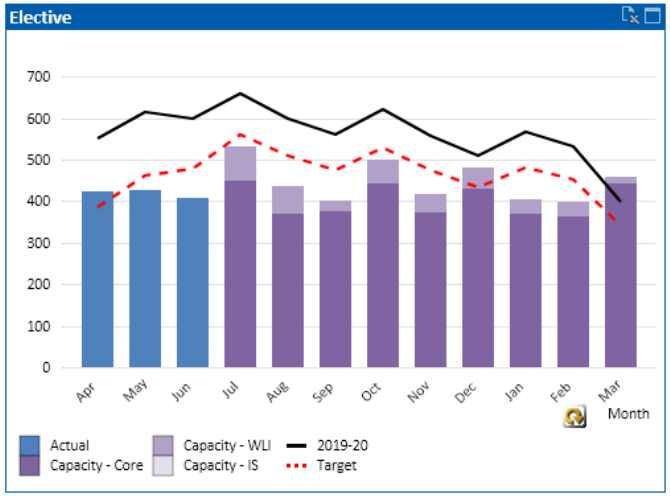
East and North Hertfordshire NHS Trust

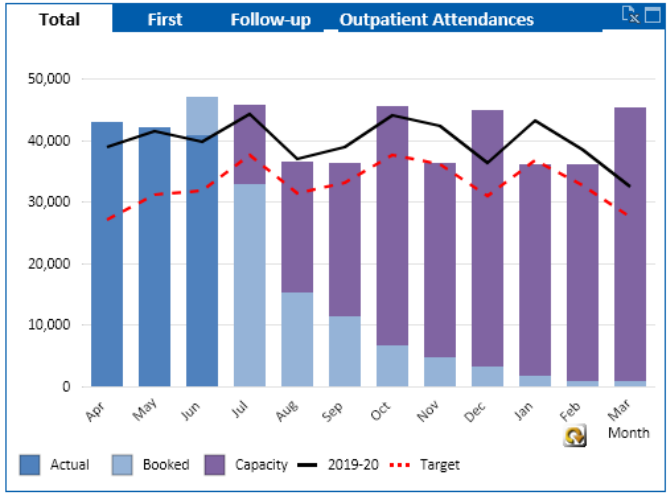
Elective Recovery Fund performance Standards measured against 2019/20 activity value:

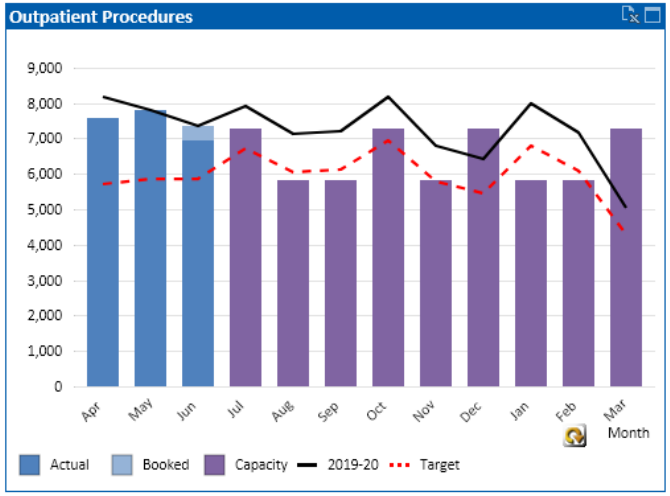
- April – 70%
- May – 75%
- June – 80%
- July – 85%

Delivery is measured as the Herts and West Essex System.









Recovery (gateway) performance

East and North Hertfordshire NHS Trust

The Trust and the Integrated Care System are required to deliver on 5 gateways, supporting delivery and securing the Elective Recovery Fund:

Gateway 1: Clinical Validation, Waiting List and Long Waits

- 98.% of patients prioritised on a admitted pathway (see next slide)
- Services prioritising patient based upon: P categories P1, P2, P3 time limited categories, long wait patients
- 104 weeks with consideration given to patient needs i.e. learning disabilities, then 52 weeks, 18 weeks
- System backstop position, 0 patient waits greater than 78 weeks

Gateway 2: Addressing Health Inequalities

- Analysis undertaken on patient demographics, protected characteristics by the host trust

Clinical Validation – Admitted patients

East and North Hertfordshire NHS Trust

Count of Patients											
APETreatmentFunction	-	PL1a	PL1b	PL2	PL3	PL4	PL5	PL6	Grand Total	Total	% P Code
	85	0	1	552	2212	2636	203	46	5735	5650	98.5%
100 - GENERAL SURGERY	0	0	0	23	225	154	11	7	420	420	100.0%
101 - UROLOGY	0	0	0	150	250	394	5	0	799	799	100.0%
103 - BREAST SURGERY	0	0	0	35	2	0	1	1	39	39	100.0%
104 - COLORECTAL SURGERY	0	0	0	20	131	42	1	2	196	196	100.0%
107 - VASCULAR SURGERY	0	0	0	47	22	22	1	2	94	94	100.0%
110 - TRAUMA AND ORTHOPAEDICS	11	0	0	26	365	601	50	13	1066	1055	99.0%
120 - ENT	0	0	0	26	73	126	14	9	248	248	100.0%
130 - OPHTHALMOLOGY	20	0	0	43	186	770	1	1	1021	1001	98.0%
140 - ORAL SURGERY	16	0	0	9	63	241	3	0	332	316	95.2%
160 - PLASTIC SURGERY	7	0	0	62	121	127	17	3	337	330	97.9%
171 - PAEDIATRIC SURGERY	0	0	0	0	2	3	1	0	6	6	100.0%
191 - PAIN MANAGEMENT	2	0	0	14	585	64	92	2	759	757	99.7%
211 - PAEDIATRIC UROLOGY	5	0	0	5	22	5	0	1	38	33	86.8%
214 - PAEDIATRIC TRAUMA AND ORTHOPAEDICS	1	0	0	3	16	1	0	0	21	20	95.2%
215 - PAEDIATRIC EAR NOSE AND THROAT	0	0	0	8	25	26	1	1	61	61	100.0%
216 - PAEDIATRIC OPHTHALMOLOGY	0	0	0	0	1	1	0	0	2	2	100.0%
219 - PAEDIATRIC PLASTIC SURGERY	1	0	0	3	12	19	0	0	35	34	97.1%
320 - CARDIOLOGY	16	0	0	66	17	1	1	1	102	86	84.3%
420 - PAEDIATRICS	4	0	0	0	1	0	0	0	5	1	20.0%
422 - NEONATOLOGY	1	0	0	0	0	0	0	0	1	0	0.0%
502 - GYNAECOLOGY	1	0	1	12	93	39	4	3	153	152	99.3%

- 98.06 % of admitted patients are clinically stratified, this is now a consistent position

Recovery (gateway) performance

East and North Hertfordshire NHS Trust

Gateway 3: Transforming outpatients

- Face to Face vs. virtual appointments:

Consultation Medium Used - (Grouped) - Submission Approval Figures

Month	Face to Face	Video/Telephone	Telemedicine	Other (Not Listed)	Blank	Unable to Speak
May 2021	64.81%	34.93%	1.00%	1.70%	0.00%	0.00%
Apr 2021	60.67%	39.01%	1.00%	1.43%	0.00%	0.00%
Total	63.08%	36.64%	1.00%	1.59%	0.00%	0.00%

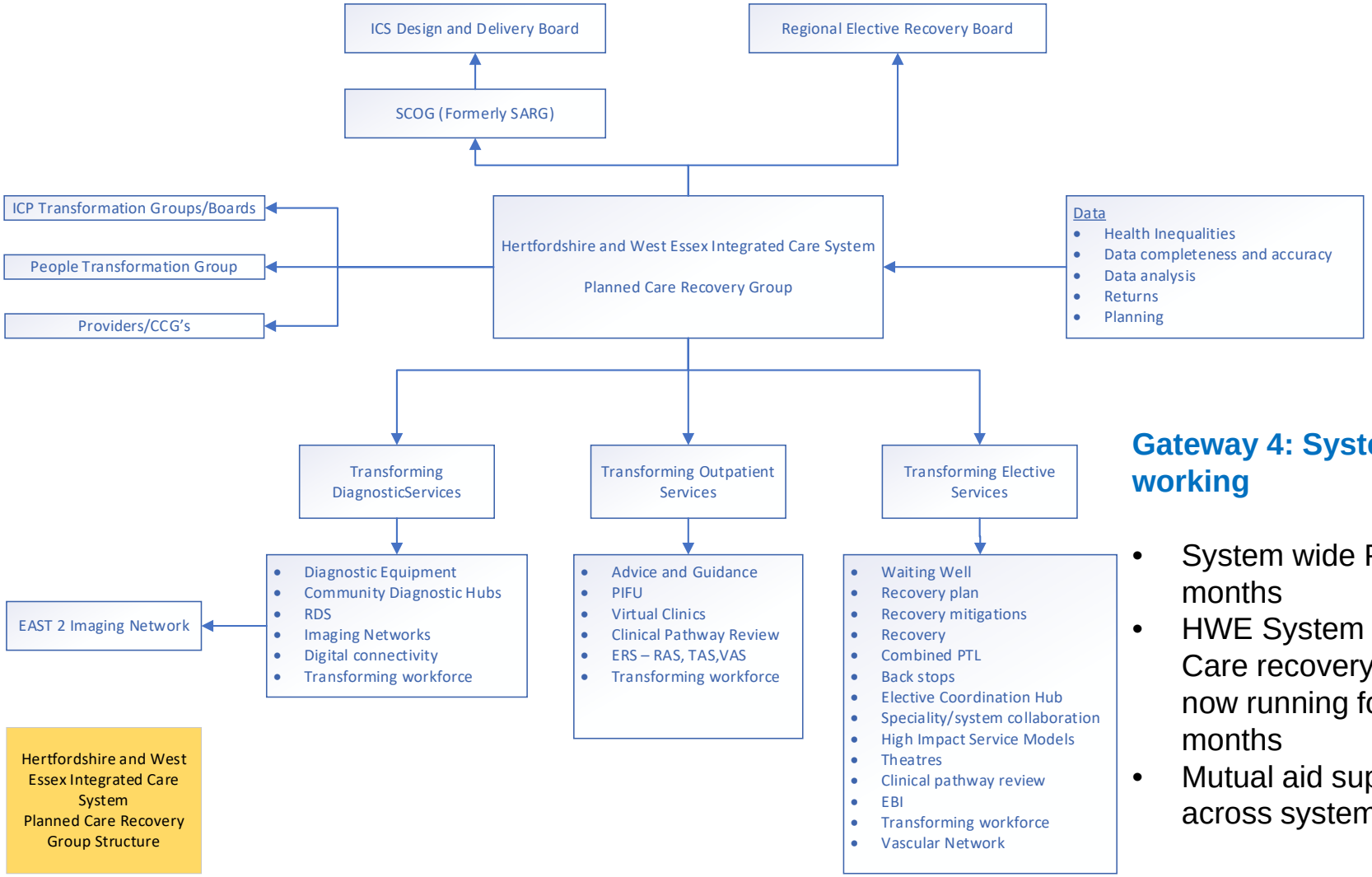
- Patient initiated Follow Up (PIFU)
  - Four specialities to go live with PIFU in July 2021 – Neurology, Ear Nose and Throat, Urology, Benign Breast.

- Advice and Guidance
  - All services published
  - Request received:

Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
377	453	541	604	736	1027	1083	865	950	1028	1007	948	817	885	1100	774	959

Recovery (gateway) performance

East and North Hertfordshire NHS Trust



Gateway 4: System working

- System wide PTL – 10 months
- HWE System Planned Care recovery group now running for 14 months
- Mutual aid supported across system

Recovery: People

East and North Hertfordshire NHS Trust

Specialist care referral (psychological care)

Here to help

Active services such as Health at Work and EAP (Employee Assist Programme), Employee Relations (ER), reflective team events, staff networks, wellbeing training, mental health first aid, speak up guardians and more. **Support if needed.**

Being at our best

Establishing a culture that supports the wellbeing of self and colleagues as essential to success. A wide range of supportive initiatives from exercise, hobbies and family to mindfulness, online services, helplines and apps. **Caring for our people.**

Building effective teams

Be active, compassionate, visible and inclusive. Healthy leadership creates collaborative networks, a sense of purpose, belonging and promotes autonomy.
Coaching people's potential.

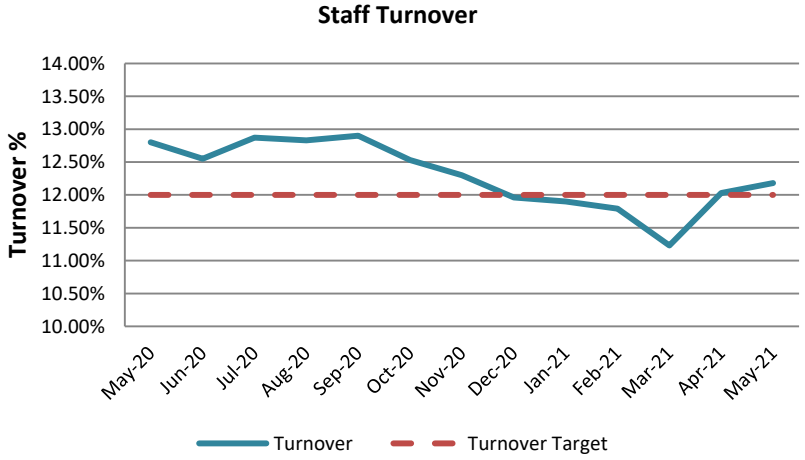
Relentless attention to working conditions

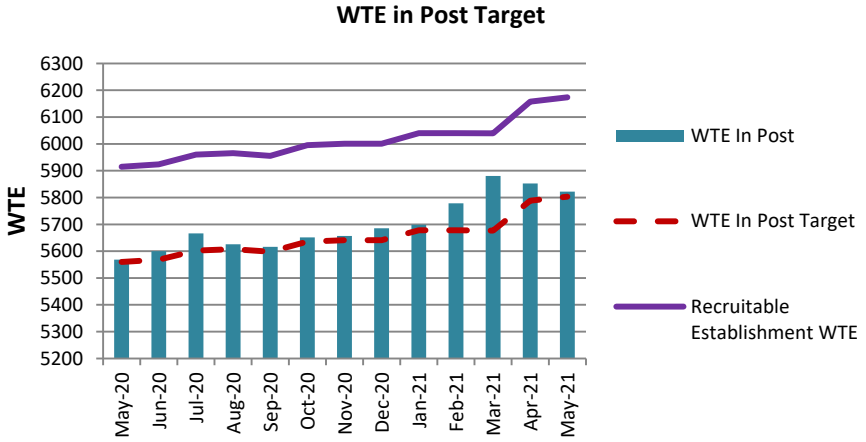
The environment, rest areas, refreshments, flexible working, transport, benefits, resources, communication, technology, policies and processes.
Pride in getting the basics right

Recovery: People

East and North Hertfordshire NHS Trust

- Additional 256 substantive staff in post compared to May ’20 including: 154 qualified nurses, 32 clinical support staff, 16 medical and dental
- Currently no band 5 nurse vacancies in the Trust
- Turnover rate down by 0.6% overall but nursing turnover is current at 9.5% (down by 2.7%)
- Opportunity for staff to buy back carried over leave
- Programme to refurbish 82 rest spaces in progress
- 84% of risk assessments completed
- 89% uptake of COVID-19 vaccine
- Grow together cycle in place – incorporating performance and career conversations and talent forums

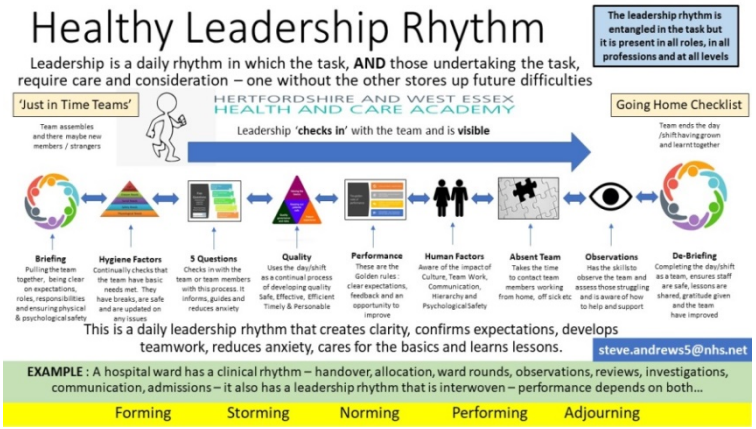




Recovery: People

East and North Hertfordshire NHS Trust

- Compassionate conversation training allocated for 150 ENHT leaders
- Appointed to head of culture role to lead on implementation of civility and respect tool kit
- Equalities & Inclusion Board commenced in May 2021 to oversee delivery of improvement plans including WRES recruitment findings and accelerated model employers targets
- Engagement in EoE reciprocal mentoring programme
- Delivery of 98 bite size learning sessions for healthy leadership rhythm and 32 grow together training sessions in May
- Recognition and thanks for all staff in the week of thanks commencing 5th July



Recovery: People

East and North Hertfordshire NHS Trust

- Reflection: 121 staff have attended a reflective space session since February and 46 have attended Schwartz rounds
- Uptake of these opportunities lower than hoped - in response to feedback, times have been changed to allow better access, vouchers for a drinks and snacks are now provided
- 656 spaces have been booked and 513 attended for a personal complimentary therapy session including massage, reiki and reflexology.
- Part of the ICS project to pilot free access to the Peppy Menopause support app - 142 of the 151 free licences have already been taken up by our employees in the first month
- Health at Work Service working with ICS partners to develop workplace services that support the recovery of staff with long term COVID health problems
- 4 Mental Health First Aid instructors fully training
- There are 11 trained first aiders, with a target to hit 200 in 12 months
- Online psychological first aid training launched to enhance awareness of psychological issues, when and how to seek help
- Shared decision making council has now been established and had its first meeting, this group of direct care staff will help evaluate the services on offer, explore barriers to taking up support and make recommendations on how to overcome them

TRUST BOARD - PUBLIC SESSION – 7th July 2021

Trust Objectives 2021/22

Purpose of report and executive summary (250 words max): The purpose of this paper is to ask Board to approve the Trust Objectives for 2021/22. Board is asked to note: • That draft objectives have been developed and reviewed by all Execs and amended accordingly • That suggested measures that support the objectives are also included • That once agreed, BAF risks will be mapped against the objectives for ongoing monitoring		
Action required: For approval		
Previously considered by: Executive Committee, 1st July		
Director: **Director of Strategy**	**Presented by:** **Director of Strategy**	**Author:** **Deputy Director of Strategy**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **BAF risks will be mapped against the objectives for ongoing monitoring**
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

Our Vision

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

Our Priorities

- **Quality:** We deliver high-quality, compassionate services, consistently across all our sites
- **People:** We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce
- **Pathways:** We develop pathways across care boundaries, where this is in the best interests of patients
- **Ease of Use:** We redesign and invest in our systems and processes to provide a consistently simple and quick experience for our patients, their referrers, and our staff
- **Sustainability:** We provide a portfolio of services that is financially and clinically sustainable in the long term

Our Objectives 2021/22

- Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030
- Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency
- Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits
- Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients
- Embed and develop the new divisional structure and leadership model to further improve service quality
- Harness innovation, technology and digital opportunities to support new models of care
- Create a staff health and well-being offer that is amongst the best in the health service
- Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider
- Progress and develop our equality performance to build an inclusive culture in the workplace

Our values

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

Objective	Measured by
Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030	Integrated Business Plan written; key developments costed and impact on workforce understood; clinical strategy in place for Trust and Divisions
Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits	Meeting key targets set by NHSEI re activity to reach 85% of 2019/20 capacity from July; all patients prioritised by clinical need; ongoing clinical reviews of waiting list; reduced RTT; reduction of patients waiting over 52 weeks; plan in place to step up covid response if required; cancer performance targets met; Ockenden review recommendations implemented; ED performance improved
Embed and develop the new divisional structure and leadership model to further improve service quality	Divisional governance structures established; performance and quality improved; skill mix reviewed and developed, supported by ENH Academy; improved staff survey reults
Create a staff health and well-being offer that is amongst the best in the health service	Offering in place; reduced sickness rates; health and wellbeing conversations routine; covid vaccination plan in place; improved staff survey results
Progress and develop our equality performance to build an inclusive culture in the workplace	Equality, Diversity and Inclusiveness Board established; EDI mentoring established; improved staff survey figures; improvement in WRES
Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency	Establishment of PIFU pathways for at least three specialties; establishment of at least four high volume pathways for the ICP Virtual Hospital; all patients on RTT clinically prioritised and analysed by ethnicity and deprivation; Ockenden report recommendations implemented
Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients	Commencement of at least three ICP 'proof of concept' project pilots; Vascular hub established; shared review of RTTs across ICS; review of mental health support in ED and on wards; collaboration projects identified
Harness innovation, technology and digital opportunities to support new models of care	Development of ePMA; vCKD; digital Front Door integration; new Maternity and Ophthalmology systems, allowing patient risk stratification in support of PIFU
Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider	Cancer strategy developed; progress made against preparation plan for transfer

Agenda Item: 12

TRUST BOARD - 7 JULY 2021
Board Assurance Framework Risks 2021/22

Purpose of report and executive summary (250 words max):
The BAF risks continue to be reviewed with each Director and Executive Team each month and at the Board and Board Committees and used to drive the agendas. The Trust's strategic risks for the Board Assurance Framework 2021/22 on one page. **Appendix a.** These with the exception of removing the reference to the short term risk of spending the capital allocation for 2020/21 (Risk 4) the scope of the risks remain unchanged for 2021/22. A formal review of the strategic risks will take place in the final stages of the development of the Trust's new Organisational Strategy.

The Trust's strategic priorities and have been mapped to the draft Trust objectives for 2021/22 providing assurance on the coverage. Please note the objectives are subject to final Board approval. The mapping will be updated to reflect the Board decision. **Appendix b.**

The current BAF 2021/22 has been completed with each of the lead directors, **appendix c,** using the revised template approved by the Audit Committee. This supports greater visibility of the actions linked to the gaps in controls and assurance. A cycle of deep dive reviews of the strategic risks is currently being finalised with the Chair of the Audit Committee.

Since the previous Board meeting the key points to note are:

- The role of the new Inclusion Committee has been into account and formally noted as joint oversight Committee for risk 2 - People and risk 9 – Culture.
- Following the discussion at the Strategy Committee on the new guidance on Integrated Care Systems the impact of this on the organisation and system, Risk 6 - ICP/ICS and Risk 7 – governance will be kept under review.
- The Committees reviewed all their risks in the June Meetings and the following changes to the risk rating were approved:
    - Risk 4 - Capital remained at 20 at the end of 2020/21 and following review, including structures and monitoring in place, further actions and oversight of the risks, and the Committee discussions in May 21, the rating has reduced to 16. (Lead Committee FPPC)
    - Risk 10 – Estates remained at 20 at the end of 2020/21 and following review and the Committee discussions in May/June 21 taking into account the estates strategy development, assurance paper and review of directorate risks, the rating has reduced to 15. (Lead Committee QSC)
    - Risk 12 – Pandemic, the Committee considered the assurances received including confirmation of maintaining compliance with the EPRR standards 2020/21 and supported reduce this risk from a 15 to 10. (Lead Committee QSC)
    - Risk 11 – MVCC, the Strategy Committee discussed MVCC Programme transfer update and noted the completion of the UCLH due diligence. However, due to the level risk of a potential delay to the programme increasing, the Committee increased the current risk score from 12 to 16. Work is being undertaken to mitigate the risk and will be discussed further at Trust Board (Private Session).

Action required: For discussion

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

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

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Yes – as noted
Any other risk issues (quality, safety, financial, HR, legal, equality): As documented under each risk

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

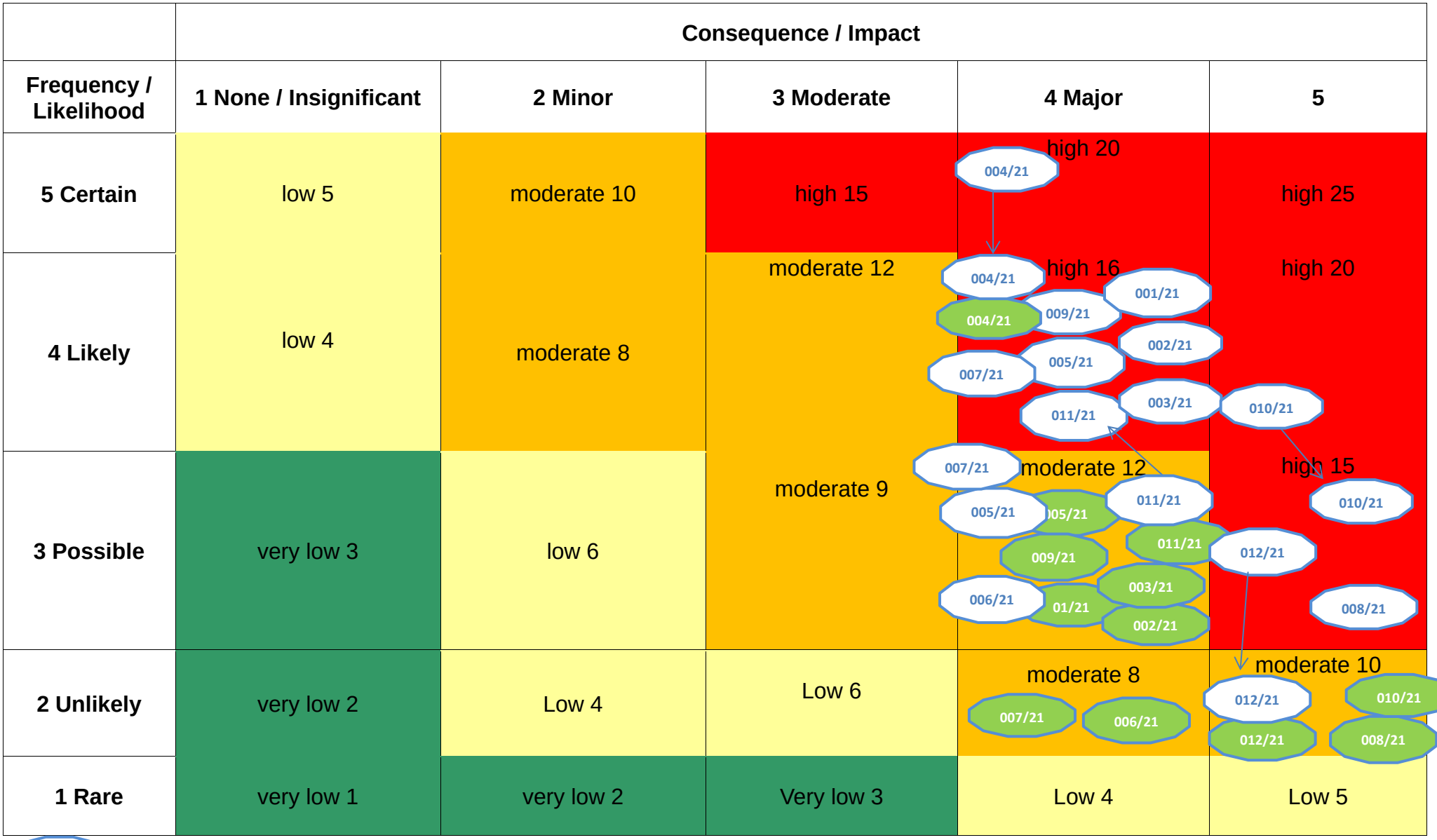
Likelihood / Impact	1 Rare (Annual)	2 Unlikely (Quarterly)	3 Possible (Monthly)	4 Likely (Weekly)	5 Certain (Daily)
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2021/22	Lead Executive	Committee	Current Risk June	Last Month May	3 months ago	6 months ago)	Target Score	Date added (Target dates for risk score/ changes)
001/21	Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	Chief Operating Officer	**FPPC**	**16**	**16**	16	16	**12**	01.03.18 (June 21)
002/21	There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public	Chief Nurse /Medical Director/CPO	**FPPC & Inclusion**	**16**	**16**	16	16	**12**	01.03.18 (April 21)
003/21	Risk of financial delivery due to the radical change of the NHS Financial Framework	Director of Finance	**FPPC**	**16**	**16**	16	16	**12**	01.04.19 (TBC)
004/21	There is a long term risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments (Updated May 2021)- **(risk reduced)**	Director of Finance	**FPPC**	**16** ↓	**20**	**20**	**20**	**15**	01.03.18 (TBC)
005/21	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Chief Information Officer	**Strategy**	**12**	**12**	**16**	**16**	**12**	01.04.17 (At target)
006/21	There is a risk ICP / ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	Director of Strategy	**Strategy**	**12**	12	12	12	8	01.04.20 (April 22)
007/2	There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive / Chief Nurse	**Board**	**12**	**12**	16	16	**12**	01.03.18 (21/22)
008/21	There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	Chief Nurse /Medical Director	**QSC**	**15**	**15**	**15**	**15**	**10**	01.03.18 (TBC)
009/2	There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community	Chief People Officer	**QSC & Inclusion**	**16**	**16**	16	16	**12**	01.03.18 (March 21)
010/2	There is a risk of non-compliance with Estates and Facilities requirements due to the ageing estate and systems in place to support compliance arrangements -**(risk reduced)**	Director of Estates	**QSC**	**15** ↓	**20**	**20**	**20**	**10**	22.01.19 (TBC)
011/21	There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC **(risk increased)**	Director of Strategy	**Strategy**	16 ↑	12	16	16	12	01.04.20 (TBC)
012/21	Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care **(risk reduced)**	COO/Chief Nurse	QSC/Board	**10** ↓	15	20	20	10 (Met June 21)	04.03.20 (April 21)

Board Assurance Framework Heat Map –June 2021



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

East and North Hertfordshire NHS Trust

Our Vision

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

Our Priorities

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

Our Objectives 2021/22 *DRAFT FOR Exec review & Board approval*

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

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

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

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

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

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

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

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

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

Our values

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

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

Strategic Aim: Pathways: To develop pathways across care boundaries, where this delivers best patient care Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic c) Embed and develop the new divisional structure and leadership model to further improve service quality g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients h) Harness innovation, technology and digital opportunities to support new models of care i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider**	**Source of Risk:**	Strategic Objective IPR National Directives	**BAF REF No:** 001/21
Principal Risk Decription: What could prevent the objective from being achieved? Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	**Risk Open Date:**	01/07/2020	**Executive Lead/ Risk Owner** **Chief Operating Officer**
	Risk Review Date:	Jun-21	**Lead Committee:** **FPPC**

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Increases / changes to capacity and demand . ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes iv) Impact of COVID 19 measures - PPE, testing, social distancing, staff and patient risk assessments, availability of workforce. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retention and recruitment, impacting on effectiveness of the cancer team.	i) Limited ability to respond to changes in capacity and demand impacting on service delivery - changes to referal patterns following COVID. Patients presenting later to GP's ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation - Public confidence	**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**
Risk stratification of patients is ongoing, overseen by the Clinical Advisory Group. The group is chaired by a consultant. The Trust continues to have oversight of performance through three Delivery & Oversight Groups which meet monthly and focus on (1) Quality and Safety, (2) Performance and Transformation and (3) Finance and Workforce. In addition, a range of groups meet regularly to focus on specific aspects of performance and recovery. These groups take a targeted approached to review performance, identify risks and determine corrective action. These groups include a system-wide Cancer Board chaired by Trust's Chief Operating Officer, a weekly Gastroenterology Surveillance group and the weekly Executive Committee. A weekly access meeting takes place. Recovery plans are in place for all specialities and progress is reviewed on a weekly basis. A series of deep dives are planned for 2021/22.	We have a set of 'flat pack' Covid escalation plans ready for use if required and we have developed Covid policies and procedures. We have developed a recovery dashboard which is divisional and specialty based. FPPC receives and reviews our IPR, performance reports and deep dives at its meetings. It also reviews ED performance and configuration, progress in relation to the endoscopy review and demand and capacity modelling. In addition we have divisional delivery operational groups, divisional Board meetings and a fortnightly clinical transformation group.	Recovery of our performance continues to be good and we are exceeding our plans. Performance against RTT and diagnostics is improving. -RTT and DMO1 deep dive to FPPC June 21. The number of patients waiting over 18 weeks is decreasing.		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
C1 Complexity of operation recovery in the context of COVID C2 National changes to guidance and policy requiring local response at short notice C3 Phase 3 capacity modeling to deliver national targets within financial model	A1 Define metrics to support monitoring of recovery A2 Capacity to support increased demand post COVID - endoscopy and other specialities - delivery against plans A3 Effectiveness of winter planning initiatives/ transformation with community A4 Optimisation and effective discharge	Green	Effective control is in place and Board satisfied that appropriate assurances are available			
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient			
		Red	Effective controls may not be in place and assurances are not available to the Board.			

Action Plan to Address Gaps (Action plan under review with Lead Direcotr and Managing Directors's)

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Deliver Operation Recovery Programme inline with national guidance and with risk stratification	C1, C2, C3	COO, MD's (Planned and Unplanned Care)			

ii) Continue to engage with our ICS and ICPs. Develop system recovery plan with ICP, PCN's, Community and Social Care services (e.g. further development of Ambulatory care to create ED capacity; discharge to assess)	C1, C2, C3, A1, A3, A2	COO, MD's (Planned and Unplanned Care)			
iii) Delivery of the ED reconfiguation programme and SDEC	A1, A3	Unplannned Care Managing Director			
iv) Delivery of discharge improvement programme	A4	COO			
v) Delivery of bed reconfiguration programme	A2., A3	COO/ Director of Estates			
iv) Review delivery performance metrics in line with standards	A1,	COO		Review of new national ED standards. Measures running in shadow form; paper to FPPC in Feb 21. Exploring the use of predictive analyitics (FPPC in June 2021)	
Summary Narrative:					

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

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

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

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

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

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

Action Plan to Address Gaps					
Action: (Actions under review with CPO)	Cross reference to gaps in controls and assurances (C1, C2...../ A1, A2 etc)	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Ongoing implementation of the People Strategy to support staff recruitment and retention, in particular through the development of a strategic forum to link future organisational design requirements with job design and provision of necessary educational support.	C1, A1	Chief People Officer		Staff experience Group in place to consider exit interview data / undertaking workforce planning with services via the integrated business planning process will identify new ways of working and roles to support development / education board considers other development and training mechanisms to support R&R	
ii) Enhance areas of staff supply	C2	Chief People Officer		Continue to work with NHS Professionals on bank recruitment to support staffing shortfalls, plans have been agreed for 21-22 with clear targets in place throughout all staff-groups. / International recruitment continues to identify and recuit additional staff as needed	
iii) Work with divisional leadership on demand and capacity modelling, and establish workforce architecture/modelling approach and capability	C1, C2, A1	Chief People Officer		Workforce Planning gap identified in current establishment, has been addressed in the revised people team structure. Some work has been undertaken with the planning team around demand and capacity modelling but in it's infancy.	
iv) Improve the offer to staff around flexible working.	C4, A2	Chief People Officer		flexible working review being undertake in conjunction with establishment review to assess winter and summer plans and options appraisals.	
Summary Narrative:					

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

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

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

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
• Change in the national funding framework during COVID • Mid Year change in funding framework• Good financial management and governance not maintained • Allocation of resources via system mechanisms rather than based on activity volumes• Impact of revised operational targets (eg. P3 recovery / Winter & COVID Resilience) • Dilution of financial understanding and knowledge within divisional teams• New operational structures weakening traditional arrangements for strong financial control	• Significant increase in costs above funding levels • Financial balance not maintained • Failure to track expenditure causation • Unable to invest in service development • Challenge in tracking spend for regulatory and audit purposes • System funds allocated on differential basis• Spend committed recurrently in response to non recurrent circumstances• Breakdown of regular financial / business performance meetings• Weakening of traditional balance between - Finance / Performance & Quality	**Inherent Risk** (Without controls):	4	5	**20**	⇔
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Regular Monthly financial reporting arrangements in place• COVID expenditure tracking and approval processes in place• Recruitment approval mechanisms in place• Financial appraisal and pre-emptive agreement of winter pressure and P3 programmes • Attendance at regular national, regional and ICS DOF briefing and engagement sessions • Suite of weekly internal Finance SMT meeting to track financial delivery and governance issues • Mth 1-6 and M7-12, internal budget frameworks in place • Strong framework of BI financial reporting tools deployed to track and monitor delivery • Weekly Demand & Capacity meetings to track P3 delivery achievement and associated PAM meetings to support accurate and comprehensive activity capture • MVCC Due Diligence meeting, plus Critical Infrastructure meeting • Implementation of Divisional Finance Boards to promote strong financial governance - Financial Planning 2021/22 & including ICS developments to FPPC in January 21.	Monthly Finance Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • COVID governance and reporting briefing to FPPC • COVID financial planning updates to monthly FPPC and Exec Committee• Monthly Accountability Framework ARMs including Finance (L1) • Bi- Monthly Financial Assurance Meetings & PRM with NHSE (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly D&C activity tracking meetings • Forecast activity and winter planningbed model in place linked to M7-12 financial plan • Internal Audit review programme - Costing Assurance Audit and action plan to FPPC in June 2021			I&E delivery against financial plan Cash balances maintained within prescribed limits • Capital spend to be maintained within approved levels • Temporary staffing spend to be maintained within agreed threshold
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**			
C1 nconsistent delivery of routine budget management meetings across divisions C2 Impact from the system funding distribution under the new finance framework C3 Variable capture and escalation of winter and in year cost pressures C4. Weak temporary staffing control environment in respect of medical and nursing staffing C5 Ongoing COVID ineffiencies	A1. Impact future funding frameworks on Trust financial sustainability strategy A2. Embedding of core financial and business competencies within divisional teams A3 Clarity in respect of NHS contract and business arrangements for 21/22 A4 Impact of the Implementation of 'ENHT Way' as a means of delivering future financial savings A5 Assurance in respect of the delivery of the 21/22 summer and winter bed plans within agreed parameters, with the associated risk of additional unplanned costs	Green	Effective control is in place and Board satisfied that appropriate assurances are available		
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient		
		Red	Effective controls may not be in place and assurances are not available to the Board.		

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

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

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

Strategic Aim: Quality: To deliver high-quality, compassionate services, consistently across all our sites. Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

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

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
Lack of available capital resources to enable investment • Weakness in internal prioritisation processes • Weak in year delivery mechanisms to ensure commitment of resources • Weak assessment of the long term capital resources to meet strategic objectives • Requirement to repay capital loan debts • Volume of leased equipment not generating capital funding resources • COVID capital funding arrangements impact BAU capital requirements • Weak internal understanding of NHS capital funding arrangements • Poor internal business case development skills	• Aged equipments and assets - at our beyond lifespans • Increased associated risks to continuity and reliability of service delivery eg. Radiotherapy • Limited ability to invest in IMT, equipment and services developments • Limited innovation and associated limitations on ability to deliver efficiencies • Negative Impact on the potential to deliver the overarching Trust strategy • Annualised and sub optimal process of competitive short term bidding • Difficulty in expressing a coherent capital profile to external stakeholders eg. ICS / Region / DH	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
• Six Facet survey undertaken in 17/18• Capital Review Group meets monthly to review and manage programme spend • CRG Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Asset Register Maintained by the Finance Department • Mandatory training• Equipment Maintenance contracts • Monitoring of risks and incidents • ICS capital monitoring processes across the system • Directors of Finance and E&F meet weekly with teams to track and facilitate capital spend • Equipment review process to support covid 19 pandemic requirements • Implementation of the new Capital and Cash Framework • Detailed Qlikview Capital Monitoring Application in place • Bi weekly MVCC Critical Infrastructure group with stakeholders	• Annual AE report on Fire Safety to H&S Committee (L2) - Monthly Fire Safety Committee • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committee (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Steering Groups in place to oversee strategic programme delivery eg. Vascular, Renal, Ward Reconfiguration & ED • Capital programme report, FPPC May 21. - Risk Register reports to CRG	• External Audit process reviews the appropriate accounting and treatment of capital assets. • DH / NHSE review and approval of strategic business case schemes requiring funding		

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

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete

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

June 2021 ,following review, including structures and monitoring in place, further actions and oversight of the risks, and the FPP Committee discussions in May 21, the rating has reduced to 16.

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

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

Strategic Objective: **Trust Objective:** **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030** **b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic** **f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency** **g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients** **h) Harness innovation, technology and digital opportunities to support new models of care** **i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider** **Digital Objective: The design and delivery of a Digital programme to support the Trust clinical strategy**	**Source of Risk:**	Digital Programme/ Strate	**BAF REF No:**	005/21
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:**	Jun-20	**Executive Lead/ Risk Owner**	**Chief Information Officer (CIO)**
	Risk Review Date:	May-21	**Lead Committee:**	**Strategy Committee**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Staff Engagement / Adoption Lack of Clinical/Nursing/Operational engagement in system design - reduces likelihood of system adoption Lack of Clinical/Nursing/Operational adoption of digital healthcare creates innefective process which can introduce clinical risk ii) Financial / Resource AvailabilityFailure to resource its delivery within timescalesTrusts may not be in a position to finance the investment (including Lorenzo renewal 2022) iii) Business RiskIT resources may get diverted onto other competing Divsional projects iv) Knowledge & ExperienceDelivery team does	i) Unable to deliver the Clinical strategy ii) Unable to deliver target levels of patient activity iii) Unable to meet contractual digital objectives (local, national, licience) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Staff Engagement Risk:Digital steering group(Consultant led design focus) and IT steering Group (Project Led delivery led) are in place for project Governance, prioritisation and to support clinical engagementBusiness Risk:CIO is member of the executive team and CIO/CCIO have an agenda item on at the Private board to ensure board members are apprised of progress and risks.Financial / Resource Availability Risk:Finance and PMO to be involved throughout the Business case processFinancial / Resource Availability Risk:Business case identifies resourcing from the Divisions and makes provisions for back-fill where appropriateKnowledge & Experience Risk:Key roles (Programme Director, Procurement consultant, Architect etc.) are identified and recruited at and early stage an retained.New Performance Delivery Framework Clinically led workstreams feeding into the Digital Steering Group (model from EPMA) Digital roadmap to 2022, with 2020/21 priorities (July 2020)	• Reports to Executive Committee,Strategy Committee and Board (L2)• Weekly Executive monitoring(Where appropraite) aligned with clinical strategy- staff engagement acorss all sites, at all levels during COVID 19 adopting new many technologies for communication and service delivery Transformation DOG - Strategy for "Evolving our technology" , including including road map to 2022 presented to Strategy Committee, Feb 2021.			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Poor attendance from stakeholders at the Digital steering group C2. Availability of capital to deliver priorities C3. No long term digital plan beyond 2022 (Contractual end date for Lorenzo) C4 Integration into Divisional planning for resource management delivery of tachical solutions to delivery the five priorities rather than the digital road map NHS I/ D/ X expection that we implement with little time and enable of - systems / timeface to enable local scruitinty	A1. Delivery of the roadmap and measures of progress A2. DSO and IGM capacity to support the DPIA processes for increase pathway changes (action to be confirmed with CIO)	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i)Engagement and delivery of the digital roadmap against plan	C1, A1	**CIO**		Strategy for "Evolving our technology" , including road map to 2022 presented to Strategy Committee, Feb 2021.	In progress
ii) Seek investment through ICS where available	C2	CIO		250k awarded to Trust in february 21 to develop a detailed strategy and application for Digital Aspirant Programme	On going
iii) Long term Lorenzo strategy/commercials to be finalised	C3	CIO		Position paper to FPPC in July 2020	
iv) Implementation of a Business partner process (Post Silver)	C4	CIO		In progress	In progress
v) Relaunch of EMPA roll out	A1	Deputy Medical Director, Chief Pharmacist and CIO		Training and rollout plan recommenced and on track. Paused due to Covid surge 2.	In progress
Summary Narrative:					

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

Strategic Aim: Pathways: To develop pathways across care boundaries, where this delivers best patient care Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

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

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of effective collaborative system leadership ii) Executive, clinical and operational leadership and capacity iii) Ability of the ICP to effectively engage primary care iv) Lack of synergies between organisational, ICS and ICP strategic development and priorities v) Lack of risk and benefit sharing across the ICP vi) Complex ICP governance arrangements	i) Failure to progress. Lack of strategic direction and modelling of collaborative leadership ii) Slow pace of ICP development and transformation of pathways. Perpetuautes inefficient pathways. iii) Primary care is not effectviely engaged in the development of the ICP impacting the scope and benefits of integration iv) Unwillingness or inability of organisations to adopt new pathways / services because of contractual, financial or other risks v) Impedes the pace and benefits of transformation	**Inherent Risk** (Without controls):	4	4	**16**	⇕ ⇩ ⇔
		Residual/ Current Risk:	4	3	12	⇔
		Target Risk:	4	2	8	

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

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

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

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Continue to review and evolve the ICP and ISC governance structures in line with national guidance	C1, A3	Chief Executive (with Associate Director of Governance & Trust Secretary)		MoU recommended for approval by statutory Boards. New ICS guidance published June 2021 for review.	in progress
ii) Agree and deliver approach ICP priorities through collaboration - developing risk and benefit sharing	C3, A2	COO/ Director of Strategy		ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission.	in progress

iii) To consider with the ICS/ICP a joint improvement model to collaborate on to facilitate cross organisational working and building capability and capacity. E.g 'here to improve'	C4	Director of Improvement			
iv) continue to identify clinical leadership capacity to support the development of collaborative, ICP integrated pathways	C2, C4	Medical Director/Director of Nursing			
v) To share the ENHT population health data with the wider ICS and ICP to facilitate discussion and agreement of priorities	C3, A2, A1	Director of Finance			
vi) To review the Trust representation at the revised ICS workstreams for 2021/22	A3	Director of Improvement with COO/ Director of Strategy			
Summary Narrative:					

June 21 - MoU recommended for approval by statutory Boards. ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Work underway to test alternatve models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission.

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

Strategic Aim: Quality: To deliver high-quality, compassionate services, consistently across all our sites Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **the new divisional structure and leadership model to further improve service quality to build an inclusive culture in the workplace** **c) Embed and develop e) Progress and develop our equality performance g) Working with system partners, progress development and delivery of**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:** 007/21
Principal Risk Decription: What could prevent the objective from being achieved? Quality: To deliver high-quality, compassionate services, consistently across all our sites Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term	**Risk Open Date:**	01.04.2020	**Executive Lead/ Risk Owner** **Chief Executive**
	Risk Review Date:	May-21	**Lead Committee:** **Board**

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

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

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Effectiveness of governance structures at ward to Divisional level C2 Implementation of Internal Audit Recommendations C3 HSE Improvement notices received on V&A, MSD and sharps in October 2019 (awaiting formal closure with HSE) C4 The Trusts existing clinical strategy is no longer appropriate to manage emerging risks and system changes C5 Changes to Board members/ organisational leadership	A1 Embedded risk management and risk appetite - CRR and BAF A2 Embedding effective use of the Integrated performance report / BAF in discussions A3 Evidence of timely implementation of audit actions A4 Consistency in the effectiveness of the governance structure's at all levels A5 Capacity to ensure proactive approach to compliance and assurance A6 Ensuring compliance with other external reviews and follow up	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Implementation against plan of the revised Compliance and Risk Framework	C2, C3, A1, A3, A6 , A5	Associate Director of Governance		Compliance and Risk framework combined and priorities drafted. Discussed divisional oversight group in May 21.	In progress
ii) Review of the Board and Divisional Governance structure to ensure effective and reduce duplication (including links to ICS/ICP)	C1, A2, A4	Associate Director of Governance	Q2	Board and Board committee review in progress.	In progress
iii) Recruitment of new CEO	C5	CPO/Chair	Dec-21	Commenced	In progress
iv) Implementation of the Strategic Planning Framework and Integrated Business Plan Structure	C4	Deputy CEO/ Director of Strategy		Implementation of the Strategic Planning Framework and Integrated Business Plan Structure presented to Strategy Committee in February 2021; recommended to Board for approval. Strategy Sessions commenced. Monitored by IBP steering group and Strategy Committee.	In progress
v) review of external regulatory actions - CQC and HSE to support closure at next review.	C1, C3, A6	Associate Director of Governance		CQC inspectiion action plan - shceduled for closure in June 2021; testing compliance. Testing HSE actions; training elements recommenced	In progress
vi) Scope / consider independant well led review in line with the national guiidance	C1	Associate Director of Governance			
Summary Narrative:					

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

Strategic Aim: Quality: To deliver high-quality,compassionate services,consistently across all our sites People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce Pathways: To develop pathways across care boundaries, where this delivers best patient care

Strategic Objective: **strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 a)Develop a new structure and leadership model to further improve service quality c) Embed and develop the new divisional plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency f) Using a population health management approach to delivery of integrated and collaborative services, making them easier to use for patients g) Working with system partners, progress development and care h) Harness innovation, technology and digital opportunities to support new models of**	**Source of Risk:**	Objectives Quailty Assurance data / CQC Inspection	**BAF REF No:** 008/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner** Chief Nurse/ Medical Director
	Risk Review Date:	Jun-21	**Lead Committee:** QSC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of consistent approach to quality improvement. ii) Need to embed culture of improvement and learning iii) Inconsistent ward to board governance structures and systems iv) Workforce skill mix, capability and capacity	1) Limited learning opportunites from current and future continuous quality activities 2) Poorer patient and staff experience 3)Limited leadership development of all staff 4) impact on reputation 5 increased regulatory scrutiny	**Inherent Risk** (Without controls):	5	4	**20**	⇔
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Quality and Safety Governace Structure - reporting into Patient Safety Forum, Patient and Carer Experience, Clinical Audit and Effectiveness, ICP, Safeguarding, Health and Safety Reports to QSC as per annual cycle including deep dives. Pathways to excellence framework and programme 'Here to improve' programme Training and development programmes including Leadership pathway and QI Harm free care and deteriorating patient collaborative Patient and Carer Experience Programme Patient safety specialists / leads Mental Health Srategy Group Complex discharge Improvement group Quailty and Safety Dash boards Oversight of 'hot spots' with clear leads and committee structure, May 21 (QSC and Q&C DOG) Learning events - IPC, safety huddles Clincal Harm Review process and panel Divisional quailty structures GIRFT Board Health Inequalities Committee	ToR, Minutes and papers for the Quailty and Safety Committee Structures Report and deep dives to QSC Internal Audit Programme CQC TRAs Quailty and Safety visits and audit programme Action plans from Mental Health Strategy Group / Discharge Group	Positive CQC TRA reviews for Medicine (lister and MVCC) and Surgery Core Pathways (with supporting gap analysis and evidence on KLOE) and well led. Internal Audits 2020/21 reasonable or substancial assurance on Serious incidents, clinical audit, risk management, BAF, compliance framework, health and safety, DSPT,		
	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
•C1 National guidance and GIRFT Gap analysis identifies areas for improvement C2 Consistency with engagement with clinicians C3 Patient safety team and complaints team capacity (impact of COVID) C4 Complex discharge pathway (core action and oversight listed in Risk 1) C5 3 Never events were reported in 20/21 C6 Increased number of Mental Health Patients presenting at the Trust - Adults and CYP C7 VTE compliance	A1 Consistency in following care bundles A2 Implementation and tracking of action plans related to GAPS associted with National Audit & NICE guidance, GIRFT recommendaions, NatSSIP Audit compliance A3 Embedding of learniing from SIs/Learning from Deaths/ never events A4 Delivery against CQC improvement plan A5 Delivery of harm review process following COVID impact on 52wk waits , follow up and survieliance A6 Effectivness of Pathway for safe discharging of complex patients - complaints and referals A7 Assurance on Ockenden Report recommendations and PFD (Maternity) A8 Implementation of End of Life Strategy A9 Ward to Board visibility of key Q& S metrics	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps					
Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) i) Delivery of the Quality Strategy Priotrities	C1-7, A1-9	Chief Nurse / Medical Director	ongoing	2021/22 priorities under review	In progress
ii) Delivery and monitoring of CQC improvement plans and preparedness for future inspections	A4, C2,	Associate Director of Governance		Quailty visit programme recommenced	in progress
iii) Implemention of patient safety strategy priorities	A2, A3, A5, A7	Patient Safety Specialists			in progress
iv) Implementaiton of End of Life strategy and priorities	A8	Medical Director			In progress
v) Develop and implement Mental Health Stategy for Acute Care and work in collboration with the system to support patients required to stay longer in acute care whilst awaitng speciaist beds	C6	Chief Nurse			In progress
vi) Implementaion of pathways to excellence	A3, A5	Chief Nurse			In progress
vii) Review harm review, hospital onset COVID reviews and mortality review processes due to increased demand following COVID	C3, C2	Medical Director and Chief Nurse			In progress
iv) Review complaints process and oversight in line with PHSO guidance and increases following COVID	C3	Chief Nurse			In progress
vii) Complete Gap analysis on GIRFT reports and develop and monitor action plans	C1	Medical Director			
viii) Review the quailty and safety metrix ward to board with BI	A9	Associate Chief Nurse			In progress
ix) Implementation of Datix Icloud	A9	Associate Director of Governance	Q2/Q3	Project plan and workstreams in place. Awaiting IT to complete the required technical solution due in July 2021. Will then progress to commence inplementaion across Q2/Q3	In progress
Summary Narrative:					

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

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

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

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Staff not sufficiently involved in changes that affect or impact them. ii) Organisational failure to invest in line manager skillset/capability. iii)Management style/actions may not enable staff engagement or empowerment. iv)Organisational failure to drive inclusivity, so some groups feel they cannot make their voice heard. v)Staff may not be able to access the support or training they need to develop in their role.	i) Quality and Safety Improvement Culture is not fully achieved ii) Opportunities for improving patient care are missed iii) Staff leave the Trust, resulting in higher recruitment costs, loss of skills, talent, organisational memory, and increased focus on induction rather than on staff development.	**Inherent Risk** (Without controls):	4	5	**20**	⇔
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i)Trust People Strategy designed to offer mitigations to this risk. ii) All staff are expected to embody PIVOT values. iii)Trust policies such as Dignity and Respect Policy and Raising Concerns Policy provide route for staff to voice concerns. iv) Freedom to Speak up Guardian can support staff to make their concerns known, so that the organisation can respond to those concerns. v)Staff Experience Group and Divisional Forums provide space for constructive dialogue with staff to impove staff engagement/experience. vi) Education Board provides means to drive forward new approaches to education and development for all staff. New role of Head of Culture to commence in June 2021 Equailty and Inclusion Committee from May 21	i) Staff surveys, including quarterly Pulse survey ii) Monitoring of trends via reports to Trust Board and accountability through scrutiny at Trust Board. iii)Monitoring of level of challenge through application of staff policies, for example from under-represented groups.			
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
C1. failure to review and update some staffing policies C2. Need to develop education approach to supporting staff in under-represented groups C3. Need senior leadership development programmes to support the service improvement and transformation agenda. C4. Maximising the support networks abilty to influence service and culture change C5. Maximining staff access to wellbeing offers	A1. Failure to achieve Integrated Performance Review targets is an indication of negative assurance where the targets are relevant to this risk. A2. Capacity of F2SUG and static reporting	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Embed compassionate leadership approach to organisational management.	C1,	**Chief People Officer**	Jul-21	leadership rhythms and compassionate leadership conversations being roled out across the orgnaisation. 150 targetted to attend ICS sessions 145 confirmed. Additional programmes being identified as part of culture strategy for FPPC consideration in July 2021	
ii) Develop improved education and training offer for all staff groups.	C2	Chief People Officer	Oct-21	Education board to consider equitable offer of CPD across the organisation, ENH academy launch has ensured all staff have easy access to elearning packages. Review off offer to be undertaken in Autumn	

iii) Improve staff engagement through promotion of the EDI agenda, including support for staff networks.	C4	Chief People Officer	Aug-21	Head of culture in post from 4.6.2021 identifying new ways of working to relaunch culture strategy / staff network chairs backpay agreed via Exec in June 2021 / EIC to include feedback from staff networks / reciprocal mentoring planned for September 2021 / listening events planned in August to hear what is working and what improvements could be made	
Support and develop staff wellbeing services, in line with NHS People Plan and Trust People Strategy.	C5	Chief People Officer	Oct-21	wellbeing pyramid in place for all staff / regular communication of how to access and feedback given on effectiveness / review of interventions to be iundertaken in Autumn 2021	
Provide effective channel for staff communication through Staff Experience Group and Divisional Forums	A1	Chief People Officer	Sep-21	Staff voice and staff experience group ongoing with regular reports to SEG and FPPC. Next report in September 2021	
Roll out talent management approach and support career conversations across whole Trust.	A1, C2, C3	Chief People Officer	Oct-21	Grow together launch on ENH academy taken place in May 2021, managers and staff to discuss long term plans plus CPD. Review in Autumn 2021	
Review of Freedom to Speak Up approach and implement development plan	A2	Chief People Officer/ Chief Nurse	Oct-21	FTSU guardian identified and project plan being developed. Detailed plan to be delivered to FPPC Autumn 2021	
Summary Narrative:					

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

Strategic Aim: 1. Quality: 5. Sustainability:

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

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of robust data regarding current compliance ii)Lack of available resources to enable investment ii) Ineffective governance processes iii) Reactive not responsive estates maintainance iv) skill mix, expertise and capacity	i) lack of information to inform risk mitigation and decisions ii) Lack of assurance that routine maintainance is completed ii) risk of regulatory intervention iii) poor patient experience iv) potiental staff and patient safety risks	**Inherent Risk** (Without controls):	5	5	**25**	
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Revised leadership and governance structure within Estates & Facilities, Premises assurance framework/data base Specialist Authorised engineers in place as per statutory requirements, annual reports to H&S Health and Safety Group reports into QSC. Meets 6 weekly. Health and Safety Strategy 2020 Fire Policy and Procedures Capital funding prioritiesed Other statutiry groups and supportive workstreams Audit programme including - Weekly environmental audits Water safety group and action plan Ventilation group Links to corporate meeting includign COVID speciatist advisory group.	Assurance reports under statutory requriements - June QSC 21. E&F risk register reviewed and updated. - Risk clinics / workshops held in 2021 Authorised engineer reports Fire safety annual report			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Ineffective estates and facilities governance structures C2. Estate strategy due for renewal C3. Lack of capital funding to bring the Lister and other sites to compliance C4. Implementation of actions from the AE reports C5 Limited visibility on the compliance status for the Trusts satellites locations. C6 Confirmation of level of compliance with Premisis Assurance Model (PAM) to inform gap analysis and work programme. C7. Optimal Space utilisation and decision making process for changes	A1. Limited assurance from other sites trust operates from A2. Actions to adress limited assuranceassessment for H&S, Medical Gases, Ventilation and decontamination A.3 PAM GAP analysis and action plan to inform decision making	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Substantive recuitment into leadership structure and other vacancies	C1, A1	Director of Estates and Facilities	Aug-21	Recruitment of E&F Compliance and Deputy Director of E&F underway	In progress

ii) Development of Estates Strategy in line with the Organisational strategy	C3, C2	Director of Estates and Facilities	TBC	Progress report to Strategy Committee in June 21.	In progress
iii) Space Utilisation review and implement governance of decision making	C7	Director of Estates and Facilities	TBC		
iv) Ensure actions plans and monitoring in place to raise the areas of 'limited assurance' to 'reasonable assurance' - for H&S, Medical Gases, Ventilation and decontamination . Including HSE notices.	C3, C2	Director of Estates and Facilities			
v) Complete the PAM gap analysis	A3, C2, C6	Director of Estates and Facilities			
vi) Review mechanisms of oversight of complaince across all sites to ensure effective	C1, C3, C5, A1	Director of Estates and Facilities			
Summary Narrative:					

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

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

Strategic Objective: i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider	**Source of Risk:**	Specialist Commissioning Review	**BAF REF No:** 011/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC.	**Risk Open Date:**	Apr-20	**Executive Lead/ Risk Owner** Director of Strategy
	Risk Review Date:	Jun-21	**Lead Committee:** Strategy

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of continued commitment of the preferred provider to progress service transfer ii) Failure to make decision on long term service model following public consultation iii) Inability of NHSE to reach agreement with providers, including investment required, and execute the transaction iv) Failure of service sustainability in the pre transition phase due to failture to address critical infrastructure priorities	i) Increase in uncertainty over future of MVCC and adverse impact on recruitment, retention, morale and research. ii) Potential detrimental impact on care pathways at Trust sites. Protracted strategic uncertainty impacting the abilty to deliver a sustainable service model for future services provided by MVCC iii) Protracted strategic uncertainty and increased financial pressures on the Trust iv) Potential impact on quality, safety and ability to sustain safe service	**Inherent Risk** (Without controls):	4	5	**20**	↑
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
- Programme Board governance in place for Strategic Review of the MVCC - Weekly ENHT, UCLH and NHSE Director level call in place - Fortnightly Due Diligence governance meeting in place (NHSE, UCLH, ENHT) - UCLH Transition Team in place at MVCC - ENHT MVCC Transfer Programme leadership (Programme Director) and governance (Steering Committee and Task & Finish) in place - Escalation reporting to Strategy Committee and Board - Clinical policies - Monthly ENHT, UCLH and NHSE critical infrastructure review in place underpinned by agreed action plans and risk register	- Regular reports to Strategy Committee and the Board - Status reporting through ENHT Steering Committee	- Strategic review and recommendations from clinical advisory panel re MVCC, July 2019 - Positive Risk Review with Specialist Commissioners, December 2019 - Jan 20 NHSE approved the recommendation that UCLH is the preferred tertiary provider for MVCC (Jan 2020) subject to due diligence outcome. - NHSI/E Risk Review - significant assurance provided and decision to step down to BAU assurance monitoring. - Dec 2020 MVCC Review Programme Board - supported recommendation for full replacement and enhancement of current MVCC services on an acute site; shortlisted Watford (meets all essential criteria) and supported full options appraisal on the Watford site. - May 2021 Submission of Due Diligence reports from UCLH to NHSE		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
C1) NHSE Strategic Review Programme Office capacity for governance including budget, plan and risk management: - Unaligned governance on budget, plan and risk management between ENHT, UCLH and NHSE	A1) Confirmation by NHSE of route to access capital for reprovision by UCH, and outcome of public consultation as required by UCH Board A2) Mitigation of financial impact of transfer on our Trust A3) Confirmation of UCH operational and corporate capacity to conclude DD to outcome and implement transition A4) Confirmation of ENHT operational and corporate capacity to implement transition	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Request joint mechanism for routine review of Strategic Review programme plan, risks and budget as part of programme governance	C1	Sarah Brierley, Director of Strategy	May-21	- NHSE / ENHT / UCLH weekly tripartite meeting effective from May 2021	In progress
ii) Provide input and support as relevant to NHSE activities to access capital	A1	Sarah Brierley, Director of Strategy	Ongoing	- Input provided to capital paper shared with NHSE Finance colleagues	In progress
iii) Chief Executive briefing of regional team to support activities in relation to access capital	A1	Nick Carver, CEO	Ongoing	- Briefing of Ann Radmore	In progress

iv) Support public consultation process through effective development and execution of ENHT communications and engagement plan	A1	Sarah Brierley, Director of Strategy	Dec-21	- Plannng to start once timing of Public Consultation is clearer, dependent on capital assurance	Not yet started
v) Finalise assessment of ENHT stranded costs	A2	Martin Armstrong, Director of Finance	May-21	- Initial Financial Impact Assessment of MVCC Transfer on ENHT has been developed; detailed analysis in progress	In progress
vi) Negotiate settlement with NHSE to address ENHT stranded costs	A2	Martin Armstrong, Director of Finance	Jul-21	- Discussions ongoing with NHSE regarding stranded costs. Review will be ready for submission to NHSE mid June 2021	In progress
vii) Lead definition and execution of plans to reshape corporate departments to deliver target reductions in corporate overheads	A2	Martin Armstrong, Director of Finance	Mar-22	- Meetings initiated in May at which Corporate Directors are sharing their plans	In progress
viii) Seek assurance from UCH of commitment to resourcing and plans at programme governance forums	A3	Joanna Osbourne, Programme Director – MVCC Transfer	May-21 and Jul-21	- Assurance sought from UCH re resourcing and commitment to delivery Due Diligence activities to revised plan - Initital discussions underway between ENHT and UCLH to discuss transition planning principles, approach and governance	In progress
ix) Lead the programme-level development of transition and decoupling plans to identify corporate and divisional resources required to implement transition	A4	Joanna Osbourne, Programme Director – MVCC Transfer	Jul-21	- Prior to confirmation from NHSE supporting work at risk, initial transfer and transition/de-coupling activities underway	In progress
Summary Narrative:					
May 21 - Due Diligence is due to complete at the end of May. Overall Strategic Review Programme milestones are under review, to be presented at May Programme Board, with an expected commitment to continue to target an April 22 transfer date. June 21 - Strategic Review Programme Board in May presented a 'Plan A' timeline with Transfer date of April 22 and 'Plan B' timeline which would move the transfer date to July 22. Both dates are at risk due to critical dependency on route to capital, which remains unclear. UCLH Due Diligence reports with revenue and capital requests were submitted at end May 21 to NHSE for assurance process. June 21, Strategy Board - discussed MVCC Programme transfer update and noted the completion of the UCLH due diligence. Due to the level risk of a delay to the programme increasing the Committee increase the current risk score from 12 to 16. Work being undertaken to mitigate the risk was noted.					

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

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

Strategic Objective: **b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients** **g) Working with system**	**Source of Risk:**	External/ Civil Contingencies Act	**BAF REF No:** 012/21
Principal Risk Decription: What could prevent the objective from being achieved? **Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care**	**Risk Open Date:**	04-Mar-20	**Executive Lead/ Risk Owner** Chief Operating Officer/ Chief Nurse
	Risk Review Date:	Jun-21	**Lead Committee:** QSC/ Board

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Covid 19 outbreak/pandemic - impact of varients nationally and world wide - increasing testing, self isolation, school closures, sickness. ii) Potential increased need of respiratory and critical care beds iii) Potential increase from containment to 'social distancing' iv) Enactment of the Civil Contingency Act v) Insufficent capacity for the increased demand - including ED and assessment and side room capacity	i) Risk of staff unable to attend work - due to self isolation or covid 19 positive. ii) Risk to patient safety as unable to provide safe staffing iii) There is a risk to the Trust's reputation if an outbreak was to occur/or criticism of our procedures. iii) Risk that some services are suspended for a period e.g. non urgent elective surgery, training iv) Risk of not meeting regulatory requirements	**Inherent Risk** (Without controls):	5	4	**20**	⇩
		Residual/ Current Risk:	5	3	10	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Major incident Plan and Business continuity plans in place. Major Incident Command structure - Gold , silver, bronze Command structures reviewed/adapted to ensure continued support to organisation / major incident Communication plan - internal and external Linked intoand represented at Local and National resilience fourms/ communications/ conference calls Emergency Planning Group - Chaired by COO COVID Specialist advisory group with task and finish group structure reporting to it On call rotas - various Staff training programme - MI, loggist, Fit testing, skills refresh. Mortuary Capacity Plans IPC Policies and BAF Review and monitoring of O2 and ventialation Staff well being programme and deployment / reassignment processes - flexible Monitoring, review and recording of all national guidance and directives recieved re pandemic People and placed based risk assessments re COVID Social Distancing strategy Regional and Trust Local Indicators to suport decision making Flat packed pathways e.g. Ability to step up capacity esp in respiratory and critcal care pathways LFT testing available for all staff Staff vaccine hub and vaccination programme Visitors Policies	COVID dashboard Weekly Audits on environmental, IPC, H&S and social distancing Minutes from GOLD, COVID SAG Trust Communications	Complaint with Emergency Planning standards 2020/21.	Report to QSC, June 2021	
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
C1.Possibility of insufficient staff available on all shifts who have passed their FFP3 Fit testing C2.Possibility of staff coming back or being exposed to people who have come back from the affected regions and presenting for work without checking with Health at Work first. C3.Possibility of Trust visitors coming back or being exposed to people who have come back from the affected regions and presenting at the Trust. C4.There is a risk that patients are not screened on admission as per questions based on PHE	A1 BCP's for high risk areas / small specialitist services/ On going resilience to sustain responsiveness to national guidance which is updated daily (esp in small teams / single posts) A2 Continuity of supplies as position changes - responding to national guidance and alerts A3 Adequacy of Ventilation in clinical areas	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	

guidance about recent travel. C5.There is a risk that Trust and agency/bank staff may be confused by various external sources of information about WN-CoV and IPC precautions to take C6. There is a risk people in the community with symptoms are directed to ED, when they should stay at home - due to unclear community guidance C7. Business continuity plans may need to include WN-CoV. C8. Updates to national advice daily as the position changes C9. Demand for assessment and beds exceeds sideroom and bed capacity Requested regent to enable patient and staff testing internally / capacity of CUH to support increased testing Impact of COVID surge 2 on capacity and staffing		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) COVID Specialist Advisory Group oversight and leading policy, guidance and expertise - PPE, logistics, testing, social distancing, IPC issues	A2, C1, C2, C3, C4, C5,	Chief Nurse, Medical Director	Ongoing	Currently meets fortnightly. IPC Summer BAF inder review. Ongoing audit programme	Ongoing
ii) Review of ventilation in clinical areas and develop proposal for improvement	A3	Director of Estates and Facilities/ Ventilation AE	Q1-Q2	Engaged with external company to review the adequacy of the ventilation in the clinical areas and developing a proposal for improvement. This is being monitored through Covid SAG and Health and Safety Committee.	In progress
iii) Prepare for any future National COVID Vaccination Programme in line with National Guidance	C2, C5,	DoF/ CPO / Emergency Planning			In progress
iv) Monitoring of triggers to enable responsivness and 'unflat packing' of COVID response if/when required.	C9	COO / Emergency Planning	On going		
iv) Implementaion of lessons learnt from previous COVID surges (internal and system)	C7, A1	COO / Emergency Planning	on going		
v) Annual review programme and testing of the emergency planning standards	A1, C7	COO / Emergency Planning	on going	2020/21 assessment - compliant with the EPRR standards - Report to QSC June 2021.	
Summary Narrative:					

June 2021, the Committee considered the assurances received including confirmation of maintaining compliance with the EPRR standards 2020/21 and supported reduce this risk from a 15 to 10. Noted triggers and action in place to 'unflat pack' surge plans and plan in place/underdevelopment for potential increase in children young people attendances/ admissions.

East and North Hertfordshire NHS Trust

Agenda Item: 13

TRUST BOARD – 7 JULY 2021
Nursing Establishment Review

Purpose of report and executive summary (250 words max):
Due to the COVID-19 pandemic the regular bi-annual establishment review did not happen in 2020.

The nursing establishment review was undertaken April 2021. Actual worked staffing, patient acuity and dependency data, was collected over a 20 day period on all inpatient wards. The data was then analysed using validated framework, professional judgement, quality and safety indicators, benchmarking with other Trusts using NHSI Model Hospital [Appendix 1] and national guidance for safe staffing.

There are three key recommendations from the review:

- To increase the establishment across the inpatient areas to reflect the skill-mix requirements across the 24/7 period at a cost pressure of £55k (Table 4)
- To increase the funded headroom from 21% to 22% (Table 5) with a plan to increase this up to 26% reflecting the suggested recommendations within the NHS Model Hospital (Carter 2016).
- To increase the substantive workforce up to 117% of the 122% headroom and enforce the enhanced controls on the deployment of the substantive workforce as set out within Appendix 10.

Action required: For approval

Previously considered by:
QSC and FPPC, 29 and 30 June 2021

Director:	**Presented by:**	**Author:**
Chief Nurse	Chief Nurse	Acting Deputy Chief Nurse, Workforce Lead Nurse, E Roster Manager

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

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

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

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

1. Introduction

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2012) which make explicit the Board's corporate accountability for quality and safety.

The Nursing and Midwifery Council (NMC) sets out nurses responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the six essential standards that all healthcare providers must meet to comply with the Care Quality Commission (CQC) regulation. This is also incorporated within the RCN (2021) Nursing workforce standards and the NICE guidelines 'Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals' (2014).
The Carter report (2016) recommends the implementation of care hours per patient day (CHPPD). This preferred metric's provides NHS Trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards.

The Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2021) and NICE 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014), suggest wards have a planned registered nurse to patient ratio of no more than eight patients to one registered nurse on day shifts.

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

- The COVID 19 pandemic has had a huge impact on the nursing and midwifery workforce and continues to create ever increasing challenges.
- It is well documented the effect the pandemic has had on our workforce with an increased focus on recovery and how we support our staff health and wellbeing.
- Increasing patients with mental health needs both adult and children. All requiring different skill set and patient pathway.
- The increasing complexity of the patient population and being able to meet this need with a skilled, stable workforce.
- The result of funding and successful international recruitment has enabled the Trust to get to zero vacancies for registered nurses, however still reliant on temporary staffing with no resilience in flex to meet surge plans.
- Our bank staff are mainly trust staff, the split of multi-post holder and bank only is 75/25.
- The continued growth in services, and recovery plans requiring a constant focus on finding creative ways to recruit and retain.
- Safely staffing across a 24 hour period 7 days a week in a fair and consistent way to all, whilst also trying to meet the flexibility staff now require.
- Implementation of the NHS People Plan.

2. Establishment Review Methodology

In order to undertake the establishment review various national guidance validation tools were used to help with this calculation.

These were:
- Current assumptions & validation
- Care Hours Per Patient Day
- Safer Nursing Care Tool
- Professional Judgement
- National Benchmarks

The review consisted of having full clinical engagement involving all Ward Managers, Matrons, Divisional Nursing and Quality Directors / Deputies, the people team and financial colleagues, ensuring robust clinical discussions and context were captured.

A full review of the data, collection processes and methodologies can be found in Appendix 3.

2.1 Current assumptions – Skill Mix and Registered Nurse to bed ratio

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

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

Table 1
Planned Registered Nurse to Patient ratio per division

Division	RN to Bed Ratio		
	Early	Late	Night
Unplanned	1/5	1/5	1/5
Planned (Excluding Critical Care)	1/6	1/7	1/7
Cancer	1/5	1/5	1/7

2.2 Care Hours per Patient Day (CHPPD)

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

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

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

Division	Service Model CHPPD	Required CHPPD SafeCare	Actual worked CHPPD
Unplanned	7.01	6.84	8.88
Planned (Excluding Critical Care)	5.62	6.25	6.62
Cancer	6.15	5.61	10.60

2.3 Safer Nursing Care Tool (SNCT)

The SNCT is an evidence-based tool developed to help NHS hospitals measure patient acuity and dependency to inform decision making on staffing and workforce.
The tool enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/ dependency terms

The process involves using the acuity tool, over a period of 20 days on each inpatient ward to establish patient need and dependency. The tool is based on 4 levels of care, defined by National guidance.

The SNCT multipliers are based on dependency, workload literature and empirical data. The trust uses the licensed software to gain this information. The SNCT takes into account a headroom calculation of 22%. This cannot be adjusted below 22% to match the 21% that is used at ENHT.

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

Table 3

Average Divisional bed occupancy, SNCT recommended WTE, Total Funded WTE based on occupancy and variance

Division	Bed Occupancy %	CHPPD Bench Marking Data			SNCT Recommended Data	
		Total Funded Est. based on occupancy	Total Funded Establishment (21% Headroom)	Recruitable Establishment April 2021	SNCT recommended WTE (22% Headroom)	Variance of Total Funded Est. based on occupancy to SNCT recommended
Unplanned	84%	29.63	35.74	31.36	29.12	0.51
Planned (Excluding Critical Care)	84%	30.56	36.76	32.37	31.92	-1.36
Cancer	55%	17.22	31.57	28.04	14.63	2.59

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

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

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

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

2.4 Professional Judgement

All Ward Managers, Matrons, Divisional Nursing and Quality Director / Deputies, Finance, Human Resources and the E-roster team met with the Deputy Chief Nurse to review all the above data and triangulate associated quality indicators, incidents and red triggered shifts. The recommended adjustments to shift plans are based on the data review and robust discussions with all present. This process added specific clinical context to the discussions and provided an evidence based approach ensuring Ward Managers, Matrons and Divisional Nursing and Quality Director were engaged and took ownership of their clinical areas.

2.5 National Benchmarks

The latest available March 2021 data was taken as a benchmark which compares local peers with the NHSI Model Hospital Dashboard. ENHT was rated in the second lowest quartile for CHPPD for total nursing. The Trust was rated in the lowest quartile for cost per patient day. See Appendix 1

2.6 Data Validation

The following actions were taken to validate the data collection from the SNCT specifically for the establishment review:

- SNCT training was delivered throughout March – This was to ensure that the SNCT data was validated and consistent, inter-rater reliability exercises were undertaken with the nursing teams to ensure consistent application of the acuity multipliers.
- Comparing recommended establishment for both CHPPD and SNCT
- Senior Nurse Acuity Audits - Throughout the data collection period senior nurses peer audited wards to validate data inputs. Any discrepancies in the acuity data scoring were corrected and senior nurses worked with wards to ensure consistent application of the tool. Audit scores can be seen in Appendix 7. It should be noted that further training is required with SNCT scoring in areas below 90% accuracy. Ongoing workshops continue and the wards acuity scoring closely monitored on a daily basis.
- There has been no manipulation of the data to maintain the reliability and validity of the tool and this allows for benchmarking.
- External benchmarking with other organisations using the NHS Improvement (NHSI) Model Hospital Dashboard [See appendix 1]
- Professional Judgement.
- Review and discussion at ward board rounds and quality huddles.

2.7 Nursing and Midwifery Quality Indicators

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

Any indicator triggering above established threshold is subject to detailed root cause analysis and an action plan developed where appropriate to improve patient safety and experience.

2.8 Red Triggered Shifts

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

Factors affecting red triggering shifts include:

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

2.9 Recommendations:

Costings for Shift Plan
Changes to Ward establishment review - 2021/22 Nursing/CSW budgets

* This includes transfer of headroom under band 7 to band 5 - (£55k reduction)

Table 4

Ward	Budget WTE	Requested WTE	Difference WTE	Difference Cost (£)*	Comments
Acute Cardiac Unit	39.49	39.54	0.05	-1,859	Budget already reflects new location with side rooms
Ambulatory Care Lister	25.53	25.52	-0.01	-6,586	Budget matches new shift plan as changed from Ambo Care Lister
Ambulatory Care QE2	13.91	15.38	1.47	16,696	Uplift due to additional activity at QE2
AMU1	105.34	105.82	0.48	-4,195	Budget already reflects revised shift plan
AMU2	31.08	30.32	-0.76	-28,129	
Ashwell ward	36.75	38.05	1.30	9,503	CSW uplift at night
Barley	35.08	37.74	2.66	35,575	CSW uplift at night
ITU / HDU	106.23	105.45	-0.78	-35,081	
Pirton HASU	34.45	35.02	0.57	5,544	
Short Stay Unit - SSU	24.56	27.95	3.39	39,951	extra CSW at night due to acuity/MH patients.
Swift Ward - Option 1	35.13	35.53	0.40	2,022	
Ward 10A	18.60	21.25	2.65	37,217	
Ward 10B	40.75	40.34	-0.41	-13,562	
Ward 11 Respiratory	62.85	63.56	0.71	5,252	Includes RSU at 6 beds
Ward 5A	42.57	42.57	0.00	-964	Budget based on revised shift plan in May
Ward 5B	40.27	40.63	0.36	8,329	Skill mix change - band 6 instead of band 5
Ward 6A	40.99	41.62	0.63	7,165	
Ward 6B	38.69	37.80	-0.89	-15,523	
Ward 7A	37.64	37.80	0.16	-2,932	
Ward 7B	39.24	40.24	1.00	11,912	CSW uplift on late shift at weekend
Ward 8A	39.71	40.00	0.29	4,678	Skill mix change - band 5 to band 6
Ward 8B South	0.00	0.00	0.00	0	Winter ward - funded for 24 beds from Jan to March
Ward 9A Elderly Care	39.98	40.08	0.10	-5,588	
Ward 9B Elderly Care	39.37	39.99	0.62	5,366	
MV Ward 10	34.06	32.78	-1.28	-22,536	Cancer - Mount Vernon
TOTAL	1,002.27	1,015.00	12.73	52,255	

3.0 Headroom

Headroom (or timeout) refers to the calculation made by the organisation to account for managing unavailability (Hurst 2003). It is the allowance within a trust's budget that covers staff absence. The Headroom allowance typically comprises Annual Leave (at an average 15% of the total Headroom, this is the largest component of staff unavailability), Sickness and Study Leave. At ENHT parenting/maternity leave is held in a central pot and not included in the headroom calculation.

For inpatient wards the trust sets a headroom total of 21%. Broken down to 7% recruitable and 14% non recruitable this 14% is covered with temporary staff which means that even when shift plans are fully recruited too, temporary staffing is still required to cover the 14% headroom.
NHS Trusts operationalise headroom around an idealised 'target' value, which may be detrimental if set to low. Evidence suggests that having headroom of, 21% may, at best, increase spending on bank/agency staff, or, at worse, jeopardise patient safety.

The Auditor General (2002), Hurst (2003), Healthcare Commission (2005) and RCN (2006) all recommend flexible headroom allowances ranging from 22% to 25%. The SNCT tool has 22% time out allowance included in the multipliers and establishment. The Carter review (2016) recommends between 22% - 24%. Setting the Headroom correctly will help ward/department leaders in achieving the budgets set. Managing the Headroom proactively may help to reduce the reliance on Temporary Staffing (Bank and Agency) in some areas.

Evidence suggests that setting the headroom too high may prove costly; this can often be resolved by staff redeployment. However, under-stated headroom results in under-stated unit budgets (McIntyre 2016). This has implications for patient care, staff workload, staff well-being, staff retention and, indirectly, cost, due to the use of additional bank and agency staff.
Higher baseline rosters are more resilient in the face of variation and appear cost-effective. Staffing plans that minimise the number of nurses rostered in advance are likely to harm patients because temporary staff may not be available at short notice. Such plans, which rely heavily on flexible deployments, do not represent an efficient or effective use of nurses, (Griffiths et al 2020).

Appendix 9 shows that for the roster period 11th April 2021 to May 8th 2021 the Trust had an **average 32.2%** unavailability demonstrating that ward budgets cannot maintain headroom of 21%. Chart 2 shows for the same roster period the unavailability compared against other trusts. Sickness, other leave and study leave are areas that more focus and review may help reduce these in line with our comparators.

To enable ward managers to manage their unavailability flexibly within allocated budget, and to meet national recommendations of headroom above 22% it is proposed that the Trust uplifts the inpatient ward budgets headroom to 22%. This will also ensure there is a plan to meet the recovery post COVID with regards to training, clinical supervision, staff wellbeing and support. Ensuring quality and safety outcomes are improved.

The table below shows the whole time equivalent for registered and unregistered staff. This will be a cost of £311,742.

Table 5

Additional Costs – 21% headroom uplifted to 22%

Staff Group	WTE	Cost (£)
Nursing Staff	10.33	-242,044
Clinical Support Staff	4.79	-69,698
TOTAL	**15.12**	**-311,742**

4.0 Recruitable Headroom

The Trust has budgeted its inpatient ward shift plans with a 7% recruitable and 14% non recruitable. This means there is already a reliance on temporary staffing, to cover annual leave, sickness and study leave. Whilst this may look more cost effective use of staff, it has major implications on safer staffing challenges, staff wellbeing, sickness, patient safety and retention within our ward areas. It also leaves no resilience in the workforce and proved to be a major challenge during the pandemic, putting staff and patients safety at risk when moving to surge planning and winter pressures. The majority of temporary shifts are filled by the Trust own staff doing additional bank shifts, potentially putting the staff's own wellbeing even more at risk.

Due to the recruitment team's success, the team are facing challenges in allocating OSCE nurses and newly qualified nurses to wards due to the low vacancy rates. The divisions have had to recruit into headroom and maternity leave to support any gaps. It is therefore proposed that wards can flexibly recruit into the full budgeted headroom with controls put in place to restrict temporary staffing.

Controls currently in place are monitored by the Deputy Chief Nurse, all matrons, safer staffing team and Divisional Nursing and Quality Directors. They continue to meet monthly and weekly 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 Chief Nurse, Deputy Chief Nurse or Divisional Nursing and Quality Director.

Controls out to bank – the roster templates are built within the agreed financial establishment and are aligned to an authorised shift plan outlining the WTE grades to fulfil staffing requirement. Strict controls are in place surrounding the addition of duties over and above the agreed establishment. Unfilled shifts can be sent to bank by all registered ward staff to maintain safe staffing levels. Additional controls are available through the introduction of a second tier approval before shifts are sent to NHSP although not currently in use.

Appendix 10 demonstrates further control functionality through NHSP Systems.

5. Summary

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

6. Recommendations for Executive approval

- Approve the changes to nurse establishments as reviewed and recommended by the senior nurse teams at a cost of **£52,255.**
- Increase the budgeted headroom from 21% to 22%, at a cost of **£311,742**
- Recruit to the budgeted headroom for inpatient and have a flexible recruitment pipeline to specialist areas.
- When fully recruited implement 2nd approver temporary staff restrictions on E roster.
- Endorse the good principles of E Roster management and controls.
- Improved rigour around sickness management and regular sickness meetings that are managed in a consistent way.
- Implement a phased approach to the Carter review (2016) which recommends headroom of between 22% - 26%.

7. Next Steps

- Continue to work collaboratively across the system to maximise domestic recruits and increase students entering training.
- Continue to scope and support flexible routes into nursing.
- Continue with overseas recruitment to ensure a consistent pipeline for registered nurses.
- Continue to monitor key performance indicators and incidents to ensure pro-active staffing reviews are carried out in a timely fashion.
- Progress work on clinical pathways and multi-professional delivery review.
- Continued investment in recruitment and retention initiatives.
- Implement a plan to improve our sickness rates and improve staff health and wellbeing.
- To have flexibility in the rosters for staff to attend wellbeing and restorative clinical supervision sessions.
- Non ward based departments are currently under review and recommendations will be presented in October 2021.
- These recommendations will support the Excellence Pathway and improve patient outcomes and staff satisfaction levels.

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- Peter Griffiths, Christina Saville, Jane E. Ball, Jeremy Jones, and Thomas Monks (2021) Beyond ratios - flexible and resilient nurse staffing options to deliver cost-effective hospital care and address staff shortages: a simulation and economic modelling study team. International Journal of Nursing Studies Volume 117, May 2021
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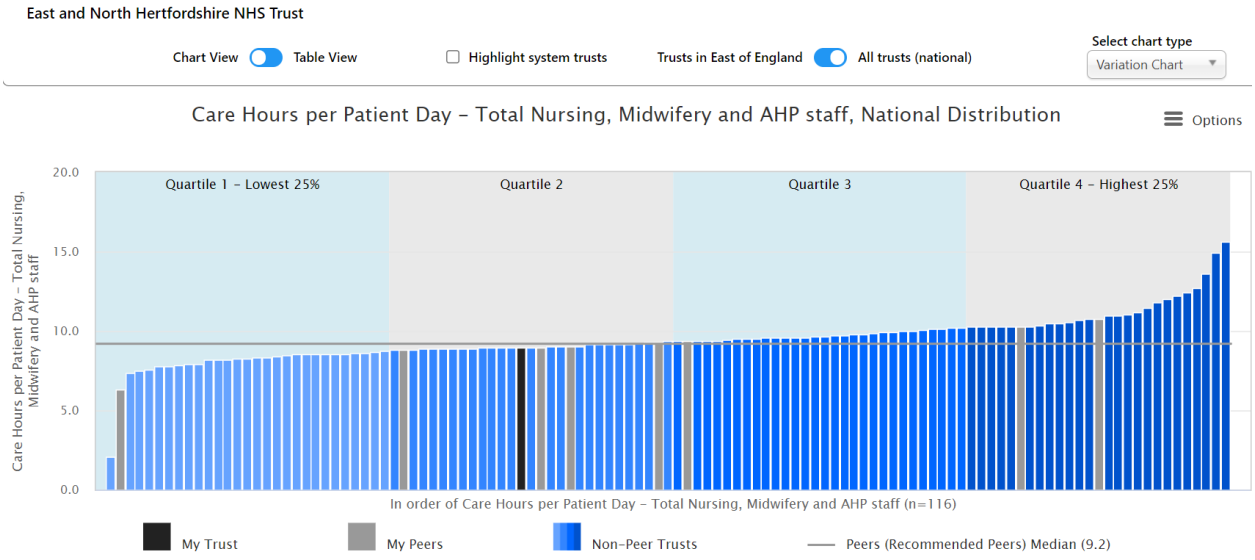
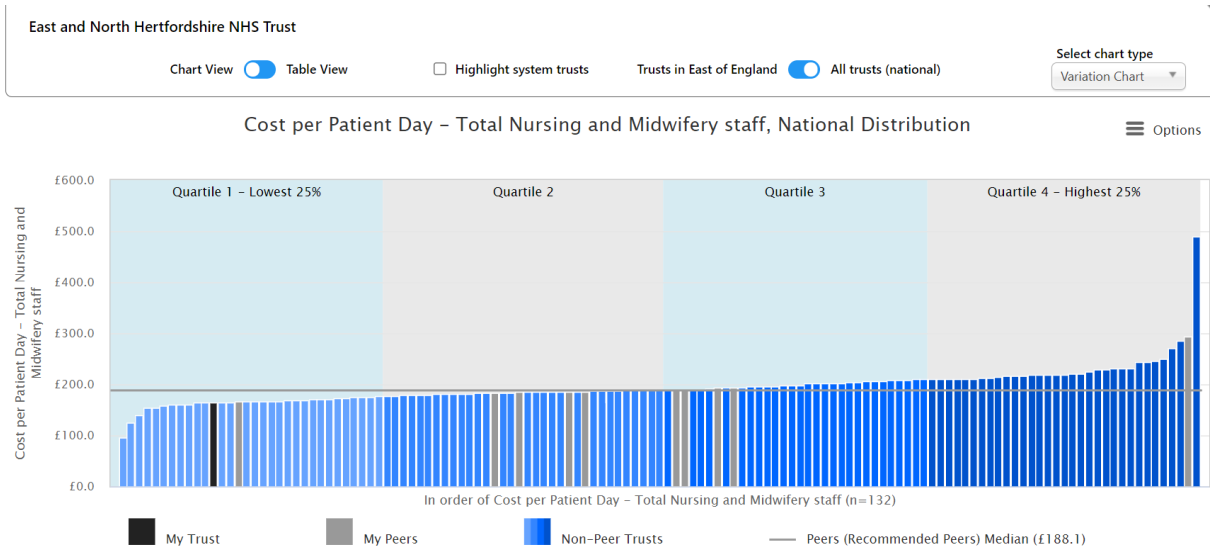
- National Quality Board safe, sustainable and productive staffing (2018)
- Royal College of nursing (2021) nursing workforce standards. Supporting a safe and effective nursing workforce. https://www.rcn.org.uk/professional-development/publications/rcn-workforce-standards-uk-pub-009681

Benchmarking data comparing local peers From the NHSI Model Hospital Dashboard – latest data available March 2021





Summary Change Request Table

Unit	Narrative	Change Request Total Funded WTE (inclusive of 21% Headroom)
Division Unplanned Care		
Acute Medical Assessment Unit (AMU-1)	Shift plan working to 8-8 2 x CC and TRN. 1 RNA in post, 1 RNA to qualify July 21. 2 x SNAs in training	+ 2.42 WTE Band 4 RNA - 1.95 WTE Band 5 RN + 2.42 WTE Band 3 SNA - 1.89 WTE Band 3 EMT
Acute Medical Ward (AMU-2)	Low occupancy on the ward. Remain at 3-2 (12 beds) due to acuity and side rooms. 1 Band 3 SNA in post. Convert 1 WTE band 2 to band 3.	+ 1.21 WTE Band 3 SNA - 1.01 WTE Band 2 CSW
Short Stay Unit (SSU)	Low occupancy on the ward. 3-2 LD and 2-1 N. High degree of specialling and mental health patients. Propose 2-2 at night	+2.54 WTE Band 2
Same Day Emergency Care (SDEC)	5-2 plus Nurse in charge. No change to current working (cost centre name Ambulatory Care Lister)	
Ambulatory Care QE2 (ACC)	Additonal activity directed to QE2 from Lister	
10A	No change to staffing numbers, add 1 WTE SNA to commence Sep 21	+ 1.21 WTE Band 3 SNA - 1.11 WTE Band 2 CSW
10B Endocrinology/Gen Med	10B has a high number of high acuity patients on compex drug regimes. There is a higher level of medication errors reported on 10B. It is therfore proposed that there is Increase skill mix at the weekend from 4-5 early to 5-4 early as per Mon-Fri as acuity does not change over the weekend. The SNCT data supports this recommendation.2 x SNAs in post	+ 0.38 WTE Band 5 + 2.42 WTE Band 3 SNA - 2.76 WTE Band 2 CSW
11A Respiratory	1 SNA and 0.8 WTE to commence Sep 21	+ 2.18 WTE Band 3 SNA - 2.18 WTE Band 2 CSW
11B RSU	6 Bed shift plan no change	
9A Elderly care	Convert RNA to SNA. No change to staffing numbers. Has regular support from the Enhanced care team with confused patients. SNCT recommendeds an uplift to WTE however poor acuity scores on Audits, Acuity scoring To be monitored, need addional training on SNCT scoring, possibly requires an uplift , 9A will be closely monitored will reviewed in 6 months	- 1.21 WTE Band 4 RNA + 1.21 WTE Band 3 SNA
9B Elderly Care	2 x SNA in establishment, 1 SNA in post. No change to staffing numbers. Has regular support from the Enhanced care team with confused patients. SNCT recommendeds an uplift to WTE however poor acuity scores on Audits, Acuity scoring To be monitored, need addional training on SNCT scoring, possibly requires an uplift , 9B will be closely monitored will reviewed in 6 months	
8A	8A is a lone ward on level 8 , previously when the surgical ward was on 8B there was cross floor band 6 cover 7 days per week. To ensure patient and staff safety it is proposed that there is an Increase Band 6 coverage at Night (current 4.5 nights)	+ 0.89 WTE Band 6 - 0.89 WTE Band 5
6A Medical/Renal	6A now covers general medicine and renal, it has a high number of complex patients and high acuity. It is proposed to ensure adequate band 6 coverage to support this they will need to increase the band 6 WTE by 0.91 and reduce the band 5 by 0.91 will Uplift Band 6 to 4 WTE. SNA within establishment for Sep 21 cohort	+ 0.91 WTE Band 6 - 0.91 WTE Band 5
6B Renal	No change to establishment. Includes SNA.	
Acute Cardiac Unit (ACU)	Due to the complex high acuity patients and the ward layout, ACU move from tower block to new ward block requires 1 RN uplift and reduction of a CSW on a Long day and night (5-2). Add SNA	+ 4.72 WTE Band 5 + 0.24 WTE Band 3 SNA - 5.28 WTE Band 2 CSW
Ashwell Frailty	Ashwell has a high number of dependant patients, they often have confused patients and need additional support to manage these patients on Bay watch. It is proposed thatUplift CSW at Night taking staffing to 3-3. The SNCT data supports the requested uplift as well as professional judgement	+ 2.54 WTE Band 2 CSW
Pirton Hyper Acute Stroke	SNA included in establishment. No change	
Barley Stroke Rehab	Band 7 SV 3 days a week, reduce Band 5 2 x early. Includes SNA x 2. Uplift CSW at Night. The SNCT data supports the requested uplift as well as professional judgement	- 0.39 WTE Band 5 + 2.54 WTE Band 2 CSW
Bluebell	SNA	
Children's ED	SNA x 2	

Unit	Narrative	Change Request Total Funded WTE (inclusive of 21% Headroom)
Division Planned		
5A	5A has changed speciality and now covers ENT, Plastics and Gynae. To manage the complex patients and airway patients it is proposed to Increase band 6 at night to full coverage (3 nights). Add SNA. Convert RNA to RN. Remove band 3 CSW (cost pressure)	+ 1.09 WTE Band 6 - 0.12 WTE Band 5 (+ 0.97 - 1.09) - 1.21 WTE Band 4 + 2.42 WTE Band 3 SNA - 1.54 WTE Band 3 CSW + 0.17 WTE Band 2 CSW
5B	5B now takes trauma and NOF patients. Due to the acuity it is proposed that there is an Increase band 6 at night (4 nights) reduce Band 5 (4 nights). The SNCT data supports this shortfall.Convert RNA to RN. Add SNA x 3 (includes Sep 21 cohort), remove band 3 CSW.	+ 1.45 WTE Band 6 - 0.34 WTE Band 5 (-1.45 + 1.11) - 1.21 WTE Band 4 + 3.63 WTE Band 3 SNA - 2.54 WTE Band 3 CSW - 1.09 WTE Band 2 CSW
7A	SNA Sep Cohort	+ 1.28 WTE Band 3 SNA - 1.42 WTE Band 2 CSW
7B	7B has a misture of complex urology and colorectal patients, acuity remains consitant over the 7 day week. It is therfore requested that the staffing plan remains constant 7 days per week. This requires an Increase of a CSW late at weekend from 4-3 to 4-4, add SNA	+ 1.21 WTE Band 3 SNA - 0.77 WTE Band 2 CSW (-1.11 + 0.34)
Swift	Plastics , ENT and Gynae have now moved to 5A so the additional RN has been moved to the 5A shift plan. Reduce band 5 early weekday (remove RNA as not recruited to) and increase CSW Long Day Mon-Fri (4-3 weekdays). add SNA x 2 (1 Sep 21 Cohort) and Band 3 CSW	- 1.21 WTE Band 4 RNA + 2.42 WTE Band 3 SNA + 1.21 WTE Band 3 CSW - 2.01 WTE Band 2 CSW (Option 2 - 0.19 WTE)
Critical Care	Shift plan remodelled for 18 Beds on Level 4 (9 Level 3 and 9 Level 2 patients) with Critical Care staffing guidelines. Includes 2 x SNAs	
Division Cancer		
Ward 10	Reduce RN Long Day at weekends due to reduced activity	- 0.7 WTE Band 5

Methodology

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

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

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

Skill Mix

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

Service model skills mix

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

Actual skills mix

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

Registered nurse to bed ratio

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

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

Care Hours per patient day (CHPPD)

The data for this metric is collected from the service model shift plans, the Trusts e-roster system and SafeCare. It is assumed that the service model shift plan is an accurate representation of the service, the roster is an accurate reflection of the hours worked and

SafeCare has accurate patient acuity and dependency scores input for each patient. As SafeCare uses an external formula to calculate the required and actual CHPPD values, it is assumed that this formula is correct and the Shelford Acuity and Dependency model is appropriate for the service. The calculations for this metric are:

Service Model CHPPD

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

Required CHPPD

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

Actual CHPPD

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

Safer Nursing Care Tool

Summary of SNCT Classifications

Level Descriptor

0	Patients requiring hospitalisation whose needs are met by normal ward care
1(a)	Acutely ill patients needing intervention or who are unstable with a greater potential to deteriorate
1(b)	Patients who are stable, but depend on nursing care to meet most or all of the activities of daily living
2	Patients who can be managed within clearly identified and designated beds and resources with the required expertise and staffing level or may require Dictated Level 2 facility/unit
3	Patients needing advanced respiratory support and/or therapeutic support of multiple organs

Multipliers Example

For acute inpatient wards (there are separate multipliers for acute assessment units included in the tool)

Level 0: 0.99 12 patients; 0.99x12=11.88
Level 1a: 1.39 7 patients; 1.39x7=9.73
Level 1b: 1.72 8 patients; 1.72x8=13.76
Level 2: 1.97 1 patient; 1.97x1=1.97
Level 3: 5.96 0 patients
Total 37.34 whole-time equivalents
(Multipliers include 22% uplift for annual leave etc)

The Safer Nursing Care Tool helps nurses decide on safe nurse staffing for acute wards based on patients' level of sickness and dependency. Acuity data is collected over a 20 day period and the licenced spreadsheet is used to compare with best practice wards data
It also includes quality indicators linked to nursing care to help ensure staffing levels achieve best patient care. The tool must be applied correctly and consistently for data to be valid, and to allow benchmarking against agreed standards. It should be combined with nurses' professional judgement and account for local factors. Fenton et al (2015)

Professional Judgement

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

Table 1

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

Div	Speciality	Ward	Service model registered nurse %	Service model unregistered nurse %	Actual registered nurse %	Actual unregistered nurse %
Unplanned	Respiratory	**11A**	57%	43%	54%	46%
		11B RSU	75%	25%	61%	39%
	Oncology	**10A**	57%	43%	55%	45%
	General	**10B**	58%	42%	48%	52%
	Renal	**6A**	58%	42%	52%	48%
	General / Renal	**6B**	67%	33%	63%	37%
	Gastro	**8A**	59%	42%	50%	50%
	Care of the Elderly	**9A**	57%	43%	47%	53%
		9B	57%	43%	47%	53%
	Cardiology	**ACU**	71%	29%	62%	38%
	Acute	**AMU Assessment**	57%	43%	46%	54%
		AMU Ward	60%	40%	53%	47%
		SSU	63%	37%	59%	41%
	Frailty	**Ashwell**	56%	44%	46%	54%
	Stroke	**Barley**	57%	43%	53%	47%
		Pirton	67%	33%	62%	38%
	Paediatrics	**Bluebell**	73%	27%	72%	28%
Planned	General Surgery & Vascular	**7A**	59%	41%	53%	47%
	Urology & Colorectal	**7B**	59%	41%	54%	46%
	Plastics & ENT, Female Surgery	**5A**	59%	41%	55%	45%
	T&O & NoF	**5B**	58%	42%	47%	53%
	Elective Surgery	**Swift**	67%	33%	63%	37%
	ATCC	**Critical Care**	85%	15%	97%	3%
Cancer	Oncology	**Ward 10**	57%	43%	62%	38%

Table 2

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

Div	Speciality	Ward	RN to Bed Ratio Early	Late	Night
Unplanned	Respiratory	**11A**	**1/7**	**1/7**	**1/7**
		11B RSU	**1/2**	**1/2**	**1/2**
	Oncology	**10A**	**2/9**	**2/9**	**2/9**
	General	**10B**	**1/6**	**1/7**	**1/7**
	Renal	**6A**	**1/6**	**1/7**	**1/7**
	General / Renal	**6B**	**1/5**	**1/5**	**1/6**
	Gastro	**8A**	**1/6**	**1/7**	**1/7**
	Care of the Elderly	**9A**	**1/7**	**1/7**	**1/7**
		9B	**1/7**	**1/7**	**1/7**
	Cardiology	**ACU**	**2/9**	**2/9**	**2/9**
	Acute	**AMU Assessment**	**1/5**	**1/5**	**1/5**
		AMU Ward	**1/4**	**1/4**	**1/4**
		SSU	**1/5**	**1/5**	**1/7**
	Frailty	**Ashwell**	**1/6**	**1/6**	**1/8**
	Stroke	**Barley**	**1/6**	**1/6**	**1/8**
		Pirton	**2/9**	**2/9**	**1/7**
	Paediatrics	**Bluebell**	**1/4**	**1/4**	**1/4**
Planned	General Surgery & Vascular	**7A**	**1/7**	**1/7**	**1/7**
	Urology & Colorectal	**7B**	**1/6**	**1/7**	**1/7**
	Plastics & ENT, Female Surgery	**5A**	**1/6**	**1/6**	**1/7**
	T&O & NoF	**5B**	**1/6**	**1/7**	**1/7**
	Elective Surgery	**Swift**	**1/5**	**1/6**	**1/6**
	ATCC	**Critical Care**	**7/9**	**7/9**	**7/9**
Cancer	Oncology	**Ward 10**	**1/5**	**1/5**	**1/7**

Appendix 5

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

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

Div	Speciality	Ward	Service Model CHPPD	Required CHPPD SafeCare	Actual worked CHPPD
Unplanned	Respiratory	**11A**	5.45	5.36	6.65
		11B RSU	15.07	6.95	15.01
	Oncology	**10A**	7.92	6.60	9.61
	General	**10B**	5.46	6.33	6.87
	Renal	**6A**	5.5	6.13	6.31
	General / Renal	**6B**	6.43	7.94	9.02
	Gastro	**8A**	5.42	7.46	6.40
	Care of the Elderly	**9A**	5.26	5.97	6.47
		9B	5.26	7.48	6.73
	Cardiology	**ACU**	7.17	7.72	9.41
	Acute	**AMU Assessment**	9	7.14	13.90
		AMU Ward	9.45	7.62	12.01
		SSU	6.03	7.07	7.80
	Frailty	**Ashwell**	5.9	6.61	7.16
	Stroke	**Barley**	5.8	9.10	6.89
		Pirton	6.18	5.22	8.28
	Paediatrics	**Bluebell**	7.91	5.50	12.43
Planned	General Surgery & Vascular	**7A**	5.12	5.63	6.40
	Urology & Colorectal	**7B**	5.39	7.30	6.00
	Plastics & ENT, Female Surgery	**5A**	5.78	5.78	7.27
	T&O & NoF	**5B**	5.53	7.30	7.03
	Elective Surgery	**Swift**	6.26	5.21	6.38
	ATCC	**Critical Care**	21.72	22.63	19.83
Cance	Oncology	**Ward 10**	6.15	5.61	10.60

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

Div	Speciality	Ward		CHPPD Bench Marking Data			SNCT Recommended Data	
			Bed Occupancy %	Total Funded Est. based on occupancy	Total Funded Establishment	Recruitable Establishment April 2021	SNCT recommended WTE (22% Headroom)	Variance of Total Funded Est. based on occupancy to SNCT recommended
Unplanned	Respiratory	**11A**	88.10%	32.07	36.40	32.12	36.92	-4.85
		11B RSU	80.83%	17.69	21.88	19.28	9.15	8.53
	Oncology	**10A**	91.00%	16.94	18.61	16.39	10.37	6.57
	General	**10B**	95.17%	35.93	37.75	33.31	41.57	-5.64
	Renal	**6A**	95.00%	36.09	37.99	33.46	39.84	-3.75
	General / Renal	**6B**	73.33%	26.08	35.56	31.37	23.56	2.52
	Gastro	**8A**	94.00%	35.21	37.46	32.99	35.37	-0.16
	Care of the Elderly	**9A**	99.00%	36.04	36.40	32.12	47.49	-11.45
		9B	97.67%	35.55	36.40	32.12	45.23	-9.68
	Cardiology	**ACU**	82.50%	30.38	36.83	32.5	24.32	6.06
	Acute	**AMU Assessment**	63.30%	60.24	95.17	83.94	40.53	19.71
		AMU Ward	66.25%	17.44	26.33	23.14	14.78	2.66
		SSU	78.00%	18.56	23.80	18.63	13.59	4.97
	Frailty	**Ashwell**	96.46%	31.56	32.72	28.72	34.79	-3.23
	Stroke	**Barley**	91.88%	30.02	32.67	28.82	34.22	-4.20
		Pirton	81.36%	25.56	31.41	27.71	23.80	1.75
	Paediatrics	**Bluebell**	60.63%	18.29	30.17	26.47	19.51	-1.22
Planned	General Surgery & Vascular	**7A**	85.67%	30.33	35.40	31.24	29.36	0.96
	Urology & Colorectal	**7B**	91.67%	34.16	37.27	32.82	33.67	0.49
	Plastics & ENT, Female Surgery	**5A**	56.00%	22.46	40.10	35.25	21.08	1.38
	T&O & NoF	**5B**	92.67%	35.39	38.19	33.63	45.32	-9.93
	Elective Surgery	**Swift**	92.69%	30.46	32.86	28.92	30.14	0.31
	ATCC	**Critical Care**	76.39%	79.63	104.24	92.29		79.63
Cancer	Oncology	**Ward 10**	54.55%	17.22	31.57	28.04	14.63	2.59

Ward SNCT Acuity Audit Results

Results by league table

Date range: Apr 2021

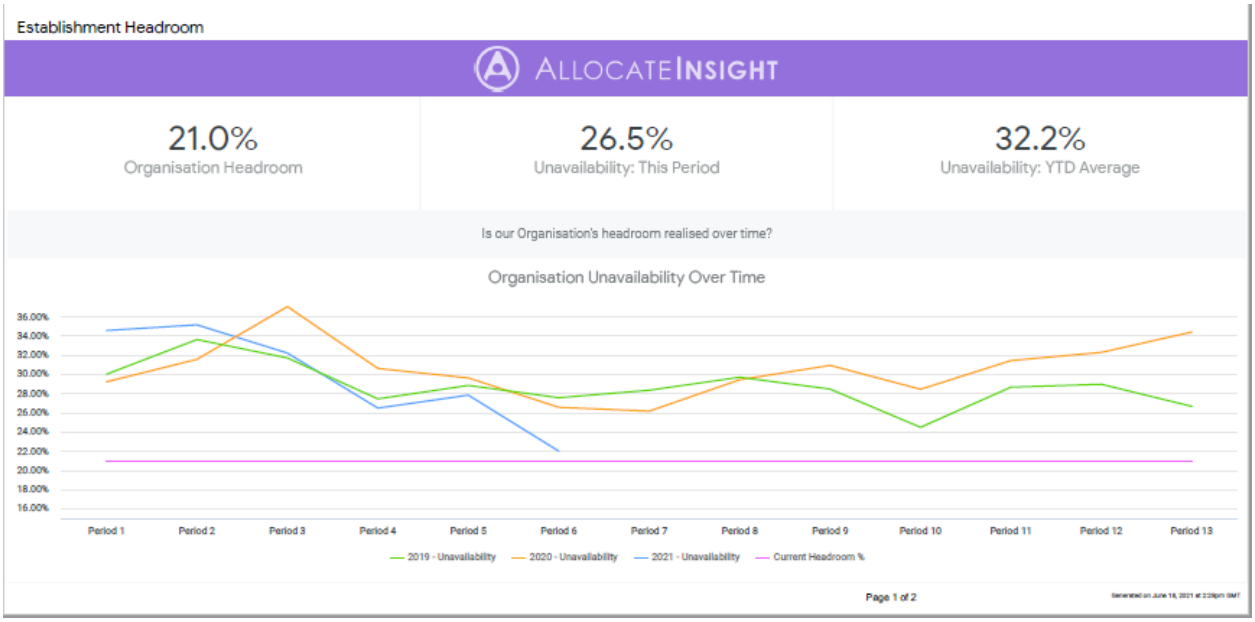
Ward Acuity Audit Ward League table

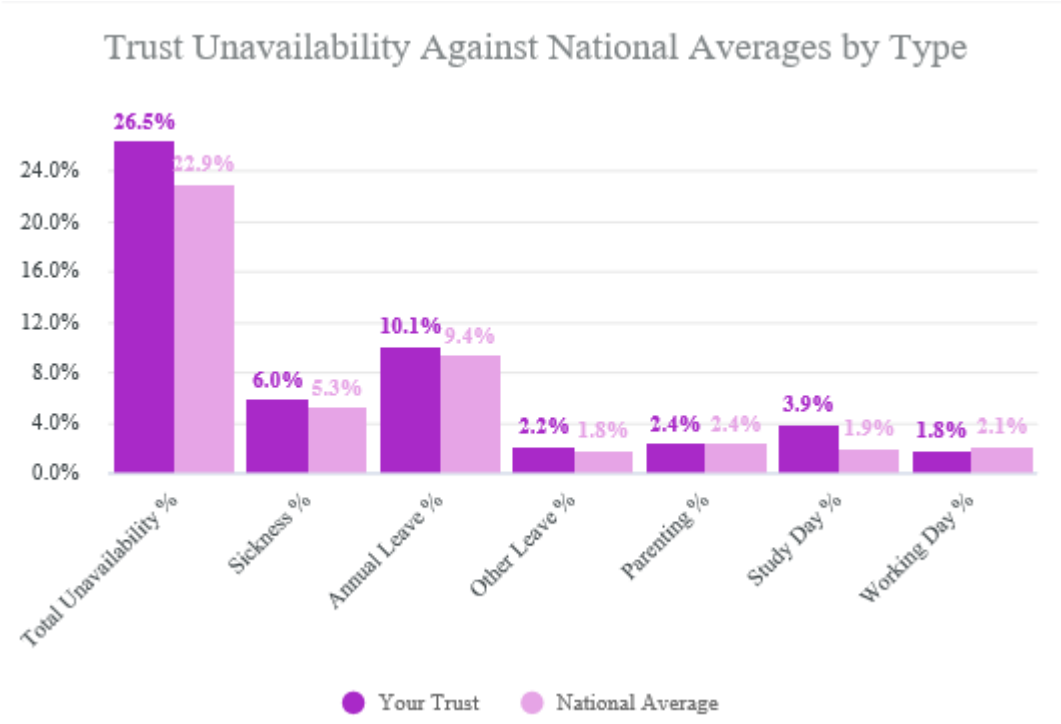
Level: Ward
Question: All items selected
View: Ward

Rank	Movement	Ward	Score	Returns
1	2	Barley	100.00	2
2	-1	Swift Ward	98.78	15
3		MVCC Ward 10/11	98.04	4
4	-3	8A	96.47	3
5		SSU	95.35	4
6	-5	Pirton	94.12	2
7		6B	93.75	2
8		6A	92.11	4
9		Acute Cardiac Unit (ACU)	90.74	3
10		10A	88.24	4
11	-9	7B	87.06	5
12		10B	86.67	1
13		AMU1	84.62	2
14		5B	81.48	4
15		Ashwell	79.17	3
16		11B	77.78	2
17		7A	72.92	4
18		9A	70.00	3
19		9B	69.77	2
20		11A	68.97	2
21		AMU2	59.09	2
22		5A	42.86	1

Red Triggering Shifts Data Collection period 20 days in April – Final RAG status

Division	Ward	Red	Amber	Green	Grand Total
Unplanned	10A		8	82	90
	10B	2	31	57	90
	11A	2	22	66	90
	11B RSU	1	29	60	90
	6A		26	64	90
	6B		21	69	90
	8A	3	24	63	90
	9A		22	68	90
	9B	1	29	60	90
	ACU		40	50	90
	AMU-1	1	36	53	90
	AMU-2		7	83	90
	Ashwell		37	53	90
	Barley		21	69	90
	Bluebell		36	54	90
	Pirton		18	72	90
	SSU		18	72	90
Unplanned Total		**10**	**425**	**1095**	**1530**
Planned	5A	1	26	63	90
	5B	5	28	57	90
	7A	6	21	63	90
	7B	8	16	66	90
	Critical care 1		33	57	90
	Swift	1	19	70	90
Planned Total		**21**	**143**	**376**	**540**
Cancer	**Ward 10**	2	8	80	90
Cancer Total		**2**	**8**	**80**	**90**
Grand Total		**33**	**576**	**1551**	**2160**


Establishment Headroom
ALLOCATEINSIGHT
21.0%
Organisation Headroom
26.5%
Unavailability: This Period
32.2%
Unavailability: YTD Average
Is our Organisation's headroom realised over time?
Organisation Unavailability Over Time
36.00%
34.00%
32.00%
30.00%
28.00%
26.00%
24.00%
22.00%
20.00%
18.00%
16.00%
Period 1
Period 2
Period 3
Period 4
Period 5
Period 6
Period 7
Period 8
Period 9
Period 10
Period 11
Period 12
Period 13
2019 - Unavailability
2020 - Unavailability
2021 - Unavailability
Current Headroom %
Page 1 of 2


Trust Unavailability Against National Averages by Type
26.5%
22.9%
24.0%
20.0%
16.0%
12.0%
8.0%
4.0%
0.0%
6.0%
5.3%
10.1%
9.4%
2.2%
1.8%
2.4%
2.4%
3.9%
1.9%
1.8%
2.1%
Total Unavailability %
Sickness %
Annual Leave %
Other Leave %
Parenting %
Study Day %
Working Day %
Your Trust
National Average

NHSP Booking Controls

Visibility of Staff & Management of Shifts	- All staff and shifts on one system - Consolidated view on Healthroster of all Trust, Agency and NHSP (bank) shifts - Better management of shift fill due to use of Trust roster templates - Less chance of shift duplication - Two-tier authorisation can be set up in Health Roster
Safer Process	- The Interface utilises the existing controls built into Healthroster to ensure adherence to Trust policy (rules, warnings, and violations) - WTD adherence & rules will still be in place in NHSP (for Bank and Substantive workers)
Efficiency	- The Interface enables a more efficient and faster process of sending shifts (reduces data entry) as shifts are fed directly from Healthroster to NHSP - Multiple shifts can be sent simultaneously - All unfilled shifts can be sent to NHSP as soon as the Roster has been created providing a greater lead time
Reporting	Better reporting due to all shifts on one system (Health Roster) - standardising rostering - applying universal rules - detailed auditable evidence - prevents breaching of sickness absence protocols - prevents breaching WTR - Flexible Worker tracking - Evidence of temporary staffing utilisation in areas which can add quality monitoring and for use as evidence for CQC etc.
Our: Bank	- **Second Tier Authoriser** – this function means only temporary staffing shifts that are approved by a secondary authoriser will be visible to flexible workers, levels of authority can be set by user. When this function is switched on, the shift will show as pending until approved by a Senior Manager - **Agency Bumping** – lower cost Agencies can remove higher cost agencies from shifts if they have a worker, they can book in. - **Bank Bumping –** Bank workers can bump Agency workers out of shifts up until 24 hours before the shift start time - **Reallocate Bank –** This function is used when a ward no longer needs a worker, they are provided with the opportunity to rebook the worker in a vacant shift that suits their competency's - **Golden Key/Padlocks** – The Trust can restrict what shifts go to Agency, this can be managed via Golden Keys and Padlocks and can only be removed by nominated individuals

	- **Duty reset to fulfilment** – Our: Bank will link in with the Trusts roster to ensure only shifts that are within the Wards template are sent to Bank Controls over Direct Bookings – restrict the use of agency but ensuring users are unable to book shifts directly, only nominated users will be able to do this. - **Agency Cascades -** the NHSP system facilitates the cascade of shifts to agency's based on preferences, a tiering system means Agency's will see shifts at varying times. These tiers are based on Agency booking behaviours and cost - **Reporting** – Shift reports can be run directly from Our: Bank - **Assignment Codes –** Workers will only see shifts that apply to them, competencies are assessed, and codes are added accordingly - **New to Ward** – our Bank will indicate when a flexible worker needs to take an induction, this function helps keeps our workers and Trust patients safe - **Access Levels –** Users can have varying access levels, these include: o View Only o Booker Only o Booker & Authoriser o Senior Admin

East and North Hertfordshire NHS Trust

Agenda Item: 14

TRUST PUBLIC BOARD – 7 JULY 2021

Quality Account 2020/21

Purpose of report and executive summary (250 words max):
Quality Account Regulations 2010 require Trusts to publish their Annual Quality Account by 30 June each year. The amended regulations 2020 confirmed that an External Audit will not be required this year.

The Quality Account 2020/21 has been prepared in line the regulations and shared with all Board members, key leads and the CCG for comment. The feedback has been positive and consensus that it is a fair and transparent account of quality performance over the last year. Suggestions have been incorporated into the final version. Key changes since the draft version include:

- Inclusion of the Chief Executive Statement
- Re ordering the presentation of the strategy section
- Linking the components of the Quality Strategy to each of the Quality Account priorities
- Minor rephrasing
- Inclusion of the statements from the CCG, Healthwatch and Hertfordshire County Council (annex 3, at the end of the document)
- Graphics

The Quality and Safety Committee approved the Quality Account 2020/21 on 29 June 2021 for submission and publication and noted the stakeholder (CCG, Healthwatch and Hertfordshire County Council) comments at the end of the document.

The Board is asked to formally note the Quality Account 2020-21.

Action required: For information		
Previously considered by: Board members, Executive Team Committee, CCG. Approved by QSC 29 June 2021.		
Director: Chief Nurse	**Presented by:** Chief Nurse / Associate Director of Governance	**Author:** Associate Director of Governance

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

NHS
East and North Hertfordshire
NHS Trust

Quality Account
2020/21

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

Quality | People | Pathways | Ease of use | Sustainability

PART 1

1.1 How we are accountable for quality

East and North Hertfordshire NHS Trust have created a holistic approach to align quality across our clinical and non-clinical services. The clinical strategy provides an overarching framework underpinned by five key strategic priorities; one of which is quality.

Clinical strategy (2019-24)

2020/21 was the second year of the Trust's five year strategy to 2024. This was developed with input from our staff, patients, their families and carers, members and key stakeholders, including the Hertfordshire and West Essex Sustainability and Transformation Plan. The Trust's vision is to be "Proud to deliver high-quality, compassionate care to our community".

The Trust has identified five Strategic Priorities:

- **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 is in the best interests of patients.
- **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.

These are underpinned by our PIVOT values: **Putting** patients first; striving for excellence and continuous **improvement**; **valuing** everybody; being **open** and honest; and working as a **team**.

The Trust has a number of enabling strategies to support the delivery of the Clinical Strategy and quality priorities including the People Strategy 2020 and the Quality Strategy 2019. The strategic priority for quality and its guiding principles are shown in the section below. Details of how the strategic priority will be delivered are outlined within our Quality Strategy.

Quality Strategy (2019-2024)

The Quality Strategy aims to improve our quality management systems by approaching quality with a more holistic view that includes: quality planning, quality assurance and quality improvement.

This strategy guides our staff to work safely, by giving them the skills and authority to make changes that drive continuous improvement for our patients. The strategy supports our Trust 'pivot' values.

Key objectives of the Quality Strategy include:

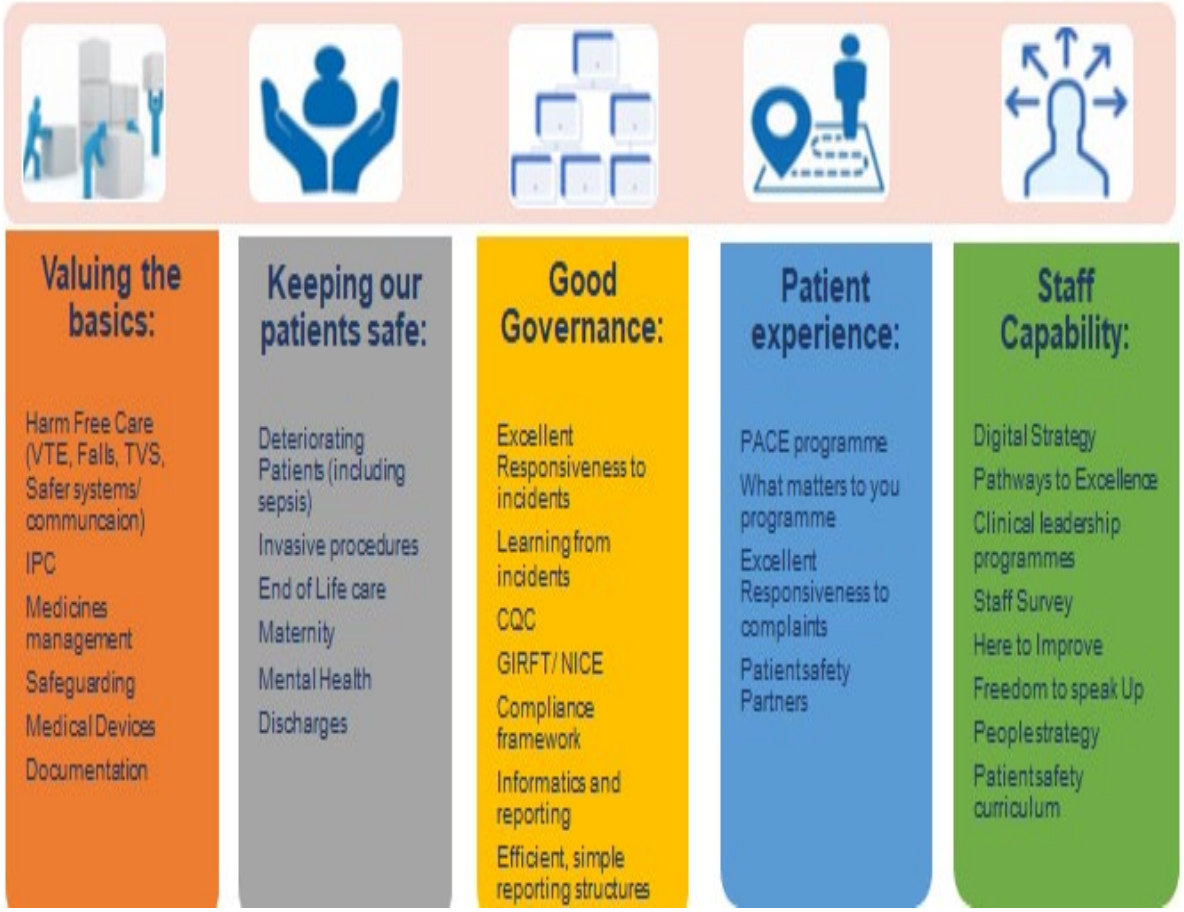
To understand where variation exists and uses data to proactively drive improvement by reducing the 'unwarranted variation'. Aiming to enable staff to develop analytical capabilities, and access to real-time data from ward to board.

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

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

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

Five components of the Quality Strategy have been identified to provide a structure in which to focus our efforts of continuous improvement. These are:



Each component represents key priorities identified through triangulation of data and information across the Trust. These priorities are linked through small to large scale programmes of work, with detailed measurement plans, strategic and local leadership and robust monitoring and tracking processes. The relationship between these components and the quality account priorities are shown at the top of each section within this report.

People Strategy 2020

The Trust has continued to implement the People Strategy which was approved in January 2020, which is based on four 'People Strategy Pillars': Work Together, Grow Together, Thrive Together and Care Together, although the context of its implementation was different from that originally envisaged due to the pandemic.

Each of the pillars aim to improve the engagement and experience of our people and, clarifies the desired leadership behaviours to support the delivery of the Clinical Strategy and Quality Strategy.

However, 2020/21 was fundamentally different to the year the Trust had envisioned. The Trust was impacted by, and needed to respond to the COVID pandemic, with a complete change of focus for clinical and operational teams throughout the year. In March 2020 NHS England and Improvement wrote to all Trusts outlining ways for "Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic." This included pausing some of the national programmes and data collections. For example, 7 day services, clinical audits and performance targets. This has impacted on the delivery of the quality priorities that had been originally planned, however, the challenges posed by the COVID pandemic also brought about opportunities for change and working together as an organisation and system in different ways to provide care safely.

The Trust responded to two waves of the pandemic; the first from March 2020 - June 2020; and the second from October 2020 – March 2021. A full summary of the Trust's response is set out in the Trust Annual Report 2020-21 and the Quality Account sets out the delivery against the quality priorities.

Organisational Structure

The Trust completed an organisational redesign in 2020/21, reducing from four clinical divisions to two: Planned Care and Unplanned Care. Clinical leadership has been strengthened, with each division having a Divisional Medical Director, who is a senior clinician, a Divisional Nursing and Quality Director, and an Operations Director whom report to a Managing Director. This triumvirate structure is replicated at specialty level. This supports the delivery of the Trust's strategies.

Supporting the clinical divisions are corporate teams covering areas including: finance and IT; medical practice, education and research; nursing practice; operations; strategy; estates and facilities; transformation, and workforce and organisational development.

1.2 Statement from the Chief Executive

Our primary objective at the start of the COVID-19 pandemic was to keep our patients and staff safe. This 2020/21 Quality Account outlines how we did this, as well as demonstrating our commitment to continuous quality improvement and how we have been drawing on patient experience to inform this.

While the impact of COVID has meant some of our plans to build on our quality improvement capability and capacity has yet to be fully realised, we have made significant steps forward over the past year. In 2020, we launched 'Here to improve' – a model to develop quality improvement skills and knowledge across all our workforce groups at every level of the organisation. I am proud that the Trust is one of only 14 NHS trusts in England chosen to be part of the Pathways to Excellence ® international recognition of nursing and midwifery excellence.

The components of quality in healthcare are safety, effectiveness and patient experience. We are achieving, and indeed exceeding, our intentions in some areas such as improving mortality, reducing medication errors and maintaining our cancer performance. However we know there are other areas where further improvements can be made – with the pandemic posing unique challenges. These include earlier interventions around sepsis care, provision of seven-day service standards and decreasing wait times for operations.

We have welcomed working with our regulators on quality assurance and ever closer with system healthcare partners to provide high-quality care to our population. The pandemic has acted as a catalyst for this, with innovative new services such as virtual wards helping us to deliver care to those at home. We have also seen further improvements in identifying vulnerable families and earlier interventions, following the merging of our adult and children safeguarding teams.

I would like thank all of our staff for their continued hard work, commitment and professionalism whilst caring for our community. Their dedication to continued high-quality, compassionate care has been outstanding.

This report describes just some of their achievements. To the best of my knowledge the information in this document is accurate.

Nick Carver, Chief Executive

PART 2

2.1 Priorities for improvement

Priority One: Build ENHT Quality Improvement Capability & Capacity

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

Link to the Quality Strategy: Staff Capability

Monitoring: Quality and Safety Committee

Reporting: Scheduled update to Quality and Safety Committee

Responsible Directors: Chief Nurse /Director of Improvement/ Medical Director

Theme	Measure	19/20	20/21	21/22*
1.1 Clinical and Non-Clinical staff are offered opportunities to gain knowledge on Quality Improvement theory.	Quality Improvement for all Theory & Practitioner level	Ascertain organisational readiness and set trajectory	QI introductory session for all staff on induction to the Trust. Adopt patient and carer experience information to focus 'what matters to you' design to training.	QI introductory session for all staff on induction to the Trust. Adopt patient and carer experience information to focus 'what matters to you' design to training.
	Quality Improvement for Leaders	Ascertain organisational spread and set trajectory.	Align continuous quality improvement leadership through: • Patient safety • Patient Experience • Clinical Leadership Programme priorities	Align continuous quality improvement leadership through: • Patient safety • Patient experience • Clinical Leadership Programme priorities
	Organisational wide quality learning events	Minimum one summer and one winter event.	Deploy 'virtual' summer celebration with assistance of Organisation Development (OD) and communications teams	Deploy 'virtual' summer celebration with assistance of Organisation Development (OD) and communications teams
	Measurement masterclass sessions	Deliver approx. 1 per quarter	Offer 1 virtual masterclass	Offer 1 virtual masterclass (inclusive of corporate and divisional leadership teams)
1.2 Staff are supported to	Establish 'quality clinics'	Deliver approx. 1 per	Offer a virtual clinic every week with a QI	Offer a virtual clinic every week with a QI

Theme	Measure	19/20	20/21	21/22*
practically apply Quality Improvement knowledge through QI coaching.	that will empower all staff to discuss quality, scope new ideas and think how they could work differently.	month	coach to explore a QI idea	coach to explore a QI idea
	Agree and deliver curriculum for Quality Improvement coaches	Ascertain organisational readiness and set trajectory	Train all of band 7's and 8's from the patient experience team to this level exploring the use of virtual training and coaching them while they run a project	Offer training to all band senior leaders (band 7's and 8's) from the corporate and divisional leadership teams to this level exploring the use of virtual training and coaching them while they lead improvement projects.
	Recruit to Quality Improvement Team	AIM: 4 WTE posts dedicated to QI capability building	N/A Action complete	N/A Action complete
1.3 Deliver organisational wide structured Quality Improvement continuous learning programme	Adopt 'Patient Safety Breakthrough Series Collaborative'	Successfully recruit approx. 10-15 improvement teams who contributing over 18 month programme.	Look at lessons learned from SIM teaching and COVID response and offer a virtual breakthrough series to build on this.	Look at lessons learned from the Trust-wide simulation team teaching and COVID response and offer a virtual breakthrough series.
1.4 Clinical Excellence Framework	Design and imbed ENHT Exemplar ward programme	Following published accreditation criteria, all adult in patient areas shall have undertaken accreditation assessment.	Scale and spread quality improvement plans to drive continuous improvement across pathway pillars	Scale and spread quality improvement plans to drive continuous improvement across accreditation pathway pillars.
1.5 Adopt a framework that reflects and values patient co-design	Patient co-design faculty shall be established	N/A	Following a 'what matters to you' model ENH QI & Engagement team shall continue to build new ways of working that promote meaningful patient involvement though continuous quality	Following a 'what matters to you' model ENH QI & Engagement team shall continue to build new ways of working that promote meaningful patient involvement though continuous quality improvement plans

Theme	Measure	19/20	20/21	21/22*
			improvement plans	

* Due to the impact of COVID the milestones from 2020/21 have not been able to progress in full and have been reviewed and rolled forward for 2021/22. The progress made to date is outlined below.

1.1 Clinical and Non-Clinical staff are offered opportunities to gain knowledge on Quality Improvement theory

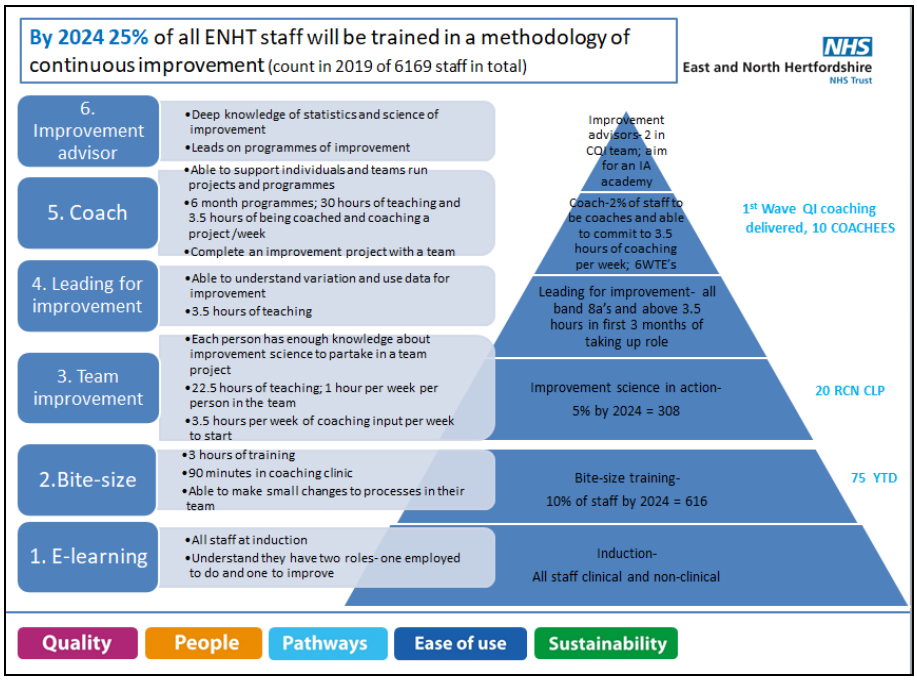
The quality improvement team was set up in September 2019 and restructured in 2020. The team have worked alongside our transformation, education, organisational development and digital teams to develop the East and North Hertfordshire model for a cohesive '7 steps for improvement', known as the 'Here to improve' model (figure 1.1.1).

Figure 1.1.1

The Trust is committed to develop skills and knowledge across all workforce groups, this will drive a saturation of staff successfully having achieved different levels of skill required within their roles. A saturated 'tipping point' in the organisation shall produce a shared language and understanding of how to apply and drive improvement tools and knowledge.

Reaching our organisational saturation point will be achieved through adoption of an evidenced based, tiered dosing formula of skills required at each level of the system. Our progress against each level of skills and knoweldge can be seen in figure 1.1.2 below.

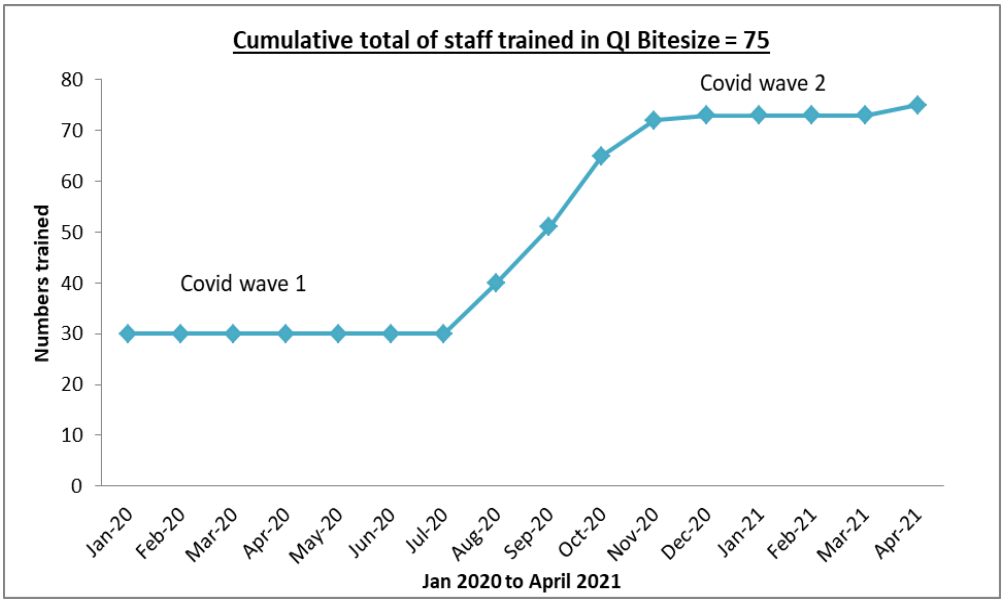
Figure 1.1.2



Level 1 shall target all staff in the Trust to have a basic understanding of key principles to improvement. While recent induction and on-boarding mandatory training has required adjusting due to the pandemic, quality improvement level 1 material and content has been designed and is ready to be launched on the new Trust learning system as a key induction and essential training modules throughout 2021/22.

Level 2 has been targeted to staff that have some basic quality improvement knowledge and would like to learn specific subject topics in a little more depth. These sessions have successfully been delivered through the design of short, targeted 'Bite-size' sessions. This teaching is offered to anyone in the Trust and includes 3 hours of training in the 7 steps for improvement e.g. how to design an improvement aim, how to analyse data for improvement, how to innovate and test new ideas. This has been successfully delivered to 75 staff across 2020/21.

Figure 1.1.3



Level 3 has been targeted to more 'team' leadership and wide commitment to adoption of quality improvement. Staff attending these sessions has been more submersed in many more aspects of quality improvement; and are expected to drive an improvement project over a moderate period of time. Through partnering with the Royal College of Nursing Clinical Leadership Programme 20 ward leaders undertook 12 months of study together and successfully delivered improvements in quality within their services e.g. staff experience, patient experience, waiting time, medication safety. These projects were celebrated and presented at a shared learning event online in November 2020.

Below in figure 1.1.4 demonstrates an example of the ward leader's projects.

Fig 1.1.4

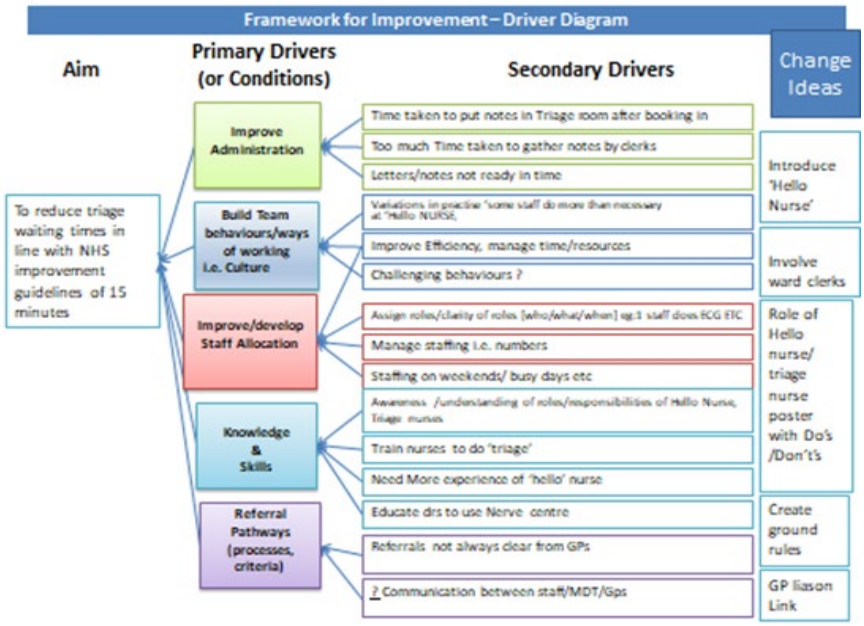
Project: Improve the triage process within ambulatory emergency care to improve patient flow, safety and experience

Background:
In November 2019, Ambulatory Emergency Care was transformed, and a higher percentage of patients attending would be 'emergency patients' either from GP or Emergency Department. This required improvements to key aspects of the service. The team set an aim to align with ED standards that all patients would be assessed within 15 minutes of arrival.

The baseline performance demonstrated that for the period December 19- January 20 the initial triage times were between 20 and 75 minutes.

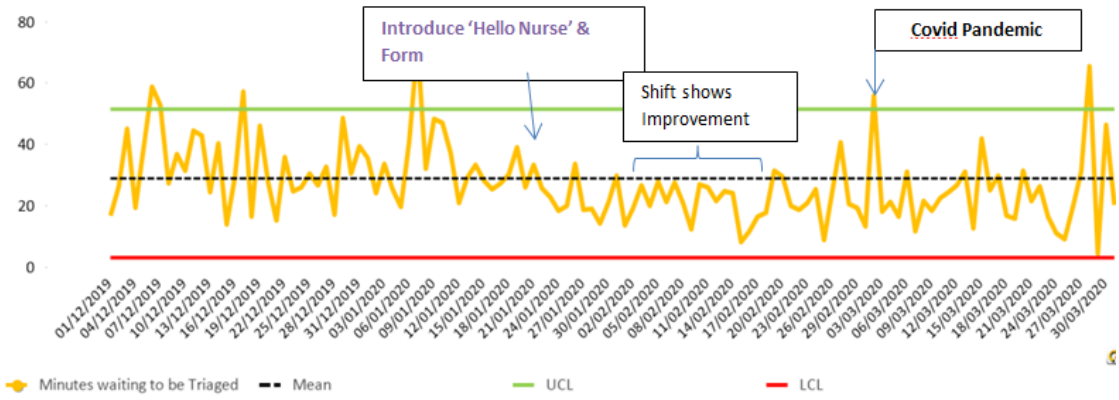
The driver diagram below shows the team aim to improve all triage times to 15 mins and the identified primary and secondary drivers to target to achieve this improvement. The Trust has since redesigned front door services and ambulatory care is no longer a clinical area however, while the project was being carried out before COVID significant improvement was achieved. The work was celebrated at a shared learning event in November 2020.

Driver Diagram



New idea tested:
Following consultation with the wider service team members and medical leaders, the team introduce a new 'Hello Nurse' at point of triage. With continuous review of current and new processes of steps the team worked together to re-design assessment and escalation steps to ensure a safe and more timely triage of patients.

Outcomes:
Patients are now being assessed within 15 - 30 minutes of arrival. This has seen triage times improve from January 2019 at 40-60 mins to March 2020 at 15-25 mins.



Staff feedback included that they were 'Proud to be part of a team' that could successfully drive service improvements, with ward clinical leaders feeling more accomplished and more confident.

Patient feedback included "The service was well timed, with friendly staff who knew what they were doing and explained everything". The project also demonstrated an improvement in Friends and Family feedback, with an increase in the number of patients that would recommend the service from 94.49% Sept 2019 to 100% in February 2020.

Level 5 - The quality improvement team co-designed an inaugural wave of a QI coaching course for the Trust. This course is designed to enable people to develop skills in coaching others to carry out improvement projects and was successfully delivered to 10 leaders within the organisation with leading improvement as a part of their role.

Capability and capacity building next steps:

- Current strategic plans include the ongoing development and co-designing of the Trust 'Here to improve' curriculum. This educational offer shall enable faster scaling of our capability and capacity building programme by working with colleagues in education, transformation and organisational development.
- The Trust has adopted a quality improvement project platform, recommended by our regional Academic Health science Network and NHSE/I called 'LifeQI'. This sharing system enables staff to easily collaborate across teams and, follow a structured approach to driving quality improvement. It shall accelerate regional sharing of improvement efforts and improve local reporting on projects and programmes within the Trust.
- The development of more in-depth knowledge (level 2 and 3 skills) shall be supported through ongoing access of externally accredited learning products such as Institute of Health Care Improvement open school licenses and lean six sigma training modules.

These are proved packages to provide scale and submersion of quality improvement skills.

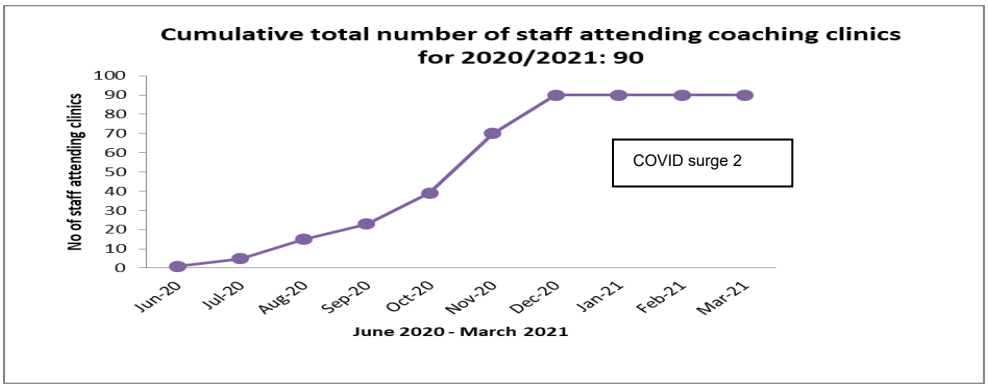
- The Trust has committed to a second cohort partnership with the RCN Clinical Leadership programme. A further 20 clinical leaders are enrolled and ready to undertake a new 2021/22 twelve month programme, commencing May 2021.

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

Coaching support for staff is provided from qualified improvement coaches, of which the Trust as two full time coaches and who are supported by the Head of Continuous Improvement and Associate Director for Quality and Safety. Coaching staff has been provided through two main forums – coaching clinics and the RCN Clinical leadership programme.

1. Coaching clinics are available twice a week for anyone with an interest in improving any aspect of quality. Staff are encouraged to come along to the clinic and be coached to take the next step in their QI project. Each project is scored and resource allocated on the basis of key aspects of QI being considered, for example co-design with patients.
2. Coaching clinic attendance has progressively supported 90 staff in total since June 2020.

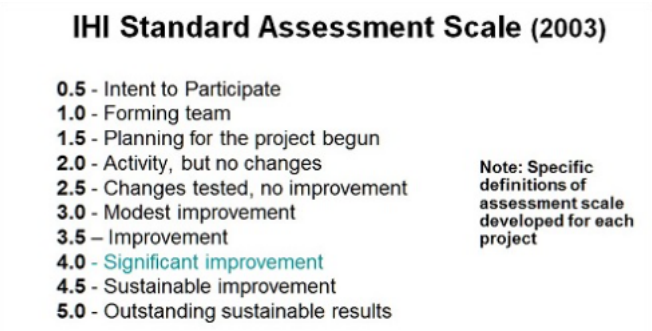
Figure 1.1.4



3. Each candidate within the RCN Clinical leadership programme had an identified coach to support practical application of QI skills and knowledge. In the formal classroom learning session staff expressed positive feedback on the support from the coaches towards them successfully achieving results. The coaches supported 16 projects to completion, 8 of which focused on improving patient safety, 7 focused on staff and patient experience and one focused on efficiency.

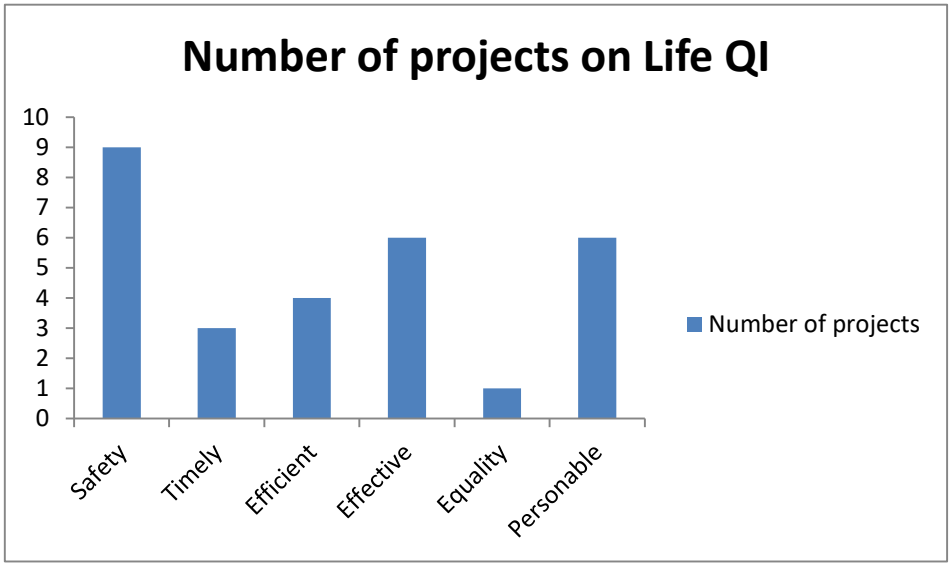
Project progression is tracked through an Institute for Healthcare Improvement (IHI) scoring scale, allowing staff and coaches to track project progress over time using a scale between **0.5 - 5.0, see figure 1.1.5.** All projects reached improvement scores between 2 and 5 on the IHI project score rating scale with a mean of 3.

Figure 1.1.5



The coaches have supported staff to adopt the recording of their quality improvement projects and programmes on sharing platform LifeQI. There are currently 16 active and 11 completed projects. Each project contributes to a quality priority and in some cases more than one.

Figure 1.1.6



1.3 Deliver organisational wide structured Quality Improvement continuous learning programme

We recognise the importance of investing in our staff and supporting their well-being to ensure high-quality care and better outcomes for our patients. We have developed the ENH Continuous Improvement model. 'Here to Improve' provides a simple, easy to understand model using familiar language and terminology for staff at every level of the organisation to adopt and use. It is a model that is underpinned by a common approach, identity and underlying toolkit that supports both local, small scale improvements, to large-scale, complex, transformational change projects and programmes. Here to Improve dovetails with our Quality Strategy and People Strategy and seeks to develop our people capability and drive ownership and continuous improvement through services.

Colleagues from education, organisational development, transformation and workforce are working collaboratively to deliver capability and capacity building in the 'Here to Improve' 7-step model for improvement launched in November 2020.

The approach will deliver training at different levels of the organisation to encourage all people to understand that in the organisation they have two requirements. These are to meet the requirements in the job description and to continuously improve in that role.

In addition the Trust is one of only 14 organisations in England chosen to be a part of the Clinical Excellence programme (part of the Pathway to Excellence programme). The Pathway to Excellence programme is recognised globally as enabling nursing excellence and offers proven strategies to help ensure that the care that we deliver to our patients is of the highest standard. The programme was paused in wave one of COVID and relaunched in July 2021. See section 1.4 for further details and priority 2 section for details of other Trust-wide improvement programmes.

1.4 Clinical Excellence Accreditation Framework

The Pathway to Excellence® programme is a nursing excellence framework aiming to create a positive practice environment for nursing and midwifery staff that improves nurse and midwife satisfaction and retention. Following a competitive nomination and selection process, ENHT was selected as one of 14 Trusts, and one of three in the East of England, to participate in the first national cohort.

The Pathway to Excellence® is made up of three components which come together to demonstrate different ways to support nurses and midwives to influence and effect change:

1. Nursing and midwifery excellence – six pathway standards
2. Local accreditation
3. Shared decision making

1. Nursing and midwifery excellence – six pathway standards

The six pathway standards are essential to develop a positive practice environment for nursing and midwifery staff:

- **Shared decision making** creates opportunities for direct care nurses to network, collaborate, share ideas and be involved in decision-making.
- **Leadership** supports a shared governance environment by ensuring that leaders are accessible and that they facilitate collaborative decision-making. This standard also emphasizes leadership development, orientation, retention, accountability and succession planning.
- **Safety** prioritizes both patient and nurse safety, and fosters a respectful workplace culture free of incivility, bullying, and violence.
- **Quality** is central to an organization's mission, vision, goals, and values, and is based on person- and family-centred care, evidence-based care, continuous improvement and improving population health.
- **Wellbeing** promotes a workplace culture of recognition for the contribution of nurses and the healthcare provider team. Additionally, this standard provides staff with support and resources to promote their physical and mental health.
- **Professional development** ensures that nurses are competent to provide care and provides them with mentoring, support and opportunities for lifelong learning.

Our Pathway Standard Leads are supporting with embedding the culture of excellence within the organisation.

2. Local accreditation

Our local accreditation is incorporated within the Clinical Excellence Accreditation Framework (CEAF) introduced in 2019. The CEAF brings together key measures of nursing and midwifery care to enable a comprehensive assessment to be made of the quality of care provided at ward level. The CEAF aligns with the six pillars within the Nursing, Midwifery and AHP Strategy:

Pillar 1: Developing and strengthening leadership
Pillar 2: Optimising pathways
Pillar 3: Valuing people
Pillar 4: Inspiring and innovating through research and quality improvement
Pillar 5: Ensuring quality and safety
Pillar 6: Partnership working

The CEAF Metrics set out a range of standards within each of the 6 pillars and each standard is assessed as either 'not achieved' or achieving bronze, silver, gold or platinum level. Points are awarded for each standard depending on the level met and an overall award made.

The assessment process includes:

- **Baseline/self-assessment** of the standards in the metrics, a staff and volunteer survey, completing the self-assessment templates and preparing a portfolio of evidence.
- **Independent assessments** against the metrics supported by specialist teams e.g. Infection Prevention and Control, Tissue Viability, Pharmacy, Patient and Carer Experience etc.
- **Time to Shine discussion** which is an opportunity for the multi-disciplinary team to share all that they are proud of.
- Collating the **evidence and clinical assurance** that the fundamental standards are met.
- **Credentialing Award panel** where the final award level is agreed.

Since the CEAF was introduced, we have assessed 11 ward areas and have awarded 3 gold and 6 silver wards. The CEAF provides the senior nursing and midwifery team with assurance of the standards being met within each clinical area and enables the Trust to reward and recognise excellence in care.

Pirton, Barley, Bluebell and 5B ward receive their awards (October 2020)

3. Shared decision making

Implementing shared decision making with our staff is key to driving forward continuous quality improvement. We have developed our pathway of shared decision making through the introduction of shared decision making councils (SDMC). Shared decision making is a collaborative leadership approach, where our point of care staff are given a platform to get involved with decisions that are being made. We encourage all of our colleagues from a variety of professional backgrounds and bands to join and participate. Members of the shared decision making councils are given the opportunity to have their say on what matters to them, to their colleagues and to their patients. They have the opportunity to network with a multi-professional team, develop leadership skills and to share their learning.

Within the Trust we have different types of councils:

- **Ward Councils –** Team members from one ward or department create their own local SDMC and develop improvement initiatives for their areas. They then have the opportunity to share their learning.
- **Themed Councils -** Team members from across the whole Trust create a SDMC focussing on a particular theme such as Staff Wellbeing and developing improvement initiatives to share with the Trust.
- **Specialist Councils -** Team members from across the whole Trust create a SDMC representing a specialist area such as Research and developing improvement initiatives to share with the Trust.

Currently within the Trust we have six shared decision making councils and the Trust's first Leadership shared decision making council. Each council member is given working time to attend the monthly council meetings.

Ward Councils	Themed Councils	Specialist Councils
▪ NICU	▪ Well Being ▪ Reward & Recognition ▪ Newly Qualified	▪ Research ▪ Pharmacy

Each shared decision making council will nominate a council chair. The council chair is invited to the Trust's Leadership Council where they have the opportunity to share their initiatives and outcomes. The Chief Nurse chairs the Leadership Council and provides support to the councils by connecting them with the right people and helping them overcome obstacles. This enables our point of care staff to share their thoughts, feelings and ideas from the 'shop floor' to board level and informs the board of what really matters to our colleagues.

To support the development of shared decision making and all council members the Nursing and Midwifery Excellence team hold a training session once a month: An introduction to shared decision making. This training provides an overview on how shared decision making works and what is looks like, what shared decision making councils are and why the pathway of shared decision making is so important for our Trust. The Nursing and Midwifery Excellence team work alongside the Quality Improvement team and Research team who both offer additional support and training for our shared decision making councils.

- **Research Training:** Coaching sessions, Bite-size training and drop in sessions, 1:1 support, Critical appraisal course.
- **Quality Improvement Training:** Bite-size QI, Project Coaching.

Plans for 2021-22:

Nursing and midwifery excellence: Organisational culture survey with registered nurses and midwives Develop gap analysis Work with Pathway Standard Leads to embed culture of excellence Develop our Elements of Performance demonstrating the culture of excellence Document submission for Pathway to Excellence	May 2021 June 2021 Ongoing Ongoing January/February 2022
Clinical excellence accreditation: Cohort 4 – 9A, 9B Introduce our 'fundamental standards' within the metrics Cohort 5 – 6A, 10A, AMU2, Ashwell	 May 2021 June 2021 July 2021

Cohort 6 – AMU1, 5A, 11A/B, Critical Care Cohort 7 – ACU, SSU, MVCC 10/11 Cohort 8 – 7B, 8A, Gloucester, Dacre Reassessments: 6B, 7A, 10B, Swift, 5B, Neonatal, Pirton, Barley, Bluebell	August 2021 September 2021 October 2021 Ongoing
Shared decision making: Development of more Shared Decision Making Councils. Council representation at Executive committees: Nursing and Midwifery Executive Committee, Nursing and Midwifery Excellence Committee Introduce an additional platform for sharing the learning – Recognition of council work and celebration commencing with presentation to the Nursing and Midwifery Quality Huddle. Development of training- Bitesize training, Exploring the idea of E-Learning for shared decision making.	Ongoing Developments

Priority two: Keeping our patients safe

Reason: These are quality goals within the Quality Strategy (2019-2024).

Link to Quality Strategy: Valuing the Basics and Keeping Our Patients Safe

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

Reporting: Scheduled updates to the Quality and Safety Committee

Responsible Directors: Chief Nurse

	Theme	Measure	19/20	20/21	21/22
2.1	Medication management	Omissions of critical medications	<5%	<4%	<4%
		Medicines optimisation framework score (max 168)	135	150	135
		Antimicrobial stewardship	>90%	>90%	>90%
		Electronic prescribing / administration	-	Launch	Launch
2.2	Sepsis pathway compliance	Screening for sepsis in ED	>97%	>95%	>95%
		Neutropenic sepsis door to needle time	>80%	>95%	>95%
		Antibiotics in ED within an hour	>90%	>95%	>95%
		Antibiotics on the ward within an hour	>90%	>95%	>95%
2.3	Safer Invasive Procedure Standards	Phased approach to developing and imbedding Local Standards for Invasive Procedures	>95%	LocSSIPS for 80% of invasive procedures	LocSSIPS for 80% of invasive procedures
2.4	Deteriorating patient	Reduce rate of cardiac arrests	<0.8%	<0.8%	<0.8%
		Audit of compliance with timely observations	> 95% reliability all observations	Variable	Variable
		Launch escalation module and develop a means of monitoring the escalations	Launch	Launch	Launch
2.5	Safeguarding adults and children	Ensuring reduction of harm of patients with known learning disability	Ascertain baseline data and set trajectory	Triangulate incidents, complaints & mortality data	Triangulate incidents, complaints & mortality data
2.6	VTE risk assessment	Improved compliance with VTE risk assessment part 1 and part 2	>95%	>95%	>95%

2.1 Medication management

Medicines and COVID-19 Pandemic

The COVID pandemic required rapid change and flexibility in how we managed medicines and provided care.

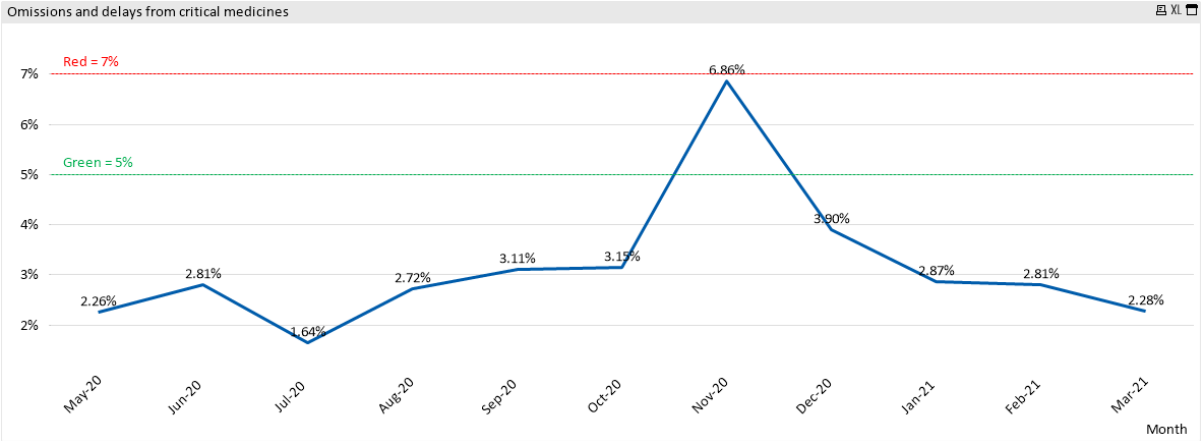
- Pharmacy staff upskilled to provide a specialist clinical pharmacy service and medicines support to critical care.
- A dashboard to manage the shortage of medicines was developed, and real time stock control systems were introduced to ensure critical care medicines were always available despite local and national surges in demand.
- Introduced an outpatient prescription delivery service to our vulnerable and shielding patients.
- The aseptic service prepared prefilled syringes of critical medicines for ease of administration by nursing staff to free up time.
- Pharmacy along with the nursing staff reviewed and developed a Trust-wide COVID medicines management policy to ensure all medicines were safely managed during the pandemic and electronic medicine ordering was introduced in some areas.
- New evidence was reviewed in a timely manner and guidance was developed to manage patients with COVID such as thromboprophylaxis and the safe introduction of specialist medicines for treating COVID such as tocilizumab and rituximab, and support of the Recovery Trial.

Medicines Management

	Target 2020/2021	Achieved 2020/2021
Omissions of critical medications	<4%	Average 3.1%
Medicines optimisation framework score (max 168)	150	130
Antimicrobial stewardship	>90%	Average: 92%
Electronic Prescribing	Launch	Launched (and paused due to COVID)

Omissions and delays in critical medicines

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



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

The denominator is the total number of doses of critical medications prescribed in the previous 24hours.

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

The Trust's Medicines Optimisation Strategy for 2019 – 2022 was developed using the NHS Improvement, Hospital Pharmacy and Medicines Optimisation Assessment Framework. The strategy was reviewed and updated in April 2021 post COVID pandemic.

The framework establishes a baseline assessment of current approach and practices; identifies areas of existing good practice but also areas for development and provides assurance on medicines optimisation and pharmaceutical services. The core domains and criteria used in the framework draw on a wide variety of sources. These include standards and guidance published by the Department of Health and Social Care, National Patient Safety Agency (now part of NHS Improvement), Care Quality Commission, NHS Litigation Authority, the Audit commission and the Royal Pharmaceutical Society (RPS).

The outcome of the baseline assessment, conducted in February 2019, showed an achievement score of 115 out of a maximum score of 168. We aim to improve our score over the next three years to be comparable with the highest achieving Trusts. The target for 2020/2021 was 150. This improved from 123 in November 2019 to 130 in April 2021, however, further plans for improvement have been impacted by COVID.

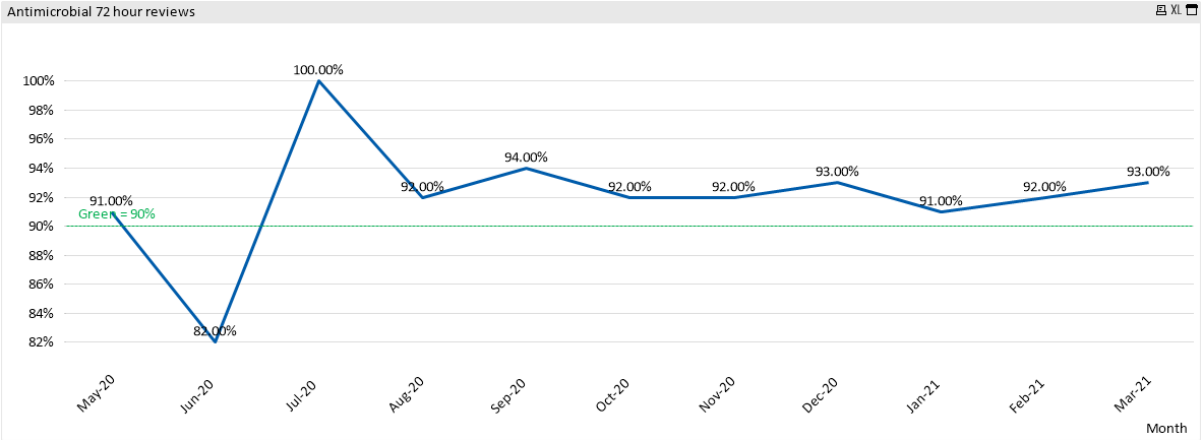
Despite the COVID pandemic progress has been made in the following areas:

- The Medicinal Products Policy is regularly audited across the Trust; quarterly controlled drugs audits are performed by pharmacy, unlicensed drugs audits, safe and secure medicines audits and drug chart completion audits are all performed on a bimonthly basis.
  The clinical areas and wards have demonstrated they have consistently achieved the target of 85% for ambient and fridge temperature recording.
- The Medicines Optimisation key performance indicators (KPIs) on Qlikview have been presented at Planned Divisional Board, the Nursing Quality Huddle, Medication Forum and Pharmacy Rolling Half Day.
- The Medical Director and the Director of Nursing receive a biweekly report and action plan on Medication Safety and Security from the Pharmacy and Senior Nurse Executive Walk Around.
- A Therapeutics Policy Committee biannual report was presented to the Clinical Effectiveness Committee in September 2019.
- An audit has also been completed to assess the level of adherence for non-formulary drug prescribing and supply against recommendations set by the Hertfordshire Medicines Management Committee (HMMC). A new Trust-wide formulary is being introduced in May 2021. This will bring benefits of improved compliance against HMMC recommendations as well as improved patient safety due to better access to up to date clinical information.
- The pharmacy department introduced the electronic staff rota system.
- Following the pilot phase Lorenzo Electronic Prescribing and Medicines Administration system (EPMA) is now embedded on two wards; Pirton and Barley. The EPMA project board resumed in April 2021 after a pause due to COVID-19 with a provisional Trust-wide roll out later this year.

Antimicrobial stewardship

Antimicrobial stewardship is a coordinated program to promote the appropriate use of antimicrobials (including antibiotics) to improve patient outcomes and reduce resistance in the long term. Reviewing antibiotic usage helps to ensure they are used optimally – long enough to be effective; yet not too long to develop resistance.

The aim is to achieve >90% compliance with good governance of antibiotic stewardship. The graph below demonstrates the results of a monthly audit and shows the target have consistently been met since July 2020.



The pharmacy team will focus on the medicines management and the roll out of the Lorenzo EPMA system for 2021-2022. The Trust-wide roll out of EPMA will improve medicines optimisation and therefore patient safety.

2.2 Sepsis pathway compliance

Antibiotics administration within one hour for ED and wards was selected as thermometer for the Trust Integrated Performance Report.

While the target has not been met, when compared to 2019/20 the figures remained substantially stable in ED, noted a slight improvement in the inpatient settings.

	Aim	Achieved
Antibiotics in ED within an hour	> 95%	70%
Antibiotics on the ward within an hour	> 95%	38%
Neutropenic sepsis door to needle time	> 95%	83%
Sepsis six bundle	>95%	31%

Emergency department Sepsis Care

Throughout the pandemic the sepsis team have been redeployed to support direct patient care. While this has supported on going delivery of sepsis care, it has also impacted on reliability of data collection related to timely delivery of sepsis interventions.

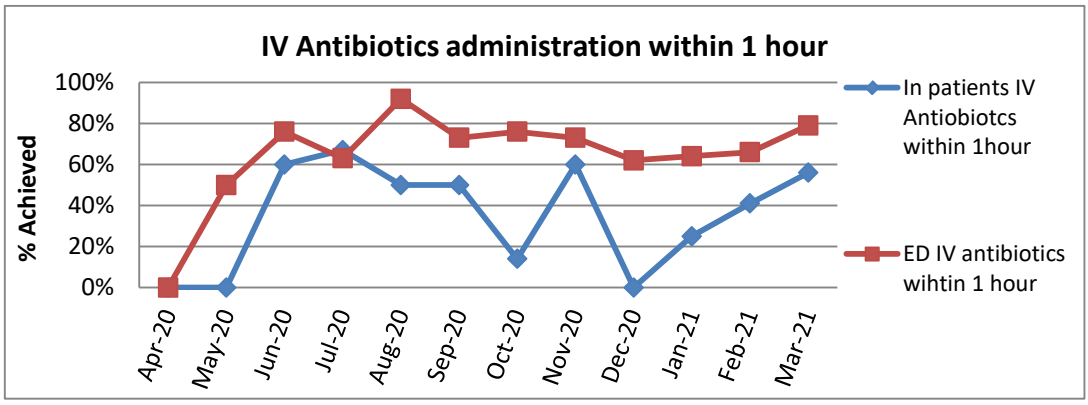
Compliance figures have been variable throughout the year; on average IV antibiotics have been given in the ED with 60min time frame 70% of the time. The variation overtime can be seen in figure 2.2.1 below, with a range of 45%-80%.

Inpatient Sepsis Care

Compliance figures within in patient setting timely IV antibiotics within 60min time frame on average 38% of the time. The variation overtime can be seen in figure 2.2.1 below, with a range of 14%-60%. Learning themes identified include:

- Time to escalation by ward team after first red flag (trigger for immediate action)
- Time to doctor review after trigger
- New antibiotics being written on the regular side of the drug chart rather than stat (single dose)

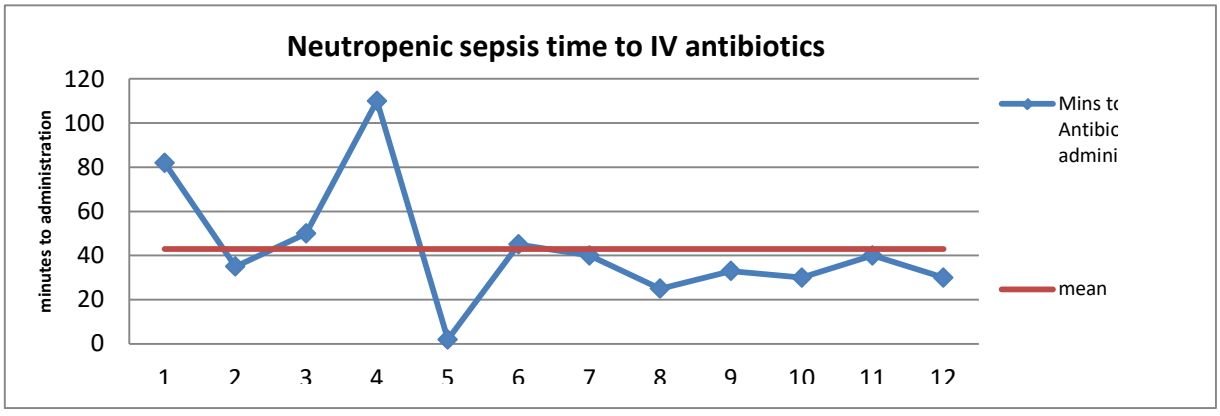
Fig 2.2.1



Neutropenic sepsis

A total of 12 patients were audited for neutropenic sepsis between the period of January 2021 and April 2021 across the Mount Vernon Cancer Centre (MVCC) and Lister Hospital. The average time of administration to antibiotics following sepsis red flag triggers was 43mins. 83% of patients had the antibiotic within 60 min recommended timeframe. The variation across 12 patients can be seen in fig 2.2.2

Fig 2.2.2



Sepsis 6 bundle

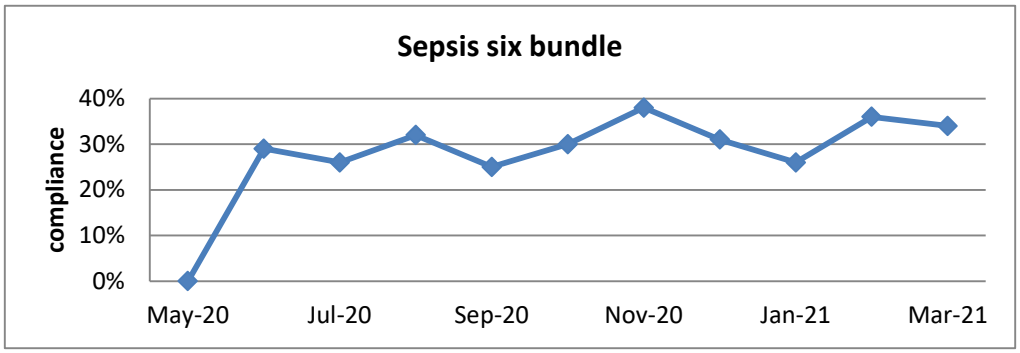
During 2020/21 the Trust had focused on reliability of delivering all aspects of the sepsis bundle:

- Administration of IV antibiotics
- Serum lactate measurement
- Accurate Fluid Balance chart

- Sample for blood culture
- Administration of IV fluid challenge
- Administration of 02 therapy

Compliance with all six elements of the bundles has varied throughout 2020/21, with an average compliance of 31% as seen in figure 2.2.3 below.

Fig 2.2.3



Sepsis is a priority for improvement as part of the Trust-wide Deteriorating Patient Collaborative. Targeted work continues with the acute kidney injury team; critical care outreach team and resuscitation team on fluid balance monitoring and observations competencies.

Changes made in 2020/21 include:

- Combined sepsis and critical care outreach clinical teams and clinical leadership
- Introduced out of hours emergency cannulation and phlebotomy team
- Improving practice and access to gas machine in patient areas
- Piloting new sepsis grab bags within in patient setting
- Improved awareness and early confirmation of optimum antibiotic, taking account of allergies.
- Ongoing root causes analysis of all per-arrest calls, identifying and feedback early sepsis care learning
- Pilot of ePMA to facilitate more accurate measurement of doses of antibiotics and intravenous fluid therapies administered

Priorities 2021/22 are:

- Improving competency and reliably of recording vital signs, including fluid balance chart
- Learning programme that includes Sepsis and deteriorating patient simulations and core essential training for all clinical staff embedded core learning modules in the Trust centralised learning system.
- Real-time patient level feedback sessions with clinical teams
- Scaling of ePMA to facilitate more accurate measurement of doses of antibiotics and intravenous fluid therapies administered

2.3 Safer Invasive Procedure Standards

	Aim	Achieved
Phased approach to developing and embedding Local Standards for Invasive Procedures	LocSSIPS for 80% of invasive procedures	Approach finalised

A procedure is invasive when a cut is made into the body. The most obvious invasive procedures are undertaken when a person has an operation which most likely requires a general anaesthetic. However other procedures such as insertion of heart stents to help treat angina, or insertion of feeding tubes through the abdomen are also invasive.

National Safety Standards for Invasive Procedures (NatSSIPs) outline a range of standards that optimise safety during an invasive procedure. Trusts are required to develop their own Local Safety Standards for Invasive Procedures (LocSSIPs) for the invasive procedures they carry out.

Whilst elements of the NatSSIPS have been commonplace within the organisation the Trust did not have a range of LocSSIPs against which to audit compliance and therefore demonstrate safety.

In addition, surgical checklist audits have been undertaken for a number of years and have focused on documented completion of safety critical moments. Despite evidence of good documentation we have had three significant incidents where surgical safety fell below the standards required. We have recognised many other contributing factors towards surgical errors, hence our continuous priority ‘safer surgery work stream’.

The Trust Invasive Procedure Group has an aim that 80% of invasive procedures undertaken at the Trust will have published LocSSIPs by March 2022. This governance

shall oversee the delivery of the national standards across multiple specialities, while also focusing building capability and better understanding of human factors.

Through the pandemic many teams involved in invasive procedures, particularly the Trust theatre team, have ran multiple team high fidelity simulations to practise safely carrying out procedures whilst adopting enhanced PPE polices and changing national guidance.

During 2020 there has been successful launch of new re-designed theatre 'Natssip' paperwork – that will follow the patient pathway across pre, intra and post-operative Care. (See annex 1)

The adoption of the new NATSSIP audit tool has been challenging to fully implement during the pandemic; however this has now been re-launched with the new theatre paper work and being adopted for other clinical specialties.

Standardisation of the theatre white-boards across 19 theatres are now fully implemented and embedded with completion of a safer surgery demonstration video showing all steps involved in Nattsip steps, this shall be adopted as tool within the Trust essential training modules on the Trust learning management system.

A patient safety human factor curriculum in under design and will be used with teams to support learning together on implementation of Natssip guidance and learning from internal safety incidents.

2.4 Deteriorating patient

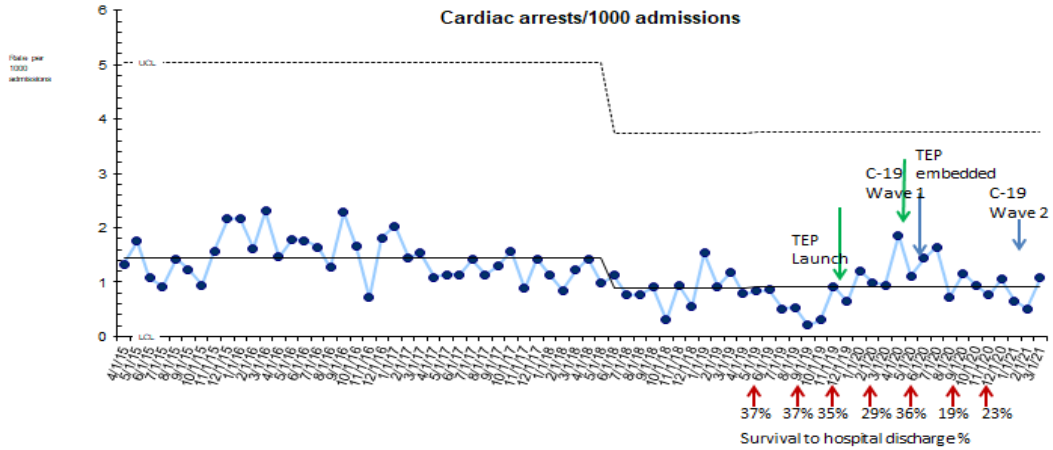
	Aim	Achieved
Reduce rate of cardiac arrests	<0.8%	Sustained reduction
Audit of compliance with timely observations	> 95% reliability all observations	Variable
Launch escalation module and develop a means of monitoring the escalations	Launch	Partial progress

Cardiac arrests

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

The chart below shows that Trust cardiac arrest data demonstrates a sustained reduction in in-hospital cardiac arrests, with an average rate of 0.9 per 1000 admissions. The Trust cardiac arrest rate can be see below in Fig 2.4.1

Fig 2.4.1



It also shows the Trust's survival to discharge following cardiac arrest during 2020-March 2021 has ranged from 19%- 23%, this has improved from 2019 and is now below the national average range of 23.9-25% survival to discharge home.

Timeliness of observations

The deteriorating patient improvement steering group, including team members from patient safety, critical care outreach and specialist services such as sepsis leads, acute kidney injury leads and the resuscitation teams, continue to review data and share learning on a monthly basis.

Following the challenges faced by the pandemic, large scale improvement work due to January 2020 had to be redesigned. A key priority for improving the recognition and management of the deteriorating patient is the reliability and competency across clinical teams to record and escalate vital signs, including Fluid balance assessment.

Clinical areas have been prioritised for targeted improvement work following occurrence of. serious incidents to work closely with subject matter experts including critical care outreach, resuscitation, sepsis, acute kidney injury and learning disabilities to re-establish training and competency standards for recording vital signs.

This is a Trust-wide training initiative that aims for 95% of all clinical staff to have passed the structured competency training by December 2021.This will be tracked and monitored through the Trust's central learning system as an essential core competency skill.

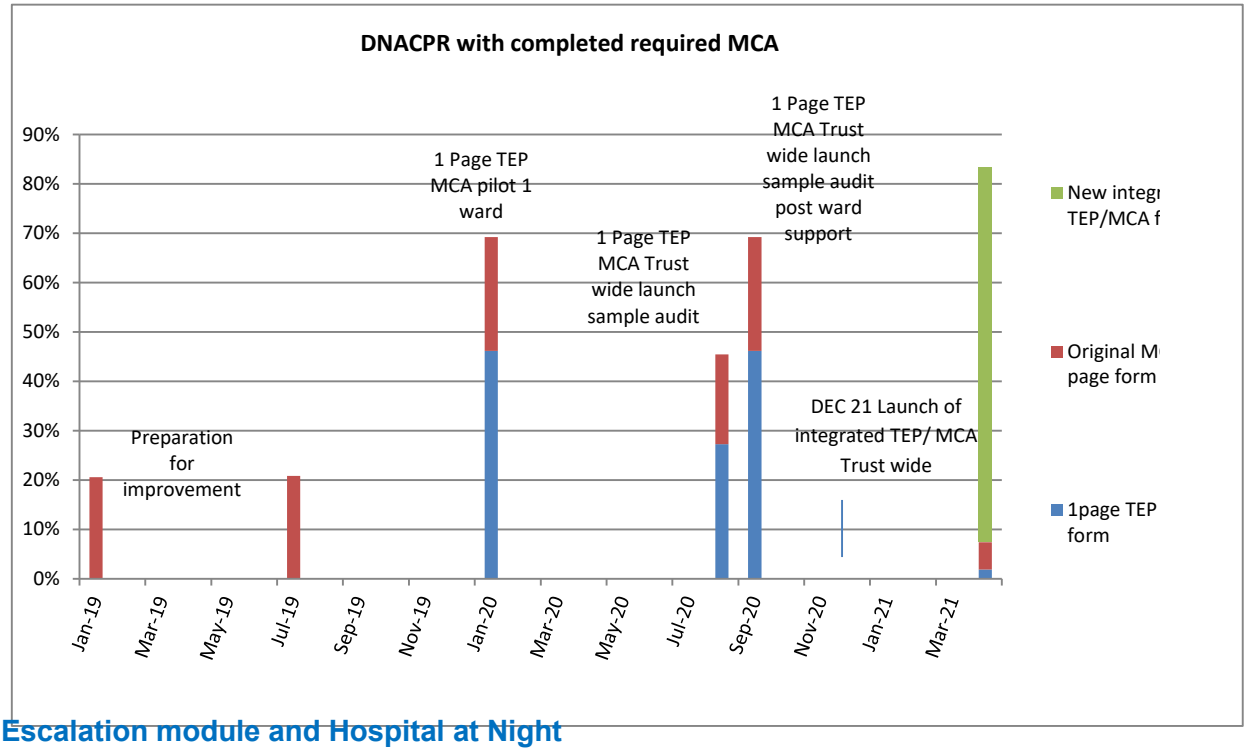
DNACPR and Treatment Escalation Plans (TEP)

In October 2020 the Department of Health and Social Care commissioned the CQC to conduct a review during November - January 2021 to review how DNACPR decisions are made in the context of advance care planning, across all types of health and care sectors. Nationally 750 people shared their experiences of the distress they faced when they did not feel involved in decisions about their care. The Trust has undertaken gap analysis against the 8 recommendations following this review.

Following the launch of the Trust Treatment escalation plan in 2019, further development in January 2020 included a pilot of a combined TEP and Mental Capacity Assessment documentation that showed an increased compliance to 69% of a high quality documented decision making process.

Ongoing development of the document was supported through staff education and training, with a final integrated document launch across the Trust in December 2020 of an integrated MCA and Treatment Escalation Plan (TEP) document (see annex 2). In March 2021 a Trust-wide audit of 'Do Not Attempt Resuscitation' and high quality document 'TEP and MCA' decision making saw improved compliance at 83%. This improvement journey can be seen in fig 2.4.2 below

Fig 2.4.2



Escalation module and Hospital at Night

In alignment with Harm Free Care approach to safer systems, the designing of a new hospital at night system and doctors escalation digital module are now under way. This has involved deployment of new hand held devices, and will be supported through training and escalation awareness to junior doctors. The new hospital at night team structure has been agreed and plans are under way to operationalise in early 2021. This shall be monitored and tracked through both our Harm Free Care and Deteriorating patient collaborative groups.

2.5 Safeguarding Adult and Children

	Aim	Achieved
Ensuring reduction of harm of patients with known learning disability	Triangulate incidents, complaints & mortality data	Achieved

Safeguarding remains an integral aspect of patient care within the Trust, and we continue to undertake our duties under the statutory frameworks of the Care Act 2014 and Children's Act 1989 and 2004.

The Chief Nurse is the executive lead for safeguarding the Trust.

All staff receive training and regular updates based on the guidelines within the Intercollegiate documents for adults and children's safeguarding, based on local and national safeguarding policy, research and learning from case reviews.

The Trust continues to be an active member of the Hertfordshire safeguarding boards and partnerships – with work this year looking at medication errors, complex case reviews, Female Genital Mutilation guidelines, Serious Crime and Violence strategy and Neglect Strategy. In addition, we participate in Partnership learning for serious case reviews, domestic homicide reviews and Rapid Reviews.

During 2020/2021, the 2 safeguarding teams (adults and children's) for ENHT merged and undertook a restructuring process to form one Trust safeguarding team in order to provide a safeguarding team spanning the whole life course and further embedding a 'think family' culture within the organisation. This has led to further improvements in identifying vulnerable families and earlier intervention and more timely responses to risk and vulnerabilities.

There is strong evidence how social isolation increases the risk of abuse significantly. Nationally there has been an increase in safeguarding concerns in what has been referred to as a safeguarding surge, in direct correlation to the impact of the restrictions imposed in response to COVID-19.

Children are not visible to external agencies by virtue of not attending school, or by the different methods employed by agencies to 'keep in touch' have changed, giving less opportunity for safe disclosure. Adults in care homes are not visited by relatives and the usual agencies that can potentially identify concerns. As the lock down measures continue to ease – children and adults will become more visible, meaning opportunities to identify /disclose safeguarding and abuse will only increase. Agencies working with people must make the most of every opportunity to identify concerns and respond in a timely fashion.

In line with the national picture we have seen a significant increase safeguarding referrals and issues. The following section identifies the activities and how we have worked together with our internal and external services:-

- Adapting to the COVID-19 pandemic and the implications for safeguarding – including response to a 'safeguarding surge' in complex cases.
- Launch of the Safeguarding Dashboard.
- Achieved 'Good' and elements of 'outstanding' in the section 11 external assessment.
- 60% increase in child protection medical examinations.
- 3% increase in referrals to children's social care – despite a significant reduction in attendance to the Trust as a result of the COVID 19 pandemic.
- An increase in children being seen for neglect child protection medicals.
- Parental mental health is the predominate reason for a referral to children's social. care, with children's mental health as the second reason for a referral being made.
- 39% increase in strategy meetings involving the Trust.
- 24% increase in maternity information sharing forms.
- 33% increase in maternity safeguarding initial child protection conferences.
- 29% reduction in request for information under section 17 and 47.
- 14% reduction in information sharing forms for pediatrics, with a 40% reduction in overall attendance to unscheduled care (based on Liaised activity).
- 19% increase in the number of adult safeguarding concerns raised in the organisation a total of 620 individuals reporting to be victims of abuse were supported by the team.
- 16% of concerns raised against a Trust service were substantiated and largely centred on omissions in the discharge process and tissue viability incidents – a further 12% re awaiting section 42 enquiries to establish if the concerns will be substantiated. A Trust-wide Discharge Improvement Plan has been informed by these incidents to improve the care and safety of the patients.
- Domestic abuse was the biggest cause for concern raised by Trust staff in relation to abuse perpetrated in the community – accounting for 27% of all the referrals made, with Neglect and acts of omission accounting for 26% of all referrals made.
- 43% increase in deprivation of liberty applications.
- 8 serious incidents six of these incidents related to omissions in discharge process
- 2 Hertfordshire Safeguarding Children's Partnership rapid reviews, 2 learning events and 1 learning discussion.
- 1 Hertfordshire Safeguarding Adult Board Safeguarding Adult Review.
- 2 Domestic Homicide Reviews.
- New Safeguarding Training passport and Safeguarding Learning and Development Strategy.
- Multi Agency Child Exploitation information sharing process established.
- Child in Need information sharing process introduced for unscheduled care settings.
- The safeguarding team continue to place a high priority on the care of individuals with a learning disability. We have a dedicated working group to ensure that LD standards for acute hospital Trusts set out by NHS England / NHS improvement are met. The key achievements of this group during 2020/21 included the provision of easy read appointments letters bespoke for individuals with LD, a revised radiology department policy including an outline for the provision of reasonable adjustments. Guidance in easy read format was developed and introduced so that patients and/or carers know how they can raise concerns about their care or the service. The Trusts LD champions programme was reinvigorated (60 LD champions recruited). Basic LD awareness added to the mandatory training requirements for all staff.

- Members of the safeguarding team continued to attend site safety huddles several times a week to advise ward matrons on the management of concerns and provide education on the management of the various categories of abuse.
- Prevent Level 3 training was extended to all staff and it is anticipated that we will reached 85% of staff completion in July 2021.
- All Clinical staff in the Trust continue to receive training and education on the clinical application of the mental capacity act. Work is currently being undertaken to ensure education is delivered to staff in preparation for the introduction of Liberty Protection Safeguards which is expected to come into statutory force from April 2022.
- Full business continuity was achieved by the safeguarding team throughout 2020/21 unaffected by the pandemic.

2.6 VTE Risk Assessment

A blood clot in the leg (deep vein thrombosis) or lung (pulmonary embolism), collectively known as a venous thrombo-embolism (VTE), may develop for a number of reasons eg. reduced mobility. Patients in hospital tend to be less mobile than at home and therefore may be at a greater risk developing a clot. As part of the admission process patients should be assessed as to their risk of developing a clot, and be prescribed anti-coagulant (blood thinning) medication if required.

The part 1 risk assessment is that measured at the point of admission. The part 2 reassessment is required 24 hours after admission or when there is a change in a patient's situation.

VTE risk assessment historically has been measured in several ways within the Trust:

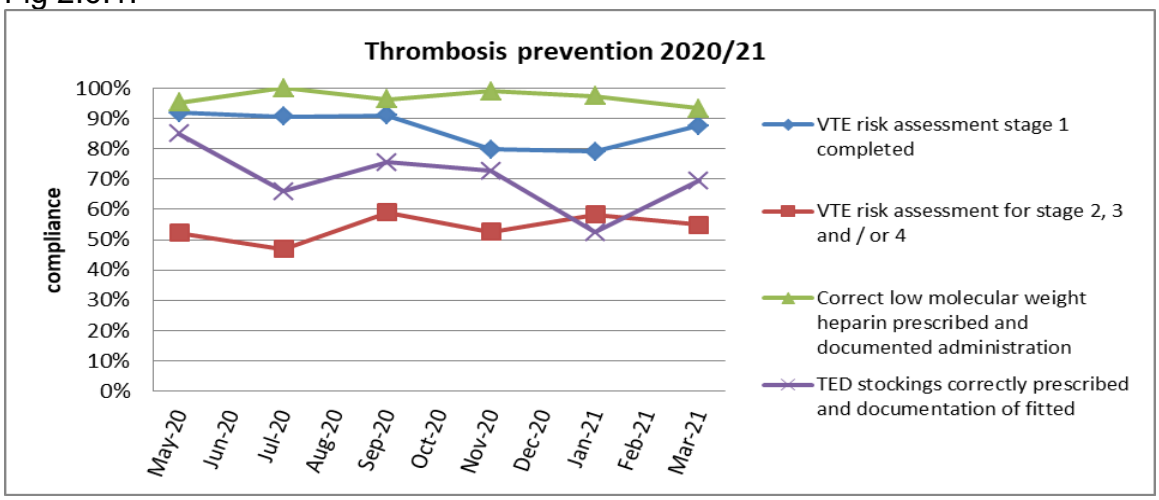
- National safety thermometer- a point prevalence audit on one day each month – currently suspended during pandemic.
- National NHS Quality Standards – currently suspended during pandemic.
- Internal Pharmacy audit- random sampling in real time in the patient setting, continued reporting. Results can be seen in fig 2.6.1 below.

	Aim	Achieved
Improved compliance with VTE risk assessment part 1 and part 2	>95% compliance with part 1 and parts 2-4	Pharmacy survey: 87% (part 1)
		54% (part 2)

Pharmacy inpatient sampling

The data below shows data collected by the pharmacy team who reviewed 10 samples each month, looking at thrombosis prevention interventions and risk assessment stage 1 (on admission) and stages 2-4 (reassessment after 24 hours; when there has been a change).

Fig 2.6.1.



While the Trust has seen good compliance with correct dose of VTE prevention heparin administration, we recognise the documentation of Stage 1 risk assessment data shows an average of 87% compliance; and stages 2-4 show less reliable completion of VTE risk re-assessments average of 54% compliance; both remain a priority for improvement.

Root cause analysis learning is undertaken when potential hospital associated thrombosis (HAT) cases are identified. Trends can be seen whereby the reassessments have been missed or not re-performed when clinical condition changes.

Learning captured from medical staff during the pandemic include the challenges around both continuity of medical staff on wards with the added challenge of practicalities of undertaking high quality ward rounds, for example due to isolation areas and limiting paperwork and computers taken to bedside. This has sometimes required an extra process to be in place to look back at charts after the round; sometimes this has left a gap in risk assessment completion.

Harm Free Care Priority

Oversight of VTE outcomes, strategy and action planning is undertaken by the Thrombosis Action Group and the Harm Fee Care Collaborative Group. The aim is to improve both stage 1 and stage 2 risk assessment to 95% by March 2022.

Changes made in 2020 include:

- Adjusting current drug charts to provide allocated space for 'time' of VTE review. This is currently missing and therefore not allowing accurate documentation of when risk assessments were completed.
- Progression towards the appointment of a VTE specialist nurse or pharmacist
- Testing of new electronic prescribing system, currently in pilot phase.

Improvement priorities:

- Whole system review to establish a more co-ordinated, sustainable HAT prevention cycle that support rapid RCA and learning
- Progression towards the appointment of a VTE specialist nurse or pharmacist
- Ongoing deployment of electronic prescribing across the Trust
- Work with other informatics and digital systems within clinical areas that can support the recognition and management of thrombosis prevention.

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

Reason: Whilst steady progress has been made there is still improvement to reach the required aims

Links to Quality Strategy: Good Governance and Patient Experience

Monitoring: Quality and Safety Committee, Finance, Performance and People Committee

Reporting: Scheduled update to the Quality and Safety Committee

Responsible Directors: Chief Operating Officer

	Theme	Measure	19/20	20/21	21/22
3.1	Improving discharge processes	Reduce number of discharge summaries not sent to GP within 24 hours of discharge	90% reduction	Stabilise	Stabilise
		Patients discharged by midday	>15%	>15%	>15%
		Reduce proportion of beds occupied with length of stay > 14 days	<19%	<19%	<19%
3.2	Improve access	Improve cancer waits from 2018/19 position	National standard	Meet all national standards	Meet all national standards
		Improve delivery of 7 days services	Ascertain baseline and agree Trajectory	Agree trajectory and monitor implementation	Agree trajectory and monitor implementation
		Reduce delays in ED 4 hour waiting time	National standard	>90%	>90%*

*shadow monitor against the proposed new clinical standards for ED

3.1 Improving discharge processes

	Aim	Achieved
Reduce number of discharge summaries not sent to GP within 24 hours of discharge	90% reduction	87.2%
Patients discharged by midday	>15%	11.6%
Reduce proportion of beds occupied with length of stay > 14 days	<19%	17.78%

Discharge summaries

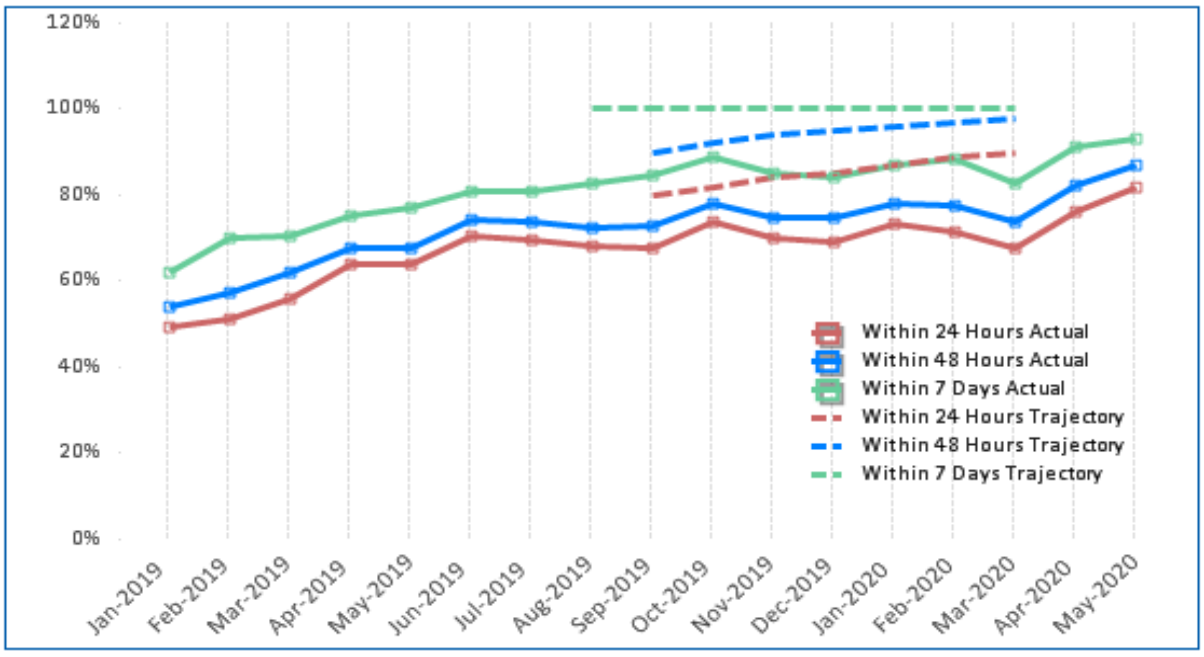
During 2018/19 it was identified that a significant number of discharge summaries had not been sent to the patient's GP within 24 hours of discharge. Any delay in sending the discharge summary poses a potential risk to a patient's future management if tests are not requested or medications not prescribed in a timely way.

A project was established with the aim of creating a more sustainable approach to continuously improve the number of discharge summaries being sent to GPs within 24 hours of discharge. Interventions have included:

- Engagement with staff involved in the discharge process
- Training and education for the creation and distribution of the discharge summary
- Review of templates standardising format
- Daily monitoring through improved data
- Improvement to process, removing unnecessary steps in the discharge process.

The backlog had reduced to 1224 by the end of the financial year 19/20. The data showed an increase of reliability sending summaries within 24 hours and within 7 days. However, the Trust acknowledged that the required targets had not been met and so this would be a continued focus for 2020/21 (see below for 19/20).

Overall for the Trust 2019/20

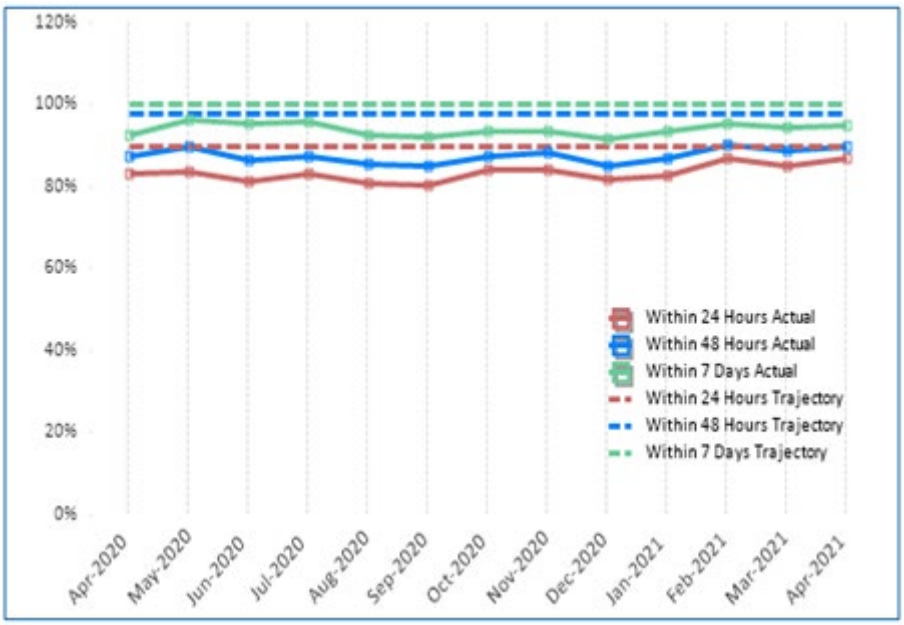


Focus has continued daily with a robust discharge summary team who validate, chase, train and advise all staff involved in outstanding discharge summaries.

An internal discharge summary audit was completed in January 2021 with actions for various teams improve not only the reduction in quantity of outstanding summaries but the quality of how they are written.

The backlog for 2020/21 is now at 148 unvalidated - 128 validated. Please see the breakdown below. This is a significant improvement from 1224 in 2019/20.

Overall for the Trust for 2020-2021 to date



Mid-day discharges

The number of patients arriving at the Emergency Department increases during the morning. Some of these will require admission. If inpatient beds are not available then the number of patients waiting within the ED will increase and the flow of patient through the department will be hindered. To maintain an effective and efficient flow of patients within the ED it must be made possible that beds become available on the wards into which patients can be transferred.

Good planning to ensure medication, transport, discharge summaries etc are ready in a timely way allows a patient to go home in the morning, thus freeing up a bed to accommodate demand from the ED and supporting a better patient experience. On average 11.6% of discharges occurred before midday.

Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Discharges before midday	11.7%	12.2%	13.7%	11.8%	11.7%	10.8%	9.6%	10.4%	10.2%	9.9%	11.3%	10.5%

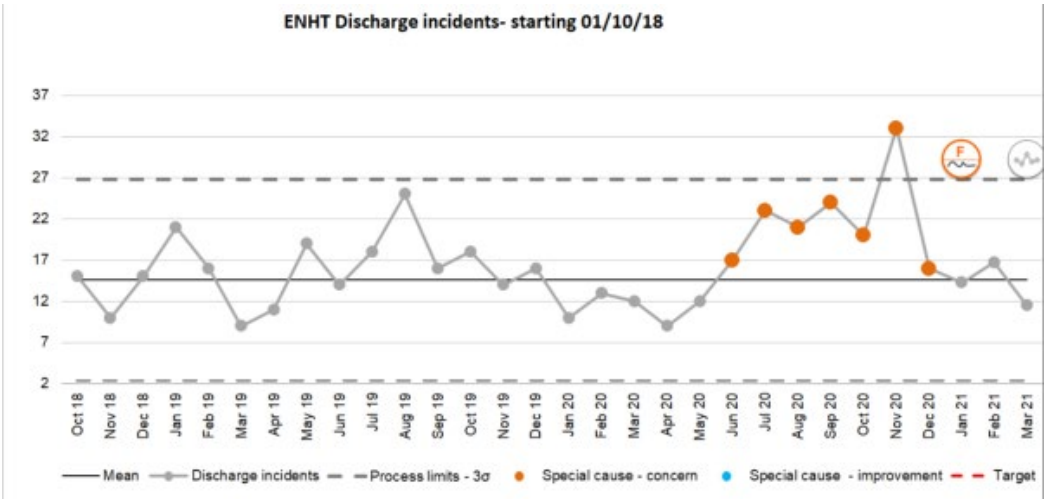
Reduce proportion of beds occupied with length of stay > 14 days

Length of stay reviews occur weekly within divisions, measurement throughout the year has shown normal variation. The Trust continues to work with community partners to safely expedite patient discharge in a timely way. On average 17.78% of beds were occupied by patients where the length of stay was more than 14 days; a slight reduction from the previous year.

Metric	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Proportion of beds occupied by patients with length of stay over 14 days	13.6%	18.4%	17.7%	15.2%	15.9%	19.0%	18.4%	17.9%	19.3%	19.4%	20.4%	18.24%
Proportion of beds occupied by patients with length of stay over 21 days	6.8%	9.1%	9.6%	7.0%	7.4%	10.4%	9.8%	8.5%	9.5%	9.4%	10.8%	9.07%

Discharge improvement programme

A number of concerns were raised to the Trust through different sources, such as family complaints and safeguarding enquiries regarding unsafe discharge arrangements. Thematic review of several different discharge incidents was undertaken in October 2020.



Learning for the thematic review identified some key areas for improvement:

- Poor understanding of processes and policies.
- Lack of clarity of roles and responsibilities within key decision makers, seen at all stages of Multi-Disciplinary Team (MDT)/board rounds and between the Patient Flow Coordinators (PFC), leading to missed opportunity to clarify discharge needs.
- Poor clarity of assessment within the Discharge to Assess (D2A) process and the requirements of the Hospital Discharge Service Requirements.
- Poor communication across the safe discharge pathway and with families and carers.

The safe and timely discharge of patients has been a Trust priority and is overseen at executive board level.

A Discharge Improvement Programme Board with an executive sponsor has been established with newly formed discharge improvement clinical and operational leads, divisional leads, subject matters experts and improvement experts.

The aims of this program are to improve the flow, safety and experience of inpatient discharges by end of March 2022, by:

- Flow- Reducing LOS for patients who are in hospital for over 7 days by 1 day.
- Safety – Reducing incidents related to serious harm from discharges by 50%.
- Experience- Reducing concerns related to discharges by 50% (including formal complaints, PALS and GP concerns).

Clinical areas and teams have been identified to test and learn about variation in the use of discharge policies and processes e.g.:

- Baseline audits for TTO's undertaken by the pharmacy team.
- The design and implemented new standardised discharge passport for the patient and carers that is started on admission and given to the patient at discharge.

Our digital systems are critical to safely plan and deploy high quality discharges. Work has started to utilise our internal patient information system 'nerve centre' for standardising our information and raising situation awareness of critical information regarding patients who meet 'criteria for discharge'. A reliable nerve centre adoption will also support the monitoring and tracking of real time safe and timely discharges.

The Trust were also successful in gaining support with National ECIST (Emergency care improvement support team) programme 'Alliance 16' who will support the emergency admissions and ward systems adopt quality improvement methodology across key priority areas.

3.2 Improve access

	AIM	Achieved
Improve cancer waits from 2018/19 position	National standard	Met 6 of 8 national standards
Improve delivery of 7 days services	Ascertain baseline and agree Trajectory	Partly met
Reduce delays in ED 4 hour waiting time	National standard (95%)	83.47%

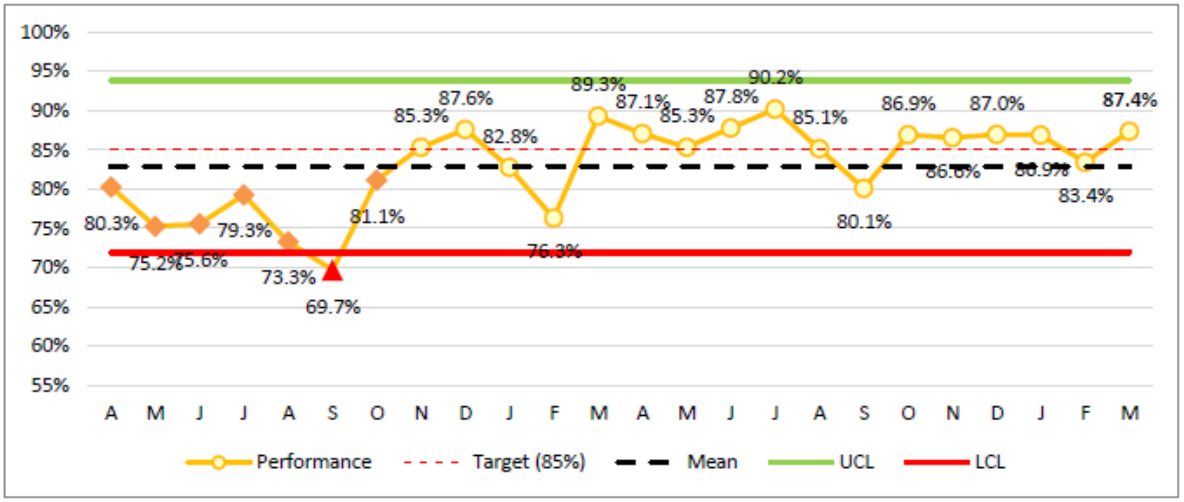
Improve cancer performance

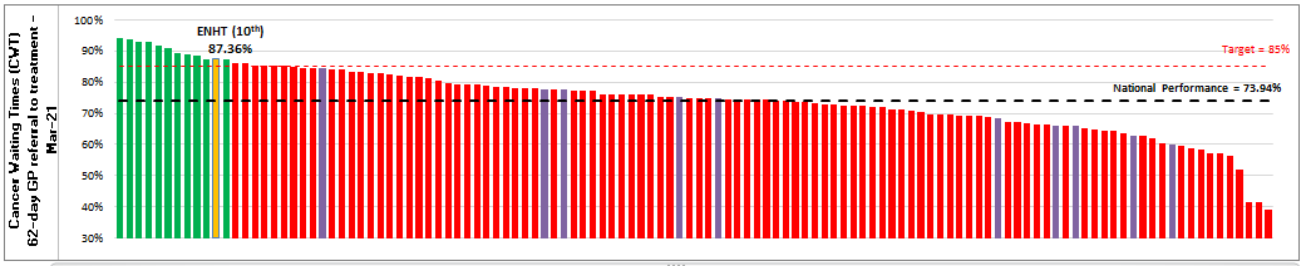
Cancer performance was sustained over the course of 2020/21. The 62 day cancer target was achieved for all months, except for September 2020 and February 2021 and our performance against this standard remains one of the best regionally and nationally.

Across all of the cancer standards, the year-end position was compliant with 6 of the 8 standards. Of the 8 standards, the Trust has achieved the 31-day subsequent Anti-cancer drugs and 31-day subsequent treatment (radiotherapy) standards in every month of 2020/21. Also for the two week wait for suspected cancer, breast symptomatic and 31 day first treatment the Trust has achieved the standards 11 out of 12 months.

The Trust continues to comply with the new faster diagnosis standard for 2020/21 on confirming or ruling out diagnosis within 28 days.

12-months' performance - all standards	Standard	Target	2019-20	2020-21												
			YTD	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD
	Two week waits Suspected cancer	93%	96.95%	97.72%	99.35%	99.32%	92.80%	95.84%	97.25%	96.74%	97.36%	98.12%	96.17%	98.00%	99.13%	97.26%
	Two week waits Breast symptomatic	93%	94.10%	79.31%	100.00%	98.59%	97.98%	98.67%	99.00%	96.36%	97.64%	93.33%	93.40%	100.00%	100.00%	97.08%
	31-day First definitive treatment	96%	96.57%	98.60%	98.50%	98.63%	94.59%	98.22%	98.48%	98.28%	98.68%	99.57%	99.05%	97.84%	96.97%	98.11%
	31-day subsequent treatment Anti-cancer drugs	98%	99.50%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	100.00%	100.00%	99.42%	100.00%	99.86%
	31-day subsequent treatment Radiotherapy	94%	99.10%	100.00%	99.39%	100.00%	100.00%	99.39%	100.00%	100.00%	98.90%	99.63%	98.76%	98.51%	99.35%	98.87%
	31-day subsequent treatment Surgery	94%	83.55%	94.44%	96.15%	100.00%	95.00%	96.15%	90.00%	95.12%	95.45%	100.00%	75.00%	92.11%	87.76%	92.68%
	62-day GP referral to treatment	85%	79.82%	87.08%	85.31%	87.78%	90.16%	85.15%	80.10%	86.92%	86.55%	86.96%	86.87%	83.41%	87.36%	86.13%
	62-day Specialist screening service	90%	76.67%	38.46%	0.00%	NIL	20.00%	0.00%	80.00%	100.00%	100.00%	84.62%	80.00%	75.00%	64.29%	69.34%





Improve delivery of 7-day services

Whilst hospitals function for 24 hours every day, the level of services offered maybe different during the weekend. The NHS is moving towards offering the same level of service every day of the week.

An assessment of provision towards meeting the 7-day objectives using the Seven Day Hospital Services Board Assurance Framework was undertaken in 2019/20. The results of the assessment against four standards are shown below alongside the 2020/21 position.

Standard	Requirement	Outcome (2019/20)	2019/20	2020/21
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission	44% for weekday admissions; 33% for weekend admissions	Not met	Partly met

Standard	Requirement	Outcome (2019/20)	2019/20	2020/21
5	Inpatients must have scheduled 7-day access to diagnostic services	All diagnostic requirements have been met but with limited provision of MRI scanning which is restricted at the weekend to the diagnosis of spinal cord compression only	Met	Met
6	Inpatients must have timely 24 hour access to key consultant-directed interventions	Interventions available, although interventional radiology is available on an ad hoc basis	Met	Met
8	Patients with high dependency needs should be seen by a consultant twice daily; then daily once a clear plan of care is in place	100% compliance with twice daily review 89% compliance with daily consultant review (May 2019 data)	Not Met	Partly met

Following the development and submission of speciality level business cases last year, a clinical Seven Day Service Investment Review Panel was held at the beginning of March 2020 to prioritise the investment recommendations for the delivery of seven day services in 2020/21. Further progress was postponed due to the needs of the COVID-19 pandemic and there has been no further formal assessment of current provision against the 7-day standards. However, there were a number of service changes as a response to the pandemic which temporarily provided additional capacity to meet standards 2 and 8 such as a 24/7 general medicine consultant rota. There have been other improvements such as 7-dayconsultant ward rounds in general surgery, urology and orthopaedics.

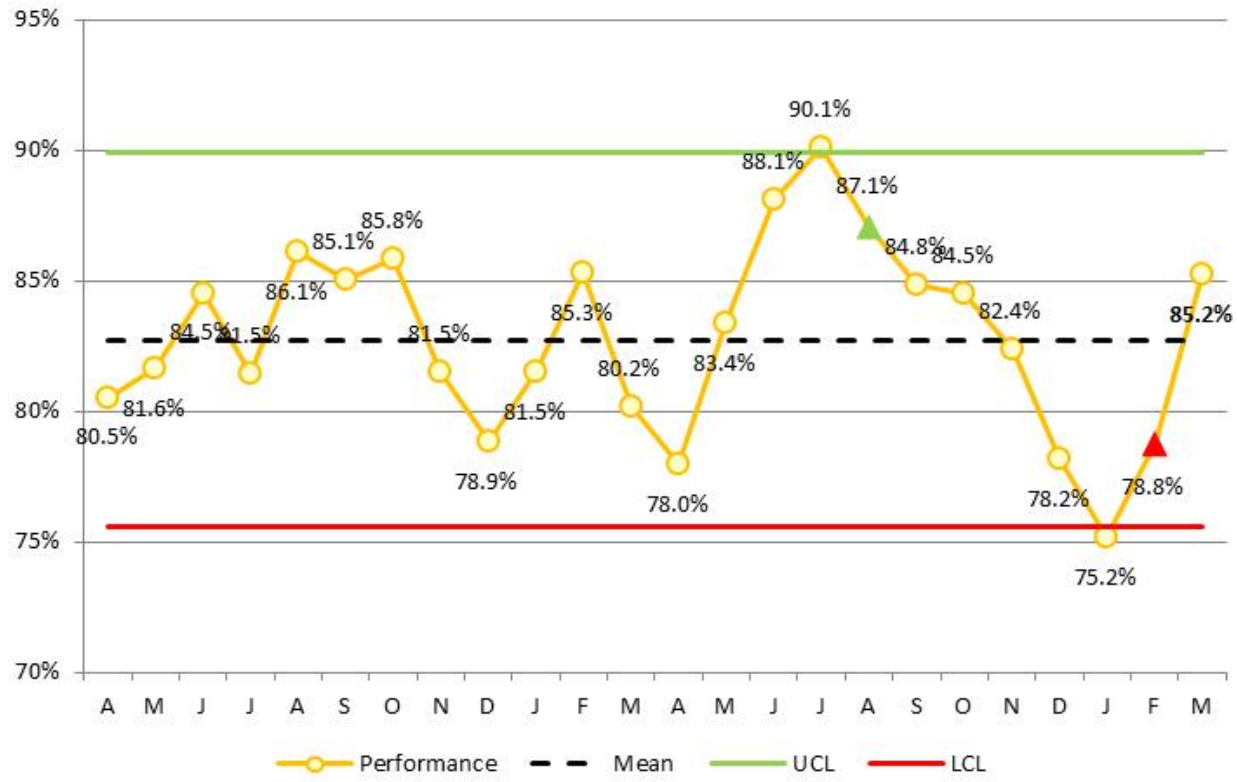
The plan for 2021-2022 is to commence the roll-out of a new job planning policy and process. Part of this includes meeting with specialty leads to discuss and agree

expectations and plan for the year ahead. It is intended that these discussions will include planning for a full 7-dayservice provision, in order to understand the financial implications of the resource levels required.

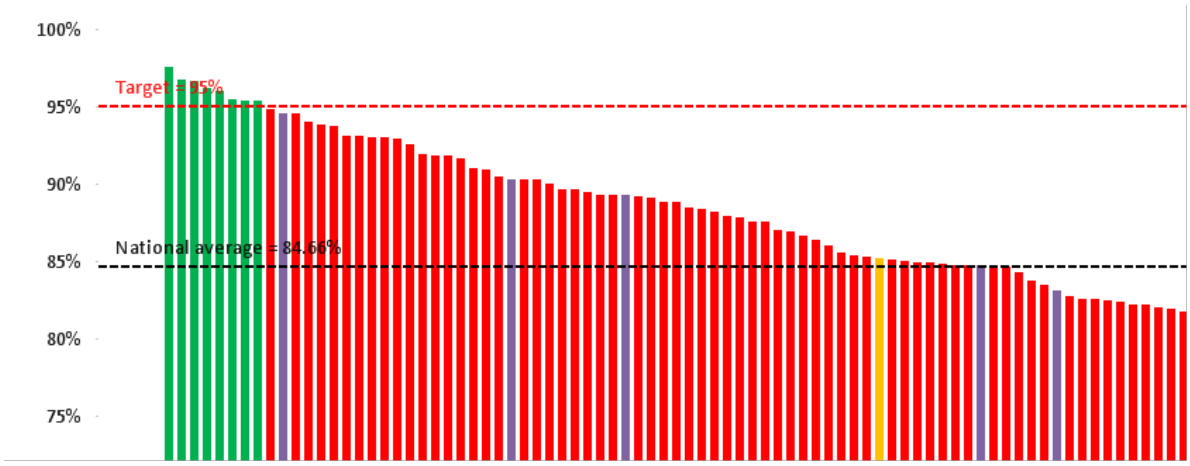
A major step towards improving 7-dayprovision in unplanned care is a staff consultation to be undertaken this summer for all those consultants on the acute medicine and general internal medicine rota. The aim is to improve continuity of consultant led post for patients admitted overnight and morning handover.

Reduce delays in ED 4 hour waiting time

The Emergency Department 4-hour standard requires 95% of patients being seen, treated and either admitted or discharged within four hours of arrival. The Trust's year-end performance was 83.47%, demonstrating improvement of over 3% on 19/20 year-end performance. There was some variation in the Trust's performance during the year, largely due to the impact of COVID-19.



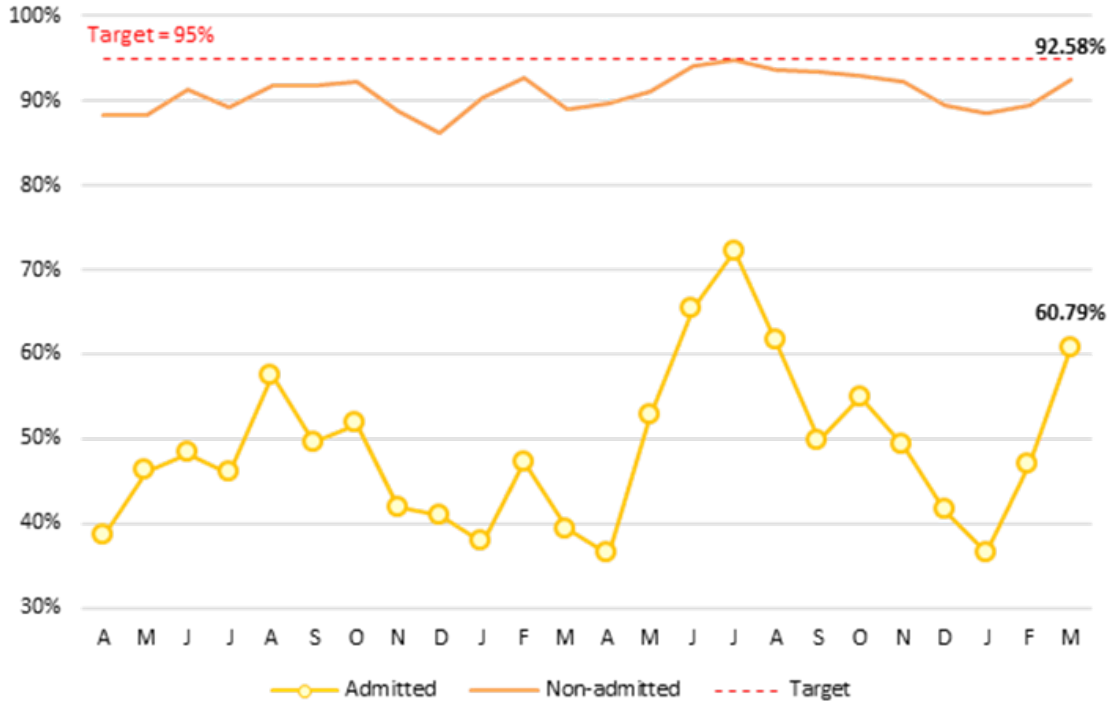
It is noteworthy that relatively few NHS Trusts achieve this target nationally and that ENHT are above the national average.



The Trust treated approximately 400 non-elective patients each day, of which 63% attend via A&E and 31% attend via the Urgent Treatment Centre. On average 36% of patients required admission. In addition the number of admissions very closely aligned with the number of discharges so delays to discharges have a detrimental effect upon the ability to move patients through the emergency department to a ward. COVID did impact significantly on ability to flow efficiently through ED due to the challenges around turnaround of COVID swab results and availability of side room capacity.

New processes were implemented in ED which included stratifying of patients' COVID status. Pathways were adopted that separated patients into COVID and non COVID areas. This was to ensure that we were compliant with infection prevention and control standards to support the reduction of microbial infections but did to some extent impact on the operational efficiency of the system.

Although an average 4 hour standard is measured it is interesting to note that the standard has almost been reached throughout the year for patients being treated but not admitted. The challenges in meeting the standards for patients requiring admission are demonstrated clearly on the graph.



Priority four: Patient & Carer Experience

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

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

Link to the Quality Strategy: Patient Experience

Monitoring: Patient Experience Committee

Reporting: Scheduled update to the Quality and Safety Committee

Responsible Director: Chief Nurse

	Theme	Measure	19/20	20/21	21/22
4.1	Patient feedback	Maintain Friends & Family Test scores (average) for inpatients, out-patients, maternity (birth) and emergency department	IP 96.7% OP 94.8% Mat 93% ED 89.6%	IP 95.84 OP 97.57 Mat 96.47 ED 94.58	IP >95% OP >95% Mat >93% ED >90%
4.2	PALS Responsiveness (new and replaces always events)	PALS response closed within 5 days	70.5%	79.2%	Aim 80%
4.3	Improve partnership working with patients and carers within key Quality Strategy goals	Design and support patient co-design within planning, design and testing phases of quality improvement initiatives.	Ascertain organisational readiness and agree Trajectory	Demonstrable involvement of patients and carers	Demonstrable involvement of patients and carers
4.4	What matters to you (WMTY) (new)	Measuring the themes of the WMTY conversations	N/A	Launch	Analysis in progress March 2021

4.1 Patient feedback

Indicator	Measure	Trust result	Time period	Trust previous result	National average

Indicator	Measure	Trust result	Time period	Trust previous result	National average
Maintain Friends & Family Test scores (average) for inpatients, out-patients, maternity (birth) and emergency department	Patients	IP 95.84% A/E 94.58% Mat 96.47% OP 97.57%	20/21	IP 96.7% A/E 94.58% Mat 96.47% OP 97.57%	Submission and publication ceased during Covid **

*Maternity indicator is a measure relating to birth experiences only

Patients are asked, as part of the Friends and Family Test (FFT) framework, to provide feedback on their inpatient/day case, emergency department, maternity or outpatient experience. Patients are asked 'how likely they would be to recommend the service to their friends and family'.

The table above confirms that the aim was achieved in all of the survey areas.

- The highest proportion of positive comments from inpatient / day case patients relate to staff being attentive, friendly and caring with good communication and care and treatment provided. Negative comments relate to the environment, noise at night, food standards and patients not able to identify their named nurse.
- Members of the public attending the outpatients department have complimented staff for being kind and helpful, and for the care, treatment and information provided. There are concerns about waiting times in clinics, appointment letters, and administration of appointments, direction to clinics and the cost of the car park.
- In maternity the majority of women have complimented the staff for the support, care and information provided to them during their birth experience. Women would like a quieter environment, provision of recliner chairs for partners and for partners to be able to stay and visit during their appointments and admission. The majority of feedback from patients in the ED is positive particularly in relation to staff being friendly, kind and caring, providing an excellent service and good communication. Negative feedback mainly relates to the length of waiting times.

Alongside the feedback the Trust is also monitoring the response rate. A high response rate provides greater opportunity for improvement. The monthly tracking of responses, rates and proportion of positive responses is shown in the table below.

Domain	FFT	Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Friends and Family Test	Inpatients	Proportion of positive responses	95%	92.7%	90.7%	93.8%	96.8%	95.5%	97.3%	98.5%	98.4%	96.7%	98.9%	92.2%	96.3%
		Total number of responses	1,778	233	689	705	780	1,031	803	710	745	657	364	424	774
	A&E	Proportion of positive responses	90%	100.0%	92.9%	89.0%	96.6%	98.3%	96.1%	98.7%	95.1%	98.3%	96.4%	93.1%	95.6%
		Total number of responses	1,241	8	56	282	149	117	103	79	81	60	28	29	114
	Maternity	Antenatal care Proportion of positive responses	93%	n/a	100.0%	n/a	100.0%	0.0%	100.0%	50.0%	100.0%	85.7%	100.0%	100.0%	88.9%
		Birth Proportion of positive responses	93%	95.7%	n/a	100.0%	100.0%	100.0%	92.6%	94.4%	96.2%	97.8%	97.9%	97.1%	95.8%
		Birth Total number of responses	137	23	0	2	1	8	27	126	133	135	143	139	142
		Postnatal ward Proportion of positive responses	93%	95.7%	n/a	100.0%	100.0%	100.0%	95.7%	95.9%	92.6%	94.4%	95.0%	95.5%	93.4%
		Postnatal community Proportion of positive responses	93%	n/a	n/a	n/a	100.0%	n/a	66.7%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Outpatients	Proportion of positive responses	95%	97.6%	95.8%	99.0%	98.9%	96.2%	95.7%	98.5%	99.2%	96.6%	91.2%	99.2%	97.0%
		Total number of responses	-	83	271	204	369	392	419	471	389	233	195	244	337

The overall response rate for the year is given in the table below.

	2018-19	2019-20	2020-21	Aim
Inpatient / Day Case FFT response rate	42.26%	43.73%	23.34%	40%
Maternity response rate (birth)	33.79%	25.14%	17.71%	30%
Emergency department response rate	3.85%	3.67%	5.75%	10%

The Trust considers that this data is as described, as it is based on data submitted directly by patients to the national surveys programme. The Trust has taken the following actions to improve this score, and so the quality of its services, by reviewing the survey responses and producing initiatives to improve patient engagement; and by reviewing patient survey responses alongside other sources of patient feedback to determine improvements.

**Data submission and publication for the Friends and Family Test (FFT) restarted for acute and community providers from December 2020, following the pause during the response to COVID-19.

Data from December 2020 onwards reflects feedback collected during the COVID-19 pandemic, while, also, implementing the new guidance after a long period of suspension of FFT data submission. The number of responses collected is, therefore, likely to have been affected. Some services may have collected fewer FFT responses, or been unable to collect responses at all, because of arrangements in place to care for COVID-19 patients. Publication of new data is expected to restart by the end of May 2021.

4.2 PALS Responsiveness (new and replaces always events)

This is detailed with Complaints in the section below in performance measures.

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

	Aim	Achieved
Design and support patient co-design within planning, design and testing phases of quality improvement initiatives.	Ascertain organisational readiness and agree Trajectory	Partial

Throughout 2020/21 an increased numbers of patient and carer partners have been invited to work with staff to design and shape our improvement work in the PACE programme, this has resulted in some individuals joining our programme board.

During the pandemic re-deployed staff formed 'task teams' to support patient experience on the wards and used daily continuous learning cycles to adopt new changes and improvements such as delivering free newspapers to the wards.

During the pandemic a 'keeping in touch' call centre was set up in January 2021 to help families to request clinical updates and request virtual visits with their loved one. This service was supported by a team of clinicians and team support workers who facilitated fulfilling those calls. In January and February 429 calls were successfully completed and service users reported 99% satisfaction with the service.

The ENHT Charity has supported the 'keeping in touch' service by donating devices for patient and carers to connect via video calls and access games and social updates e.g. newspapers.

Volunteer's services have continued to support patients across the hospital. A new role has been developed of 'rapid response volunteers' in response to COVID-19. This role supported clinical care givers through various kinds of team support functions in the ward environment.

There is also a menu of options that patients and carers can make requests from the volunteers to support people whilst inpatients for example they can request befriending or a reading service. The volunteers and the PACE team also delivered 1519 letters and 1661 photos to patients from families and friends and supported the delivery of 'knitted hearts' donated to the charity by the public, paired with patients in hospital and matching pairs sent to their loved ones to help them to feel connected.

In June 2020 the Trust held a 'what matters to you?' awareness day, to support the ongoing understanding of patient and carer's wishes and to connect more empathically in every conversation. The question 'what matters to you?' has been embedded into our 'here to improve' methodology. We now regularly ask 'what matters most to you' and ask, listen and do what matters and we are starting to collect this data.

4.4 What Matters To You (WMTY)

The WMTY initiative encourages all Trust staff to have meaningful conversations, to understand what is most important for patients, their families and carers whilst they are in hospital. As from March 2021 the PACE team have been visiting the inpatient wards and asking the WMTY question, data is stored on IQVIA.

Due to restrictions of the pandemic the 2020 WMTY day focussed on Staff conversations and embedding WMTY into our bite size QI and coaching programme and all our Quality improvement initiatives.

WMTY day shall be celebrated on 9 June 2021 and the PACE team and our volunteers will be visiting the wards and having WMTY conversations, promoting and role modelling how to ask WMTY. The Trust charity have funded a 12 month fixed term post for the " what matters to you " volunteers coordinator , who was appointed at the beginning of May 2021.

2.2 Statements of assurance from the Board

Review of services

During 2020/21, the East and North Hertfordshire NHS Trust (ENHT) provided and/or subcontracted 24 relevant health services. The ENHT has reviewed all the data available to them on the quality of care in 24 of these relevant health services. The Trust operated under the revised financial framework in the NHS last year. For further details please refer to the Trust Annual Report.

Participation in clinical audits

Clinical Audit (CA) forms part of the NHS Standard Contract requirements as well as being part of the Care Quality Commission (CQC) Key Lines of Enquiry. A robust CA programme is vital to ensure we continually strive to provide safer, more clinically effective and reliable care.

Audit activity

During 2020/21 there were 63 national clinical audits and 6 national confidential enquiries covering relevant health services that ENHT provides.

As a result of the COVID-19 pandemic NHS England advised that whilst all mandated clinical audits would remain open, data submission would no longer be mandatory, to enable clinical teams to prioritise clinical care. The ENHT clinical teams were highly commended by the Trust for participating in 57 (90%) national clinical audits and 6 (100%) national confidential enquiries.

Quality Account audits 2020/21

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries that ENHT was eligible to participate in during 2020/21.
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2020/21, and for which data collection was completed during 2020/21, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Project Name	Eligible	Participated	Numbers submitted (by % or total number)
Antenatal and newborn national audit protocol 2019 to 2022	Yes	Yes	TBC
BAUS Cytoreductive Radical Nephrectomy Audit.	Yes	Yes	Continuous data collection
BAUS Female Stress Urinary Incontinence Audit.	Yes	No	NA[1]
BAUS Renal Colic Audit	Yes	Yes	34 cases
British Spine Registry	Yes	Yes	18 cases
Case Mix Programme (CMP)	Yes	Yes	Continuous data collection
Cleft Registry and Audit Network (CRANE)	Yes	No	NA[1]
Elective Surgery (National PROMs Programme)	Yes	Yes	Continuous data collection
Emergency Medicine QIPs - Fractured Neck of Femur (care in emergency departments) Subscription-based programme	Yes	Yes	TBC

Emergency Medicine QIPs - Infection Control (care in emergency departments)	Yes	Yes	TBC
Emergency Medicine QIPs - Pain in Children (care in emergency departments)	Yes	No	NA[1]
FFFAP - National Audit of Inpatient Falls	Yes	Yes	Continuous data collection
FFFAP - National Hip Fracture Database	Yes	Yes	Continuous data collection
Inflammatory Bowel Disease (IBD) Audit - Biological Therapies	Yes	No	NA[2]
Inflammatory Bowel Disease (IBD) Audit - Organisational Element	Yes	Yes	1
Learning Disabilities Mortality Review Programme (LeDeR)	Yes	Yes	Continuous data collection
Mandatory Surveillance of HCAI	Yes	Yes	Continuous data collection
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Adult Asthma Secondary Care	Yes	Yes	137 cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Yes	279 cases
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - Paediatric Asthma Secondary Care	Yes	Yes	150 cases
National Audit of Breast Cancer in Older People (NABCOP)	Yes	Yes	162 cases
National Audit of Cardiac Rehabilitation	Yes	Yes	Continuous data collection
National Audit of Dementia	Yes	Yes	41 cases
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Yes	Yes	28 cases
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	615 cases
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	Yes	Yes	446 cases
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Yes	667 cases
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Yes	Yes	477 cases
National Comparative Audit of Blood Transfusion programme - Audit of the perioperative management of anaemia in children undergoing elective surgery	Audit postponed until May 2021 due to COVID		
National Diabetes Core Audit - Adults	Yes	Yes	Continuous data collection
National Diabetes Foot Care Audit - Adults	Yes	Yes	34 cases
National Diabetes NaDIA Harms Audit - Adults reporting on diabetic inpatient harms in England	Yes	Yes	TBC
National Diabetes Pregnancy in Diabetes Audit - Adults	Yes	Yes	Continuous data collection
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	600 cases
National Emergency Laparotomy Audit (NELA	Yes	Yes	95 cases
National Gastro-intestinal Cancer Audit Programme NBOCA - National Bowel Cancer Audit	Yes	Yes	434 cases
National Gastro-intestinal Cancer Audit Programme NOGCA - National Oesophago-gastric Cancer Audit	Yes	Yes	120 cases
National Joint Registry (NJR) - Ankle Replacement	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Elbow Replacement	Yes	Yes	Continuous data collection

National Joint Registry (NJR) - Hip Replacement	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Hospital Performance	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Implant Performance	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Knee Replacement	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Shoulder Replacement	Yes	Yes	Continuous data collection
National Joint Registry (NJR) - Surgeon Performance	Yes	Yes	Continuous data collection
National Lung Cancer Audit (NLCA)	Yes	Yes	73 cases
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Project does not collect data directly from the Trust
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	Yes	Yes	Continuous data collection
National Ophthalmology Audit (NOD)	Yes	No	NA[3]
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	306 cases
National Prostate Cancer Audit (NPCA)	Yes	Yes	1098 cases
National Vascular Registry (NVR) - Carotid endarterectomy or carotid stenting	Yes	Yes	15 cases
National Vascular Registry (NVR) - Lower-limb amputation	Yes	Yes	16 cases
National Vascular Registry (NVR) - Lower-limb angioplasty/stent	Yes	Yes	0 cases
National Vascular Registry (NVR) - Lower-limb bypass surgery	Yes	Yes	2 cases
National Vascular Registry (NVR) - Repair for abdominal aortic aneurysm (AAA), both open and endovascular (EVAR).	Yes	Yes	16 cases
Perioperative Quality Improvement Programme (PQIP)	Yes	Yes	Continuous data collection
Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	792 Cases
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Yes	Continuous data collection
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Yes	Yes	Unit data submitted
Surgical Site Infection Surveillance Service	Yes	Yes	100%
Trauma Audit & Research Network (TARN)	Yes	Yes	Continuous data collection
UK Registry of Endocrine and Thyroid Surgery BAETS	Yes	Yes	Continuous data collection
UK Renal Registry	Yes	Yes	100%

[1] Not inputting data this year due to COVID
[2] Requires a planned business meeting to review resources.
[3] Lack of financial resources to purchase and install the necessary software to submit audit data

National Audits

The reports of some of the national clinical audits the provider participated in 2020/21 were reviewed and the Trust have evidenced the following to improve the quality of healthcare provided.

National Hip Fracture Database Audit

The Trauma & Orthopaedic Team have been recognised and congratulated by the Royal College of Physicians as being one of only 9 Trauma units to have demonstrated that the quality of care provided to their patients was significantly above average across all of the 6 key performance indicators (KPI's) within the National Hip Fracture Database Audit. This is great news for our patients and a wonderful achievement for the team.

Adults Asthma Clinical Audit

The Respiratory Clinical Nurse Specialist Team have had their excellent work highlighted by the Royal College of Physicians National Audit and COPD Audit Programme (NACAP) for their Adults Asthma Clinical Audit 2019/2020. NACAP have recognised the Team's achievements at providing timely reviews and treatments with systemic steroid within the hour for patients with an asthma attack. This is a really positive demonstration of the excellent work happening in our Trust.

COVID-19 Specific National Audits

Since the start of the COVID-19 pandemic, 5 specialties have participated in 11 COVID related National Audits as follows;

- Integrate COVID-19 Emergency Care Audit – ENT
- COVID HAREM Study – General Sugery
- Rectal Cancer Management during COVID-19 Pandemic (ReCaP) – General Surgery
- CovidSurg-Cancer Study – General Surgery, Urology
- CovidSurg-Cohort Study – General Surgery, T&O, Urology
- The CHOLECOVID Audit – General Surgery
- GlobalSurg-CovidSurg Week - Determining optimal timing for surgery following SARS-CoV-2 infection – General Surgery
- COVID-19 Impact on Pancreatic Cancer Care Pathway – Cancer Centre

3 Specialties have also participated in 4 local audits, concentrating on COVID-19;

- COVID-19 testing in children – CH Acute
- A&E management of patients presenting with epistaxis during COVID-19 Era – ENT
- MRSA and COVID 19 swabbing prior to admission to CAU and Bluebell – CH Acute
- Stroke in Covid-19 positive patients: Characteristics and Outcomes – Stroke

Besides the clinical pressures caused by the pandemic, it is praiseworthy that Clinicians are contributing towards national COVID-19 datasets, and demonstrates their excellent commitment to patient safety.

Annual Audit Heroes Awards 2020

This has been an exciting year for nominations in the annual HQIP audit hero awards with Trust staff/teams being shortlisted in 4 of the 6 award categories, more than any other organisation out of the 228 nominations submitted.

HQIP reported that the standard of entries received was very high and congratulated all the individuals and teams who were shortlisted and made it into their Hall of Fame.

Our nominations were in the following;

- **Student of the Year Category** – An FY2 was nominated, shortlisted and won this award which recognises the student who evidences high levels of engagement within their area of study, understanding the importance of clinical audit to drive improvement and leading or making a substantial contribution to the successful delivery of an improvement project or initiative.
- **Florence Nightingale Category (Outstanding contribution by a Nurse or Midwife)** – Our Infection Prevention & Control Lead Nurse was nominated and shortlisted in this award for her clinical audit work to achieve a significant impact in helping to drive quality improvements within infection prevention and control.
- **Volunteer of the Year Category** - a Dr was nominated and shortlisted in this award which recognises the enormous contribution made by volunteers to our

health and care sectors. For making a significant contribution to the improvement efforts of the audit team, department or organisation they support, for providing invaluable support to a clinical audit and/or quality improvement process, as well as using their own insight and experience, or supporting other patients and users of services to give feedback, to influence and guide decision making

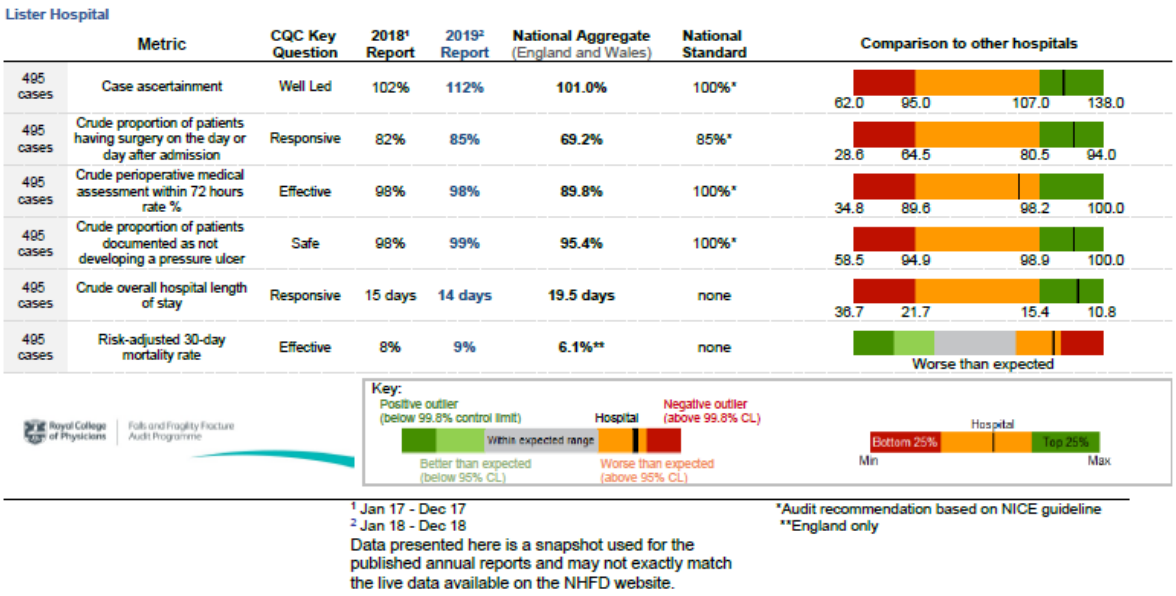
- **Team of the Year Category** - The Transitional Dialysis Unit were nominated and shortlisted in this award which is looking for teams that on or significantly contribute to systematic change in order to achieve a measurable improvement in the quality of operational processes, patient care or health outcomes, or who deliver or contribute to education and training that supports a culture of improvement, or who proactively work with patients and carers to co-design improvements/interventions that lead to better outcomes, care, or processes.

The Mount Vernon Cancer Centre Radiotherapy Department were also nominated in the Team of the Year category, for their excellent commitment to providing structured audit training for their staff, and converting this understanding in to many relevant audits that have created tangible changes to their working practise but unfortunately were not shortlisted.

National Clinical Audit Benchmarking Results (NCAB)

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

The Trust participated and were published, in 12 reports. Some examples are shown below:



Lister Hospital

	Metric	CQC Key Question	2018[1] Report	2019[2] Report	National Aggregate (England and Wales)	National Standard	Comparison to other hospitals
495 cases	Case ascertainment	Well Led	102%	112%	101.0%	100%*	62.0 95.0 107.0 138.0
495 cases	Crude proportion of patients having surgery on the day or day after admission	Responsive	82%	85%	69.2%	85%*	28.6 64.5 80.5 94.0
495 cases	Crude perioperative medical assessment within 72 hours rate %	Effective	98%	98%	89.8%	100%*	34.8 89.6 98.2 100.0
495 cases	Crude proportion of patients documented as not developing a pressure ulcer	Safe	98%	99%	95.4%	100%*	58.5 94.9 98.9 100.0
495 cases	Crude overall hospital length of stay	Responsive	15 days	14 days	19.5 days	none	36.7 21.7 15.4 10.8
495 cases	Risk-adjusted 30-day mortality rate	Effective	8%	9%	6.1%**	none	Worse than expected

Royal College of Physicians | Falls and Fragility Fracture Audit Programme

Key:
Positive outlier (below 99.8% control limit)
Negative outlier (above 99.8% CL)
Hospital
Within expected range
Better than expected (below 95% CL)
Worse than expected (above 95% CL)
Hospital
Bottom 25%
Top 25%
Min
Max

[1] Jan 17 - Dec 17
[2] Jan 18 - Dec 18
Data presented here is a snapshot used for the published annual reports and may not exactly match the live data available on the NHFD website.

*Audit recommendation based on NICE guideline
**England only

East And North Hertfordshire NHS Trust

	Metric	CQC Key Question	2018 Report	2020 Report	National Aggregate (England and Wales)	National Standard	Comparison to other hospitals
264 operations	Case ascertainment	Well Led	108.7%[1]	107.3%[4]	95.0%	none	Good (over 80%)
Incomplete data submission	Risk-adjusted post-operative length of stay >5 days after major resection*	Responsive	Not Reported[1]	Incomplete data submission[4]	62.0%	none	
Incomplete data submission	Risk-adjusted 90-day post-operative mortality rate	Effective	Not Reported[1]	Incomplete data submission[4]	3.0%	none	Not reported 0 Within expected range 20
Incomplete data submission	Risk-adjusted 2-year post-operative mortality rate	Effective	21.0%[2]	Incomplete data submission[5]	18.9%	none	Not reported 0 Within expected range 50
Incomplete data submission	Risk-adjusted 30-day unplanned readmission rate	Effective	Not Reported[1]	Incomplete data submission[4]	10.8% *	none	Not reported 0 Within expected range 30
Incomplete data submission	Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection	Effective	57.2%[3]	Incomplete data submission[6]	53.0% *	none	Not reported 0 Within expected range 90

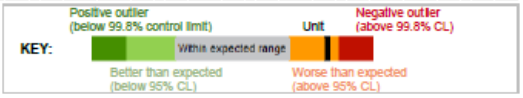
NBOCA National Bowel Cancer Audit

[1] Apr 16 - Mar 17 [2] Apr 14 - Mar 15 [3] Apr 13 - Mar 16 *England only
[4] Apr 17 - Mar 18 [5] Apr 15 - Mar 16 [6] Apr 14 - Mar 17

Lister Hospital, Respiratory High Dependency Unit

	Metric	CQC Key Question	2017/18[1] Report	2018/19[2] Report	National Aggregate (England, Wales & N. Ireland)	National Standard	Comparison to other Units
	Case Ascertainment	Well Led	Not reported for this audit			none	n/a
626 admissions	Crude non-clinical transfers	Responsive	0.2%	0.0%	0.3%	0%*	0.0 Within expected range 6.0
425 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	0.8%	0.2%	1.9%	0%*	0.0 Within expected range 25.0
3660 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	12.2%	11.1%	4.4%	0%*	Not in the worst 5% of units
604 admissions	Risk-adjusted hospital mortality ratio (all patients)	Effective	1.1[3]	1.0[4]	1.0	none	0.2 Within expected range 2.8
422 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	0.9[3]	1.0[4]	1.0	none	0.2 Within expected range 2.8

icnarc intensive care national audit & research centre



[1] Apr 17 - Mar 18 * FICM/ICS guideline
[2] Apr 18 - Mar 19
[3] ICNARC$_{M2015}$ risk adjustment model
[4] ICNARC$_{M2018}$ risk adjustment model

Key messages

- The table below summarises East and North Hertfordshire NHS Trust performance in the 2019 MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2017. Mortality rates are presented both with and without deaths due to congenital anomalies.
- When compared against trusts with a similar service provision, East and North Hertfordshire NHS Trust was up to 5% higher or up to 5% lower than the average for the comparator group in both measures.

	Metric	CQC Key Question	2018[1] Report	2019[2] Report	Comparator group[4] average (UK)	National Standard	Comparison to other trusts with similar service provision
5,640 births	Stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births)	Effective	4.66 (4.03 to 5.73)[3]	4.69 (4.04 to 5.80)[3]	4.79	n/a	Up to 5% higher or up to 5% lower than the average for the comparator group[4]
5,639 births	Stabilised and risk-adjusted extended perinatal mortality rate, **excluding congenital anomalies** (per 1,000 births)	Effective	Not reported	4.13 (3.53 to 5.23)[3]	4.16	n/a	Up to 5% higher or up to 5% lower than the average for the comparator group[4]

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

1 Jan 16 - Dec 16
2 Jan 17 - Dec 17

3 Upper and lower 95% confidence intervals
4 (4,000 or more births per annum at 24 weeks or later)

East of England Cancer Alliance

		Metric	CQC Key Question	2017[1] Report	2018[2] Report	National Aggregate (England & Wales)	National Aspirational Standard	Comparative performance
Trust-level metrics	135 cases	Case ascertainment	Well Led	>90%	81 to 90%	79%*	none	Better than national aggregate
	135 cases	Age and sex adjusted proportion of patients diagnosed after an emergency admission	Effective	11.4%	12.4%	13.3%	none	Less than 15% ▲
	Not eligible	Risk-adjusted 90-day post-operative mortality rate	Effective	Not eligible	Not eligible	3.2%	none	Not eligible
Cancer Alliance-level metrics	2224 cases	Crude proportion of patients treated with curative intent in the Cancer Alliance	Effective	37.5%	37.7%	38.6%	none	Similar to the national aggregate

National Oesophago-Gastric Cancer Audit

Key:
Positive outlier (below 99.8% control limit) | Trust | Negative outlier (above 99.8% CL)
Within expected range

[1] Apr 14 - Mar 16
[2] Apr 15 - Mar 17

*England only

Lister Hospital

		Metric	CQC Key Question	Year 4[1]	Year 5[2]	National Aggregate (England & Wales)	National Standard	Hospital performance
	136 cases	Case Asoertainment	Well Led	100%	89%	84.0%*	85%	85% and over ▲
Proportion of patients for which each process of care was met	136 cases	Crude proportion of cases with pre-operative documentation of risk of death	Effective	34%	49%	77.3%	85%	Less than 55% ●
	54 cases	Crude proportion of cases with access to theatres within clinically appropriate time frames	Responsive	96%	94%	82.4%	85%	85% and over ▲
	64 cases	Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre	Effective	73%	66%	83.1%	85%	From 55% to less than 85% ■
	69 cases	Crude proportion of highest-risk cases (greater than or equal to 5% predicted mortality) admitted to critical care post-operatively	Safe	n/a	87%	77.5%	85%	85% and over ▲
	136 cases	Risk adjusted 30-day mortality	Effective	13%	13%	9.6%	None	Within expected range

NELA
National Emergency Laparotomy Audit

Key:
▲ ≥85%
■ ≥ 55% and <85%
● <55%

Positive outlier (below 99.8% control limit) | Trust | Negative outlier (above 99.8% CL)
Within expected range
Better than expected (below 95% CL) | Worse than expected (above 95% CL)

[1] Dec 16 - Nov 17
[2] Dec 17 - Nov 18

*England only

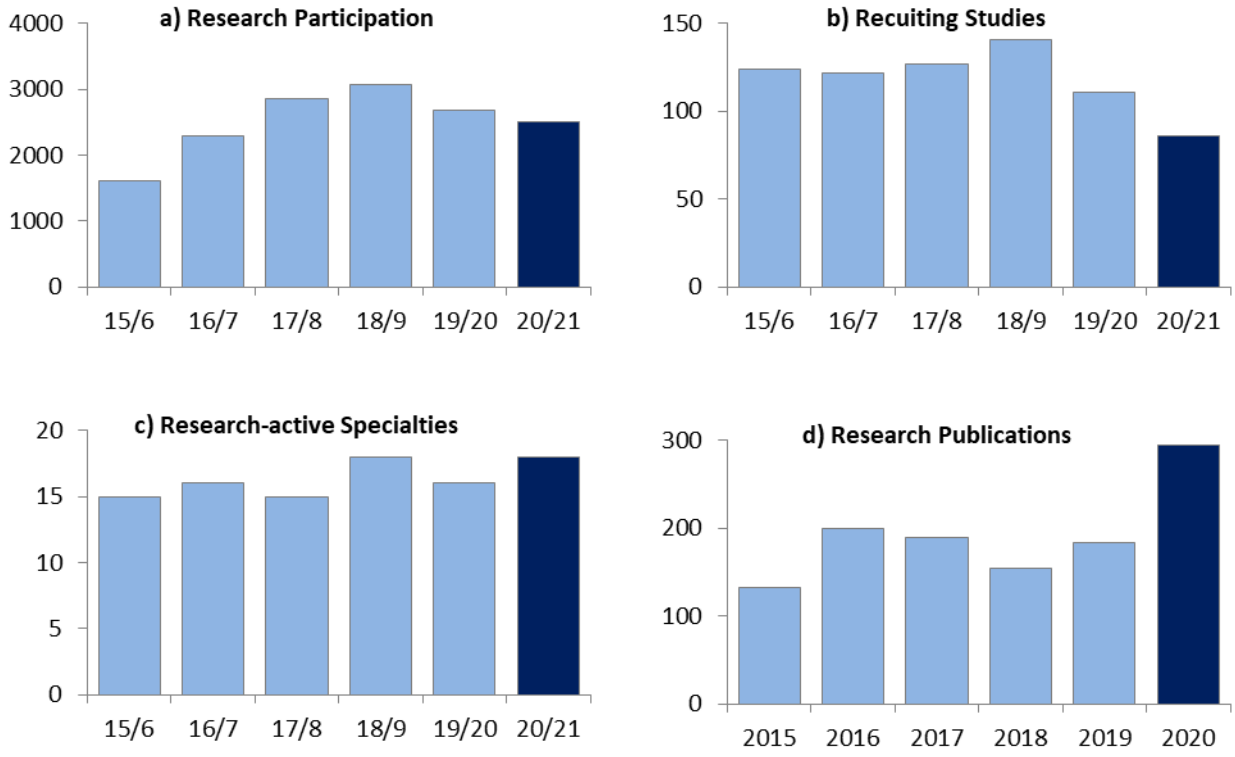
Research and development

The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee was 2,566.

Research supports the Trust vision in the following ways:

- Trust Vision: Proud to deliver high-quality, compassionate care to our community.
- Research Vision: To support high-quality, compassionate care to our community through research and innovation.
- Public & Patients: To ensure that the public and patients have the opportunity to contribute to a) the setting of the Trust's research priorities, b) the design of research studies, and c) to take part in wide range of research.
- Culture: Well trained and professional staff working within in an environment that is safe, well governed and fit for purpose.

The Trust is proud to be part of the National Institute for Health Research which has a national vision "***to improve the health and wealth of the nation through research***". Research activity over recent years is summarised below. Our Trust website has a dedicated section for Research where you can access further details.



Providing the research and evidence base for meeting the COVID-19 challenge

During 2020/1 the Trust's Research teams reviewed their research commitments so as to identify how best they could support the response of the Trust and of the nation to COVID-19. Initially all research projects were reviewed to identify which could be paused to enable staff to focus on the nationally prioritised COVID-19 studies or be redeployment to frontline care. A significant contribution was made to Urgent Public Health COVID-19 Studies as summarised below and with further details in Annex 3.

The Trust recruited 991 participants to 11 different COVID-19 studies (83 to RECOVERY) and has supported the development of new treatments–many thanks to all patients, staff and others who made this possible. In addition a large proportion of the staff were redeployed at various times to support the frontline service.

The Trust supported the national research priorities and is proud to be part of part of the Clinical Research Network in the East of England which performed very well in 2020/1 as illustrated by the highlights below:

- Overall participation in NHS research 122,000 (~3% of the East of England population).
- Overall participation in Urgent Public Health Studies 75,000.
- Overall participation in RECOVERY trial 12.9% of the eligible patients.
- Overall participation in non- Urgent Public Health Studies 47,000 (top nationally).

Continuation of cancer research
The Trust supports the delivery of cancer research at both the Mount Vernon Cancer Centre and the Lister hospital. Much of the cancer research could continue in 2020/21 and the Trust recorded the second highest recruitment to cancer studies (518 participants) in the East of England after Cambridge University hospitals NHS Foundation Trust (1603 participants).

Being ready to support all research to enhance patient experience and outcome
With the pressures of the pandemic beginning to ease and COVID-19 caseloads falling, work is underway to support the recovery of research into other conditions, and to increase the strength of the UK's research base and life sciences sector. This supports the vision set out by the Department of Health and Social Care in the document Saving and Improving Lives: the future of UK clinical research delivery.

Listening to and acting on the Patient and Research Participant voice
The Trust's Patient and Public Involvement in Research Group ensures that the patient voices is heard and acted on. During 2020/21 the Trust completed a research participant survey to find out what it is like to take part in research and a summary of the findings is given below.

Statement	Agreed or strongly agreed
• The information that I received before taking part prepared me for my experience on the study	96% (48 of 50 responses)
• I feel I have been kept updated about the research	70% (33 of 47 responses)
• I know how to contact someone from the research team if I have any questions or concerns	98% (51 of 52 responses)
• The researchers have valued my taking part in the research	92% (48 of 52 responses)
• Research staff have always treated me with courtesy and respect	98% (51 of 52 responses)
• I would consider taking part in research again	85% (44 of 52 responses)

Example qualitative feedback from research participants

I was a research scientist for 10years so very happy to be involved. I have benefited from research by others to improve treatment, so happy to be involved and help those who follow in future years. It is something positive to come from having prostate cancer.

I received extra care, attention and results. I was informed all throughout the process
Nurses on the research programme have been very supportive throughout.

I am very happy with my research experience and can't think of anything that could have improved it.

Examples of research activity are given in Annex 3.

Commissioner's contractual requirements (CQUIN)

A proportion of the ENHT's annual income is usually conditional on achieving quality improvement and innovation goals agreed between the ENHT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

There have been no CQUINs in place during 2020/21 as they were nationally suspended due to the pandemic.

Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is '**requires improvement**'. The ENHT has the following conditions on registration:

- 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

The Care Quality Commission has not taken enforcement action against the ENHT during 2020/21. The ENHT has not participated in any special reviews or investigations by the CQC during 2020/21.

Since the last inspection undertaken by the Care Quality Commission in 2019, the Trust has not received an on-site inspection. Due to COVID-19 the Care Quality Commission had to evolve their approach to regulating and develop a remote inspection programme. They adapted and develop new methods by using transitional approach to monitoring services. This focuses on safety, how effectively a service is led and how easily people can access the service. It includes:

- a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so they can continually monitor risk in a service
- using technology and their local relationships to have better direct contact with people who are using services, their families and staff in services
- targeting inspection activity where they have concerns

With this new approach CQC need to review which information they need to consider and use a risk based approach to their new remote inspection programme. CQC used information on the Trust such as previous inspection reports and ratings, monitoring information they collect through data sources and inspector knowledge on our services.
After CQC have reviewed information about the services, they hold virtual conversations with core services. This is not an inspection and CQC do not rate services following a call. In 2020/2021 CQC held the below reviews under the Transition Monitoring Approach:

- Following the first surge of the pandemic
  - Medicines Management
  - Infection Prevention and Control

- Under the Transition Monitoring Approach:
  - Urgent & Emergency Core service – Patient FIRST Review – 29 October 2020
  - Surgery Core Service – 23 March 2020
  - Medicine Core Service (Lister) – 25 March 2020
  - Well Led Review – 30 March 2020
  - Medicine Core Service (MVCC) – 22 April 2020

All the reviews were positively received and no follow up information was requested.

Further reviews for 2021/2022 are scheduled and listed below:

- Outpatients Core Service (MVCC) – 10 June 2021
- Maternity Core Service – 27 July 2021
- Outpatients Core Service (QE11) – 4 August 2021
- End of Life Core Service – 12 August 2021

To support these reviews with the Care Quality Commission each core service developed a gap analysis against the streamlined KLOE, including any gaps and mitigating actions.

At the end of May 2021 the Care Quality Commission are due to publish their new strategy outlining their new methodology for inspections going forward.

Current CQC ratings

In 2019 the Care Quality Commission inspected eight of the core services provided by the Trust across Lister Hospital, the New QEII Hospital and Mount Vernon Cancer Centre in July 2019. The Well Led Inspection took place in September 2019 and the Use of Resources inspection in August 2019. The inspectors focused on Safety, Effectiveness, Responsiveness, Care and how well led services are in eight core service lines:

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

Summary of the Trust's Ratings

Our Trust-wide rating stayed the same - requires improvement.

We were rated as good for caring and effectiveness and requires improvement for safe, responsiveness and well led.

We were rated as requires improvement for use of resources.

Ratings for the whole trust

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

Rating for acute services/acute trust

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

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
Overall trust	Requires improvement ➔➔ Dec 2019	Good ↑ Dec 2019	Good ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019	Requires improvement ➔➔ Dec 2019

Examples of outstanding practice were found in children and young people's services at Lister Hospital and in radiotherapy services at Mount Vernon Cancer Centre.
The New QEII and Lister Hospitals both showed improvements, with surgery at the Lister Hospital and Urgent Care Centre at the New QEII both moving from an inadequate to requires improvement rating.

The inspectors found that:

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

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

An action plan was developed with the teams against all of these requirements and was submitted to the CQC in January 2020. Progress is reported to Board through the Quality and Safety Committee and reported to CQC through regular engagement visits. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded and sustained across the organisation. To support sustained delivery a new Compliance and Risk Framework has been developed and approved by the Quality and Safety Committee.

The Trust adapted the Compliance Framework during the COVID-19 pandemic across the five compliance pillars which are: Intelligence Monitoring, Communication & Engagement, Departmental Visit Programme, Proactive and Not Reactive. The Trust-wide inspection programme has mainly been paused however, weekly audits and other internal audit programmes are held in collaboration with IPC, Pharmacy and estates. The Quality Assurance visits with the CCG have recommenced and will be taking place monthly with a new team or theme identified.

Data quality

East and North Herts Trust submitted records during 2020/21 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The tables below provides an update of how the Trust has performed against a few of the data items presented in the data quality reports.

Reporting Period - April 2020 to March 2021, extracted 21/04/2021. The information is intended to support data quality improvements for organisations delivering NHS services

Activity	Valid NHS Number	Valid General
Admitted patient care	99.90%	99.60%
Out-patient care	99.90%	100%

Ethnic Category	Provider % Valid	Region % Valid	National % Valid
Admitted patient care	94.80%	94.10%	95.70%
Outpatient care	91.40%	92.80%	93.60%

Accident and Emergency	Trust % Valid	STP % Valid	Regional % Valid	National % Valid
NHS Number	99.4%	99.30%	99.00%	98.10%
Registered GP	100.00%	99.90%	99.50%	98.80%

During the year 2020/21

The corporate data quality team tried to use this time as efficiently and to the betterment of the Trust and its patients as possible. They were involved in a number of programmes that improved the patient experience and assisted in the delivery of services during the pandemic.

- Implemented a Trust-wide PTL review and cleansing programme of legacy data:
  - New PTL, total number of open new referrals was just under 50,000. At the end of the programme, it had reduced to around 36,000.
  - Follow Up PTL – the team started working on breaking down the PTL into more manageable validation cohorts, this work in continuing into 2021/22.
- Data Quality Training Surgeries – during the validation and cleansing of both the New and FUP PTL, the project identified both recording errors and training needs. During the autumn of 2020, a series of training sessions were organised for staff across both divisions.
- The team were involved in populating Lorenzo with the national clinical risk stratification codes on the inpatient waiting list
- During the second wave of the pandemic, the Trust converted as many face to face appointments to telephone and the team were involved in contacting patients and updating the PAS system.
- The team were part of the Keeping in Touch project, manning the dedicated phone line for friends and family of our patients, maintaining an open line of communication
- The team were working on the development of a Data Quality Compendium (DQC), a documented record of all activity taking place and how this activity is captured across the Trust.

The team will be taking the following actions to further improve data quality across the Trust.

Plans for 21/22;

- To reinstate Data Quality Steering Group Meetings, moving from bi-monthly to monthly with both the Planned and Unplanned Divisions.
- Identify divisional champions who will promote the importance of DQ and provide first line support in the divisions.
- An output from the steering group will be a DQ improvement plan, framework for assessing data across all services, define areas for improvement, indicating short term and long term issues.
- Monthly DQ Audits – focussing on specialities, outcomes reported into the steering group.
- Educating staff on the importance of collecting data, i.e. ethnicity status, recording and the impact on population health management.
- Raising staff's awareness of their roles and responsibilities in maintaining high quality data.
- Development of the DQ Dashboard, KPI reports on DQ issues, identify areas of concern.
- Provide exception reports for staff to manage their data concerns and monitor improvements.
- Set up Trust-wide governance framework structure.
- Development of data quality training modules on the Trusts ENHT Learning Academy.

Information Governance / Data security

The Trust's assurance framework and risk register include the risks associated with the management and control of information. In this respect, the Trust has established a framework to support compliance with the ten data security and protection standards and GDPR.

In response to the COVID-19 pandemic, the Trust opted to extend the deadline for the submission of the Data Security and Protection Toolkit 2019/20 to September 2020. The Trust declared a fully compliant position.

Progress with completion of the DSPT for 2020/21 is underway to meet the June 2021 submission and is monitored at the Trust's Information Governance Steering Group meetings which are held quarterly.

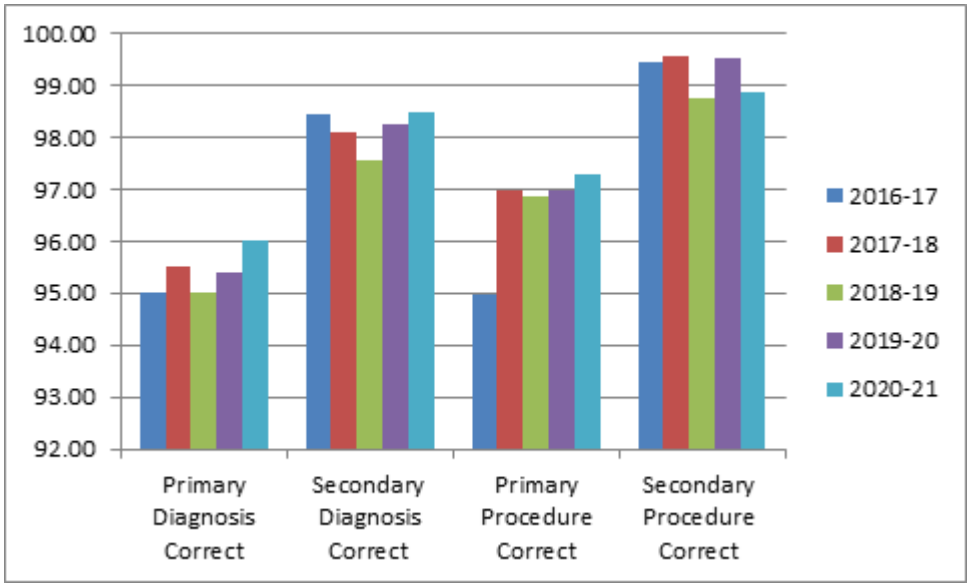
During 2020/21 we have not declared any incidents classified as Level 2 or that meet the requirements to report to the Information Commissioner's Office (ICO). All information governance incidents are reviewed by the Information Governance team and potential and actual serious incidents are reviewed in line with the national guidance through the Trust's incident review process to support learning.

Clinical coding

The ENHT was not subject to the Payment by Results clinical coding audit during 2020/21. However the Trust undertook a General Data Protection Regulation Standard 1 audit with results at Level 3 (highest level) as follows:

Year	Primary Diagnosis Correct	Secondary Diagnosis Correct	Primary Procedure Correct	Secondary Procedure Correct	Level
2016-17	95.00	98.43	94.96	99.46	3
2017-18	95.50	98.10	96.98	99.58	3
2018-19	95.00	97.55	96.86	98.77	3
2019-20	95.41	98.25	96.97	99.51	3
2020-21	96.00	98.50	97.30	98.89	3

Comparisons since 2016-17 are shown in the chart below.



Learning from deaths

Reducing mortality is one of the Trust's key objectives and processes have been established to undertake mortality reviews, monitor mortality rates and ensure learning from the learning from deaths work. It also incorporates information and data mandated under the National Learning from Deaths Programme.

Mortality review process

I. Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections.
II. Potential areas of concern (ACON's) found by reviewers trigger a Stage 2 review by the relevant Specialty with discussion and identification of learning/actions points at their Clinical Governance Forum.
III. Outputs feed into Stage 3 where the case is considered by the Mortality Surveillance Group, a subset of the Trust's Quality and Safety Committee. Here the adequacy/appropriateness of actions/learning points suggested by Specialties is considered and an avoidability of death score is agreed (using the scoring criteria adopted from the RCP methodology). Scores of ≤3 (more than 50% likelihood that the death was avoidable) have been used to answer this question. Quality of Care rating is now also agreed using the scale adopted from the PRISM methodology.

As part of the mortality review process where areas of concerns are identified these are themed to provide an at-a-glance summary. These themes are reviewed against incident themes etc to identify learning and to plan improvements.

Learning themes are shared with wider Quality Improvement initiatives such as Deteriorating Patient Collaborative and End of Life Board; where they are captured as key drivers for change ideas.

Key Themes from Mortality Review Areas of Concern: 2020-21

The content and format of the learning from deaths information below has been provided in accordance with the statutory instrument 2017 No 744 'The National Health Service (Quality Accounts) (Amendment) Regulations 2017.

Statutory Ref	**Prescribed information**	**2020-21 Response** (using prescribed wording)
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2020-21, 1555 of ENHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 370 in the first quarter; 289 in the second quarter; 362 in the third quarter; 534 in the fourth quarter.
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 31 March 2021, 785 case record reviews and 91 investigations have been carried out in relation to 1555 of the deaths included in item 27.1. In 87 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 311 in the first quarter; 207 in the second quarter; 177 in the third quarter; 63 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting	1 representing 0.06% of the patient deaths during the reporting period are judged to be more likely than not to

	period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 1 representing 0.27% for the first quarter; 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter. [Note: this does not mean that no 2020-21 deaths will be identified within the item 27.3 definition, but that by 31 March 2021 only 1 concluded ACON investigation had fallen within this definition. As detailed in 27.8 below, investigations concluded after the end of the current reporting period will be reported in next year's Quality Account]. These numbers have been estimated using the Trust's Mortality Review process. Stage 1 is undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It is a structured, evidence based review format comprised of a core section of questions relating to care that are relevant to all specialties, with additional Medicine/Surgery specific sections. Potential areas of concern found by reviewers trigger a Stage 2 review by the relevant Specialty with discussion and identification of learning/actions points at their Clinical Governance Forum. Outputs feed into Stage 3 where the case is considered by the Mortality Surveillance Group, a subset of the Trust's Quality and Safety Committee. Here the adequacy/appropriateness of actions/learning points suggested by Specialties is considered an avoidability of death score is agreed (using the scoring criteria adopted from the RCP methodology). Scores of ≤3 have been used to answer this question (Death probably avoidable, more than 50-50). Quality of Care rating is now also agreed using the scale adopted from the PRISM methodology.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	1 2020-21 death has so far been identified within the item 27.3 definition. This information is based on concluded ACON investigations considered by the Mortality Surveillance Committee by 31 March 2021. [Refer to note in 27.3] This death was declared a formal SI with ensuing investigation and report provided to and approved by our Commissioners. The Mortality Surveillance Committee considered the case in September 2020. The Committee concluded that there was strong evidence of avoidability of the death.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item	The following were the key actions/learning as a result of the SI investigation of the death: 1. All AMU ward staff to read and understand the Trust Falls Prevention and Management Policy; ward manager to email staff and maintain a record of completion. 2. All AMU staff to have basic introduction to falls prevention and management at Trust mandatory

	27.4).	training. 3. All staff to attend bite-size training focussing on the management and prevention of falls. 4. Twice weekly audit of falls documentation to take place with any issues fed-back at time of audit and to those staff where sub-optimal practice is observed; audit to ensure that assessment reflects patient need. 5. Training to support staff practice around management of the patient post fall i.e. neurological observations and when they are required, moving the patient from the floor to be arranged for all staff. 6. High risk patients and their specific requirements to be included at site safety huddle. 7. Learning from this incident was fedback to ward team and shared Trust-wide.
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	This extremely sad case had a significant impact on all acute areas. It highlighted the vital importance of certain aspects of care, which were reinforced with renewed rigour, in particular: 1. Accurate and timely handover – clear handover of relevant patient history 2. Ensuring that risk assessment is not just a paper exercise but is translated into a 'real' patient's needs i.e. what does it really mean for this patient 3. Importance of performing neuro observations correctly and appropriately – when neuro observations must be used and when AVCPU is sufficient 4. Acknowledging the increased risk to patient's when they are in a side room and are unobserved for periods of time – this is an increased risk even when the patient does not require a special or Baywatch, and taking appropriate extra precautions.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	20 case record reviews and 30 ACON investigations completed after 1 April 2020 which related to deaths which took place before the start of the reporting period.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	5 *[of the 30 investigations reported in 27.7 above]* representing 0.35% of the patient deaths before the reporting period *[ie 2019-20]* are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the mortality review process methods detailed above in 27.3.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that	6 representing 0.4% of the patient deaths during 2019-20 are judged to be more likely than not to have been due to problems in the care provided to the patient *[this represents a revised total figure incorporating the sum of 27.3 from last year's report and 27.8 above].*

	previous reporting period, taking account of the deaths referred to in item 27.8.	

2.3 Performance against national core indicators

In this section the outcomes of a set of mandatory indicators are shown. This benchmarked data, provided in the tables, is the latest published on the NHS Digital website and is not necessarily the most recent data available. More up to date information, where available, is given.

For each indicator the Trusts performance is reported together with the national average and the performance of the best and worst performing Trusts, where applicable.

Mortality

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

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. It is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers patients who died either while in hospital or within 30 days of discharge.

SHMI data is not adjusted for palliative (end of life) care. This is because there is considerable variation between Trusts in the coding of palliative care. However, to support the interpretation of the SHMI, various contextual indicators are published alongside it, including indicators on the topic of palliative care coding.

SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'.

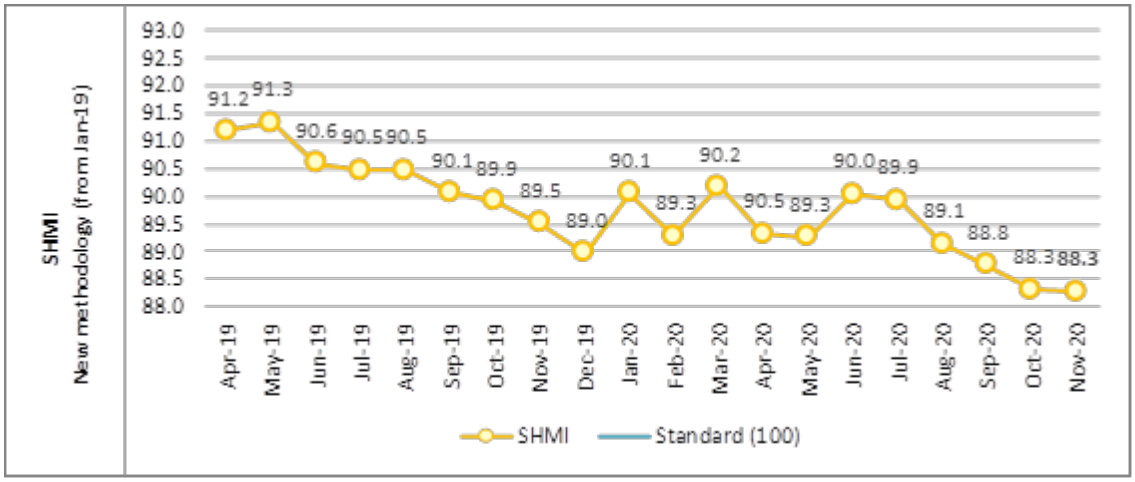
Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
SHMI	Value	0.8791	Jan-Dec 20	0.889	0.703	1.1845	1
	Banding	3 – Lower than expected		2 - As expected	-	-	N/A
% deaths with palliative care code	N/A	33		34	7	61	N/A

*NHS Digital, Published May 2021

SHMI is expressed as a ratio of observed to expected deaths so that a number smaller than '1' represents a better than expected outcome. The Trust's SHMI for the twelve months to November 2020 is **0.88**, positioned within the 'lower than expected' Band 3 category. SHMI is generally available 6/12 in arrears.

Following significant improvements in SHMI, there has now been a sustained period of stability. Our position relative to our national peers currently stands at 13th out of all acute non-specialist trusts (124).

NHS Digital has excluded COVID-19 activity from the SHMI metric. Of note is that the fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, provides some assurance that our response to COVID has not generally resulted in a disproportionate increase in deaths within 30 days of discharge.

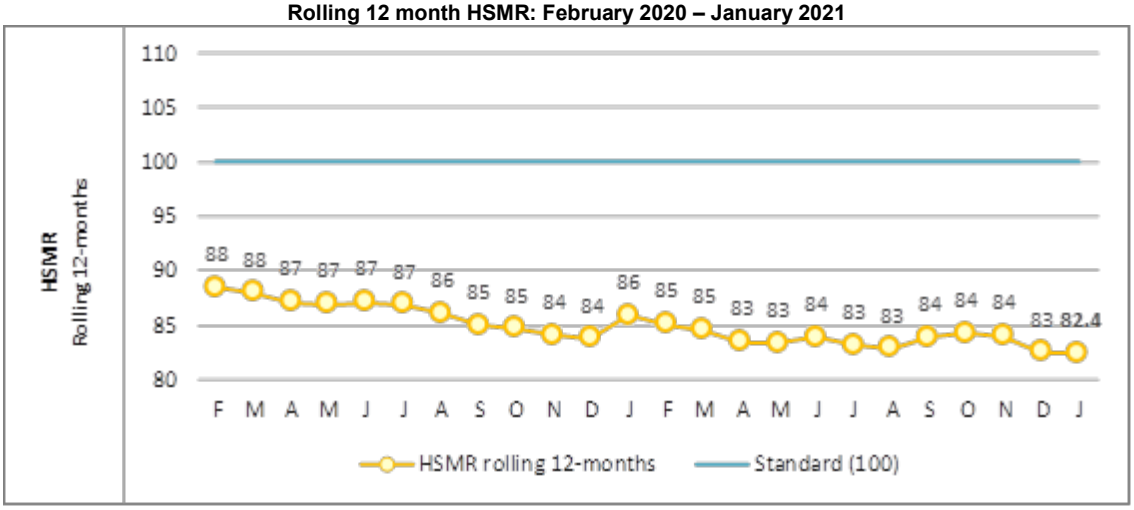


Note: In the chart above the observed to expected deaths have been multiplied by 100 (comparable to HSMR methodology) so that '100' and is comparable to the '1' as described above, where the number of observed deaths exactly matches the number of expected deaths

A different measure of mortality is the Hospital Standardised Mortality Ratio (HSMR) which measures the actual number of patients who die in hospital against the number that would be expected to die given certain characteristics e.g. demographics.

In this metric the observed to expected deaths ratio is multiplied by 100 so that when observed deaths match expected deaths the rate stands at 100 (blue line in the graph below). Again this means that a figure below 100 indicates a lower than expected number of deaths. Performance has remained consistency in the first quartile of Acute Trusts. HSMR is generally available 3 months in arrears and the latest HSMR for the rolling 12 months to January 2021 is **82.4**. It should be noted that mortality data is now taken from CHKS rather than Dr Foster. This resulted in an apparent reduction in HSMR of approximately 10 points which was due to the fact that the CHKS data rebases once every 12 months, whereas Dr Foster rebases monthly. We are currently awaiting the latest CHKS re-base. This does not affect our ability to compare our performance with peers.

Rolling 12 month HSMR: February 2020 – January 2021

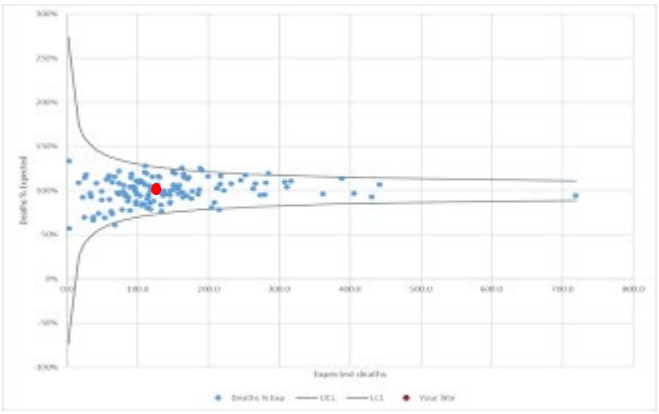


COVID-19

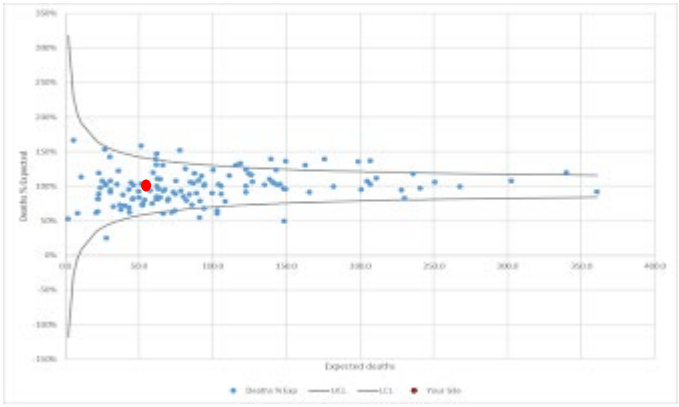
The multi-layered effects of the COVID-19 pandemic make meaningful analysis and comparisons regarding mortality data challenging. For example, there were nearly 200 more inpatient deaths in 2017-18 (the last year with a significant Winter spike in deaths) than in 2020-21, however, during 2020-21 our inpatient numbers and casemix were at times very different. Such facts underline the dangers of comparison.

CHKS, our specialist healthcare intelligence provider, is currently working on a model which will enable us to better understand our COVID mortality and the underlying reasons for mortality variances between hospitals across the country during the pandemic. They produced an interim report which showed that few trusts lie outside the expected range, indicating relative consistency in performance across English, Welsh and NI trusts. The following charts provided by CHKS show the Trust's central position relative to national peers in both the first and second COVID waves.

Covid-19 First Wave (March to May 2020)



Covid-19 Second Wave (October to December 2020)



At this point in time the following observations can be made:

COVID Deaths Pandemic start - 31 Mar-21	Definition
535	Patients who had a positive test or were clinically coded as COVID. These deaths are reported to NHS Digital so underpin our publically reported mortality rates.
493	Patients who had a laboratory-confirmed positive COVID-19 test and died within 28 days of the first positive specimen date. This is the Public Health England national reporting definition.

Additionally:

- Latest death trend has been in line with the local region and generally COVID data has shown clear alignment with the regional and national picture.
- HSMR and SHMI have remained stable & largely unaffected – providing some indication that non-COVID death rates have not significantly increased.
- CHKS latest interim COVID report indicated our performance is in line with our national peers.
- Significant increase in crude mortality April 2020 and January 2021.
- Significant increase in deaths in the January 2021 peak.
- Some changes seen to COVID deaths in the second wave regarding age and gender split, potentially due to new variants of the virus.
- Work remains ongoing to assess the impact of hospital onset nosocomial COVID infections with mortality reviews being prioritised for those patients who sadly went on to die from COVID.

The ENHT considers that this data is as described, as it is based on data submitted by the Trust to a national data collection, and reviewed as part of the routine performance monitoring. The ENHT has processes in place and takes on-going action to improve these scores, and consequently the quality of its services, including presenting and tracking monthly data to identify and investigate changes. The mortality data is also captured by diagnosis so any deviation can be investigated at a case by case level.

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) measure health gain in patients undergoing hip replacement, knee replacement and up to September 2017, varicose vein and groin hernia surgery in England.

Submissions were low for the 2020/21 as they have been impacted by COVID as a result of cessation of Elective orthopaedic surgery during this period. However, 190 submissions were received. Recovery plans are in place for the elective surgery and the Trust continues to exceed the 70% required against the 2019/20 activity levels. Sitting alongside this is a programme to support patients waiting well.

The Trust considers that this data is as described, as it is based on data submitted by users of the service to the national data collection team. The number of submissions of forms is insufficient to generate outcomes measures within the provisional data.

Patients are given questionnaires to complete before and after surgery, from which the improvement is measured. Three methods of data collection are used:

EQ-5D: The score comprises five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. The score ranges from -0.594 (worst possible health) to 1.0 (full health).

EQ-VAS: The score records the patient's self-rated health on one scale ranging from 0 (worst) to 100 (best).

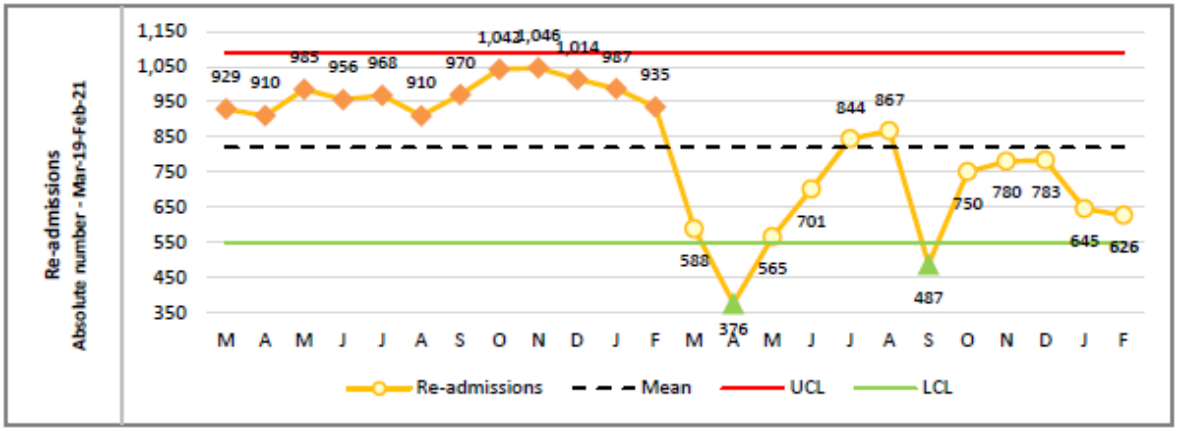
Oxford Score: The score records the views of patients on 12 aspects of their daily living with the total score ranging from 0 (worst) to 48 (best).

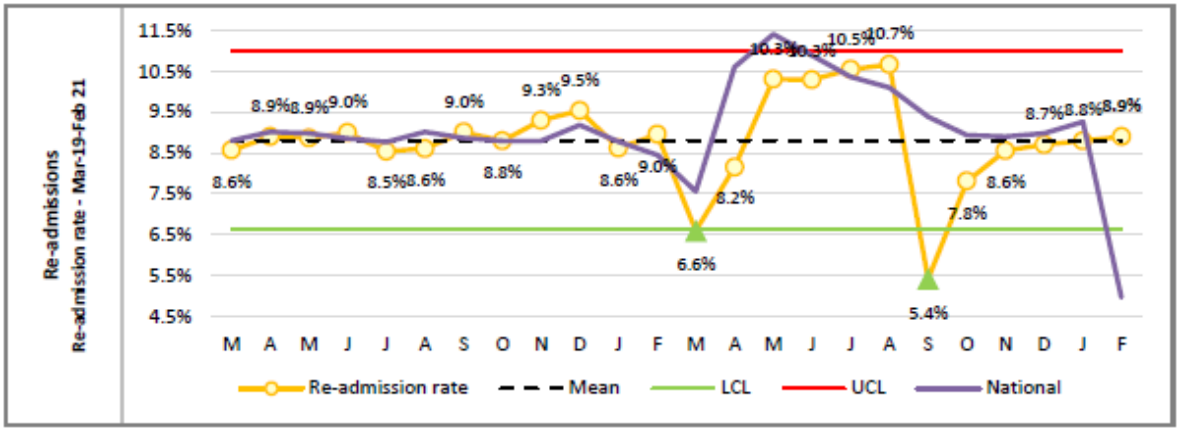
In October 2017 the collection of groin hernia and varicose vein patient reported outcome measures ceased, hence data is not provided.

Emergency readmissions

This indicator measures the percentage of patients readmitted to hospital within 28 days of being discharged from hospital after an emergency admission.

The Trust's re-admission rate has generally been consistent with the national performance. Significant dips in readmissions were seen in March and October 2020, while July and August saw the Trust's rate rise slightly above the national picture. Recent months have seen performance return to those seen pre-COVID-19, with the Trust tracking just below the national average. The significant changes in overall admissions and the change in case mix during this period make interpretation of this data challenging but the Trust's position will continue to be monitored.





Responsiveness to patient needs

The CQC Adult Inpatient survey asked the views of adults who had stayed overnight as an inpatient in July 2019. 488 patients responded to the ENHT survey, a response rate of 41.4% (compared to 42.4% in the 2018 survey). The results from the 2020 Inpatient Survey have not yet been published.

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

*CQC Insight, May 2021

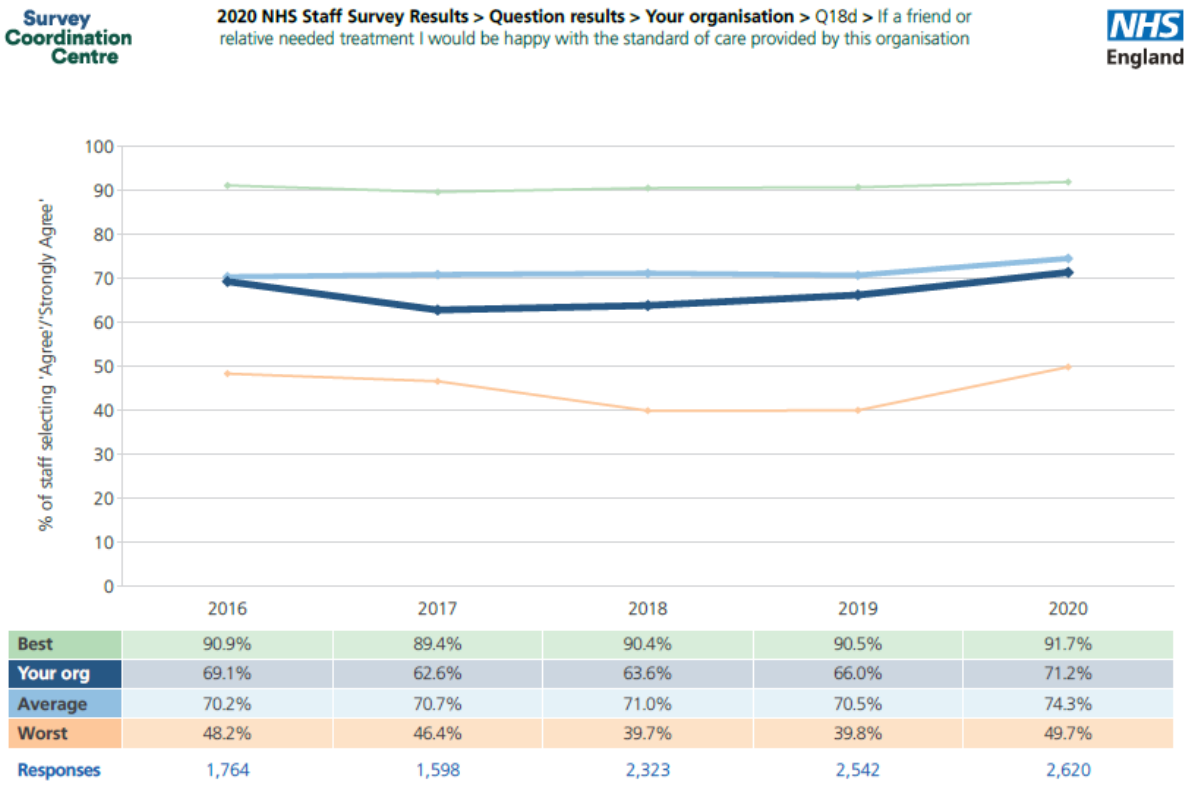
Question	Trust Score	Compared with other Trusts
Were you involved as much as you wanted to be in decisions about your care and treatment?	7.0	Same
Did you find someone on the hospital staff to talk to about your worries and fears?	4.9	Same
Were you given enough privacy when discussing your condition or treatment?	9.4	Same
Did a member of staff tell you about medication side effects to watch for when you went home?	3.7	Same
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital	7.1	Same

The Trust considers that this data is as described, and it is based on data submitted directly by patients to the national survey. The Trust continues to take action to improve patient and carer experience and this is detailed within the divisional patient experience action plans submitted to, and monitored by, the Patient and Carer Experience Group.

Staff recommending the Trust

Indicator	Measure	Trust Result	Time Period	Trust previous result	Best performing Trust	Worst performing Trust	National average
Recommend the Trust	Staff	71.2%	2020/21 Q2	66%	91.7%	49.7%	74.3%

2646 staff completed the NHS national staff survey in 2020 representing a 44% response rate. Of those surveyed, 71.2% of staff state they would recommend the organisation as a place to receive treatment. This represents an improving picture over the last three years however remains below the national average.



Throughout the survey there are again mixed scores although the year on year trends remains wholly positive and most scores are improving. When benchmarked by sector, we are however more than 0.1% below average for, 3 themes, namely; equality, diversity and inclusion; safe environment - bullying and harassment and safety culture.

Going forward it is now our priority to increase our focus on the culture of the organisation to improve staff experience in the areas listed above.

Patients recommending the Trust

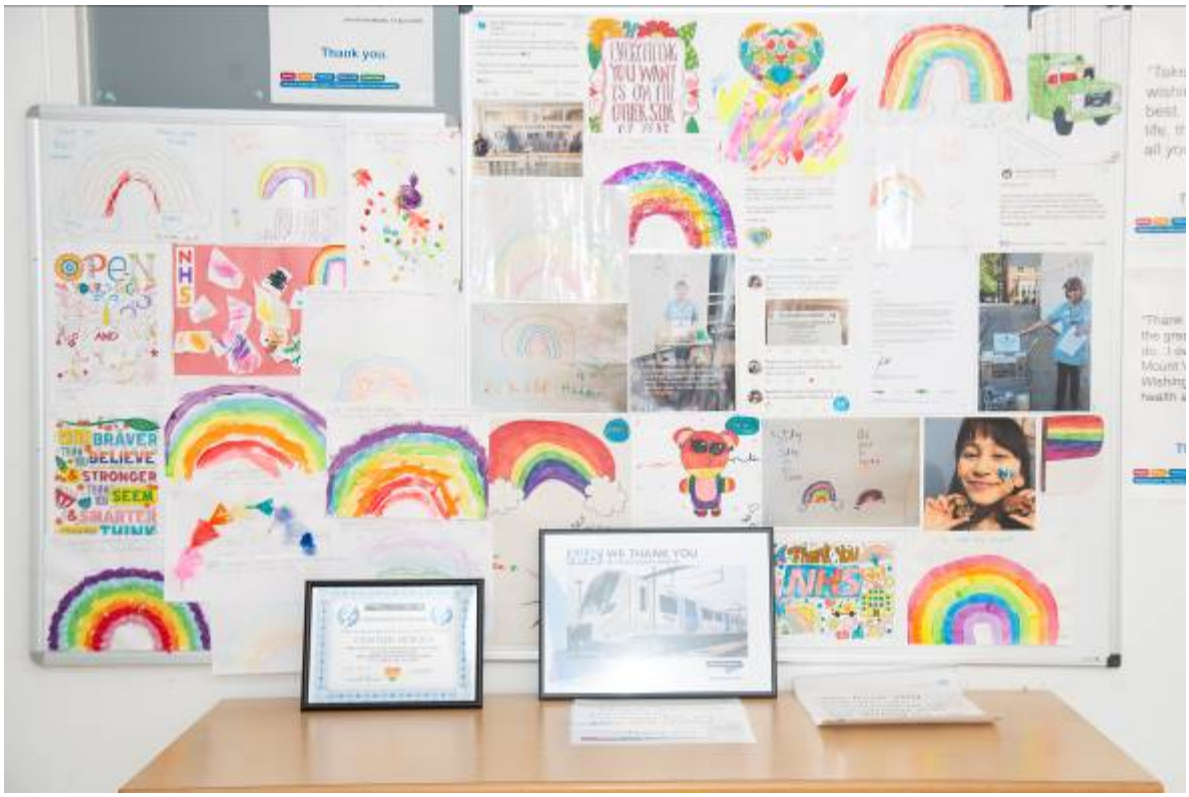
Detailed information on this indicator is given in section 4.1.

For the purpose of this section the findings are shown compared with other organisations.

Indicator	Measure	Trust result	Time period	Trust previous result	Best performing trust	Worst performing trust	National average
Recommend the Trust	Patients	IP 97% A/E 94% Mat 94%* OP 96%	Feb 2020	IP 97% A/E 91% Mat 97% OP 97%	100% 99% 100% 100%	73% 40% 86% 76%	96% 85% 97% 94%

*Maternity indicator is a measure relating to birth experiences only

The Trust considers that this data is as described, as it is based on data submitted directly by patients to the national surveys programme. The Trust has taken the following actions to improve this score, and so the quality of its services, by reviewing the survey responses and producing initiatives to improve patient engagement; and by reviewing patient survey responses alongside other sources of patient feedback to determine improvements.



Venous Thromboembolism (VTE)

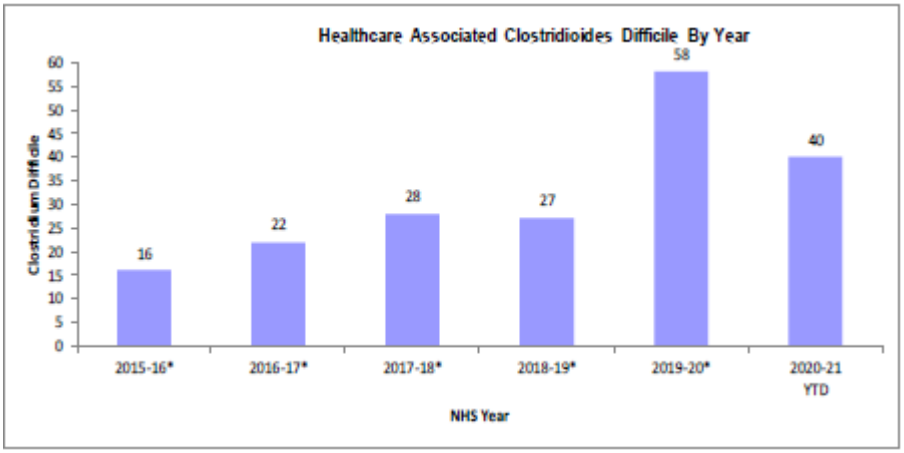
The national bench making data collection has been paused and therefore is not currently available.

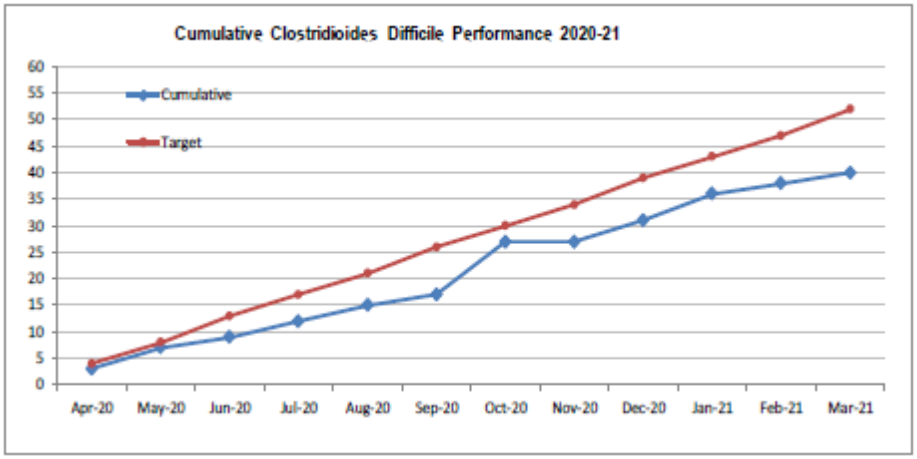
Clostridium difficile

This indicator measures the number of hospital acquired Clostridium difficile infections per 100,000 bed days.

Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of c.difficile incidences Healthcare-associated	4	3	4	2	3	3	2	10	0	4	5	2	2
Rate of c.difficile incidences per 100,000 bed days Healthcare-associated	19.0	26.2	33.8	17.5	20.4	20.4	14.1	56.8	0.0	22.7	27.9	12.4	11.2

In 2020/21 the trust reported 40 cases of *c.difficile* against a planned ceiling of 52 cases.





All cases are usually reviewed by a joint Trust & CCG panel to ensure any learning is identified and appropriate actions are put in place, and to agree cases that should be exempt from financial sanctions. However, presentation of the remaining cases has been postponed due to the COVID pandemic. The Trust has a continued focus on Infection Prevention and Control; please refer to MRSA section for further details.

Patient safety incidents

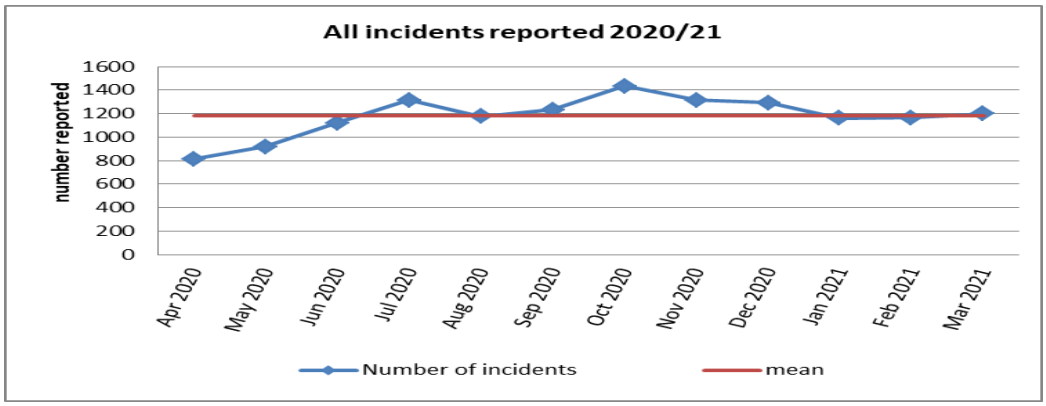
Incidents are reported on the electronic reporting system, Datix. The patient safety incident data is uploaded into a national system where incident reporting patterns, types of incidents can be analysed. The rate of incidents is the number reported per 1,000 bed days.

Between 1 April 2020 – 31 March 2021 the Trust reported a total of 11,876 patient safety incidents. This can be seen in the table.

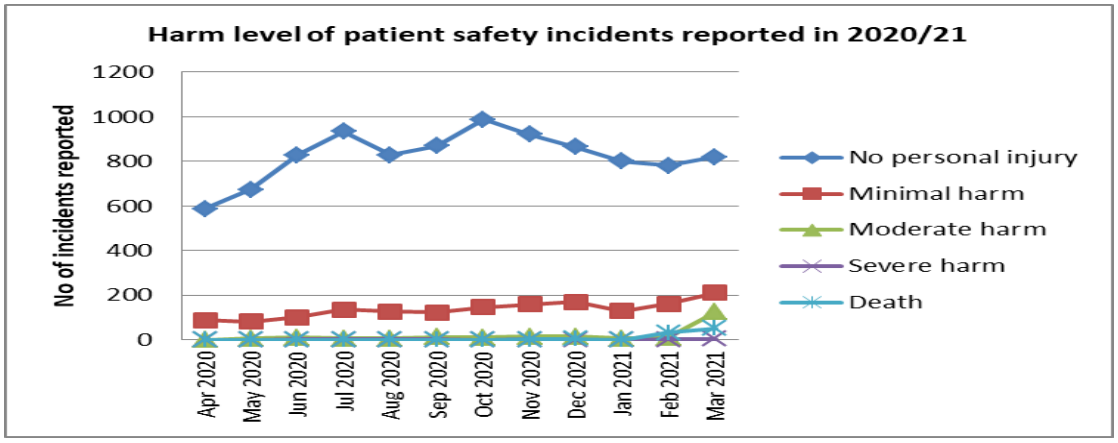
The National Patient Safety Reporting and Learning System (NRLS) noted a decrease in the numbers of incidents reported to the NRLS compared to the same period in the previous two years.

This period of April 2020 – June 2020 has been recognised as a key stage of the NHS responding to the COVID-19 pandemic which may have had an impact on reporting to the NRLS. There was an accompanying major shift in service provision during this time which could have led to limited staff capacity and lower patient demand for non-COVID-19 services. This was reflected locally as our incident reporting at the beginning of the pandemic in March 2020 noted a statistically significant decrease in reporting of all incidents, with April 2020 showing the lowest with 677 patient safety incidents reported for the month.

Through the second wave we have seen less of a decline in incident reporting, with a slight decrease to 937 reported in January 2021, with the Trust average stable at 989 patient safety incidents per month. However there remains local variation in reporting trends within some categories e.g. medication reporting, moderate harms and some clinical areas e.g. critical care.



Between 1 April 2020 and 31 March 2021, 97% of patient safety incidents (11,531) reported resulted in no or minimum harm. During February and March 2021 all of the definite and probable nosocomial COVID-19 infections were inputted onto Datix therefore during those 2 months there was an unusually high number of incidents recorded as resulting in moderate harm or above. Those incidents are currently being reviewed through the Trust nosocomial COVID-19 investigation process with harm levels being reviewed and amended as necessary.



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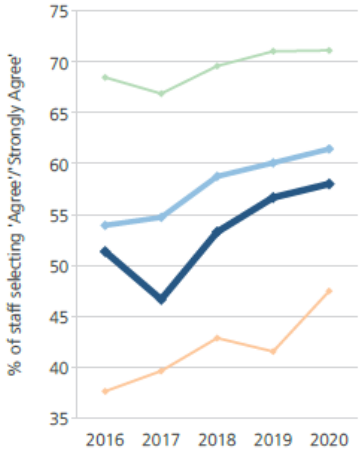
This period of April – June 2020 has been recognised as a key stage of the NHS responding to the COVID-19 pandemic which may have had an impact on reporting to the NRLS. There were also major shifts in service provision during this time which could have led to limited staff capacity and lower patient demand for non-COVID-19 services.

The next national incident reporting publication is now due September 2021.

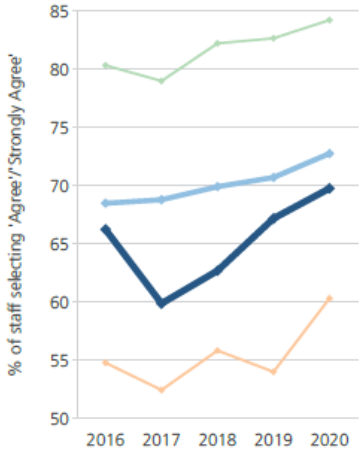
The staff survey 2020 results demonstrate continuous improvement in key cultural areas relating to incident management as shown in the series of graphs below. This remains a priority for the Trust through continued, combined efforts of strengthen the Trust's speaking up framework, developing more analytical and user friendly Datix system.

Q16a
My organisation treats staff who are involved in an error, near miss or incident fairly



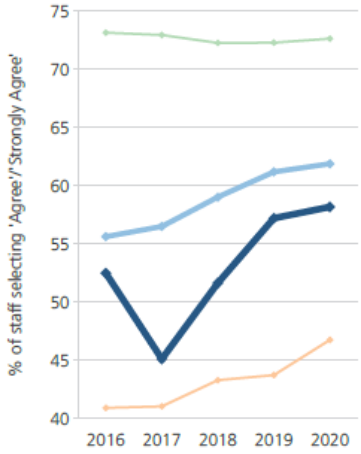
	2016	2017	2018	2019	2020
Best	68.5%	66.9%	69.6%	71.1%	71.1%
Your org	51.3%	46.6%	53.3%	56.7%	58.0%
Average	53.9%	54.7%	58.7%	60.1%	61.4%
Worst	37.6%	39.6%	42.8%	41.5%	47.5%

Q16c
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again



	2016	2017	2018	2019	2020
Best	80.3%	79.0%	82.2%	82.7%	84.2%
Your org	66.2%	59.8%	62.6%	67.2%	69.7%
Average	68.5%	68.8%	69.9%	70.7%	72.7%
Worst	54.7%	52.4%	55.8%	53.9%	60.3%

Q16d
We are given feedback about changes made in response to reported errors, near misses and incidents



	2016	2017	2018	2019	2020
Best	73.2%	73.0%	72.3%	72.3%	72.6%
Your org	52.4%	45.0%	51.6%	57.2%	58.1%
Average	55.6%	56.5%	59.0%	61.2%	61.9%
Worst	40.8%	41.0%	43.2%	43.7%	46.7%

Part 3

3.1 Review against selected metrics

Patient safety

Indicator	18/19	19/20	20/21	Aim (20/21)
Never events	6	3	**3**	0
MRSA Bacteraemia (post 48 hours)	2	6	**0**	0
Number of inpatient falls	845	816	**652**	600
Number of inpatient falls resulting in serious harm	12	2	**11**	2
Number of preventable hospital acquired pressure ulcers	101	151 (0.62 PU per 1000 bed days) 2 cat 4	**235** **1 cat 4**	0.49 PU per 1000 bed days Zero Cat 4

Never events

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations are in place. The table below indicates the number of never events reported in the Trust during the last three years.

	2017/18	2018/19	2019/20	2020/21
Wrong site surgery	1	4	1	2
Retained object	3	0	1	0
NG Feeding	1	1	0	0
Blood transfusion	1	0	0	0
Oxygen tubing to air	N/A	1	1	1
Trust	**6**	**6**	**3**	**3**

Previous to September it had been 340 days since the last reported never event.

29/09/2020 Unintentional connection to Wrong Medical gas (minimum harm)
29/10/2020 Wrong site surgery (minimum harm)
22/12/2020 Wrong site Surgery (minimum harm)

Nationally 298 never events were reported from 01/04/2021 – 31/01/2021, with the highest reporting month being October 2020.

Learning identified changes in staffing led to poor compliance with medical gas safety checks to reliably remove air outlet equipment form bed spaces. This has led to pharmacy led improvements to improve safety checks and communicate learning from this incident.

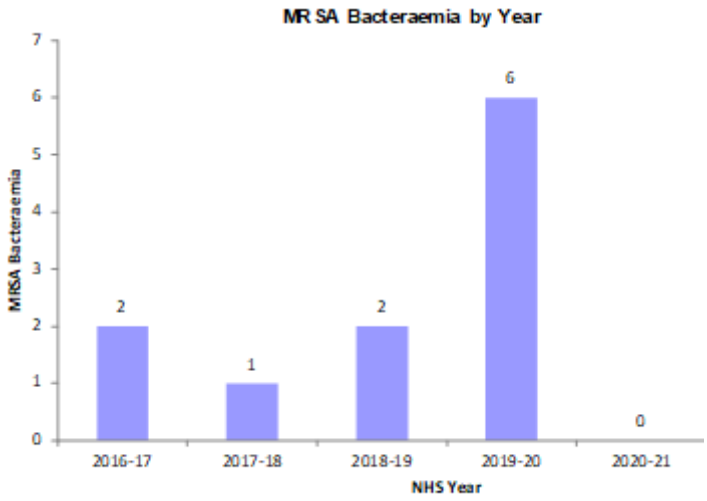
The Trust has established a 'Safer Surgery Collaborative' where clinical teams are supported to safely adopt local plans National Safety Standard for Invasive Procedures.

Ongoing multidisciplinary quality improvement efforts include:

- The Trust policy now reflects the National Safety Standard Invasive Procedure Policy (NatSSIP)
- There are ongoing plans to develop a 12 month rolling programme for teams undertaking invasive procedures to access, where they can consider and map 'Human Factors Contributory Factors' across their local invasive procedures. Plans for team videoing and learning materials are underway.

MRSA Bacteraemia (post 48 hours)

MRSA bacteraemias are classified as Hospital Onset if the sample is taken later than the day following admission. The Trust achieved the target of zero MRSA bacteraemias in 2020/21 for the first time since 2015/16. Perhaps as a result of ongoing enhanced IPC measures in place across the Trust during the pandemic.



The 2020/21 pandemic has influenced a fast changing, extreme national incident response to all Infection and Prevention Control (IPC) services.

From the 27 January 2020 the Trust started managing COVID-19 as a high level priority with daily incident response meetings. This was adopted through a strong clinical and executive leadership approach in conjunction with a structured daily national emergency planning response. The IPC service responded and developed an onsite seven day service to support the Trust at this time.

Key priorities have included:

- An infection and prevention control communication and training programme to support staff understanding and awareness of COVID risks and management.
- Supporting training and staff within local care homes to adopt new IPC standards.
- Introducing and embedding new national PPE requirements.
- Supporting staff undertake individual and local risk assessment across clinical and non-clinical workforce.
- Supporting the introduction of COVID swabbing pod sites for the community and new COVID swabbing regimes for patients while they stayed in hospital.
- Introducing a new IPC standard screening tool to enable staff to assess risk of patients presenting to services.
- Supporting the development and embedding of family and carer risk assessments when required to visit loved ones during the pandemic management.

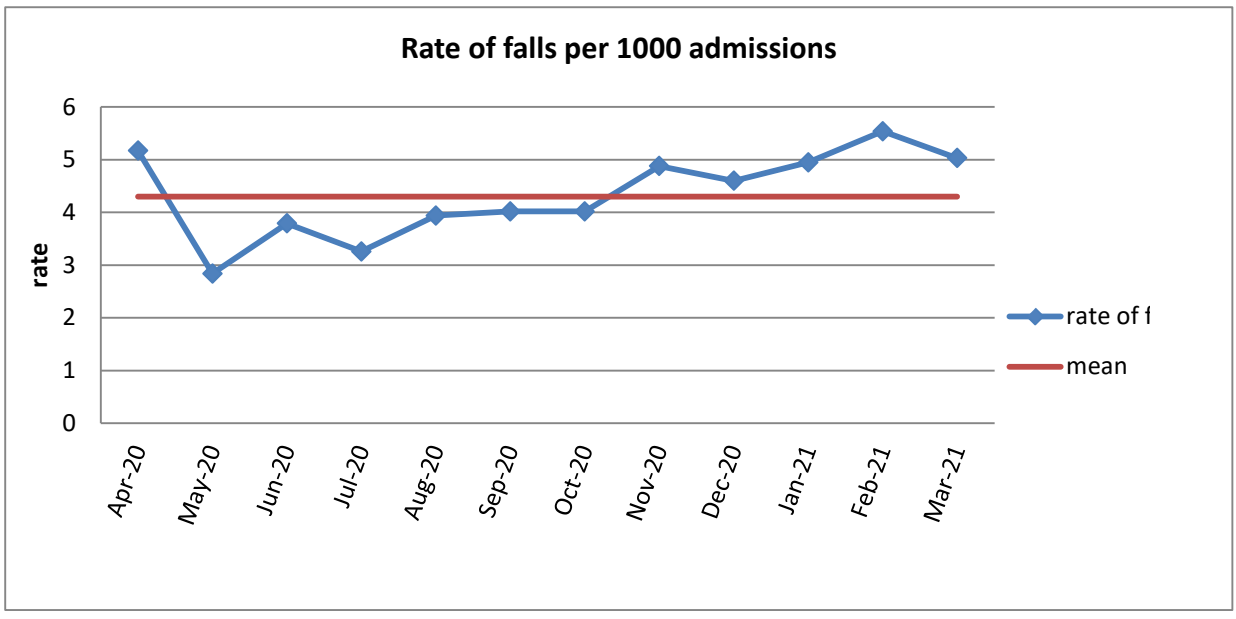
Inpatient falls

During 2020/21 there were 652 inpatient falls. This represents a 12.72% reduction when compared to 2019/20. This also meets the reduction target of fewer than 832 set for the year 2019/20. Last year has been an extra ordinary year as we have experienced a global crisis due to the pandemic. Despite of this, we have continuously meets the reduction target that was set same in the previous year.

Financial Year	Number of Inpatient Falls	Reduction year on	% of Reduction	Number of Falls with Harms	Reduction in harm
2018-2019	806	-	-	21	
2019-2020	747	59	7.32% ⇩	14	66% ⇩
2020-2021	652	95	12.72 ⇩	11	21.4% ⇩

The Trust has sustained an average falls rate of 4.3 per 1000 bed days which is lower than the national average of 6.6 (NHSI).

Rate of Falls per 1000 bed day



Number of inpatient falls resulting in serious harm
Learning from incidents.

Patients admitted to the hospital are assessed for their risk of falling within 4 hours of admission. Any identified risk should have an action plan in place to minimise these risks. The Trust has a number of measures in place aimed at minimising the risk of falling. These include use of bed rails, low rise beds, enhanced care team support and Baywatch.

Despite these measures, patient falls resulting in serious harm have occurred and remain a priority for the Trust. The level of harm associated with falls has progressively reduced from previous years 2019/2018 and learning identified from recent serious incidents are shared with the wider clinical teams. During the pandemic we have experienced new environmental challenges associated with risk of isolation required to deliver infection, prevention and control quality care, combined with challenges with reduction in safer staffing numbers at times. We continue to drive quality improvement initiatives relating to improving compliance with the Trust falls assessment and timely escalation and referral to the wider multi-disciplinary team.

Harm Free Care Priority AIM:

Quality Improvement work for falls this year is focused on the aim of further reducing Trust-wide falls by 2 % by March 2022. The overarching goal will be to improve communication and involve service users in co-designing the falls improvement work described below:

- **8A ward QIP project**
- **Priority Theme 1:** 8A has high incidences of fall for their alcohol withdrawal patients. One of the issues highlighted is that patients are not getting the right dosage of medication at the right time.
  Work Underway: Project will focus on developing an alcohol withdrawal proforma so patient gets the medication with the right dosage at the right time. Ideas will be tested and the prediction is that a new proforma will ensure that patients will have quicker turn arounds of symptoms, falls risk will be lowered, and length of stay will be shorter.
- **Assessment Areas (AMU 1, AMU 2, SSU):**
- **Priority Theme 2:** Assessment areas have a quick turnaround of patients, though risk assessments are mostly completed, actions and mitigations are often overlooked.
- **Work Underway**: Quality Improvement work in these areas will be focused on timely escalation and mitigation following the risks identified on the falls risk assessment, testing of new risk of falling – Falls Prevention Plan.
- **Baywatch**
- **Priority Theme 4**: Compliance with Baywatch has been poor since the pandemic which gives negative impact in managing high risk falls patients.
- **Work Underway:** To re-launch Baywatch High falls incidence areas, then Trust-wide, focusing on new staff and ensuring that guidelines are adhered to by offering real time/bespoke falls education training.

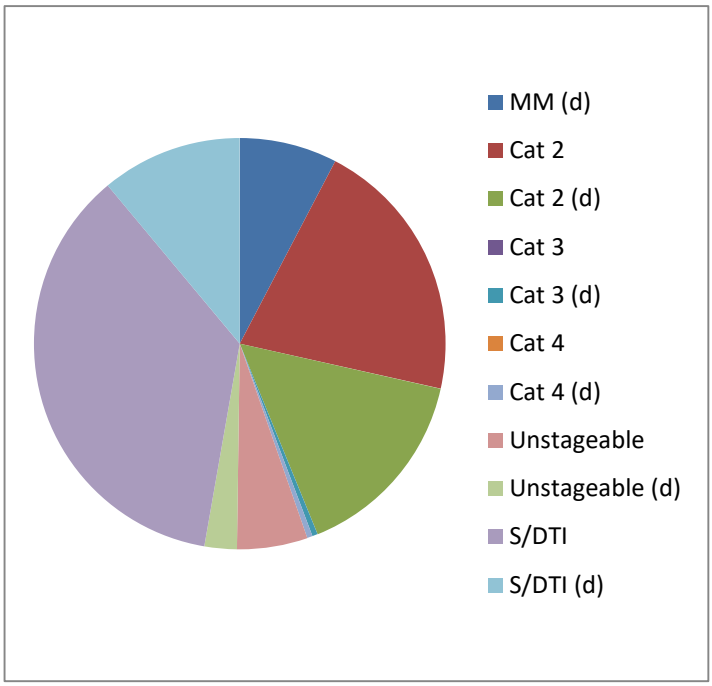
Inpatient pressure ulcers

The Trust is committed to minimising harm caused to patients whilst in hospital, particularly through the prevention of Hospital-Acquired Pressure Ulcers (HAPU) of all Categories.

In compliance with the new NHSI PU recommendations the terms Unavoidable and Avoidable are no longer used in reporting categories of pressure ulcers however, all pressures ulcers undergo a 'root cause analysis' review to capture learning. The Trust is fully compliant with the 2018 NHS Improvement measuring and reporting of PU framework including the recording and reporting of Moisture Associated Skin Damage (MASD) of all types.

	2018/19	2019/20	2020/21
Number of patients with reportable PU	101	151	235

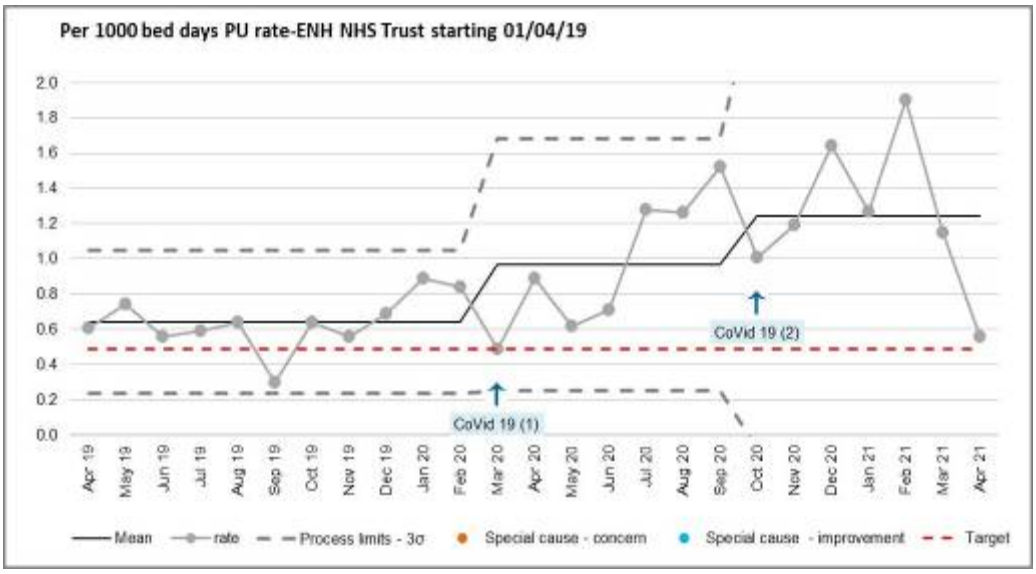
The Trust has report 235 new pressure ulcers since April 2020, the most prevalent category has been 'Category 2' tissue damage accounting for 36% (85) of total ulcers, 42% of these were associated with use of medical devise (36). Categories and prevalence can be seen in diagram below.



Category	Total PU
MM (d)	18
Cat 2	49
Cat 2 (d)	36
Cat 3	0
Cat 3 (d)	1
Cat 4	0
Cat 4 (d)	1
Unstageable	13
Unstageable (d)	6
S/DTI	85
S/DTI (d)	26
Total:	235

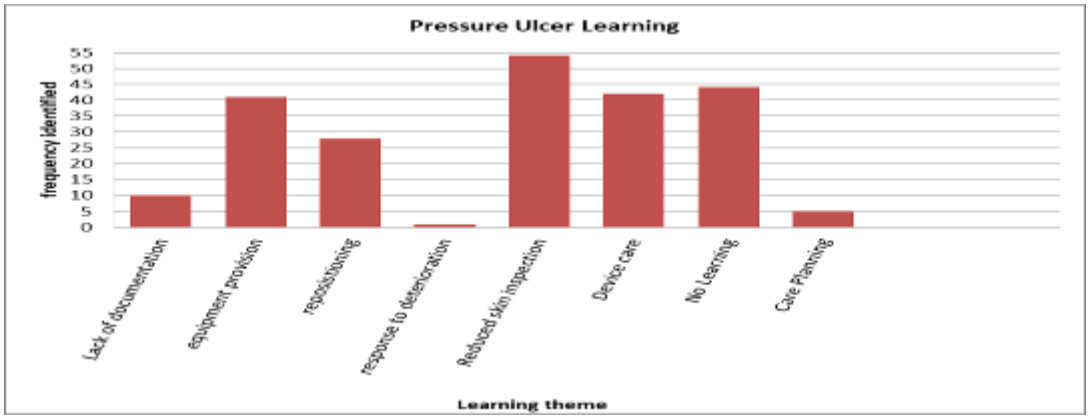
**MM = moisture membrane; DTI = deep tissue injury; (d)= medical device related*

This year we have reported 235 HAPU for 2020-2021 this is an increase of 55% from 2019 data it is likely this is partly related to the COVID 19 pandemic with 30% of PU reported (n:71/235) directly affecting patients diagnosed as COVID positive. This can be seen in the diagram below, where time series data demonstrates rate of ulcer per 1000 bed days.



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 improvements delivered. These can be seen in the diagram below.

Every HAPU identified is reported via Datix by the ward staff and validated by a Tissue Viability Clinical Nurse Specialist (TV CNS) to ensure accurate reporting and the delivery of evidenced based wound care. A Root Cause Analysis (RCA) is conducted at time of validation and themes identified are fed back to ward staff. Overall themes are reported to the Trust executive team and CCG via the monthly HAPU report. Category 4 HAPU are discussed at serious incident review panel to determine if a serious incident investigation is required. Themes this year include issues around Skin Inspection (23%), Medical Device care (18%) and equipment provision (17%). Good care could be demonstrated by nursing documentation in a further 18% and therefore no learning could be determined for these patients.



Harm Free care priority AIM

A priority is to continue to provide an infrastructure that supports recognition of clinical accurate risk assessment and early escalation to prevent the harm from Hospital Acquired skin damage occurring. Waterlow Risk assessments are audited monthly by our Clinical Nurse Advisor as part of our beds and mattress contract these audits have shown that on average 95% of patients are assessed for their risk of pressure ulceration and of this over 65% are either at High risk or Very high risk.

Through the Trust Harm free Care Collaborative, the Tissue Viability Team will work alongside the quality improvement team and apply QI methodology to drive continuous improvements. The Tissue Viability Team have identified 3 priorities for improvement work over the coming year.

1. To reduce medical device related pressure within critical care.
2. To improved repositioning care on general wards in collaboration with the clinical practice team.
3. To improve quality of SSKIN care documentation to facilitate delivery of care across the Trust.

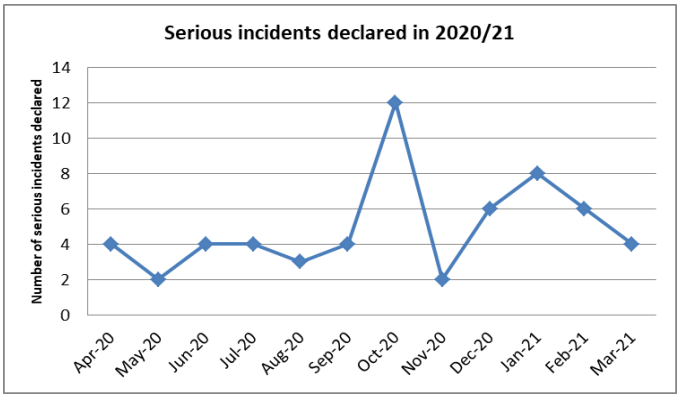
Serious incidents

When an incident occurs that might fulfil the criteria for a serious incident an initial investigation is undertaken and any immediate safety actions are identified and put into place. A short rapid incident review is completed by the relevant clinical team and discussed at the Serious Incident Review Panel that meets twice weekly, chaired by either the Chief Nurse or Medical Director. The panel consider whether any further investigation is required and, if so, what level of investigation. If the incident meets the definition as set out in the national Serious Incident Framework then a serious incident is declared and the investigation undertaken by the Patient Safety team with input from subject matter experts and relevant clinicians.

The Trust reported 59 serious incidents during the year across a wide range of categories as shown in the table below.

Category	Number	Category	Number
Care related incidents	14	Treatment incidents	3
Capacity incidents	5	Cancellations related incidents	2
Safeguarding incidents	5	Falls	2
VTE incidents	5	Infection control incidents	2
Diagnosis incidents	4	Anaesthesia related incidents	1
Resuscitation related incidents	4	Operation/theatre related incidents	1
Admissions related incidents	3	Pathology incidents	1
Discharge related incidents	3	Violence and aggression incidents	1
Obstetric incidents	3		

The graph below shows the number of serious incidents declared by month from 1 April 2020 – 31 March 2021.



Most investigations identify learning points where improvements are required. Some examples of actions completed or underway include:

- Review and update policies and guidance in accordance with any new evidence base guidance publications.
- Introduction of new additional mobile tablet devices with appropriate programme to ensure photographs can be taken of skin integrity and stored centrally as part of patient's medical records.
- Patient booking process under review to drive changes from a paper-based service to electronic with failsafe in place.
- PPCI pathway amended to include clear actions to be taken by nursing and medical staff if any concerns are highlighted pre-discharge.
- Review and design of discharge passport through adoption of QI testing tools.
- Data Quality report established for patients with no access plan.
- The focus for 2021/22 is around implementing immediate safety actions and review of SI processes to ensure a prompt investigation with appropriate learning implemented in a timely manner. We are introducing round table discussions into the SI investigation process to ensure a collaborative approach with appropriate subject matter experts from the outset and regular points along the investigation.

Clinical effectiveness

Indicator	17/18	18/19	19/20	Aim (19/20)	Aim (20/21)
Length of stay (non-elective / emergency)	3.5	4 (To Feb)	**3.78**	≤4.3	≤4.3
Stroke – thrombolysis rate	7.2%	12.3% (Feb)	**11.2%**	≥11%	≥11%
Crude mortality – rolling 12 month rate	15	12	**11**	Reduce	Reduce

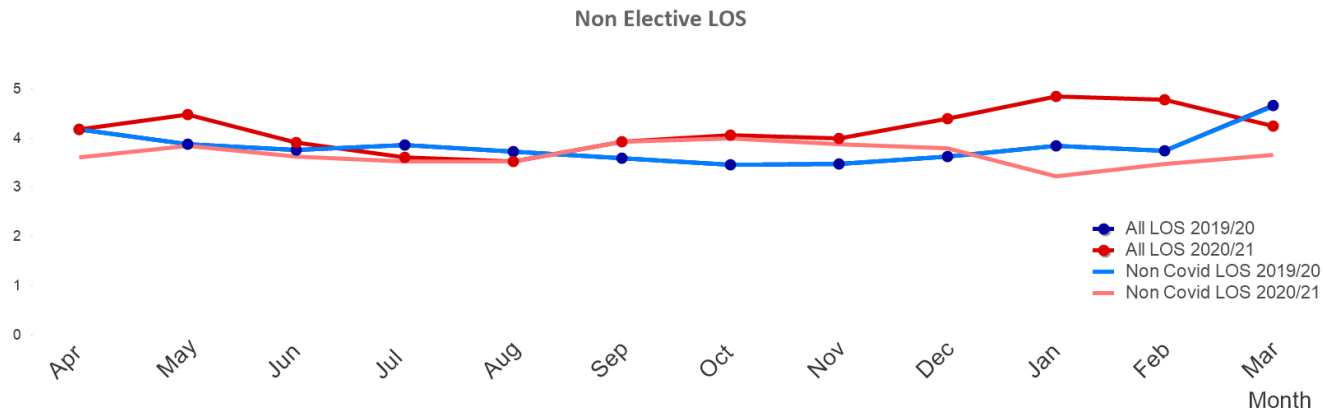
Length of stay (LOS)

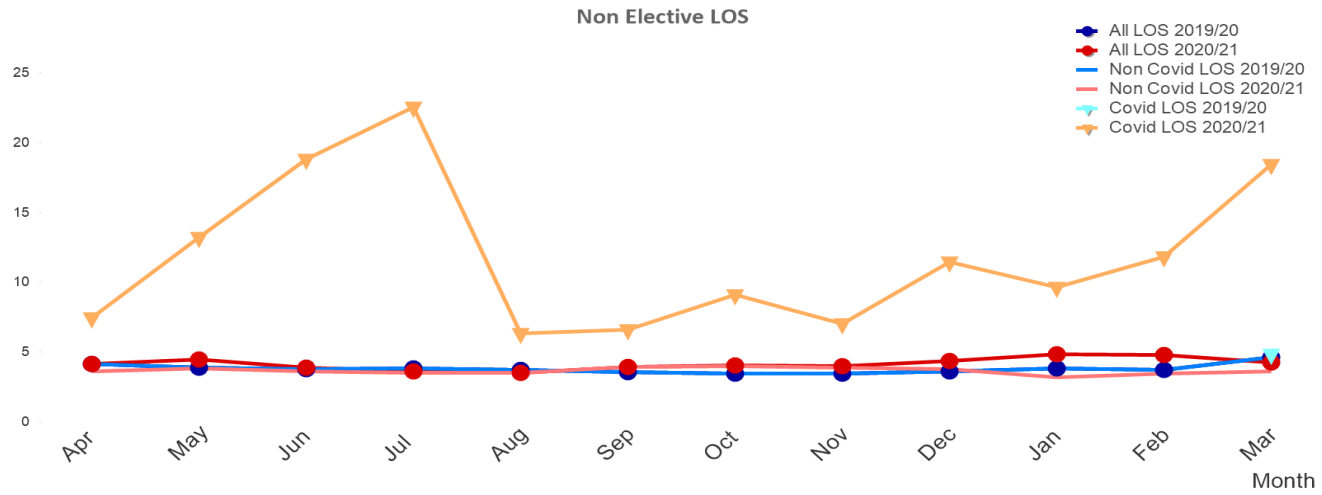
Minimising the time that a person spends in hospital is better for the patient, for the next patient currently waiting in the Emergency Department or Assessment unit and is an indicator of the efficiency and effectiveness of the organisation.

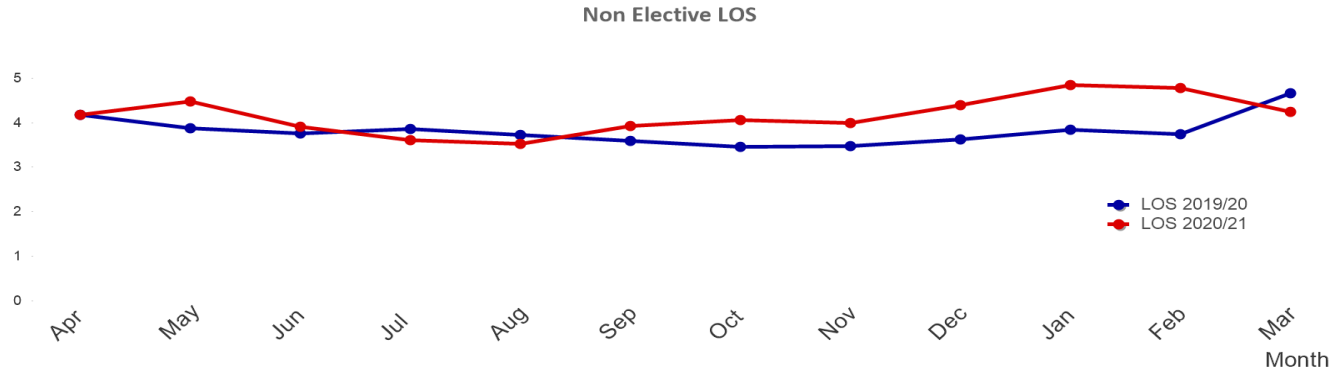
The length of the stay for both COVID and non-COVID patients is shown below demonstrating an improvement in non- COVID patients compared to the previous year with the exception of quarter 3 when the Trust experienced the impact of wave 2. The acuity of patients during this period would have been higher as other pathways and admission avoidance were in place to keep patients away from the acute Trust as well as patients not presenting either to primary care or to the Emergency Department due to the national response and lockdown. Additional support for discharge was in place including COVID virtual ward, additional community provision and system wide support during COVID. All of which have enabled improved patient flow.

The charts below show:

- All LOS and non COVID LOS
- All LOS with Covid/Non Covid LOS Splits
- Non-elective LOS







Stroke – thrombolysis rate

The Trust measures a range of stroke indicators. Providing thrombolysis (anti-clot treatment) for patients consistently when their stroke has been confirmed has been variable during the year with the aim of ≥11% being surpassed in six of the twelve months.

Metric	2020-21 Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
% of all stroke patients who receive thrombolysis	11%	14.5%	18.8%	11.4%	15.5%	9.6%	5.3%	5.7%	23.2%	11.0%	11.3%	10.6%	5.7%

A task and finish group was established in September 2020 for the thrombolysis pathway to review improvement plans for recovery of performance. This has supported an improved performance with the exception of March 2021 when the thrombolysed rate dropped to 5.7%. A review identified that this related to 4 patients of which 3 were clinical need – the patients required other treatment before thrombolysis could be safely administrated.

In light of the changes to all services due to COVID-19 both ambulance and ED triage and scanning protocols added some delays. Internal analysis of each case is to be carried out for future learning to be carried forward and to achieve the standard going forward.

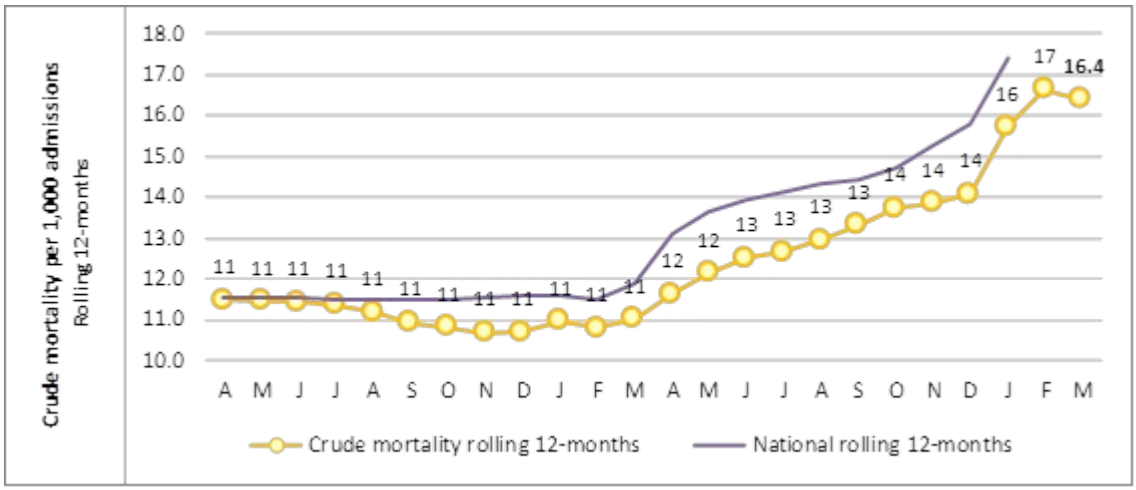
Crude mortality

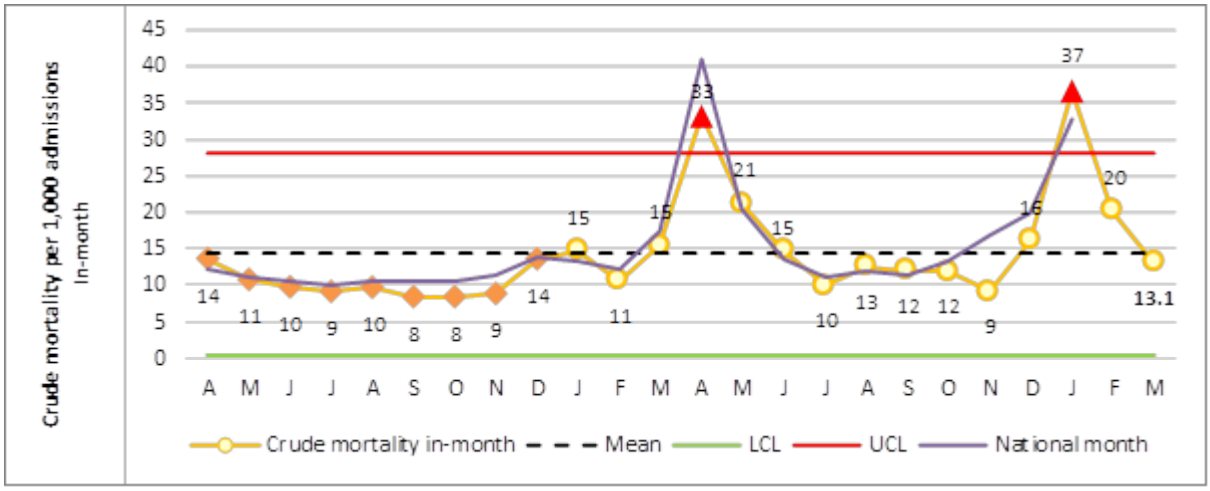
Crude mortality is based upon the number of patients who die in the Trust whilst an inpatient. It is measured per 1,000 admissions.

This measure is available the day after the month end and is the factor with the most significant impact on HSMR (see earlier section on mortality and learning from deaths).

The general improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with sepsis, stroke, etc. together with our continued drive to improve the quality of our coding.

The crude mortality has steadily improved over recent years. In the second half of 2019 our rolling 12 month crude mortality rate was consistently better than the national average. While our in-month rate increased significantly in April 2020 at the start of the peak COVID period, this steadily decreased returning to levels similar to pre-COVID period, until January 2021, when it peaked again. While recent months have seen a steady increase in our rolling 12 month rate, it has remained below the national rate for the corresponding month.





Patient experiences

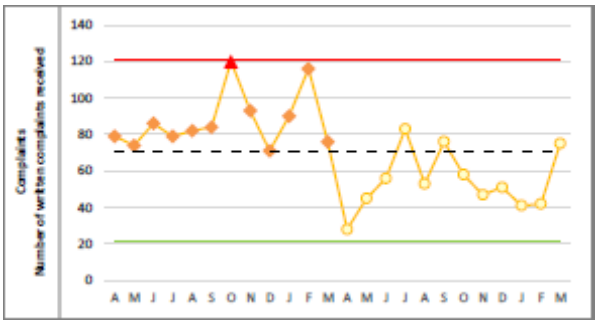
Indicator	18/19	19/20	20/21	Aim (20/21)
Number of written complaints	1036	1058	656	<previous year
Number of PALS concerns	4502	3693	2935	N/A
Number of PALS concerns closed within 5 days / %	3419 78%	2607 70.5%	2931 79.2%	80%
Complaints per level of activity - per 100 bed days	1.2-2.2	1.8	0.4	<1.9
Complaints – response within agreed timeframe	54%~	82%	89%	≥80%*

Source: Datix internal system & information held by local teams

*The Trust KPI is for 80% of formal complaints to be responded to within an agreed timeframe.

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.

In 2020/21, 656 formal complaints were received across all services (from 1058 in 2019/20) within the Trust, and 2930 informal PALS (from 3693 PALS 2019/20) concerns were received. The reduction is reflective of the pandemic.



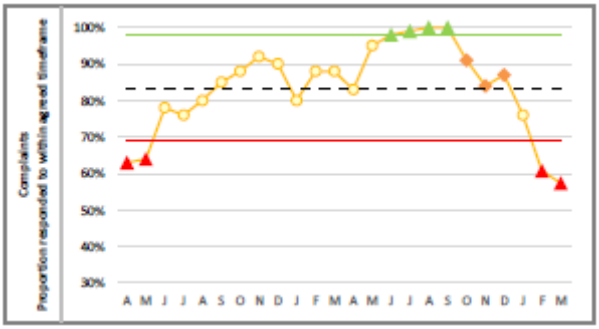
The monthly reporting pattern of the written complaints received is shown below. With the exception of July, September and March, approximately 40-50 complaints were received each month over the last year.

	Metric	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Complaints	Number of written complaints received		92	28	45	56	83	53	76	58	47	51	41	42	75
	Rate of written complaints received		1.9	0.5	0.7	0.9	1.3	0.8	1.2	0.9	0.7	0.8	0.6	0.6	1.1
	Proportion of complaints acknowledged within 3 working days		75%	100%	100%	82%	100%	100%	100%	100%	100%	100%	96%	86%	95%
	Proportion of complaints responded to within agreed timeframe		80%	83%	95%	98%	99%	100%	100%	91%	84%	87%	76%	61%	57%

The Trust aims to respond to at least 80% of formal complaints within an agreed timeframe. Current performance of responding to the patients and families is not within the expectations of the service and steps are being taken to improve this.

The Trust recognises that there were challenges in ensuring that comprehensive investigations are conducted and responded to in a timely manner and the availability of the clinical teams to support this whilst supporting the operational challenges. To address this, the complaints team are developing stronger relationships with staff across the trust to

support and review the processes. During 2021/22 we will be reviewing the complaints service in line with the new good practice standards recently published by the PHSO.



The Patient Advice Liaison Service (PALS) and the Complaint Teams received several contacts in relation to the management of appointments during the COVID Pandemic and have linked with the operations teams to be able to respond to patients.

PALS have supported relatives who are not allowed to visit patients during the pandemic by contacting the wards during busy periods and relaying messages.

Formal complaints were raised by patients in relation to the way staff communicated with them during their admission as inpatients and several patients or their relatives raised concerns regarding the quality of care provided and access to treatment. Actions have been taken locally to address these concerns including establishing a Discharge Improvement Programme.

The Trust has received complaints throughout the COVID Pandemic raised by women, their partners or MP's on maternity restrictions. During the first lockdown the Government guidance was followed that recommended women attend the maternity scans on their own. However, exceptions were made for women with a known mental health condition or if they had a carer. This was reviewed and provision was made when it was safe to do so to allow women the support of a partner during their scans. Throughout the pandemic birthing partners were still able to support women in active labour. All information in relation to the restrictions was made available on the Trust website and updated regularly. The Trust has continued to closely monitor and update the guidelines to ensure the safety of the women and their babies remains the priority. This also related to visitors in other areas where in exceptional circumstances (e.g. a vulnerable patient, end of life and dementia) and following a risk assessment a visit was facilitated.

National Cancer Survey

The Trust opted to participate in the national cancer survey, but this has not been published yet.

Staff

The following table represents some indicators relating to staff.

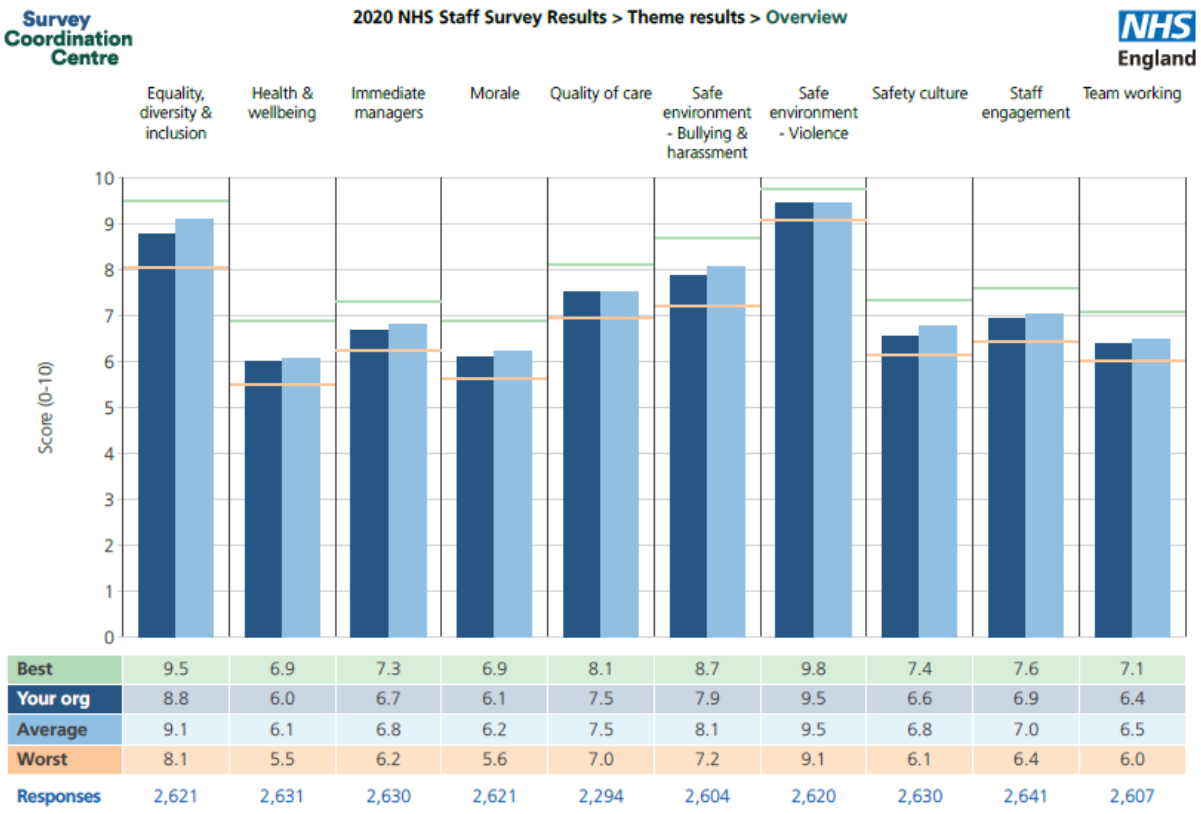
	Plan	Actual*
Permanent staff wte	6039	5656
Vacancy rate		2.63%
Turnover rate	10%	11%
Appraisal	90%	58%
Statutory / Mandatory training 100% complaint	90%	46%

*March 2021

Appraisal and statutory/mandatory training are key indicators to leadership and the support our staff are receiving from their managers. Throughout the pandemic it was recognised nationally that face to face training even for statutory/mandatory purposes could not take place. These training sessions were therefore placed on hold with incremental progression unaffected. Over the course of the year our subject matter experts supported by our capability team have converted most face to face training to on line learning events. With the development and implementation of our on line learning platform which went live in May 2021 we expect all our staff to have easier access and therefore compliance with essential learning. Recovery plans have been discussed and established within the divisions to ensure that staff are given the time to complete and update their learning following the extension to compliance last year.

National staff survey

The national staff survey was published in September 2020. 2646 staff completed the survey representing a response rate of 44%. The overall findings are shown in the chart below.



For 2021/22, we will focus on making improvements on

- Safety Culture
- Equality, Diversity and Inclusion (EDI)
- Bullying and Harassment

The survey results show a significant improvement in all areas of staff safety over the last 5 years which has led to the trust returning the same position in 2016. However, there are two key areas for improvement where we are significantly lower than the national best. These being safety in reporting concerns and confidence that action will be taken. The Freedom to Speak up process is being reviewed to support these areas being addressed.

The trends for EDI has seen our position worsen by 0.2 over the last 5 years. Unfair promotion opportunities, and discrimination from patients, carers or staff is unacceptable. While the EDI lead has made some significant changes in engaging the staff networks, additional intervention is needed to support organisation wide change. The new Equality and Inclusion Committee (subcommittee of the Board) has been introduced to provide oversight and assurance on this area.

The theme of bullying and harassment has seen very little variation over the last 5 years. As a Trust we consistently score worse in this area than the average for our sector. National toolkits for civility and respect and just culture are being considered by the Trust for implementation and will be discussed in detail at the newly formed culture group in June 2021. Similar to EDI, it is expected that initial complaints and reporting will increase. However, combined with the national toolkits to reduce tolerance and change behaviour we believe the staff survey will improve.

3.2 Performance against national requirements

National standards

The indicators in this section form part of the NHS Improvement Single Oversight Framework.

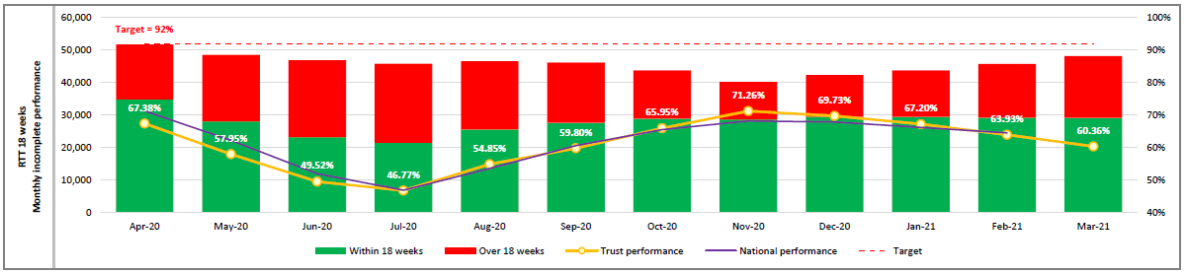
	18/19	19/20	20/21	Aim
Max 18 weeks from referral in aggregate – patients on incomplete pathways	90.3% (To Feb)	**77.4%**	60.36%	≥92%
Four hour maximum wait in A&E	81% (To Mar)	**80.2%**	Not Met 83.47%	≥95%
62-day urgent referral to treatment of all cancers	66.8% (To Jan)	**79.82% (full year)**	Met 86.13% (full) year)	≥85%
Maximum 6 week wait for diagnostic procedures	98.79% (Feb)	**99.48% (to Feb)****	Not met 33.07% (Full year)	>99%

In response to the COVID-19 pandemic, the Trust reconfigured services and wards to provide COVID-19 and Non-COVID-19 areas for patients, within the emergency department, assessment areas and across the wards. All minor injuries and illnesses were redirected to the Urgent Care Centre at the New QEII Hospital to support these reconfigurations. The Trust also increased capacity in the Critical Care Unit and worked in partnership with the independent sector to continue to treat urgent and cancer patients.

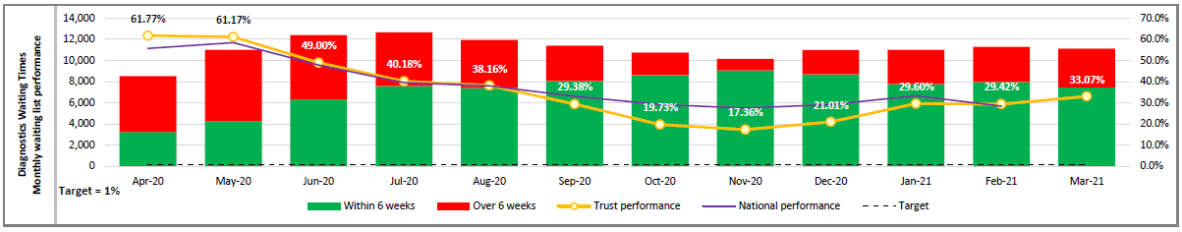
All surge capacity has been filed away or 'flatpacked' to ensure that the detailed response to COVID-19 demand and the resultant service capacity can re – emerge in response to triggers, so that the organisation remains responsive to any potential and subsequent surges.

Performance against the key operational standards should be considered in the context of the unique challenges posed by the pandemic.

18 week referral to treatment (RTT) performance was in line with the national average, though it is recognised that waiting times increased substantially as a result of the COVID-19 pandemic.



DM01 – The diagnostics performance was in line with national performance however there was a significant deterioration due to the impact of the COVID-19 pandemic.



Details of emergency department waiting standards and cancer standards have been given in earlier sections.

The focus in 2020/21 will be to recover the standards whilst maintaining access for COVID-19 patients.

Freedom to Speak Up / Raise Concerns

The Trust is committed to achieving the highest possible standards of quality, openness and accountability in all its practices. To achieve these, the Trust is committed to supporting any members of staff who are worried about any areas of poor practice, attitudes or inappropriate behaviour within our organisation. We believe in promoting a departmental culture which encourages open communication between staff and managers to ensure that questions and concerns can be raised and, resolved quickly.

The Trust positivity encourages its staff to report any concerns they may have as well as provide advice and guidance. We have several ways in which our staff can raise a concern:

- Via our Freedom to Speak Up Guardian or our NED Whistleblowing Guardian
- Via the Speak in Confidence Service.
- Through the Employee Relations Advisory Service.
- The Chief Executive or any Executive Director
- The Deputy Director for Nursing or Workforce and OD
- Raising a concern on Datix incident reporting system

Concerns can be raised in person, by telephone or in writing (including by email).

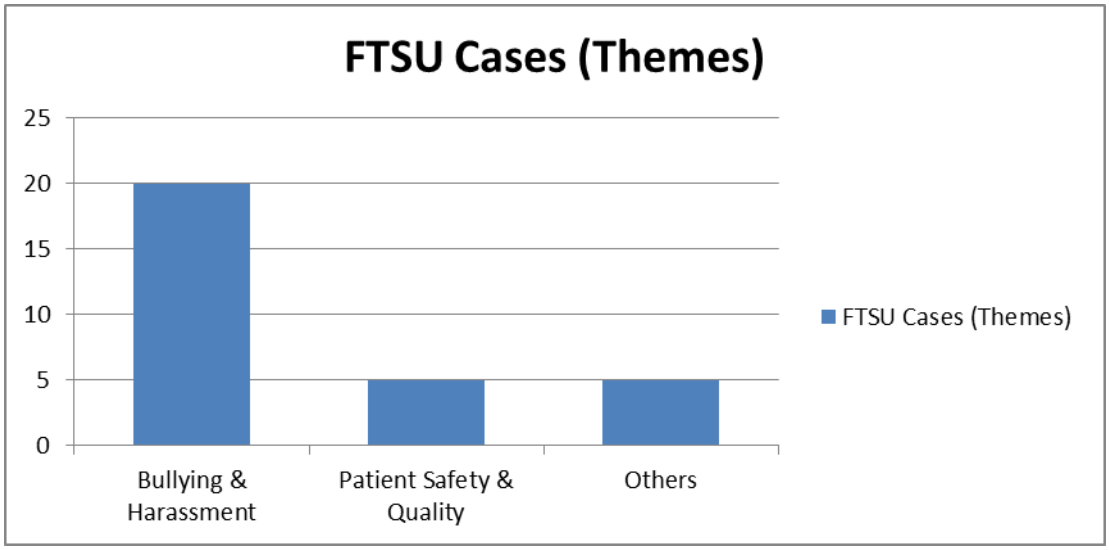
Our Commitment to our staff is:

- ‘Speak up and we will listen’. We will agree any next steps together
- To fully explore concerns in a timely, impartial and confidential manner
- To listen, investigate and feedback
- To take action to address any concerns upheld
- To ensure that there is no detriment or repercussions as a result of raising concerns

The focus of any investigation is on improving the service we provide for our patients and the working environment for our staff. Where improvements can be made, we track them to ensure necessary changes are made, and are working effectively. Feedback is given to the individual raising the concern; although this is not always possible when the concern is raised anonymously.

With reference to the FTSU cases raised across 2020/21, while overall numbers remain consistent, bullying and harassment has been the most frequent theme as illustrated by the chart below. This data is supported by recent staff survey results (2020) which showed

marginal improvement but still demonstrate bullying & harassment as an issue. Whilst it is encouraging that our colleagues are speaking up we are still a long way off seeing speaking up becoming business as usual. To improve this position the FTSU agenda will now be shared between the nursing and people directorates with identified support available within each to promote the need and change culture to support reporting.



Rota gaps

Gaps to rotas of doctors and dentists in training are monitored on a monthly basis. The table below shows the total average number of rota gaps per quarter in the financial year April 2020 to end March 2021 year. This shows a much improved position to the previous year

April-June	July-Sept	Oct-Dec	Jan-March
Data not available Junior Doctors on Emergency rotas due to COVID-19	16.67 (33.33 in 2019/20)	8.0 (30.67 in 2019/20	8.33

Actions continue to be taken to improve vacancies:

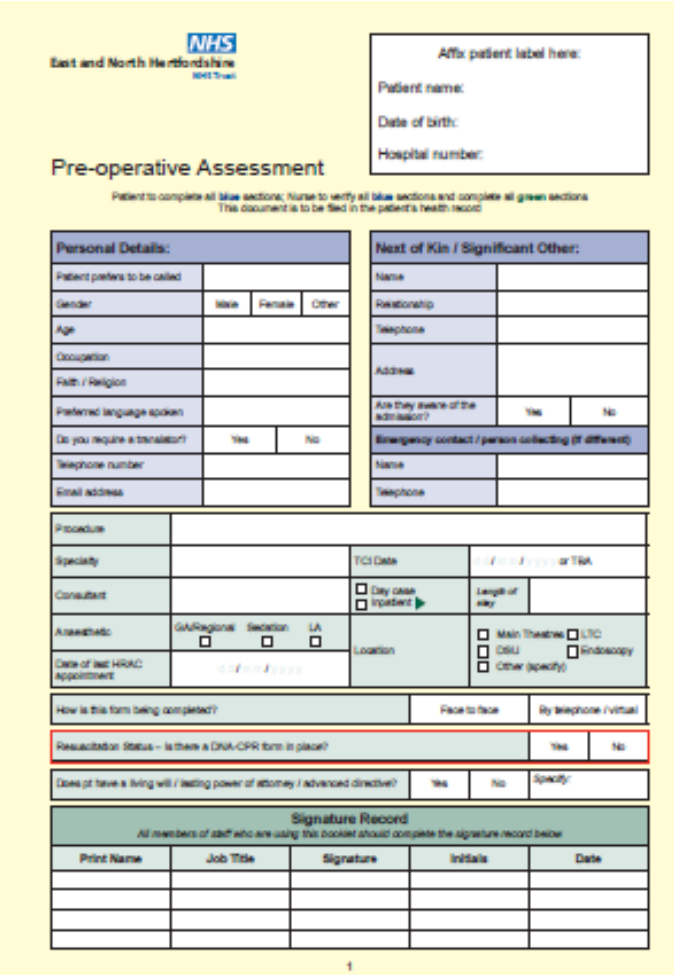
Direct

- Recruitment of Trust Grade, Clinical Fellows in temporary posts
- Recruitment of other training grades (e.g. MTI – medical training initiative for foreign doctors)
- Recruitment of temporary Locums to cover gaps and provide the clinical service

Indirect

- Improve or enhance training posts to make posts more attractive to schools
- Reconfiguration of rotas to allow for fewer trainees

Annex 1 NATSSIP documentation



East and North Hertfordshire NHS

Affix patient label here:

Patient name:

Date of birth:

Hospital number:

Pre-operative Assessment

Patient to complete all blue sections; Nurse to verify all blue sections and complete all green sections
This document is to be filed in the patient's health record

Personal Details:			
Patient prefers to be called			
Gender	Male	Female	Other
Age			
Occupation			
Faith / Religion			
Preferred language spoken			
Do you require a translator?	Yes	No	
Telephone number			
Email address			

Next of Kin / Significant Other:		
Name		
Relationship		
Telephone		
Address		
Are they aware of the admission?	Yes	No
Emergency contact / person collecting (if different)		
Name		
Telephone		

Procedure			
Specialty		TCI Date	or TBA
Consultant		Day case / Inpatient	Length of stay
Anaesthetic	GA/Regional / Sedation / LA	Location	Main Theatres / LTC / DSU / Endoscopy / Other (specify)
Date of last HRAC appointment			

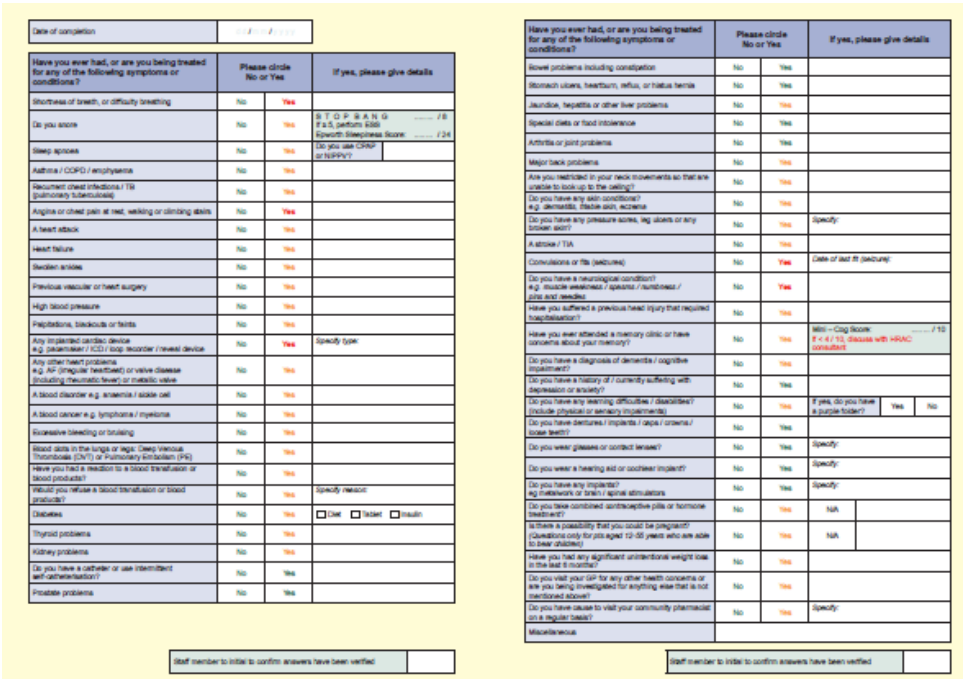
How is this form being completed?	Face to face	By telephone / virtual	
Resuscitation Status – is there a DNA-CPR form in place?		Yes	No
Does pt have a living will / lasting power of attorney / advanced directive?	Yes	No	Specify:

Signature Record

All members of staff who are using this booklet should complete the signature record below

Print Name	Job Title	Signature	Initials	Date

1



Date of completion: / /

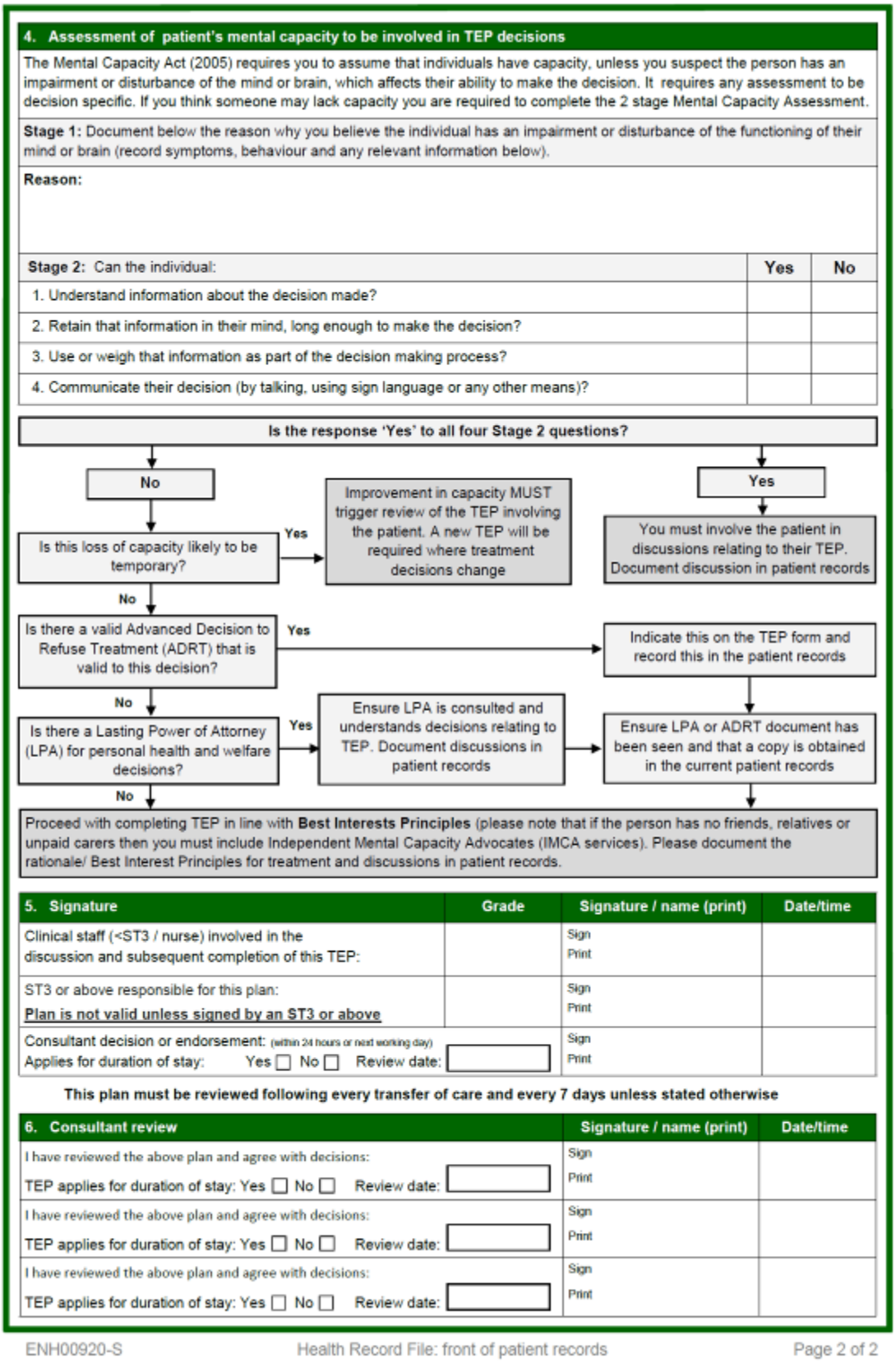
Have you ever had, or are you being treated for any of the following symptoms or conditions?	Please circle No or Yes		If yes, please give details
Shortness of breath, or difficulty breathing	No	Yes	
Do you snore	No	Yes	STOP BANG ...../8 If ≥3, perform ABG. Epworth Sleepiness Score: ...../24
Sleep apnoea	No	Yes	Do you use CPAP or NIPPV?
Asthma / COPD / emphysema	No	Yes	
Recurrent chest infections / TB (pulmonary tuberculosis)	No	Yes	
Angina or chest pain at rest, walking or climbing stairs	No	Yes	
A heart attack	No	Yes	
Heart failure	No	Yes	
Swollen ankles	No	Yes	
Previous vascular or heart surgery	No	Yes	
High blood pressure	No	Yes	
Palpitations, blackouts or faints	No	Yes	
Any implanted cardiac device e.g. pacemaker / ICD / loop recorder / reveal device	No	Yes	Specify type:
Any other heart problems e.g. AF (irregular heartbeat) or valve disease (including rheumatic fever) or metallic valve	No	Yes	
A blood disorder e.g. anaemia / sickle cell	No	Yes	
A blood cancer e.g. lymphoma / myeloma	No	Yes	
Excessive bleeding or bruising	No	Yes	
Blood clots in the lungs or legs: Deep Venous Thrombosis (DVT) or Pulmonary Embolism (PE)	No	Yes	
Have you had a reaction to a blood transfusion or blood products?	No	Yes	
Would you refuse a blood transfusion or blood products?	No	Yes	Specify reason:
Diabetes	No	Yes	Diet / Tablet / Insulin
Thyroid problems	No	Yes	
Kidney problems	No	Yes	
Do you have a catheter or use intermittent self-catheterisation?	No	Yes	
Prostate problems	No	Yes	

Staff member to initial to confirm answers have been verified

Have you ever had, or are you being treated for any of the following symptoms or conditions?	Please circle No or Yes		If yes, please give details
Bowel problems including constipation	No	Yes	
Stomach ulcers, heartburn, reflux, or hiatus hernia	No	Yes	
Jaundice, hepatitis or other liver problems	No	Yes	
Special diets or food intolerance	No	Yes	
Arthritis or joint problems	No	Yes	
Major back problems	No	Yes	
Are you restricted in your neck movements so that are unable to look up to the ceiling?	No	Yes	
Do you have any skin conditions? e.g. dermatitis, fragile skin, eczema	No	Yes	
Do you have any pressure sores, eg ulcers or any broken skin?	No	Yes	Specify:
A stroke / TIA	No	Yes	
Convulsions or fits (seizures)	No	Yes	Date of last fit (seizure):
Do you have a neurological condition? e.g. muscle weakness / spasms / numbness / pins and needles	No	Yes	
Have you suffered a previous head injury that required hospitalisation?	No	Yes	
Have you ever attended a memory clinic or have concerns about your memory?	No	Yes	Mini – Cog Score: ...../10 If < 4 / 10, discuss with HRAC consultant
Do you have a diagnosis of dementia / cognitive impairment?	No	Yes	
Do you have a history of / currently suffering with depression or anxiety?	No	Yes	
Do you have any learning difficulties / disabilities? (include physical or sensory impairments)	No	Yes	If yes, do you have a purple folder? Yes / No
Do you have dentures / implants / caps / crowns / loose teeth?	No	Yes	
Do you wear glasses or contact lenses?	No	Yes	Specify:
Do you wear a hearing aid or cochlear implant?	No	Yes	Specify:
Do you have any implants? eg metalwork or brain / spinal stimulators	No	Yes	Specify:
Do you take combined contraceptive pills or hormone treatment?	No	Yes	NA
Is there a possibility that you could be pregnant? (Questions only for pts aged 12-55 years who are able to bear children)	No	Yes	NA
Have you had any significant unintentional weight loss in the last 6 months?	No	Yes	
Do you visit your GP for any other health concerns or are you being investigated for anything else that is not mentioned above?	No	Yes	
Do you have cause to visit your community pharmacist on a regular basis?	No	Yes	Specify:
Miscellaneous			

Staff member to initial to confirm answers have been verified

Annex 2
New revised Personalised treatment plan 2020/21



4. Assessment of patient's mental capacity to be involved in TEP decisions

The Mental Capacity Act (2005) requires you to assume that individuals have capacity, unless you suspect the person has an impairment or disturbance of the mind or brain, which affects their ability to make the decision. It requires any assessment to be decision specific. If you think someone may lack capacity you are required to complete the 2 stage Mental Capacity Assessment.

Stage 1: Document below the reason why you believe the individual has an impairment or disturbance of the functioning of their mind or brain (record symptoms, behaviour and any relevant information below).

Reason:

Stage 2: Can the individual:	**Yes**	**No**
1. Understand information about the decision made?		
2. Retain that information in their mind, long enough to make the decision?		
3. Use or weigh that information as part of the decision making process?		
4. Communicate their decision (by talking, using sign language or any other means)?		

Is the response 'Yes' to all four Stage 2 questions?

No

Is this loss of capacity likely to be temporary?

Yes → Improvement in capacity MUST trigger review of the TEP involving the patient. A new TEP will be required where treatment decisions change

No

Is there a valid Advanced Decision to Refuse Treatment (ADRT) that is valid to this decision?

Yes → Indicate this on the TEP form and record this in the patient records

No

Is there a Lasting Power of Attorney (LPA) for personal health and welfare decisions?

Yes → Ensure LPA is consulted and understands decisions relating to TEP. Document discussions in patient records → Ensure LPA or ADRT document has been seen and that a copy is obtained in the current patient records

No

Proceed with completing TEP in line with **Best Interests Principles** (please note that if the person has no friends, relatives or unpaid carers then you must include Independent Mental Capacity Advocates (IMCA services). Please document the rationale/ Best Interest Principles for treatment and discussions in patient records.

Yes

You must involve the patient in discussions relating to their TEP. Document discussion in patient records

5. Signature	**Grade**	**Signature / name (print)**	**Date/time**
Clinical staff (<ST3 / nurse) involved in the discussion and subsequent completion of this TEP:		Sign Print	
ST3 or above responsible for this plan: Plan is not valid unless signed by an ST3 or above		Sign Print	
Consultant decision or endorsement: (within 24 hours or next working day) Applies for duration of stay: Yes ☐ No ☐ Review date:		Sign Print	

This plan must be reviewed following every transfer of care and every 7 days unless stated otherwise

6. Consultant review	**Signature / name (print)**	**Date/time**
I have reviewed the above plan and agree with decisions: TEP applies for duration of stay: Yes ☐ No ☐ Review date:	Sign Print	
I have reviewed the above plan and agree with decisions: TEP applies for duration of stay: Yes ☐ No ☐ Review date:	Sign Print	
I have reviewed the above plan and agree with decisions: TEP applies for duration of stay: Yes ☐ No ☐ Review date:	Sign Print	

ENH00920-S Health Record File: front of patient records Page 2 of 2

Annex 3 Research and development

Some of the 2020/21 research highlights:

ISARIC Clinical Characterisation Protocol (UKCCP) for Severe Emerging Infection - tier 0 (RD2020-15) Local lead Prof Natalie Pattison. Rapid, coordinated clinical investigation of patients with confirmed novel coronavirus infection - involving data only. Opened 12th March 2020, recruited 632 patients.

RECOVERY trial - Randomised Evaluation of COVID-19 Therapy (R&D2020-18)
Local lead Dr Pietro Ferranti. Randomised controlled trial to assess suggested treatments. Opened 7th April 2020, recruited 83 patients.

RECOVERY-RS Respiratory Support (R&D2020-23) Local lead Dr Alison McMillan. Comparison of ventilation methods: Continuous positive airway pressure, High flow nasal oxygen or Standard care. Opened 11th May 2020, recruited 4 patients.

GenOMICC (R&D2020-22) Local lead Prof Natalie Pattison. Study to identify the specific genes that cause some people to be susceptible to specific infections / severe injury. Opened 30th April 2020, recruited 63 patients.

MERMAIDS (R&D2020-26) Local lead is Carina Cru.z EuRopean study of MAjor Infectious Disease Syndromes (MERMAIDS): Acute Respiratory Infections in Adults? Opened 24th July 2020, recruited 8 patients.

RIC in COVID-19 (R&D2020-24) Local lead is Prof Diana Gorog. Can remote ischaemic conditioning reduce inflammatory markers in COVID-19 patients? Opened 14th July 2020, recruited 2 patients

CLARITY (R&D2020-48) Dr Johanne Brooks. ImpaCt of bioLogic therApy on saRs-cov-2 Infection and immuniTY. Opened 26th Oct 2020, recruited 81 patients.

Pregnancy and Neonatal Outcomes in COVID-19 (R&D2020-51) Local lead is Dr Rabia Zilll-e-Huma.
To better understand how COVID-19 affects early pregnancy, fetal growth, prematurity and virus transmission to the baby. Opened 01/12/2020 Recruited 31 patients

HICC (R&D2021-08) Local Lead Dr Alex Wilkinson. Investigating and characterising primary and secondary immunodeficiency. Opened 23/02/2021 Recruited 5 patients.

CoV-2 antibody (RD2021-15) Local Lead is Dr Enric Vilar. SARS CoV-2 antibody responses in immunocompromised patients. Opened 4th March 2021, recruited 51 patients.

UKOSS Pandemic Influenza in Pregnancy (adapted for COVID19) Local lead is Dr Rabia Zilll-e-Huma.
Study about all pregnant women admitted to hospital who are COVID-19 confirmed. Opened 1st May 2020 recruited 31 patients.

Annex 3 Statements from stakeholders

NHS
East and North Hertfordshire
Clinical Commissioning Group

East and North Herts Clinical Commissioning Group's response to the Quality Account provided by East and North Hertfordshire Hospitals NHS Trust

East and North Hertfordshire Clinical Commissioning Group (ENHCCG) welcomes the opportunity to provide this statement for East and North Hertfordshire Hospitals NHS Trust (ENHT).

2020/21 was significantly affected by the Covid-19 pandemic, and all organisations across our healthcare system have pulled together to redesign services and deliver safe care to our patients. Additionally, processes have been adapted and developed to ensure that families can communicate with their loved ones and remain updated in relation to their care. The CCG recognises the work of the Trust and thank all of their staff and volunteers for their efforts during this incredibly challenging time.

The information provided within this account presents a balanced report of the quality of healthcare services that ENHT provides and is, to the best of our knowledge, accurate and fairly interpreted, is easy to read and well set out. The Quality Account clearly evidences the improvements made and highlights innovation achieved in 2020/21 despite the Covid-19 pandemic; and recognises where further improvements are needed.

During the course of 2020/21 ENHCCG have worked closely with ENHT, meeting regularly to review quality and safety, including risks relating to the pandemic. Due to the pandemic the CCG has been unable to undertake Quality Assurance Visits because of the risks of Covid-19 transmission.

Following the Care Quality Commission's (CQC) inspection in 2019, the Trust's rating has remained as 'Requires Improvement'. The Trust had a number of CQC Transitional Monitoring Approach reviews during 2020/21 which were positively received. The Trust continue to focus on their CQC Improvement Plan and progress is regularly reported to the CCG as well as Trust Board and CQC.

During 2020/21 ENHT has had mixed results in relation to quality, patient safety and patient experience. The CCG is pleased to see the progress in relation to Quality Improvement and looks forward to seeing improved patient outcomes as a result of the Quality Improvement initiatives being undertaken. This is particularly key in relation to recognition of deteriorating patients and Harm Free Care. The CCG remains concerned regarding the limited progress in relation to compliance with the sepsis six care bundle, including the timely administration of antibiotics, and venous thromboembolism (VTE) risk assessment. An improvement over the coming year is required.

Recognising that there have sadly been a high number of Covid-19 related deaths across the country including ENHT, it is positive that non-Covid-19 mortality rates have remained stable overall and SHMI data was in the 'lower than expected' range up to November 2020. Where any outliers are identified the Trust has worked pro-actively to identify any improvements required.

During 2020/21 the Trust reported 3 Never Events; this is the same as the previous year. ENHCCG are pleased to note the ongoing improvement work as a result of identified

NHS
East and North Hertfordshire
Clinical Commissioning Group

learning and would expect to see a further reduction in Never Events occurring in 2021/22. We will continue to seek assurance that learning has been identified, and that relevant actions and improvements are being implemented to prevent reoccurrence.

Following the identification of a significant backlog of discharge summaries that had not been sent to primary care during 2018/19, the CCG recognises the continued focus that the Trust has had in relation to strengthening processes, improving the timeliness and quality of discharge summaries, and the improvements made to reduce the backlog. The CCG expects this to be an ongoing focus for 2021/22 and would like to see an additional focus on the timeliness of clinic letters sent to primary care.

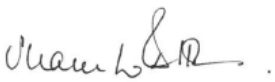
Cancer performance was sustained over the course of 2020/21. The 62 day cancer target was achieved for all except two months, and the year-end position showed compliance with six of the eight cancer standards. The CCG is pleased to see the improvements continue to be made and would now like to see the Trust build on this in order to consistently deliver all 8 of the key cancer standards.

The 2020 annual staff survey results have shown mixed results; there have been improvements relating to staff safety, and there are several questions that have shown improvement compared with the previous year. However, overall the Trust remains below the national average in a number of areas, and results relating to reporting concerns and having these addressed, and bullying and harassment are disappointing. This does need to be an area of focus for the Trust over the coming year.

The CCG supports the Trust's 2021/22 quality priorities and is pleased to see that improving care of deteriorating patients, compliance with the sepsis pathway and improvements in compliance with VTE risk assessments are priority areas for the Trust.

Additionally, ENHCCG wishes to see ongoing improvement in the timeliness and quality of discharge summaries as well as an ongoing focus on staff wellbeing and improvement in the staff survey results. The CCG looks forward to receiving progress updates on other key areas of work such as the Trust's Medicine Optimisation Strategy.

We look forward to working with and supporting ENHT in developing new ways of working in light of the Covid-19 pandemic, as well as the ongoing development of the Integrated Care System and Integrated Care Providers, in order to provide high quality services for our patients. We hope the Trust finds these comments helpful and we look forward to continuous improvement in 2021/22.



Sharn Elton
Managing Director
East and North Hertfordshire Clinical Commissioning Group
June 2021

Healthwatch Hertfordshire values the relationship with East and North Hertfordshire NHS Trust and looks forward to continuing to work closely with the Trust to help improve services for patients including supporting the quality priorities outlined in this Quality Account.

Steve Palmer, Chair Healthwatch Hertfordshire, May 2021

Quality Account 2021

2020 / 2021 has required all of us to adapt our ways of working. On behalf of the Hertfordshire Health Scrutiny Committee I would like to thank the East & North Hospital Trust for the services it continued to deliver during the pandemic and its response in recovery. We are aware of the challenges facing the NHS and will seek to continue working constructively with the trust.

Members of the committee have been appreciative of the support the East & North Hospital Trust has provided during this challenging period. The contribution from the trust has enabled the committee to maintain its overview of the health system in Hertfordshire. It enabled all our scrutiny members to hear about the impact on services and how it was seeking to address on-going needs and additional pressures. The East & North Hospital Trust has participated in committee meetings in December 2020 and March 2021; and contributed a briefing for members on hospital visiting during the pandemic (November 2020). The chief executive meet with the new HSC chairman and provided a very thorough overview of the impact of covid, challenges faced by the trust and future developments.

Despite the demands of the pandemic there has also been regular communication between the Health Scrutiny Committee, Scrutiny Officers and the East & North Hospital Trust over the last 12 months. The trust has supported the scrutiny process when approached and the Committee look forward to working with the East & North Hospital Trust in the future.

Yours sincerely

Dee Hart
Chairman Hertfordshire Health Scrutiny Committee

Annex 4 Statement of directors' responsibilities

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011, 2012, 2017 and 2020).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

29.06.21 Date ..... Chair

29.06.21 Date ..... Chief Executive

East and North Hertfordshire NHS Trust

Agenda Item: 15

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021
Learning from Deaths Report

Purpose of report and executive summary (250 words max):		
Reducing mortality is one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.		
Action required: For discussion		
Previously considered by: **Mortality Surveillance Committee 9 June 2021** **QSC – 29 June 2021**		
Director: **Medical Director**	**Presented by:** **Medical Director**	**Author:** **Mortality Improvement Lead**

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

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **No**
Any other risk issues (quality, safety, financial, HR, legal, equality): **Detailed on page 1 of report**

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

SECTION 1: LEARNING FROM DEATHS REPORT SUMMARY

1.1 Introduction

Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust. It also incorporates information and data mandated under the National Learning from Deaths Programme.

The report has been approved by the Mortality Surveillance Committee.

The transition from Dr Foster to CHKS as a reporting source has now been completed. It should be noted that the CHKS figures cannot be compared with past data from Dr Foster, however the trends should be similar in both sets of data.

Further information on the key metrics, developments and current risks summarised on this page can be found in Sections 2 and 3, together with Appendix 1.

1.2 Key metrics

Table 1 below provides headline information on the Trust's current mortality performance.

Metric	Result
Crude mortality	Crude mortality is 1.51% for the 12 month period to April 2021 compared to 1.25% for the latest 3 years.
HSMR: (data period Mar20 – Feb21)	HSMR for the 12 month period is **82.92, 'First quartile'.**
SHMI: (data period Dec19 – Nov20)	Headline SHMI for the 12 month period is **88.28 'lower than expected band 3'. One of only 13 Trusts of 124 in top band.**
HSMR – Peer comparison	ENHT is ranked 2nd (out of 9) within the Model Hospital list* of peers.

* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital, rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

1.3 Headlines

- COVID-19 update
- HSMR has remained stable and is in the first quartile nationally
- SHMI is stable and remains in the 'better than expected' Band 3
- Medical Examiners – following the initial pilot full roll-out of the service began in May
- Mortality Review Tool/Datix iCloud: development work continues
- Regular on-going mortality monitoring via Mortality Surveillance Committee, Quality and Safety Committee and Board.

1.4 Current risks

Table 2 below summaries key risks identified:

Risks	Report ref (Mitigation)
COVID-19	2.1
Fractured Neck of Femur mortality	2.4.2
Stroke mortality	2.4.2
7 day service	2.6.1
Care bundles	2.6.2
Medical Examiner Introduction	2.6.3
Mortality Review – need for content/IT development	3.1
Mortality module incorporation onto Datix iCloud platform	3.1
Severe Mental Illness – Identification/flagging of patients	3.2.3

SECTION 2: MORTALITY PERFORMANCE

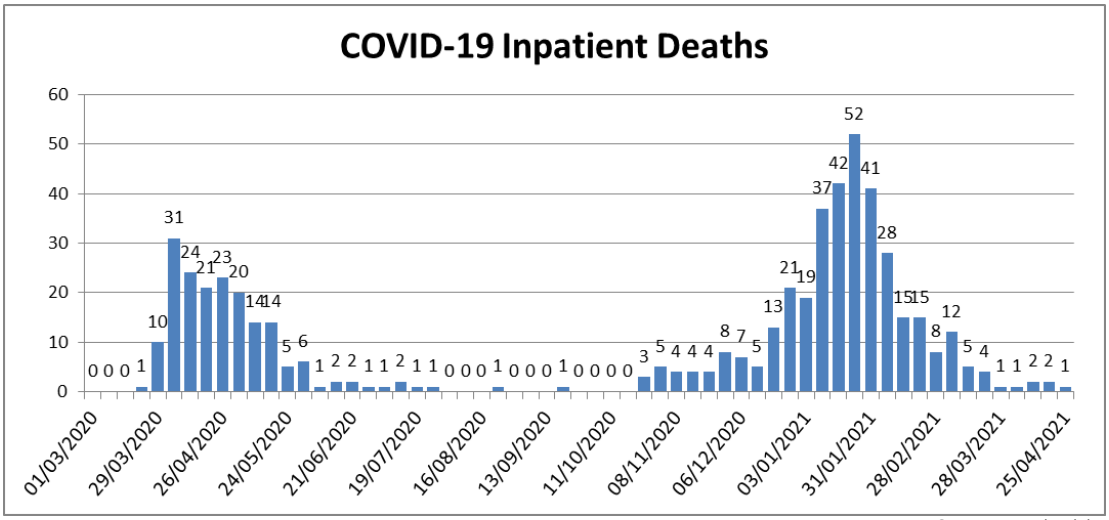
2.1 COVID-19 Update

2.1.1 COVID-19 mortality data

2.1.1.1 COVID in-patient deaths

The first COVID-19 death reported in the Trust occurred on 19 March 2020. Figure 1 shows subsequent deaths by week up to 30 April 2021. The dates shown are 'week-ending' dates. This chart shows our first local peak occurred week ending 5 April 2020. There has been far more deaths in the second wave, with the second peak occurring in week ending 24 January 2021. Please note with improved testing data available and any COVID-19 related deaths being included, the figures reported below are slightly higher than in previous reports.

Figure 1: Trust COVID-19 Inpatient deaths – 01/03/2020 to 30/04/2021 by Week



Source: ENHT local data

The multi-layered effects of the COVID-19 pandemic will make meaningful analysis and comparisons regarding mortality data challenging. To date our local data has shown the following trends.

There were 541 COVID-19 Inpatient deaths at the trust from 01 March 2020 to 30 April 2021. This figure includes both patients who tested positive for COVID-19 and patients who had a clinical assessment of COVID-19.

2.1.1.2 COVID in-patient analysis

Figure 2 shows that the proportion of deaths by gender has again changed with 38%/62% female/male compared to 34%/66% in the previous report, showing a continued increase in the proportion of female deaths in the recent months.

Figure 3 shows that our local findings regarding those patients worst impacted by the virus are broadly in line with nationally reported outcomes, namely; the elderly are worst hit and deaths are gradually affecting the younger age groups more than at the start of the pandemic.

Fig 2: COVID-19 Inpatient deaths (01/03/20-30/04/21) by Gender

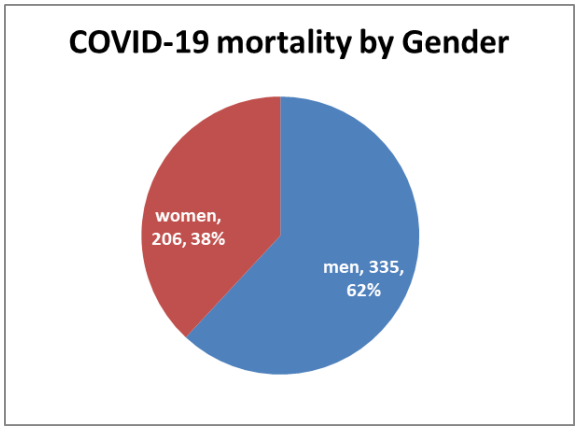
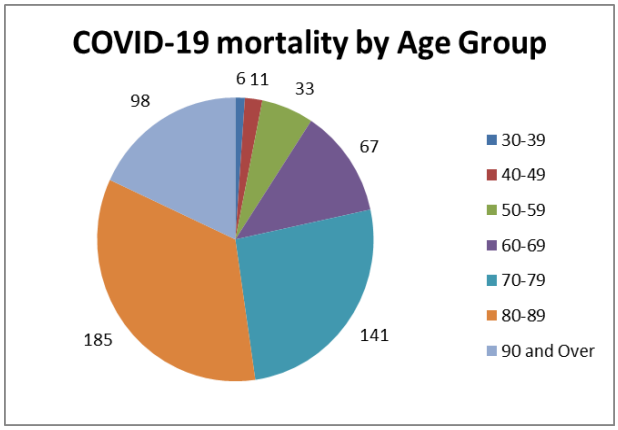


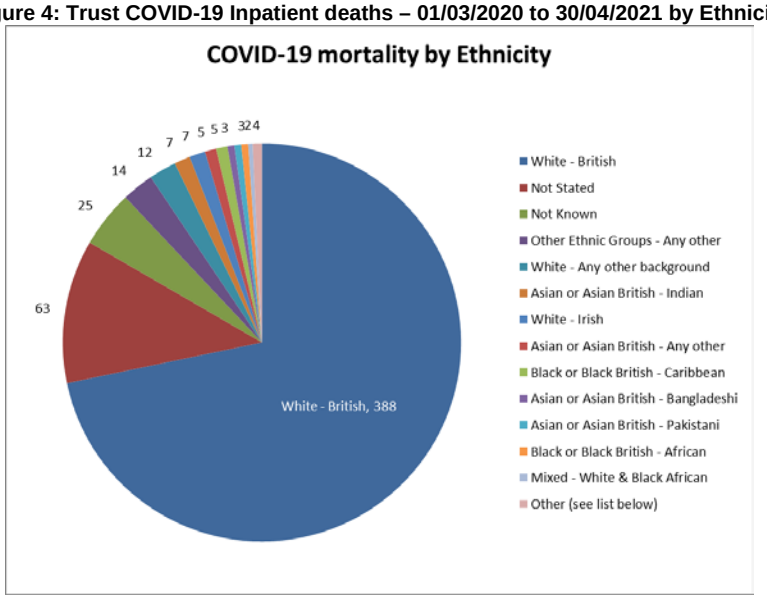
Fig 3: COVID-19 Inpatient deaths (01/03/20-30/04/21) by Age



Source: ENHT local data

Figure 4 does not demonstrate a bias towards the BAME population, but this may be a reflection of the demographics of the Hertfordshire region.

Figure 4: Trust COVID-19 Inpatient deaths – 01/03/2020 to 30/04/2021 by Ethnicity



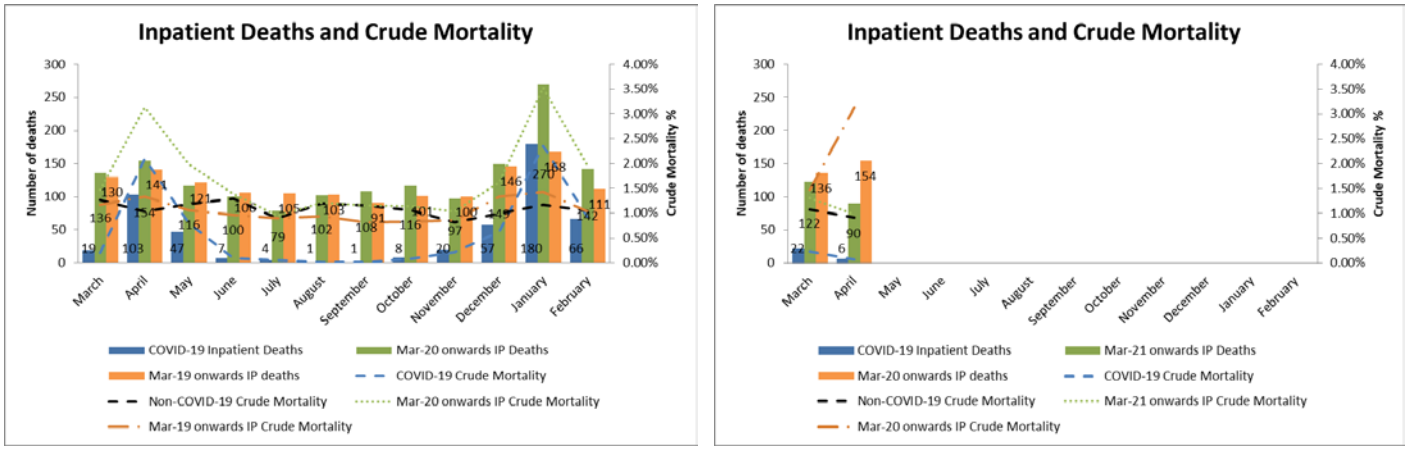
Source: ENHT local data

Note, the 4 deaths in "Other (see list below)" in Figure 5, are Black or Black British - Any other, Mixed - Any other mixed background, Mixed - White & Asian, Other Ethnic Groups – Chinese.

2.1.1.3 COVID in-patient deaths and crude mortality

Figure 5 below shows COVID-19 deaths relative to total Trust in-patient deaths, with a comparison to last year's data. It also indicates the associated crude mortality rates. The number of monthly COVID-19 deaths has been reducing since the peak in January 2021. The number of deaths in March 2021 is slightly lower than March 2020, but the direction of travel is different to that of 2020. The number of deaths in April 2021 is much lower than those in March 2020 and this is also reflected in the downward direction of the crude mortality rates.

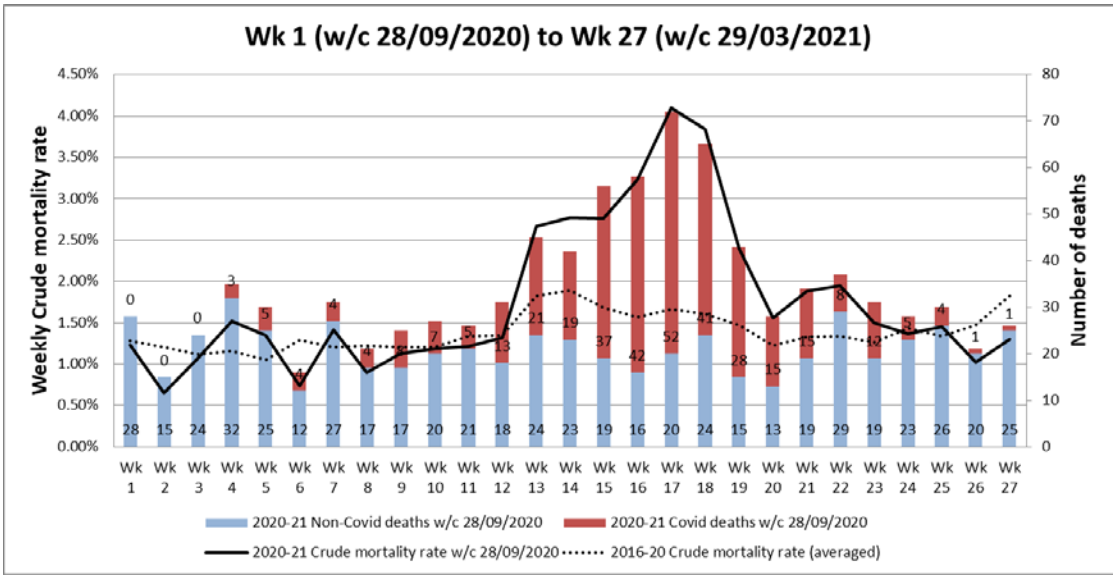
Figure 5: Trust COVID-19 Inpatient deaths – 01/03/2020 to 30/04/2021 by Month



Please note that the COVID-19 Crude Mortality has been calculated from the monthly discharges (and is not a proportion of the COVID-19 related discharges). This data has been taken from our ENHT data warehouse.

2.1.1.4 COVID in-patient Winter deaths 4 year average

Figure 6: Trust COVID-19 'Winter' Inpatient deaths 2020-21 vs 4 year average



Notes:

- *COVID deaths are COVID coded deaths and/or patient tested positive for COVID*
- *Weeks are all 7 days of data*
- *Wk 1 is calendar year wk number 40 and includes 01 Oct for each of the 5 year.*

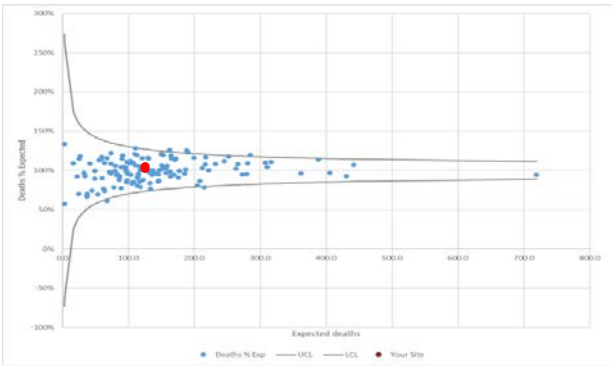
2.1.2 Potential indicators of performance

2.1.2.1 CHKS COVID Reporting

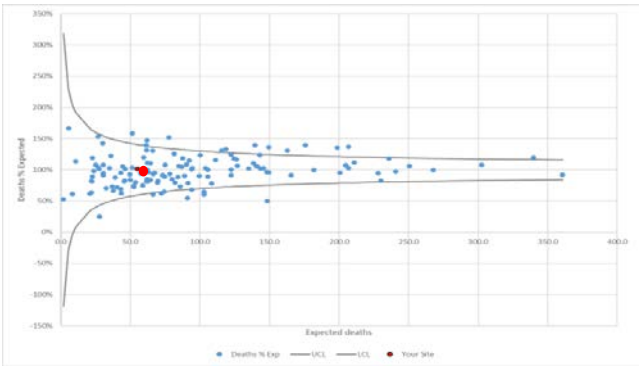
CHKS, our specialist healthcare intelligence provider, is currently working on a model which will enable us to better understand our COVID mortality and the underlying reasons for mortality variances between hospitals across the country during the pandemic. They produced an interim report which showed that few trusts lie outside the expected range, indicating relative consistency in performance across English, Welsh and NI trusts. The following charts provided by CHKS show the Trust's central position relative to national peers in both the first and second COVID waves.

Figure 7: COVID First and Second Wave ENHT mortality vs national

Covid-19 First Wave (March to May 2020)



Covid-19 Second Wave (October to December 2020)



2.1.2.2 Hospital acquired nosocomial infections

Work is currently underway to assess the impact of hospital acquired nosocomial infections. A standard operating procedure has been developed outlining the Trust's approach pursuant to NHS England and NHS Improvement (NHSEI) patient safety response to reporting, reviewing and investigating hospital-onset COVID-19 and COVID-19 deaths during a period (February – May 2021) of exceptional pressure on our health services.

All probable/definite hospital onset COVID nosocomial infections, where COVID appears on Part 1a/1b of the death certificate are subject to the outlined process. This involves the conduct of a mortality review with subsequent consideration by the SI Panel. To date 59 cases have been identified where it has been deemed likely that the patient contracted COVID in hospital and sadly went on to die. Of these, 52 have been reviewed, with details uploaded to Datix for ongoing handling by the Patient Safety team.

2.1.3 COVID-19 and mortality review

During the initial response to COVID-19 all but priority mortality reviews were suspended to allow clinicians to focus on the requirements of the pandemic. As we entered our Restart Programme, our standard review process was resumed. In January 2021 all but urgent requests were again suspended. From March 2021 reviews recommenced. By the end of April 2021 when the review year closed, despite the significant challenges posed by the pandemic, 837 (54%) of deaths in scope had been reviewed.

In additional to our BAU service, in order to better understand the impact of COVID-19, two specific cohorts of patients were identified for further scrutiny:

i) COVID-19 patients who died on a readmission to hospital within 30 days of discharge,
ii) Non-COVID patients who died in the community within 30 days of discharge.

For the first of these, the Lead Respiratory Mortality Reviewer was asked to undertake mortality reviews of 30 patients identified as having died of COVID on a readmission to hospital within 30 days. Summary detail was provided to the Mortality Surveillance Committee in December. The review showed that a number of patients may have caught COVID on their first admission and that a small number may have been discharged too soon. The review outcomes have been shared with those reviewing probable/definite nosocomial hospital acquired COVID infections. The

Committee requested a similar review to be undertaken for a period covering the second COVID peak.

The second review is still in progress in collaboration with the Coding department. Early outputs from the review have not given rise to concerns as to whether patients were discharged too soon during the peak times in the pandemic. Further deaths will be reviewed to provide additional assurance/learning.

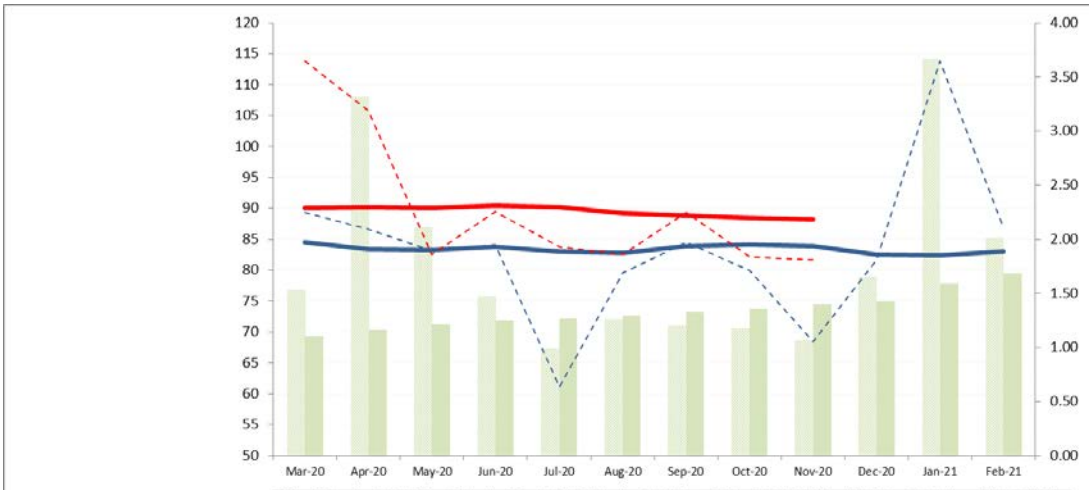
2.1.4 COVID Interim indications

- Mortality indicators have remained stable & largely unaffected – providing some indication that non-COVID death rates have not significantly increased
- CHKS 1st wave report indicates positive performance compared to peers
- CHKS 'interim' report shows the performance of the Trust is centrally placed nationally for both the first and second waves
- Significant increase in crude mortality Apr-20 and Jan-21
- Significant increase in deaths in 3rd wave
- Significant change to gender split in 3rd wave
- Gradual reduction in % of over 71yr old deaths, but they still account for large proportion of deaths
- 2020-21 winter spike significantly larger than recent years
- ICNARC Quality report 1 Apr-20 to 30 Sep-20 shows strong results for Critical Care risk-adjusted mortality rates
- Negative impact on #NOF mortality (see 2.4.2 below).

2.2 Key mortality metrics

2.2.1 Trust key metrics overview

Figure 8: Trust Key Mortality Metrics: Latest Position



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Mortality Rate - Monthly	1.54	3.32	2.12	1.47	0.99	1.25	1.20	1.18	1.06	1.66	3.67	2.02
Mortality Rate - Rolling Month	1.10	1.16	1.21	1.25	1.27	1.29	1.33	1.36	1.40	1.43	1.59	1.68
HSMR - Monthly	89.4	86.6	83.1	84.2	61.2	79.6	84.6	79.9	68.4	81.7	113.9	86.9
HSMR - Rolling Month	84.5	83.4	83.3	83.8	83.0	82.8	83.9	84.2	83.9	82.5	82.5	83.0
SHMI - Monthly	113.8	105.8	82.6	89.5	83.8	82.5	89.3	82.2	81.7			
SHMI - Rolling Month	90.1	90.2	90.1	90.5	90.2	89.2	88.9	88.4	88.3			

The chart above shows the Trust's latest in-month and rolling 12 month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI as reported by CHKS. This shows that the rolling 12 month position continues to be stable for HSMR and SHMI.

Crude mortality: CHKS compares performance of crude mortality and reports that the average national crude in-patient mortality (for HES Acute trusts, all admissions excluding well babies) is 1.83%, and is 1.98% for the Model Hospital peer group for the twelve months to February 2021. This compares to 1.66% within ENHT for the same period. The Trust's locally recorded crude mortality rate, stands at 1.51% for the latest twelve months to April 2021.

HSMR: Our rolling 12 month HSMR for the last 9 months has remained broadly stable, with only small fluctuations seen. 82.92 was reported for the latest period (March 2020 to February 2021), compared to 84.13 for the previous release December 2019 to November 2020.

SHMI: CHKS reports SHMI to November 2020 as 88.28, with the Trust continuing in the 'lower than expected' Band 3.

From the NHS Digital July 2020 publication (March 2019-February 2020) onwards, COVID-19 activity has been excluded from the SHMI. It was noted that the SHMI is not designed for this type of pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity were included.

Activity that is being coded as COVID-19, and therefore excluded, is monitored in a new contextual indicator 'Percentage of provider spells with COVID-19 coding'. For the December 2019-November 2020 SHMI calculation, 1.3% of the Trust's spells were excluded (compared to 1.0% in the previous report). NHS Digital also notes there has been a fall in the number of spells recorded by trusts between this publication and the previous SHMI publication, ranging from 0 per cent to 5 per cent. This is due to COVID-19 impacting on activity from March 2020 onwards and appears to be an accurate reflection of hospital activity rather than a case of missing data.

2.2.2 Trust In-month trend (crude/HSMR)

Figure 9 below provides the latest available in-month position, not only for crude and HSMR mortality rates, but also volume of deaths. The peak of the first wave of the COVID-19 outbreak is shown by the spike in number of deaths in April 2020. The second wave of the COVID-19 outbreak peaked in January 2021. In the subsequent three months there has been a sharp decrease in the number of deaths and reduction in the Crude Mortality rate.

The HSMR indicator partially excludes COVID-19 patients from the methodology as patients with a primary diagnosis of COVID-19 (in the first episode or second episode if the first contains a primary diagnosis of a sign or symptom) are placed in CCS group '259 - Residual codes; unclassified' and this is not one of the 56 CCS groups included in the HSMR model. At the same time it has been noted that HSMR for January 2021 did show a small spike reflecting the increase in Crude Mortality.

Figure 9: Trust Crude Mortality/HSMR latest in-month trend

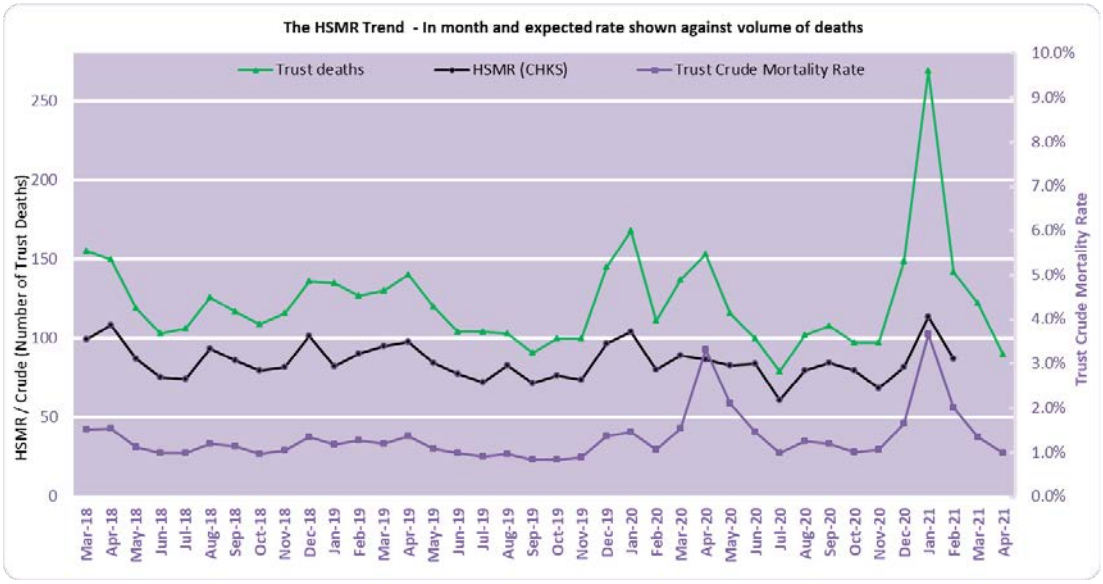
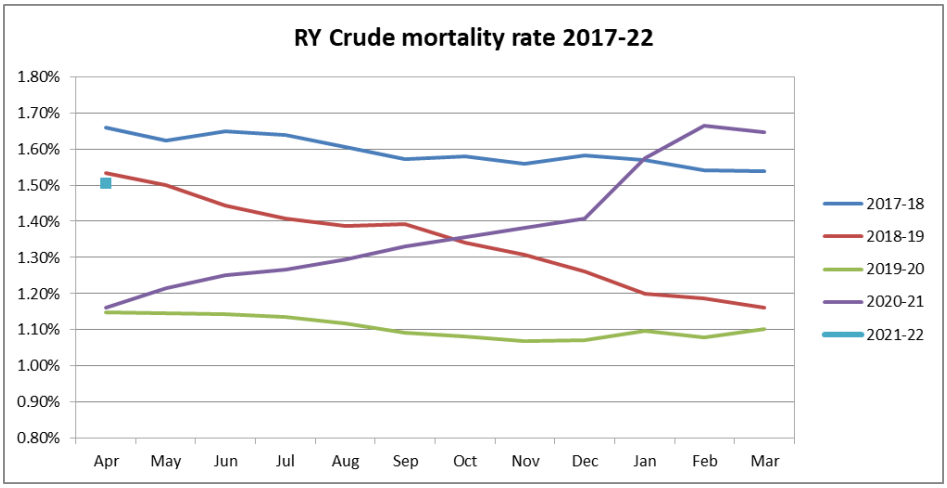


Figure 10 shows the trend in crude mortality rates over recent years. While this provides a good indication of the improving picture up to February 2020, it should be borne in mind that it has not been possible to use data solely from one source. This is due to the need for rolling year calculations to be based on changing data sources (pre-Lorenzo, our data warehouse [EDW] and most latterly CHKS).

Figure 10: 5 year crude mortality trends

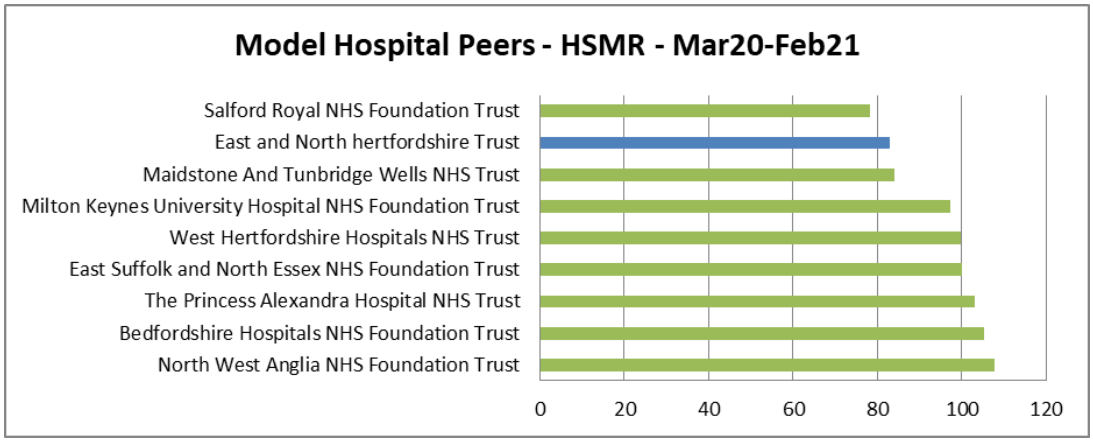


The recent higher rolling year crude mortality rate reflects the number of deaths from the waves of the COVID-19 outbreak coupled with the reduced inpatient activity at the Trust during March 2020-April 2021.

The observed number of deaths within the risk model for HSMR is the greatest factor determining the overall score for an organisation which means that crude mortality can be used as a useful predictor of coming HSMR performance. However, given the treatment of COVID-19 patients in the HSMR methodology (detailed above), there may be less of a correlation seen during the COVID period.

2.2.3 Trust HSMR peer comparison

Figure 11: Trust Model Hospital Peer comparison



For the purposes of performance assessment we have adopted the peer group indicated for ENHT in the Model Hospital framework, in place of the geographical East of England group of hospitals. It was felt that this should provide a better indication of performance. Figure 11 above shows how well placed we continue to be within this group.

2.2.4 Divisional HSMR performance

Table 3: Monthly Trust and Divisional HSMR March 2020 to February 2021

	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Rolling 12M
Unplanned Care (Spec)	84.7	90.7	85.2	79.0	90.7	62.3	87.4	88.8	84.1	73.9	85.5	121.1	102.8	87.2
Planned Care (Spec)	56.2	95.3	132.1	136.4	77.7	73.9	56.2	74.8	79.3	71.3	87.8	119.8	52.7	85.0
Cancer Pod (Spec)	42.4	0.0	26.2	22.8	0.0	15.6	0.0	23.8	26.6	0.0	15.0	15.6	0.0	12.3
Trust	**80.3**	**89.4**	**86.6**	**83.1**	**84.2**	**61.3**	**79.6**	**84.6**	**79.9**	**68.4**	**81.7**	**113.9**	**86.9**	**82.9**

Source: CHKS (scorecard alerts coloured; Specialty on Discharge)

Table 3 has been changed to the new Trust Divisional structure and shows Trust and Divisional monthly HSMR performance for the latest rolling 12 month period to February 2021. The CHKS red and amber alerts coding has been used to show HSMR above the 75th percentile Model Hospital peer group value, with red being statistically significant and amber not statistically significant.

2.3 Key quality measures

It is important to triangulate mortality data with other quality measures to give a balanced perspective on the quality of care provided by the Trust.

Table 4 below shows HSMR/SMR, together with average Length of Stay and Readmissions within 28 days. Length of Stay is an average of Bed days (excluding well babies, regular attenders or renal dialysis patients) by Spells. Using CHKS, Readmissions are spells where the patient was readmitted as an emergency within 28 days of the discharge of previous admission, and this is shown as a percentage of total spells (excluding well babies, regular attenders or renal dialysis patients). The arrows show direction of change compared to the previous report (December 2020 to November 2020).

The amber alert is relative to peers in our Model Hospital peer group.

Table 4: Key Quality Measures March 2020 – February 2021

	Trust Total		Elective		Non-Elective	
HSMR	82.9	↓	71.1	↓	83.0	↓
SMR	101.1	↑	105.2	↑	101.0	↑
Average Length of Stay	1.9	↑	0.2	↔	3.8	↑
Readmissions within 28 days (%)	8.4%	↓	3.9%	↓	**13.6%**	↓

Source: CHKS (scorecard alerts coloured)

At February 2021 Mortality Surveillance Committee the issue of readmissions was discussed. It was agreed it would be beneficial to work more closely with Primary Care, perhaps by way of a regular report to PCNs. Initial work by the Head of Coding commenced to move this forward.

2.4 Mortality alerts

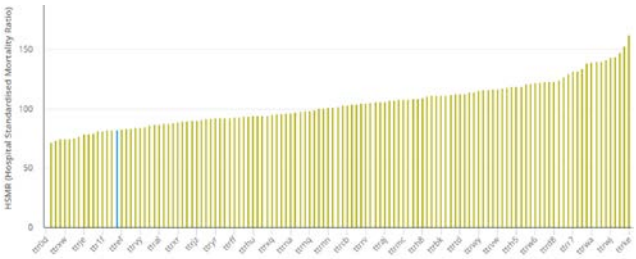
2.4.1 CQC CUSUM alerts

Following the closure of the Septicaemia alert, there have been no new CQC alerts in Q4.

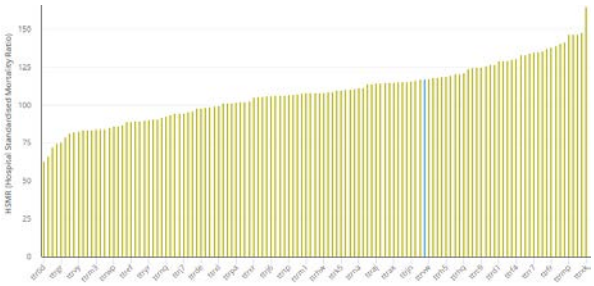
Unfortunately, as the below charts indicate, there has been a significant negative shift in our sepsis HSMR performance since the March report.

Figure 12: latest vs last reported Sepsis R12M HSMR

Septicaemia (except in labour)
HSMR R12M to November 2020: national peer comparison

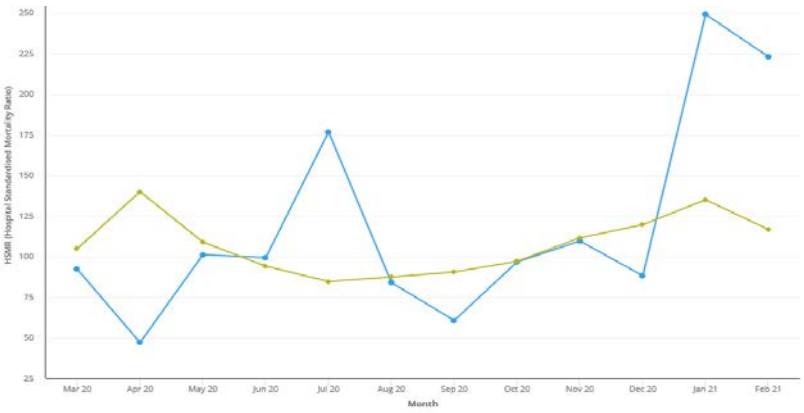


Septicaemia (except in labour)
HSMR R12M to February 2021: national peer comparison



This appears to be largely due to a significant spike in our in-month Sepsis HSMR in January 2021, when there was an increase from 88.22 to 249.21. This has resulted in a change in rolling 12 month HSMR from 81.93 for the 12 months to November 2020 reported above to 116.99 for the 12 months to February 2021.

The chart below shows the in-month HSMR timeline for the last twelve months.



A Coding review was immediately requested to understand the reasons underpinning the sharp increases.

The coded data for the two spikes in January and February 2021 were reviewed by the Head of Coding. It was found that there had been an element of confusion regarding the appropriate interpretation of detail contained in the corresponding death summaries. Amendments to Q4 errors have been made, which will be adjusted when CHKS refresh their data. A review of Q1 2021-22 showed a similar theme, with issues immediately rectified. Unfortunately it is too late to make changes to the lesser spike in July 2020.

To an extent the fact that these issues were not picked up at the time reflects the extreme pressures not only within the coding department, but the wider Trust environment in January and February 2021. The Head of Coding has committed to keeping a close eye on the situation and to ensuring coders are advised regarding the correct interpretation of the clinical data.

Throughout the pandemic the sepsis team continued to operate in difficult circumstances. The table below reflects the ongoing challenge regarding the achievement of sepsis targets:

Table 5: Sepsis: ED/Inpatients key data: Q4 2020-21

Metric	Target (per ¼)	Jan-21	Feb-21	Mar-21
Inpatient				
Sample Size	50	10	28	23
Antibiotics Within 1 Hour of Red Flag	90%	25%	41%	56%
Average Time to Receiving Antibiotics	60 mins	60 mins	164 mins	78 mins
Emergency				
Sample Size	50	15	22	43
Receiving Antibiotics Within 1 Hour of Red Flag	90%	64%	66%	79%
Average Time to Receiving Antibiotic	60 mins	87 mins	36 mins	79 mins
Sepsis 6 Bundle Compliance	90%	26%	36%	34%

The team reported that unfortunately the COVID pandemic did have a significant negative impact on compliance with the sepsis 6 and management of septic patient. However, for the first time quarterly sample size compliance was achieved for both in-patient and ED settings. Compliance has improved throughout Q4 as a result of realised pressure from the pandemic and the effort of the team.

Throughout the pandemic the sepsis team supported the Trust though the redeployment of its members during the peaks, and afterwards by assessing and screening patients alongside nurses and doctors, while continuing to support staff in the management of septic patients, providing bed side teaching.

As pressures from the pandemic have lessened the following recovery initiatives are underway:

- Management changes have been made to the team with the appointment of a new manager and team member

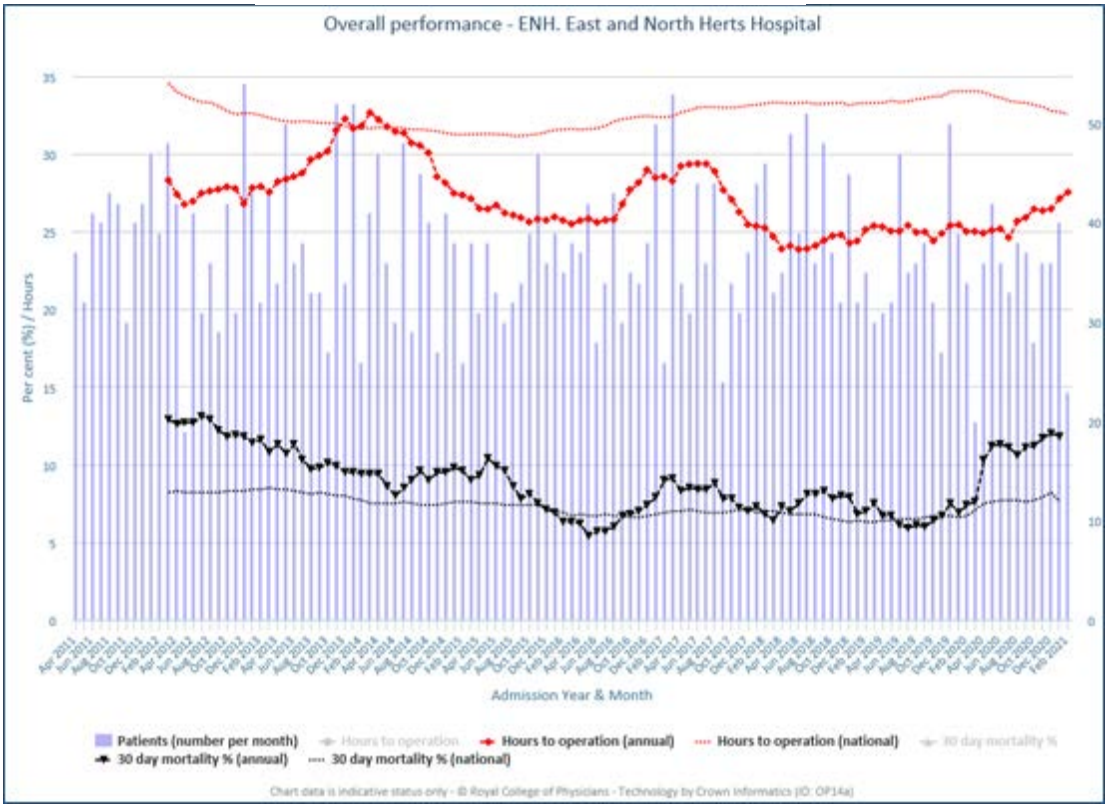
- Restart of teaching sessions that will help staff to gain confidence in the management of septic patients
- Recruitment of link nurses to help collect data and share bedside teaching
- Collaboration with the coding team to obtain a better understanding of sepsis figures across the trust
- Collaboration with the Quality Improvement team to create a project to support the achievement of sepsis targets for in-patient settings
- Collaboration with the ED matron to improve compliance in ED settings.

2.4.2 Other external alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)

The below chart is the latest from the National Hip Fracture Database, showing data to January 2021.

Figure 14: NHFD data to January 2021



Unfortunately this shows the Trust's performance during the pandemic has suffered greatly, with mortality rising to more than 3 standard deviations away from the mean.

The #NOF Lead provided the following accompanying update:

- It is clear that COVID and #NOF do not combine well. The mortality graph cumulates so the second spike of deaths in the second lockdown has caused a further increase in mortality
- It is very likely that a degree of hospital acquired COVID has contributed to the picture (being looked at separately within the Trust)

- The difficulty is in explaining why our mortality has been more adversely affected than other trusts. Possibly of note are the following:
    - There was a COVID ward outbreak in the first wave among staff and patients, which was probably under recorded due to testing practices/availability at the start of the pandemic
    - In the first wave there were many challenges to our usual processes including inappropriate location of patients, lack of OG support, non-NOF ward, delays to theatre
    - In the second wave the situation was not as bad, but the service was still negatively impacted
    - Concerns remain regarding the potential impact of any further COVID surges.

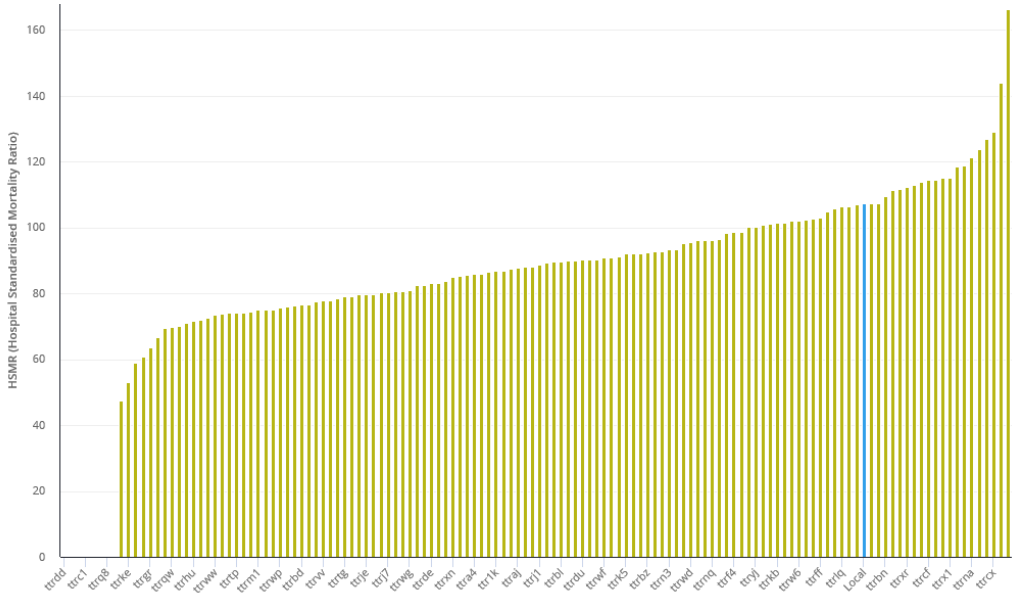
It had been understood that the NHFD was undertaking a COVID mortality review. When initially drafting this report outputs from that were awaited, and it was anticipated that we would receive a mortality outlier alert regarding our performance. Official notification was received on 2 June 2021.

Arrangements were immediately made to inform both the CCG and CQC. Discussion of the alert took place at 9 June Mortality Surveillance Committee where membership for a working group to support the required Service review and subsequent outputs report was agreed. An initial response to the NHFD is required by 9 July 2021. This has been drafted and once finalised will be sent week commencing 14 June 2021.

National Stroke Audit: Mortality Alert (January 2020)

- We were contacted by the Sentinel Stroke National Audit Programme (SSNAP) in January 2020 advising that while our position was not above the limit of 3 standard deviations from predicted mortality, and we were therefore not classified as a mortality outlier, we were ‘quite close’ to the threshold
- Although there was no formal requirement to act, a Chief Executive response was provided outlining the assurance work already undertaken and indicating that further work would follow to ensure no further opportunities for learning and improvement had been missed
- Collaborative work was instigated between Stroke and Coding aimed at creating a regular monitoring system, though limited progress has been made during the COVID pandemic
- In the meantime, while not an outlier, Stroke mortality does remain high relative to the national average and this continues to be monitored
- Our latest SSNAP rating has remained C, the continuing downgrade being largely attributable to the ongoing lack of therapy input, with the associated impact on patient outcomes and mortality. It is not anticipated that this will change when the next report is published in early June. The latest report (Oct-Dec 2020) did indicate a mortality rate below the national average – an improvement on the previous two reports
- Monitoring of Stroke data and mortality reviews continue.

Figure 16: Stroke HSMR R12M to Feb-21: National Comparison



National Emergency Laparotomy Audit (NELA)

November 2020 saw the publication of the National Emergency Laparotomy Audit – Sixth Patient Report covering procedures carried out between December 2018 and November 2019. Data submitted for this audit has shown significant improvement for the Trust in multiple areas, with our adjusted mortality rate reducing from 13.0 to 10.3 in comparison to the previous year.

At the same time the impact of COVID has meant that the actions that the NELA team wanted to have in place following the AHSN February 2020 peer review, are only now being realised as detailed in the last report.

As the Trust continues to face the challenges presented by the COVID pandemic, every effort is being made to maintain the focus on important NELA improvement work. Notable steps forward include:

- The creation of a NELA area on Qlikview, enabling the availability of real time data, which has been a key achievement in support of ongoing improvement initiatives
- Expansion of the NELA team to include an ED consultant and geriatrician. Further geriatric support for NELA patients is hoped for in May 2021.
- A crucial development has been the adoption of an MDT approach to high risk patients which includes surgeons, anaesthetists intensivists and in future a geriatrician (as the majority of deaths occur in the elderly/frail group of patients).

The improvement measures above mean the service is now in a much better position to monitor monthly outcomes and it is anticipated that mortality for year 7 will be between 8-10% bringing us closer to aligning with the national average.

2.4.3 HSMR CUSUM alerts

The latest release from CHKS showed two HSMR CUSUM red alerts for the rolling year to February 2021 (Red alert: 99.7% detection threshold). Table 6 details HSMR for the alerting CCS groups, sorted in descending order by “Excess Deaths”.

Table 6: HSMR CUSUM Alerts March 2020 to February 2021

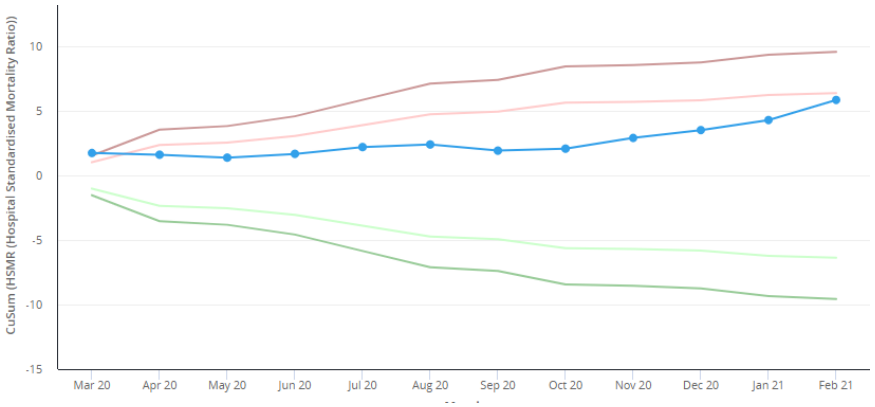
	Relative Risk	Observed Deaths	Expected Deaths	“Excess” Deaths
38 - Non-Hodgkin`s lymphoma	157.55	16	10.2	5.8
101 - Coronary atherosclerosis and other heart disease	164.37	5	3.0	2.0

Source: CHKS (CUSUM alerts coloured)

Figure 17 below shows the Trust HSMR CUSUM for Non-Hodgkin`s lymphoma with a red alert for the 12 month period to February 2021 as it breached the upper control limit (three standard deviations) in March 2020.

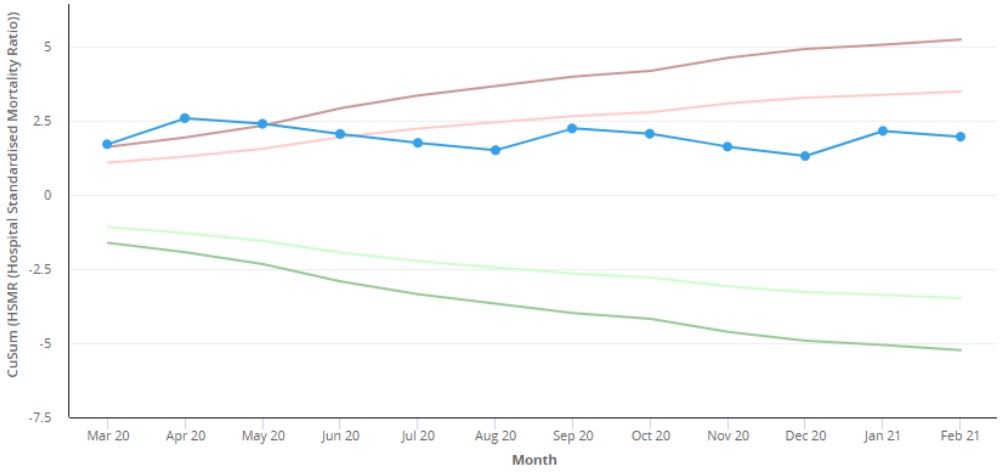
Since this point it has remained below the two standard deviations level. When this condition first alerted a review was undertaken by the Head of Coding. This indicated there were no errors in coding and did not give rise to clinical concerns.

Figure 17: Non-Hodgkin`s lymphoma CUSUM chart March 2020 to February 2021



The figure below shows the Trust HSMR CUSUM for Coronary atherosclerosis and other heart disease for the last 12 months to February 2021 and that it has breached the second upper control limit (three standard deviations) in the first three months of this period. After which it has stabilised below the second standard deviation level.

Figure 18: Coronary atherosclerosis and other heart disease CUSUM chart March 2020 to February 2021



As various elements of the Cardiology diagnoses basket have continued to alert over the last year, further investigation of the underlying causes has been agreed with the Cardiology Clinical Director. Learning will be reported in due course.

2.4.4 SHMI outlier alerts

According to the latest CHKS report there were no Red outlier alerts for SHMI groups.(Amber alert: lower confidence limit above national average; Red alert: lower confidence limit in upper quartile).

2.5 Specific actions to address high mortality conditions

Mortality Alerts meetings were suspended during the COVID pandemic. As the Mortality Surveillance Committee meetings are again held monthly (except in January/August) the Committee has decided the additional alerts meetings do not need to be reinstated as HSMR/SHMI CUSUM/outlier alerts are now closely monitored by the Committee.

The HSMR/SHMI trends of alerting groups are tracked. Investigation usually starts with a coding review. Where concerns or uncertainty persist Specialty clinical reviews are requested. A watching brief is maintained until there is assurance regarding performance. When the number of deaths is very small, or the diagnosis group consists of a number of sub categories, the situation may be monitored before action is taken.

2.6 Associated trust initiatives

2.6.1 Seven day services

The Trust continues to work towards 7 day working and fully achieving the Keogh standards set out in the report NHS Services, Seven Days A Week. Originally ENHT was confirmed as being in the tranche of trusts tasked with achieving compliance against the four prioritised standards by the end of March 2018. Nationally it was been indicated that all Trusts should be compliant with the standards by 2020. The four prioritised standards are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review.

The 2019/20 results from the audit and assessment of compliance against the four prioritised standards were:

- Standard 2: Time to Consultant Review – not met
- Standard 5: Access to Diagnostics - met
- Standard 6: Access to Consultant-directed Interventions - met
- Standard 8: On-going Review – not met

Following the development and submission of speciality level business cases last year, a clinical Seven Day Service Investment Review Panel was held at the beginning of March 2020 to prioritise the investment recommendations for the delivery of seven day services in 2020/21. Further progress was postponed due to the needs of the COVID-19 pandemic and there has been no further formal assessment of current provision against the 7 day standards. However, there were a number of service changes as a response to the pandemic which temporarily

provided additional capacity to meet standards 2 and 8 such as 24/7 general medicine consultant rota. There have been other improvements such as 7 day consultant ward rounds in general surgery, urology and orthopaedics.

The plan for 2021-2023 is to commence the roll-out of a new job planning policy and process. Part of this includes meeting with specialty leads to discuss and agree expectations and plan for the year ahead. It is intended that these discussions will include planning for a full 7 day service provision, in order to understand the financial implications of the resource levels required.

A major step towards improving 7 day provision in unplanned care is a staff consultation which is to be undertaken this summer for all those consultants on the acute medicine and general internal medicine rota. The aim is to improve continuity of consultant led post take for patients admitted overnight and for morning handover.

2.6.2 Care bundles

Following the establishment of the Medical Director Office, discussions have taken place regarding how best to provide Director level clinical support to drive this work forward. To date it has been agreed that this work will be led by the Associate Medical Director for Clinical Risk, Audit and Compliance, who has commenced research into approaches taken by trusts in our region. As we begin to emerge from the latest COVID peak, the plan for 2021-22, Q1 and Q2 is to focus on cardiology pathways including acute coronary syndrome (ACS), heart failure and primary percutaneous coronary intervention (PPCI).

In the meantime there are already quality improvements underway regarding key care bundles such as Sepsis, AKI and Pneumonia. Sepsis and AKI work has continued during the COVID period, albeit in a different shape.

2.6.3 Medical Examiner

As previously reported a team of Medical Examiners has now been recruited from within the Trust's existing consultant body and includes a Lead and Deputy, and multi-disciplinary representation. The Medical Examiner function is a process which sits outside the normal structure of the Trust and is responsible to the Medical director and the Regional Lead Medical Examiner structure. At present during the initial phase of introduction the process is non-statutory.

The Lead Medical Examiner has continued to work towards the introduction of the service. However, the planned pilot start date of 1 March 2020, was postponed due to the first wave of the COVID-19 pandemic. Despite this fact the Medical Examiners liaised with the Bereavement team throughout the first wave to give advice regarding death certification.

After suitable office space was finally identified in July 2020, the Medical Examiner service commenced on 1 October 2020. Following an initial small test pilot the service is now up and running well, covering CCU, Surgery, Cardiology and Care of Elderly, which account for approximately 50% of all deaths. No major issues or trends have been identified. Full implementation of the service was proposed from 1st April 2021. This full roll-out has now occurred and started at the beginning of May 2021.

The next phase of the roll out will be to all deaths including in the community. The Lead Medical Examiner and staff are working towards this and will be liaising with our

community colleagues. This expansion will require a significant increase in the number of MEOs and Medical Examiner sessions.

As previously reported, the update from NHS Improvement in June 2019 highlighted the need for close collaboration between the Medical Examiner function and Learning from Deaths programme, with Medical Examiners being responsible for flagging cases warranting further review. This required interaction has commenced from the outset of the service with priority mortality reviews requested where any concerns have been raised. Development work regarding the migration of the Trust's mortality review process to the Datix iCloud platform is also involving consideration of the potential for incorporation of the Medical Examiner process to further streamline our governance, quality and learning framework.

2.6.4 Coding/data quality

The heads of both Coding and Data Quality continue to drive forward quality improvement initiatives. These are not only of direct significance regarding the provision of better quality information, but are also resulting in greater engagement by Clinicians, as confidence in data provided to them increases. The seeds of this cultural shift continue to support future improvements. Clinical coding is reaching out to clinicians to help improve clinical documentation. Awareness sessions with junior doctors are being set up in which the importance of documentation is discussed and presented.

COVID-19 assignation of clinical codes is continually monitored and validated to ensure the coded data is correct. Regular coding training sessions are used as a forum to provide feedback on the various reviews undertaken by the Clinical Coding department. Clinical Coding continues to manage the Independent sector activity recording on Lorenzo with two dedicated staff members. There is a good relationship between the Trust and Independent sector and where queries are escalated, act immediately.

GDPR Standard 1 Data Security Clinical Coding Audit has been completed and the Trust maintains a Level 3 compliance.

SECTION 3: LEARNING FROM DEATHS

3.1 Mortality case record review process and methodology

Following the decision to adopt the Datix iCloud platform to support our Clinical Governance framework, development work to support implementation is continuing. Following concerns raised by the Mortality Surveillance Committee, it has been agreed that the mortality module will not go live until the link between the Datix system and Lorenzo has been established, the timeframe for which will be dependent on our IT forward plan capacity.

While capacity for development in the COVID environment has been challenging, it has continued, if at a slower pace than originally planned. While initial configuration of the mortality module is nearing completion, this has involved significant change to the existing mortality review content and processes, which of necessity has gone ahead with limited clinical input. There will therefore need to be a significant element of clinical testing and review to ensure the final tool is fit for purpose and user friendly.

Current progress towards implementation has also been hampered by further technical IT issues.

3.2 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below. In this report data has been provided for Q4 2020-21.

3.2.1 Learning from deaths dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This is currently being used and is attached at Appendix 1.

It should be noted that for cases where Areas of Concern are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 1, which only details the conclusion details for 2020-21 deaths which can appear to skew the data. Therefore for the sake of transparency and robust governance this report details ACONs relating to all deaths which have been concluded during the quarter in question where the Mortality Surveillance Committee agreed an avoidability of death score of 3 or less (irrespective of the year in which the death occurred). This should be noted in Q4 no ACONs were given a score of 3 or less.

Table 7: Q4 2020-21 Concluded ACONs: Avoidability Score ≤3

ID	Year of death	Serious Incident	Avoidability score	Avoidability definition
-	-	-	1	Definitely avoidable
-	-	-	2	Strong evidence of avoidability
-	-	-	3	Probably avoidable: more than 50-50

In addition to agreeing on the avoidability of death, the Mortality Surveillance Committee now also makes an independent assessment of the quality of care received by the patient. This assessment is based on the following scale, taken from the PRISM mortality review model:

Table 8: Concluded ACONs: Quality of Care Rating Scale

Quality of Care Rating (PRISM model)	Definition
A	Excellent
B	Good
C	Adequate
D	Poor
E	Very poor

This report will detail concluded ACONs where the quality of care was assessed as D/E.

Table 9: Q4 2020-21 Concluded ACONs: Quality of Care Rating D/E

Quality of Care Rating	ID	Serious Incident
D	412	No
	423	No
	408	No
	400	No
E	448	No
	511	No (RCA)

From the above table it can be seen that of the 6 cases where care was considered to have been poor or very poor, 1 case had been investigated and a Root Cause Analysis had been completed.

In the 5 cases that had not been considered as a Serious Incident, one case related to the to a delay in diagnosis, two cases related to the failure to diagnosis Myocardial Infarction, one case involved the failure of staff to identify a deteriorating patient and one case involved the decision not to drain the patient's abscess.

Table 10 below provides the full year summary of concluded ACONs indicating both avoidability of death and quality of care ratings.

Table 10: 2020-21 concluded ACONs ratings

Apr-Mar 2020-21: 68 concluded ACONs discussed by Mortality Surveillance Committee		
Avoidability of Death Rating	**Definition**	**SI/RCA detail**
1	**Definitely avoidable**	**1 (SI)**
2	**Strong evidence of avoidability**	**9 (7 SIs, 2 RCA)**
3	**Probably avoidable, more than 50-50**	**1 (SI)**
4	Possibly avoidable, but not very likely, less than 50-50	9 (3 SI, 1 RCA)
5	Slight evidence of avoidablity	24 (2 SI, 1 RCA)
6	Definitely not avoidable	24 (1 RCA)
Quality of Care Rating	**Definition**	**SI/RCA detail**
A	Excellent	0
B	Good	9
C	Adequate	18
D	**Poor**	**32 (9 SIs, 2 RCAs)**
E	Very poor	9 (5 Sis, 3 RCA)

Note: the above data relates to ACONs concluded during 2020-21, irrespective of when the death occurred.

It is intended that the creation of a more useful dashboard will form part of the process developments alluded to in 3.1 above.

As the current dashboard does not cover all the data that the national guidance requires, the additionally mandated detail is provided below.

3.2.2 Learning disability deaths

Table 11: Q4 Learning Disability Deaths

	Jan-21	Feb-21	Mar-21
Learning disability deaths	3	4	3

In Q4 ten deaths occurred of a patient with a learning disability. These have been reported to the national LeDeR programme. Nine have so far undergone a regular mortality review, with no concerns raised regarding care and all of the deaths judged to have been unavoidable. One death remains outstanding for review. Copies of all our reviews are provided to support the local external LeDeR mortality review. Of note 6 of the 9 deaths reviewed involved COVID as the direct or a contributory factor in the death.

In March 2021 NHS England and NHS Improvement published an updated LeDeR Policy which outlined a number of changes to the existing process. While many of the changes will be the responsibility of the ICSs, an important development affecting the Trust is the inclusion, from 2021, of patients who have a diagnosis of autism. Discussions are currently taking place with our Safeguarding Leads to ensure our internal policies and processes are appropriately updated to reflect the new requirements.

3.2.3 Severe mental illness deaths

The learning from deaths guidance stipulates that Trusts must have systems in place to flag patients with severe mental health needs so that if they die in an Acute Trust setting their care can be reviewed and reported on. No clear indication was given in the national guidance regarding what definition should be attached to the term 'severe mental illness'.

As previously reported, following discussions with our expert mental health colleagues at Hertfordshire Partnership University NHS Foundation Trust (HPFT), we decided to base our criteria for mortality review on the 'red flags' detailed in the national guidance for NHS mental health trusts, which was drawn up by the Royal College of Psychiatrists (RCPsych) in November 2018.

Prior to COVID, Internal approval was given to include a supporting alert on Lorenzo. It was noted that further work would be required prior to the alert being activated, including creation of a supporting SOP to ensure clarity regarding identification of relevant patients and use of the alert. This was to be taken forward via the 'Treat as One' Task and Finish Group. The outstanding requirements are now being picked up by the recently formed Mental Health Strategy Working Group.

Additionally, now that clarity has been gained as to which diagnoses should be considered for this cohort of patients, a regular report of deceased patients has been devised by the Business Information team but not finalised. This will not only include patients with Lorenzo flags, but will also use the relevant ICD10 codes recommended by HPFT.

One death of a patient with a mental illness was identified in Q4.

Table 12: Q4 Severe Mental Illness Deaths

	Jan-21	Feb-21	Mar-21
Severe mental illness deaths	0	1	0

A mortality review of this death has been requested but not yet completed.

3.2.4 Stillbirth, children and maternity deaths

Q4 statistics are provided below:

Table 13: Q4 Stillbirth, Children and Maternity Deaths

	Jan-21	Feb-21	Mar-21
Stillbirth	1	0	0
Children	0	0	0
Maternity	0	0	0

There was associated learning regarding the stillbirth regarding the relevance of offering a Kleihauer test in all stillbirth cases even when it is felt the cause of death is

known; the importance of the roll-out (already underway) of the continuity of care midwife pathways together with the need to consider whether POC testing for drug and alcohol abuse should be offered to all women. With regard to the latter point discussions are ongoing regarding the feasibility of such an offering with the associated need for a business case for funding.

3.2.5 Serious Incidents involving deaths

Table 14: Q4 Serious Incidents Involving a Patient Death

Serious Incidents involving the death of a patient	Jan-21	Feb-21	Mar-21
Serious Incidents reported	3	4	3
Serious Incidents: final report approved*	0	0	0
Key learning: N/A since no SI reports were approved in the quarter			

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

3.2.6 Learning from complaints

Table 13 below provides detail of the number of complaints received in Q4 that relate to a patient who has died while an inpatient.

Table 15: Q4 Complaints Involving a in-patient Death

	Jan-21	Feb-21	Mar-21
Complaints received relating to an in-hospital death	0	1	3
Key themes: • Treatment received and communication during COVID visiting restrictions • Some concerns related to DNACPR conversations and expectations			

3.2.7 Learning from inquests

Table 16: Q4 Inquests into a Patient Death

	Jan-21	Feb-21	Mar-21
Requests for a Report to the Coroner	0	5	1
Regulation 28: Report to Prevent Future Deaths	0	0	0

3.2.8 Learning from mortality reviews

Prior to COVID cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews, were central to the topics covered at clinical governance Rolling Half Days. The RHD meetings provided a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represented a key element of the Trust's learning from deaths framework.

Changes necessitated by COVID-19 meant that fewer ACONs were concluded during the pandemic, partly due to competing commitments and partly due to changes to the conduct of Specialty meetings. Now in the recovery phase we are working hard to clear outstanding cases.

Table 17 below provides summary mortality review related data for 2020-21.

Table 17: 2020-21 Summary Deaths/Reviews/ACON data

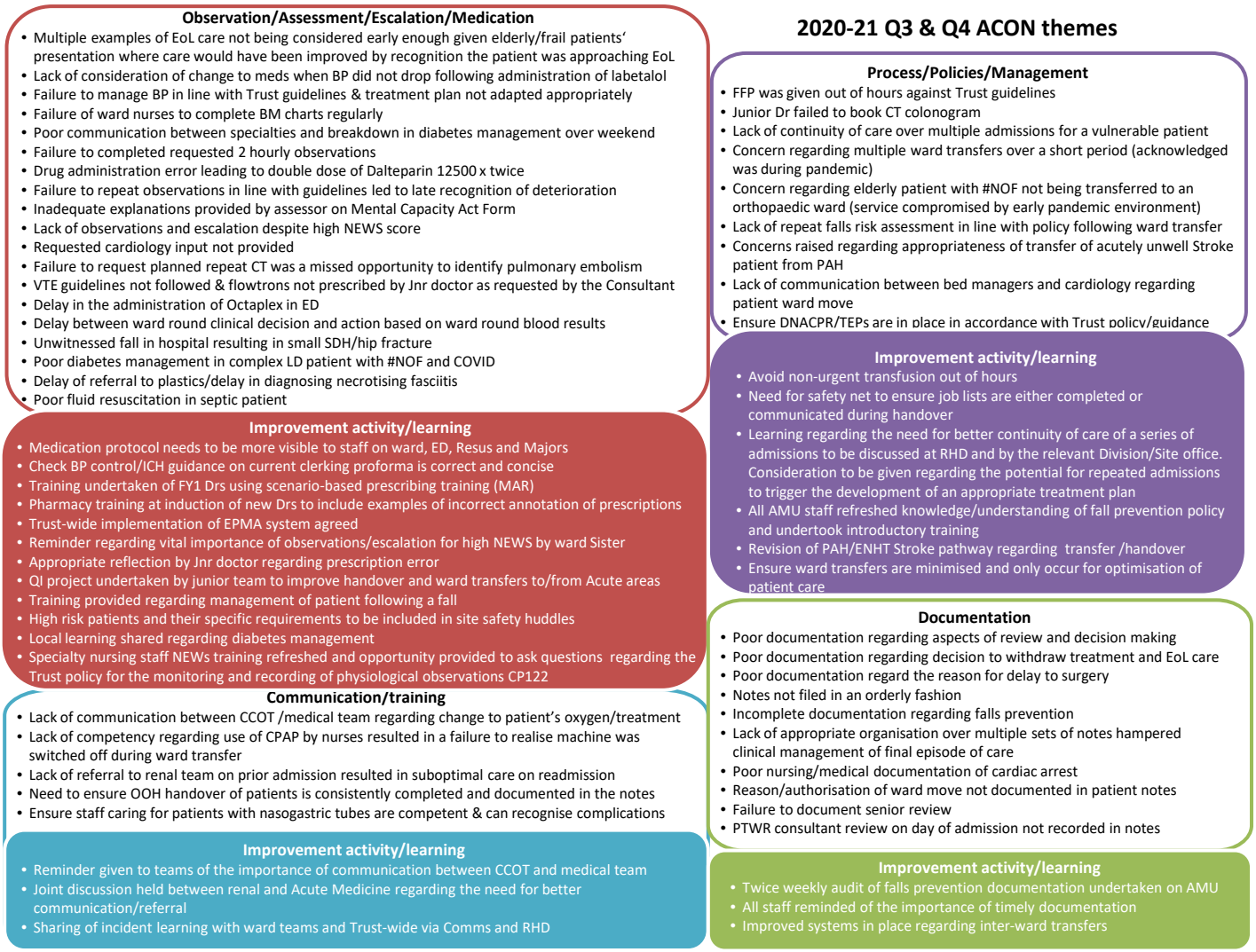
2020-21	Annual total
Total in-patient deaths	1555
Total deaths in scope for Trust review	1537
Total mortality reviews completed	837 (54%)
Total ACONs raised	91
Of which = SIs	11
Of which = COVID hospital onset probable/definite nosocomial infections	54

As detailed above in 2.1.2.2, the Trust has committed to reviewing all probable/definite hospital onset COVID nosocomial infection deaths where COVID appeared on part 1a/1b of the death certificate. The majority of these deaths have now been reviewed with outputs provided to the Serious Incident Panel for consideration.

Throughout the year emerging themes are collated and shared across the Trust via governance and performance sessions and specialist working groups. The information will also be used to inform broad quality improvement initiatives.

Key themes from ACONs concluded in Q3 and Q4 have been amalgamated and are detailed below.

Figure 19: 2020-21 Q3&Q4 concluded ACON themes



Additionally key themes from ACONs concluded for the whole year have been summarised in the diagram below.

Figure 20: 2020-21 ACON Key Themes

4.0 Options/recommendations

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

Appendix 1: ENHT Learning from deaths dashboard March 2021

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: March 2021

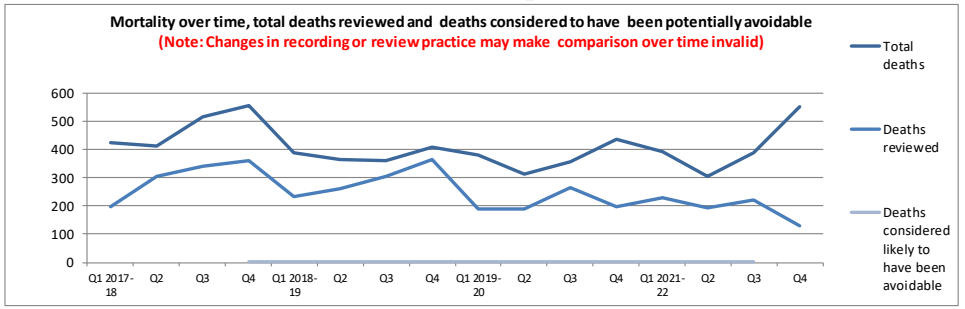
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Summary of total number of deaths and total number of cases reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
126	144	83	11	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
552	387	128	220	0	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1634	1484	769	841	2	1

Time Series: Start date 2017-18 Q1 End date 2020-21 Q4



Total Deaths Reviewed by RCP Methodology Score

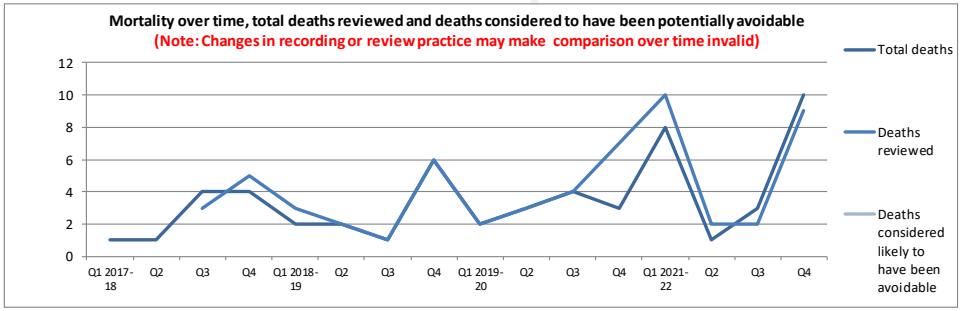
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	65	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	114	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	3	0.4%	This Year (YTD)	0	0.0%	This Year (YTD)	3	0.4%	This Year (YTD)	8	1.1%	This Year (YTD)	737	98.1%

Summary of total number of learning disability deaths and total number reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
3	4	2	4	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
10	3	9	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
22	12	23	9	0	0

Time Series: Start date 2017-18 Q1 End date 2020-21 Q4



East and North Hertfordshire NHS Trust

Agenda Item: 16

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021

Nursing, Midwifery and Allied Health Professionals Strategy Annual Progress Report

Purpose of report and executive summary (250 words max): Attached is the Nursing, Midwifery and Allied Health Professionals Strategy Annual Progress Report for discussion. *Please note: Some pictures included within the report were taken prior to social distancing and face mask guidance coming into effect.*		
Action required: For discussion		
Previously considered by: **N/A**		
Director: **Chief Nurse**	**Presented by:** **Chief Nurse**	**Author:** **Chief Nurse**

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

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

East and North Hertfordshire NHS Trust

Nursing, Midwifery and Allied Health Professionals Strategy 2019-24

Progress report

April 2020 – March 2021

Our vision: Proud to deliver high-quality, compassionate care to our community

Quality | People | Pathways | Ease of use | Sustainability

Contents

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

Introduction

#hello my name is…

Rachael

The last year has been memorable for so many reasons. I am so proud of how all our nursing, midwifery and allied health professional colleagues have pulled together to provide the very best care for our patients under extraordinarily difficult circumstances. We have shared the high's and low's together during the year and have grown to appreciate even more the importance of looking out for each other's wellbeing and taking care of ourselves.

The Nursing, Midwifery and Allied Health Professionals (AHP) Strategy for 2019-24 sets out our vision for nurses, midwives and AHPs. It was developed through collaborative working and is aligned to the Trust's Clinical Strategy and Quality Strategy. The six key priorities identified are:

- Developing and strengthening **leadership**
- Optimising **pathways**
- Valuing **people**
- Inspiring and innovating through **research** and **quality improvement**
- Ensuring **quality and safety**
- **Partnership** working

It has been a privilege for me to lead our nursing, midwifery and allied healthcare professionals to deliver safe and excellent patient care and experience and I am delighted to be able to share with you the progress that has been made towards our strategy over the last year. This report provides an update on progress made between April 2020 to March 2021.

I look forward to working with you all over the coming year as we focus on managing the long-term consequences of the pandemic and moving forward with our trust strategies.

Rachael Corser
Chief Nurse

Developing and strengthening leadership

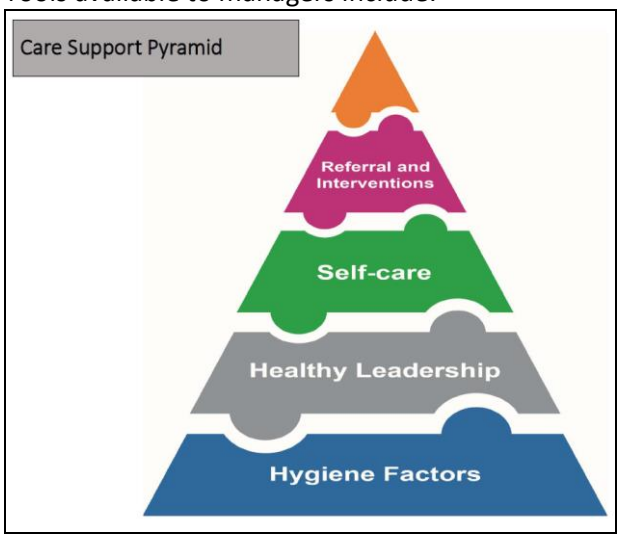
by:

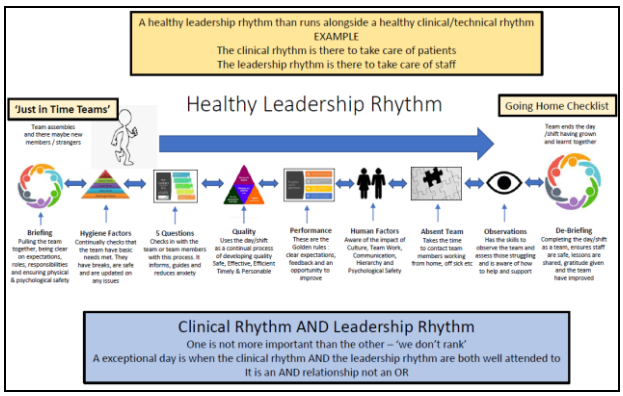
- **Nurturing a culture where all staff feel valued.**
- **Working with Health@Work to reduce staff sickness.**
- **Creating clear career pathways and learning resources, making it easier for staff to access development opportunities**
- **Introducing a multi-disciplinary teaching programme for all newly qualified staff.**
- **Creating programmes that will develop staff trainers and coaches**
- **Introducing a structured ward leaders programme.**
- **Making it easier for staff to access senior leaders.**
- **Encouraging all senior clinical staff to take part in FUNdamental Friday, an initiative that demonstrates excellence in care.**

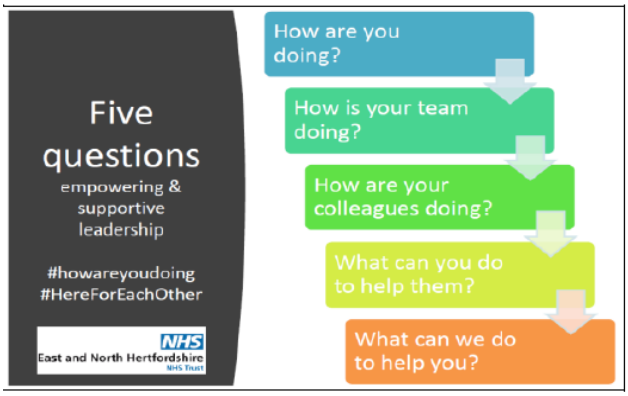
Nurturing a culture where all staff feel valued:

Nurturing a culture where our nursing and midwifery staff feel valued has been pivotal to responding to the challenges faced during the COVID-19 pandemic. The Leadership Team have provided vital support, resources and training to ensure that managers are equipped with all the resources they need to support their staff. Our staff have responded to the challenges of the pandemic by working flexibly and going above and beyond in their daily work.

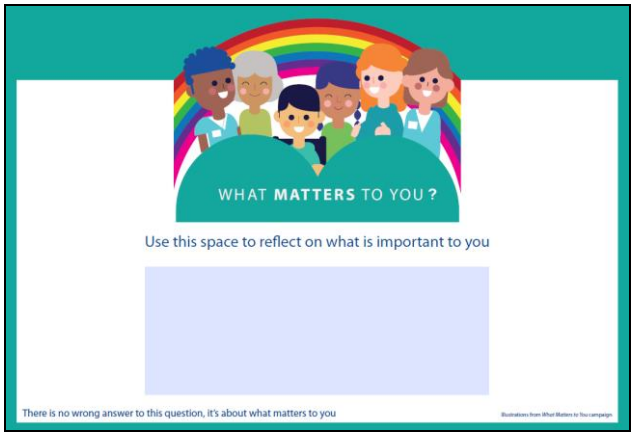
Tools available to managers include:







New 'Grow together' appraisal paperwork has been developed to promote a conversation between managers and staff incorporating time for reflection, feedback, review and career progression. Staff are encouraged to share 'what matters to you'.



International Day of the Midwife and Nurses Day

We were delighted to celebrate the International Day of the Midwife and International Nurses Day in May 2020. Although celebrations had to be done in a different way to meet COVID-19 guidance, our midwifery colleagues were able to share the many messages of thanks and appreciation from patients, their families and colleagues, to remind them how valued they are.

International Day of the Midwife – 5 May 2020

In the midst of the global pandemic, midwives rose to the challenge to support one another in the fight to protect women and babies. To celebrate the day, our hardworking midwives at the trust enjoyed snacks kindly donated from charities and, celebrated their achievements on social media.

Two of our midwives shared what inspired them to take up midwifery as a career to mark International Day of the Midwife.

Student midwife Keira Cooper was in her third year of training and had just joined the trust – returning to the Lister Hospital 10 years after giving birth to her eldest at the hospital. Midwife Led Unit ward manager Carly Barnes is also based at the Lister, having started out at the QEII. She is determined every day to give expectant mums "the birthing experience of their dreams".

International Nurses Day – 12 May 2020

Cheers, balloons, Clarins care packages and ice lollies were just some of the ways that our wonderful nurses celebrated International Nurses Day. This was a day to celebrate the hard work and dedication of our nurses in all areas and across all of our hospitals.

It was a day for nurses to shine and an opportunity for us all to reflect on the impact our professions have on keeping patients safe and protecting our population's physical and mental health and wellbeing.

Nursing colleagues at Lister

Nursing colleagues at the New QEII

As part of the celebrations for International Nurses Day, three of our nurses were interviewed and shared their personal stories of why they chose a career in nursing. The interviews were part of a feature on International Nurses Day broadcast by Channel 5.

Working with Health@Work to reduce staff sickness

The Health@Work team provide independent advice to both managers and staff to optimise health at work, reduce sickness absence and prevent work related ill health and injury.

We know that many of our staff have experienced stressful situations both at work and at home which may lead to sickness absence. In addition, staff may have been required to shield or self-isolate in line with government guidance.

A COVID-19 risk assessment tool and guidance was developed and all managers required to carry out an individual risk assessment with every member of staff. This considered whether the staff member was vulnerable, the likelihood of exposure to COVID-19, working environment etc. and documented any adjustments to be made to ensure the member of staff is able to work safely.

Individual risk assessment tool

Date of Assessment		Department/Ward	
Division		Manager	
Employee's First Name		Employee's Last Name	
Employee Number		Employee's DOB	

Has employee been defined as clinically extremely vulnerable? *If yes, they are automatically assessed as high risk*	Yes / No
If employee is not defined as clinically extremely vulnerable complete the following risk assessment-	

Risk factor	Indicator	Adjustment
Age	<50	0
	>50	1
	>60	2
	>70	4
	>80	6
Sex at Birth	Female	0
	Male	1
Ethnicity	Caucasian	0
	Black African descent	2
	Indian Asian descent	1
	Filipino descent	1
	Other (including Mixed race)	1
Diabetes and Obesity	(Type 1 or Type 2) uncomplicated*	1
	(Type 1 or Type 2) complicated*	2
	BMI≥35kg/m2	1
Cardiovascular disease	Angina, previous MI, stroke or cardiac intervention	1
	Heart failure	2
Pulmonary disease	Asthma	1
	Non-Asthma chronic pulmonary disease	2
	Either above requiring oral corticosteroids in previous year	1
Malignant neoplasm	Active malignancy	3
	Malignancy in remission	1
Rheumatological conditions	Active treated conditions	2
Immunosuppressant therapy	Any indication	2

*Complicated diabetes = presence of microvascular complications or HbA1cs64mmol/mol

Interpretation	Score
Lower Risk	<3
Medium Risk	3-5
High Risk	≥6 and All people defined as clinically extremely vulnerable who have been shielding

Outcome of risk assessment- see next page for suggested adjustments

- o Able to work in existing role and area
- o Undertaking existing role but redeployed to a different work area
- o Redeployed to different role
- o Work from home – existing role
- o Working from home, different role
- o Special leave
- o Other:

Comments:

Date for next review:

Managers signature:	Employees signature:

Individual risk assessment tool

Health@Work supported managers to reduce sickness absence and produced guidance to support a safe return to the workplace for staff who have been shielding.

Staff and volunteer deployment hub

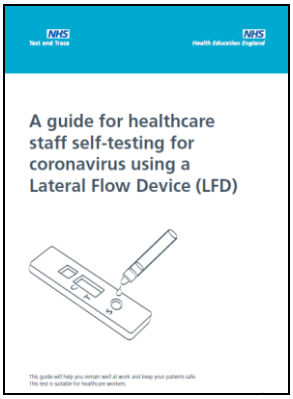
During the pandemic the staff and volunteer deployment hub was set up. This central team co-ordinated the deployment of staff and volunteers to work within the hospital. Managers were able to temporarily reassign staff to work where additional support was needed.

People were asked to self-assess against a checklist of skills they could support with in the clinical areas. The teams were briefed and debriefed daily with learning captured. This learning led to immediate actions to rectify any problems or appropriate escalation for issues that required longer-term resolution. This standardised approach and support enabled people to work outside of their usual roles and areas safely and confidently. All members of the team were encouraged to make suggestions for improvement which flattened hierarchies and enabled real-time improvement.

Staff/Volunteer Recruitment and Deployment Hub

Staff testing for COVID-19

Testing for COVID-19 has been made available for all clinical staff, this is providing vital information to support our staff, enabling where possible, an earlier safe return to work and reductions in levels of sickness absence.



Creating clear career pathways and learning resources, making it easier for staff to be able to access development opportunities

Continuing Professional Development (CPD)

For the financial year April 2020 to March 2021, the Trust was allocated £691,000 of CPD funding, by Health Education England (HEE). This funding was to support the continued development of all registrants employed by the Trust.

Funding was allocated under the 5 categories specified by HEE and aligned to Trust strategy and requirements:

Course Category	Funding Allocated
Supply	£56,804
New Roles	£4,392
New Ways of Working	£101,638
Leadership	£32,645
Up-skilling	£492,073

£88,219 of this funding was utilised in-house to deliver:

- An in-house clinical programme for registrants delivered by Trust Subject Matter Experts
- Extra in-house delivery of clinical skills for permanent staff, to support service delivery during the challenge of the COVID 19 pandemic (IV drug administration, cannulation and venepuncture, Central Venous Access Device Training)
- An upskilling programme designed by the nurse education team for the volunteers and redeployed registrants during the pandemic. 373 registrants received refresher/upskilling training to enable deployment to clinical areas.

This generated income was re-invested into education for:

- Pharmacy (not classed as registrant)
- Clinical Support Workers (unregistered)
- E learning packages to align with ENH Academy
- Maternity
- Quality Improvement
- Research

8812 educational opportunities were funded between April 2020 and March 2021. This includes access to e-learning packages for Insulin Safety and National Early Warning Score for registrants.

Introducing a multi-disciplinary teaching programme for all newly qualified staff

The Trust recognises that the experience a newly registered professional has in the period directly after initial registration is significantly important and can positively influence their journey to becoming a confident professional.

As a trust, we offer a period of one year for preceptorship to registrants. This provides the basis for the beginning of a journey of reflection, and the ability to self-identify continuing professional development needs. This programme is currently structured in a blended learning approach, which uses a combination of classroom and self-directed learning aligned with the four domains of the Nursing and Midwifery Council (NMC) Professional Code – Prioritise people, Practise Effectively, Preserve Safety, and Promote Professionalism and Trust. We have a total of seven sessions for each preceptee over the course of 12 months. The study days comprise of 7.5 hours per session. Upon completion of the programme, a certificate of completion is issued to each registrant.

Action learning forms a vital portion of the classroom sessions, a format which involves discussion of an issue relevant to the topic of the study day with participants presenting an issue they would like help with. There is a focus on listening and open questioning rather than problem solving and a belief that we have the answers already.

At present, we have 164 preceptees on our programme. We are currently restructuring our training programme in order to accommodate a multi-professional approach to preceptorship.

In response to the COVID-19 situation in January 2021, the Nursing and Midwifery Council (NMC) introduced emergency education standards to allow more flexibility in programme delivery, and specifically to allow students to undertake extended paid placements without the requirement for supernumerary status to support the health and social care workforce.

The trust, in collaboration with the University of Hertfordshire and the private sector, invited the final year students of the BSc programme to join the NMC emergency register so they could support the workforce during the pandemic.

As Band 4 members of staff, they were vital assets in maintaining the quality and standards of clinical care delivery while being supported for their learning needs and objectives during their training programme.

Student Nurses

The Trust commenced the Student Nursing Associate (SNA) programme, formerly known as the Trainee Nursing Associate programme, in 2017. This is a 24-month programme for Clinical Support Workers (CSWs) who would like to progress with their nursing career towards becoming a Registered Nursing Associate (RNA). At present, we have 32 SNAs in the Trust. We currently have 15 RNAs working in the Trust, 8 of which are undertaking the Degree Apprenticeship Programme to become Band 5 Registered Nurses.

Student Nursing Associates

Registered Nursing Associates

Allied Health Professionals (AHP)

There have been key new appointments in the leadership of AHP services: a clinical director for Ophthalmology, the first time this role has been given to a non-medic in the ophthalmology service. An Occupational Therapy clinical lead post to support therapy services and an Operational Lead Radiology post.

Creating programmes that will develop staff trainers and coaches

We have developed professional nurse advocate (PNA) roles within critical care and community paediatrics. The PNAs facilitate support for wellbeing and facilitate restorative supervision to colleagues and teams.

Introducing a structured ward leaders programme

During 2019-20 20 ward leaders embarked on a 12 month leadership development programme in partnership within the Royal College of Nursing (RCN) Clinical Leadership programme. The ward leaders were allocated 1:1 support from the Trust quality improvement coaches to support the practical application of the quality improvement and leadership theoretical skills and knowledge. The support from the coaches and the formal classroom learning sessions provided very positive feedback. The coaches supported 16 projects to completion, 8 of which focused on improving patient safety, 7 focused on staff and patient experience and one focused on efficiency.

The improvement projects were showcased and celebrated with the executive team on the finale celebration event at the end of the course.

All leaders who have completed the leadership programme have been invited to share their quality improvement project at the nursing and midwifery quality huddles to ensure sharing of learning throughout the trust. Quality improvement projects include:

- Mouthcare marshall
- Escalation of the deteriorating patient
- Reducing TPN infection rates
- Criteria led discharge
- Improving communication with families
- Joy in work
- Postnatal discharge
- Fluid balance

Cohort 1 RCN Clinical Leadership

The trust has committed to a second cohort partnership with the RCN Clinical Leadership programme. A further 20 clinical leader are enrolled and ready to undertake a new 2021-22 twelve month programme, and have started their leadership development journey in May 2021.

Making it easier for staff to access senior leaders

Nursing and Midwifery Quality Huddles

Our regular Friday morning nursing and midwifery quality huddles took place virtually throughout the pandemic and were paused for just a few weeks early 2021 at the height of the pandemic. These sessions are chaired by the Chief Nurse or Deputy Chief Nurse and all staff are invited to join, participate and suggest topics for discussion. The quality huddles now take place on Microsoft Teams and the time has been extended due to the popularity of the sessions. As well as a networking and supportive opportunity for all nursing and midwifery colleagues examples of updates received include:

- Bereavement advice
- Family Liaison Clinicians
- COVID-19 research
- Pharmacy – Antibiotics / Missed doses of critical medicines / recording ambient temperatures / VTE risk assessments/ Insulin / controlled drugs
- Staff carer network
- Infection Prevention and Control / COVID-19 testing and swabbing / PPE / social distancing
- Bed reconfiguration programme
- Pathway to Excellence and clinical excellence accreditation framework
- Incident reporting, learning from incidents
- NHS People Plan
- Glucose training
- World sepsis day
- Dementia and delirium
- Safeguarding training strategy / Liberty protection safeguarding / chaperoning
- Trust major haemorrhage policy
- Skin integrity
- Mortality review
- Staff wellbeing

Virtual Nursing & Midwifery quality huddle

Other ways that senior leaders ensure that they are visible and accessible to staff include:

- Participation in on call rotas
- Supporting task teams
- 1:1 and Team meetings
- Meeting new staff at induction
- Whats-App groups
- Twitter/Facebook
- Shared decision making councils

The chair of each shared decision making council is invited to join the Leadership SDMC, chaired by the Chief Nurse. This is an opportunity for direct care staff to share their projects and ideas for improvements with the Chief Nurse.

Encouraging all senior clinical staff to take part in FUNdamental Friday, an initiative that demonstrates excellence in care

The Chief Nurse, along with senior nursing and midwifery colleagues, set aside regular time on Friday's to spend time in the clinical areas in the trust. This is an opportunity to talk to a variety of staff in the clinical areas including direct care nurses and midwives.

Rachael Corser, Chief Nurse, on the wards providing care to patients and PPE support to staff

Optimising pathways

by:

- **Improving multi-disciplinary engagement in clinical areas to improve patient flow.**
- **Maximising golden discharges and use of the discharge lounge.**
- **Collaborating with patients and service users to co-create pathways that best meet their needs.**
- **Creating pathways that are easy to use and access, so that patients are cared for in the right place and at the right time.**
- **Raising awareness of the Quality Improvement Hub, using it to create evidence-based care pathways.**
- **Promoting IT training for staff that supports new ways of working.**
- **Identifying more Digital Exemplar wards that will help us to make better use of our systems.**

Improving multi-disciplinary engagement in clinical areas to improve patient flow and maximising use of the discharge lounge

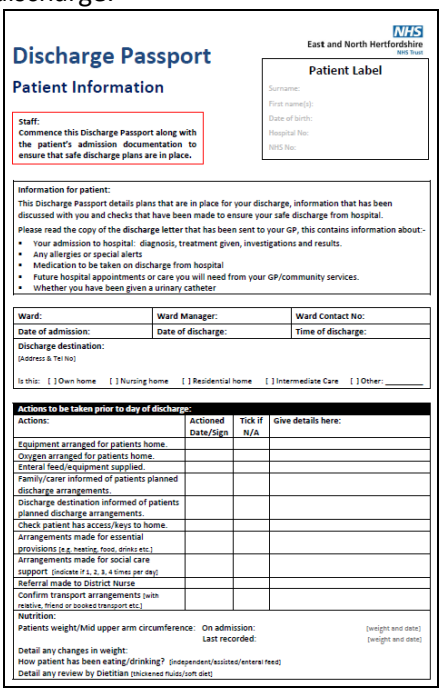
A discharge improvement programme has been established with the aim to improve the flow, safety and experience of patient discharges:

Flow:	**reduce length of stay for patients who are in hospital for over 7 days by 1 day**
Safety:	**reduce discharge clinical incidents resulting in harm by 50%**
Experience:	**reduce complaints including discharge related issued by 50%**

A Discharge Improvement Programme Board with an executive sponsor has been set up with the discharge improvement clinical and operational leads, divisional leads, subject matters experts and improvement experts:

Processes:

- Two wards have been identified to test and learn about variation in the use of discharge policies and processes
- Medication- Developed 6 standards and audits for take home medications undertaken by the pharmacy team
- Communication- in order to improve communication we standardised a discharge passport for the patient and carer that is started on admission and given to the patient at discharge:



NHS
East and North Hertfordshire NHS Trust

Discharge Passport

Patient Information

Patient Label
Surname:
First name(s):
Date of birth:
Hospital No:
NHS No:

Staff:
Commence this Discharge Passport along with the patient's admission documentation to ensure that safe discharge plans are in place.

Information for patient:
This Discharge Passport details plans that are in place for your discharge, information that has been discussed with you and checks that have been made to ensure your safe discharge from hospital.
Please read the copy of the discharge letter that has been sent to your GP, this contains information about:-
- Your admission to hospital: diagnosis, treatment given, investigations and results.
- Any allergies or special alerts
- Medication to be taken on discharge from hospital
- Future hospital appointments or care you will need from your GP/community services.
- Whether you have been given a urinary catheter

Ward:	Ward Manager:	Ward Contact No:
Date of admission:	Date of discharge:	Time of discharge:

Discharge destination:
(Address & Tel No)

Is this: [ ] Own home [ ] Nursing home [ ] Residential home [ ] Intermediate Care [ ] Other: _____

Actions to be taken prior to day of discharge:

Actions:	Actioned Date/Sign	Tick if N/A	Give details here:
Equipment arranged for patients home.			
Oxygen arranged for patients home.			
Enteral feed/equipment supplied.			
Family/carer informed of patients planned discharge arrangements.			
Discharge destination informed of patients planned discharge arrangements.			
Check patient has access/keys to home.			
Arrangements made for essential provisions (e.g. heating, food, drinks etc.)			
Arrangements made for social care support (indicate if 1, 2, 3, 4 times per day)			
Referral made to District Nurse			
Confirm transport arrangements (with relative, friend or booked transport etc.)			

Nutrition:
Patients weight/Mid upper arm circumference: On admission: [weight and date]
Last recorded: [weight and date]
Detail any changes in weight:
How patient has been eating/drinking? (independent/assisted/enteral feed)
Detail any review by Dietitian (thickened fluids/soft diet)

Systems:

- Utilising Nervecentre for standardising our data collection regarding patients who meet criteria for discharge

Culture:

- We have joined the Alliance 16 run by emergency care improvement support team (ECIST) who will support the front door and ward systems and processes through the use of quality improvement methodology

Volunteer drivers supporting patient discharges

Our Workforce Transformation team led a successful project to develop a team of volunteer drivers to improve the timeliness of patient discharges and build increased capacity within the wards and discharge lounge. This has helped alleviate pressure on the patient flow team and discharge lounge and help increase patient flow in coordination with the East of England transport service.

Volunteer drivers with our Patient Flow Lead and Discharge Lounge Nurse Manager

Collaborating with service users to co-create pathways that best meet their needs / Creating pathways that are easy to use and access, so that patients are cared for in the right place and at the right time

- All improvement starts with asking service users 'what matters most to them' to know if the suggested changes will meet their needs.
- Patient and carers support the harm free care and patient and carer experience improvement programmes.
- We have patient and carer input in designing our programmes and recently they supported us to design the reopening of patient visiting and our 'what matters to you' day.
- We encourage and support teams to have service users involved in all projects, for example, a parent was involved in a project in children's service to reduce medication errors.
- Patient partners are trained in quality improvement methodology and supporting our improvement coaching clinics.

Ophthalmology Services

Two optometrists and an ophthalmic technician have taken on traditional medical roles in the diabetic eye screening service and extended roles within the Glaucoma, Medical Retina and Urgent Eye services. There has been further development of four Ophthalmic Clinical Nurse Specialists to work in an extended role capacity in the service; 90% of the intravitreal injections, traditionally a procedure performed by the medical team, are now delivered by our Ophthalmic nurses and they are also working in or being developed to work in our Glaucoma, Urgent Eye and Oculoplastic clinics.

Virtual pathways during the pandemic which are continuing as part of the return to 'business as usual' are being facilitated by the Ophthalmic technician team and Nurses/Allied Health Professionals working in an extended role to deliver the diagnostic portions of these pathways. Virtual consultations and telephone contacts will become standard within Orthotics and Orthopaedics are reviewing the opportunity to deliver pre-operative elective joint surgery classes virtually.

Critical Care Team

The Critical Care and Theatre teams worked together to prepare for the increased numbers of patients expected with COVID-19. They increased the critical care capacity in AMU2 with an additional 18 beds, bringing the total to 43.

Critical care staff trained and supported a large number of colleagues from theatres and other departments to be able to work in the units.

Critical care team

Digital Solutions

During the pandemic, a range of digital solutions were put in place to support patients to continue their care and treatment, these included:

Attend Anywhere

The video consultation service Attend Anywhere was adopted and piloted by our Diabetes Specialist Midwife in response to COVID-19 to maintain quality care for patients.

This has reduced the number of hospital visits women have had to make whilst continuing to provide them with the care and support they need. Women commented that the video consultations have been very helpful, easy and convenient in the current climate and much better than a telephone call.

Sascha Koutrouza, Diabetes Specialist Midwife

The Women's and Children's Division are one of many who have successfully rolled out a number of Attend Anywhere clinics, most recently for Fertility and Endometriosis.

Virtual respiratory clinic

The Respiratory Team has been running a virtual COVID-19 clinic. Adult patients with suspected or confirmed COVID-19 are referred into the virtual COVID-19 clinic, post discharge, from all areas within the trust.

The aim of the clinic is to:

- Provide a safety net for patients
- Identify appropriate re-admissions
- Prevent inappropriate re-admissions
- Provide education, support and reassurance to patients

Findings from the clinic were published in the Nursing Times and the respiratory clinical nurse specialists invited to speak at the Association of Respiratory Nurse Specialists virtual conference in August.

Respiratory nurses showcase virtual COVID-19 clinic

Telephone and Video consultations at Mount Vernon Cancer Centre

Telephone and video consultations have been offered to patients at MVCC and feedback invited from patients regarding their satisfaction with these appointments. The convenience remote appointments offer was commented on frequently and responses from patients indicated several factors that are likely to have a positive impact on their experience. These included having enough time to address all issues and raise questions and shorter time windows for appointment times. Some patients acknowledged that the lack of visual clues can lead to greater difficulty in feeling that you have been heard and a number of patients expressed anxieties about the inability to have physical symptoms examined.

Cardiac rehabilitation virtual support for patients

The cardiac rehabilitation team found new ways to ensure that patients were able to receive much-needed treatment despite the limitations of social isolation and distancing. The team modified its service delivery in line with measures recommended by the British Heart Foundation and British Association for Cardiovascular Prevention and Rehabilitation.

Assessments, consultations and advice are now being delivered by phone or video call if necessary. In addition, a home exercise programme and information leaflet are sent out in the post to the patient to support the advice given over the phone.

Cardiac Rehabilitation Team

Connecting parents and their premature babies

Staff in the neonatal unit at Lister are now able to make secure videos via vCreate and send them to parents who are not able to be in the neonatal unit. These short videos and messages can brighten the hospital experience for parents during a difficult time, giving reassurance and easing anxiety at being separated from their baby. The videos can be viewed by parents on their smartphones or computers once home and kept to create a diary of the baby's stay in hospital.

Outpatient phlebotomy nursing service

The trust launched a phlebotomy nursing service at the New QEII, Hertford County Hospital and Lister outpatient departments.

When patients come in for their appointments, a member of the nursing team is available in the clinic area to take blood samples immediately after their appointment. This has removed the need for patients to make an additional trip to the

pathology department and this new way of working supports social distancing in pathology and reduces the amount of time a patient spends in hospital.

Promoting IT training for staff that supports new ways of working

During the pandemic the IT department have equipped staff with guidance and technology to support home working and supported staff with different ways of connecting virtually with patients.

MS Teams

Microsoft Teams has been rolled out for staff to use for 1:1 and team meetings. Virtual training on use of MS Teams and written reference guides are available for staff via the Knowledge Centre:

Identifying more Digital Exemplar wards that will help us make better use of our systems

Pirton and Barley wards recommenced their pilot of the Electronic Prescribing and Medicine Administration (ePMA) system using a digital programme Lorenzo ePMA instead of paper drug charts. This will help improve the quality of prescribing and drug administration, and support patient safety.

ePMA teams on Pirton and Barley wards

New digital endoscopy system

The new Medilogik electronic management system for endoscopy was launched that will streamline patient bookings and improve clinical reporting. It gives the endoscopy department an easier way to report and connect to the National Endoscopy Database.

Valuing people

by:

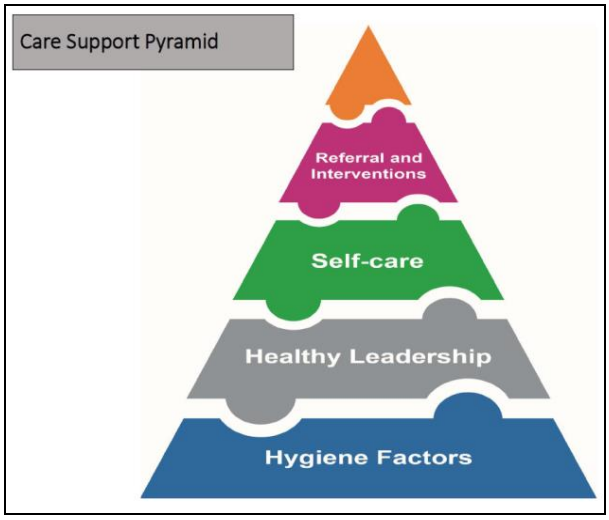
- **Fostering an environment where staff feel valued.**
- **Promoting excellence by using models of best practice.**
- **Recognising staff achievements and examples of outstanding care more often.**
- **Supporting good physical and mental well-being.**
- **Striving to be the first choice of employer for multi-professional staff.**
- **Championing personal development and resilience.**
- **Offering more education and training.**
- **Creating a culture that encourages continuous learning and well-being.**

Fostering an environment where staff feel valued / Championing personal development and resilience

The base of the care support pyramid is 'hygiene factors'. These are the basics that must be in place to ensure that our staff feel valued.

Hygiene Factors:

'Relentless attention to working conditions: the environment, rest areas, refreshments, flexible working, transport, benefits, resources, communication, technology, policies and processes. Pride in getting the basics right.'



The Trust Charity are co-ordinating the refurbishment of staff rest areas throughout the trust funded by donations from the public.

Bite Size training for staff

These short 'BiteSize' sessions explore issues concerning leadership and wellbeing. The aim is to offer staff practical tools and models that help and support day to day challenges and future development. The modules are built around leadership, teamwork, communication, culture, wellbeing, psychological safety and more.

Time to Shine

As part of the Clinical Excellence Accreditation Framework, wards are given the opportunity for a 'Time to Shine' discussion with the senior nursing team. The whole multi-disciplinary team are encouraged to attend to share their achievements and the things that they are proud of.

Clap for Carers

Throughout the pandemic the trust has supported the #ClapForCarers campaign which is encouraging everyone to clap for the NHS. Supportive messages and videos have been shared on the trust's social media channels.

Talent, Leadership and Organisational Development Programmes and Development Opportunities

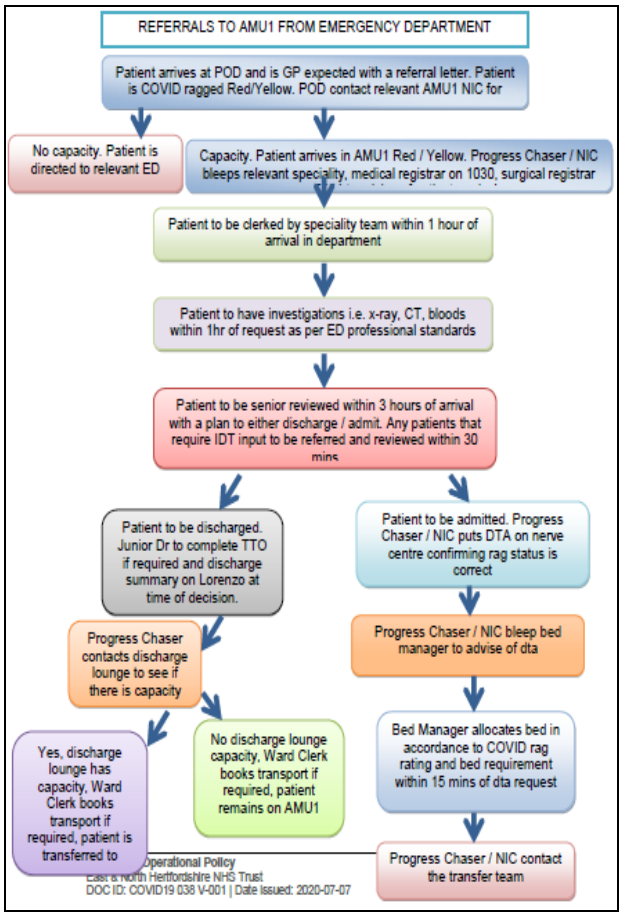
A wide range of development opportunities are available to staff including:

- Creating a high performance culture
- Inclusive leadership
- Strategic thinking
- Organisational culture
- Diversity, inclusion and belonging
- Strategic agility

Promoting excellence by using models of best practice

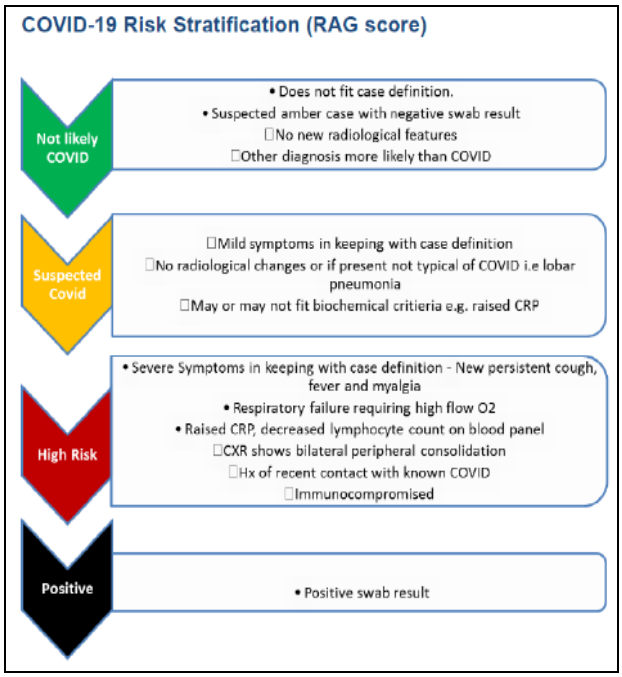
During the last year systems and processes have been developed to produce a robust infection, prevention and control response to COVID-19 to ensure that we are adhering to best practice, and to focus on the safety of our patients and staff. This entailed scrutinising new and revised national guidance and responding locally via the Infection Prevention and Control Lead Nurse and Deputy Lead Nurse, the Infection Control Doctor, and the specialist advisory group (SAG) when needed.

Local guidance was then produced in the form of risk assessments, standard operating procedures (SOPS), and algorithms. Examples of this are the Red and Yellow pathways developed to support the Unplanned Care Division's Emergency Department and assessment areas, so that patients at high risk of COVID-19 were physically separated from those who were of lower risk. This supported the Health and Safety Executive requirements for all acute trusts.



Dr Alex Wilkinson brought forward a suggestion to stratify our patients in their likely risk of COVID-19 early in 2020 before there was a national system of low, medium, and high risk patients to COVID-19.

The RAG rating system was discussed by the SAG and was approved, and has been further developed throughout the pandemic, to ensure that early identification on admission, early detection during the incubation period and appropriate isolation and de-isolation, and discharge all take place. As this proactive approach came before national risk rating of the patients, this allowed the trust to segregate patients from initial assessment and triage, providing increased safety for patients and staff.



Recognising staff achievements and examples of outstanding care

These are just a few of the amazing achievements of our staff that have been celebrated this year:

Lister is the Pride of Stevenage

The Lister Hospital was winner of the Judges' Special Award at the Pride of Stevenage Awards presented in 2021. The annual event, organised by Stevenage Borough Council, focused on the town's response to the coronavirus pandemic. The Judges' Special Award honours long and exceptional service, work and dedication during 2020.

Hertfordshire Community Awards NHS Hero

Catherine Spreckley, Bluebell ward manager was named as 2020's 'NHS Hero' in the Hertfordshire Community Awards. The awards – organised by the Comet, Herts Advertiser, Royston Crow and Welwyn Hatfield Times media titles – saw more than 500 entries in all, with Catherine nominated in the NHS Hero category by a family whose daughter was on Bluebell Ward for five weeks.

Catherine Spreckley and the Bluebell team

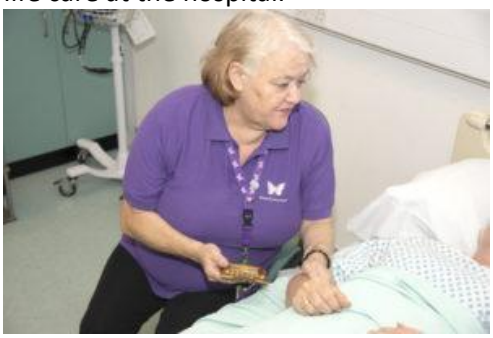
Chief midwifery officer's national recognition

Midwives Pam Langford and Sascha Koutrouza received national recognition from England's most senior midwife. Multiple birth specialist Pam and diabetic specialist Sascha both received Chief Midwifery Officer Awards in recognition of their major contributions to women and the midwifery profession.

Professor Jacqueline Dunkley-Bent OBE – the first chief midwifery officer for England – praised and thanked the trust's maternity team for their "phenomenal" work. Pam has created a Continuity of Care pathway for women who are experiencing a multiple pregnancy, while Sascha oversees an entirely virtual pathway for pregnant women with diabetes.

Butterfly Volunteers

The trust's Butterfly Volunteer Service was honoured with the Queen's Award for Voluntary Service – the highest award a voluntary group can receive in the UK. These amazing and passionate volunteers have made such a difference to end-of-life care at the hospital.



Cavell Star Awards

Nursing and midwifery staff can celebrate the exceptional care and compassion provided by their colleagues by nominating them for a Cavell Star Award. The awards recognise nursing and midwifery colleagues who show exceptional care to their colleagues, patients or their patients' families. Our amazing winners were:

- Kim Skelton, Lead Pain Management CNS
- Alison Baker, Gynaecology Cancer Nurse Specialist
- Eileen Fowler, Nurse Team Leader - Paediatrics
- Sarah Collins, Ward Manager – Paediatrics
- Sally Steptoe, Sister in Paediatrics

Supporting good physical and mental wellbeing

HowAreYouDoingTeam

The HowAreYouDoing team were established at the start of COVID-19 providing a range of advice and training to support staff during the pandemic:

Help spaces:
- HowAreYouDoing hub
- Rest, relax and refresh zone
- Staff support area

Interventions – for individuals and teams
- 1:1 support
- Group support
- Link support
- Structure debriefs
- Bite size learning
- Mindfulness and exercise
- Leadership in a crisis
- Communication in a crisis
- Debrief tools
- Working from home – top tips
- Team huddle
- What to do if staff are struggling
- Health and wellbeing support – useful websites and apps

#HowAreYouDoing

The Wall of Appreciation in the #HowAreYouDoing hub at the Lister was filled with messages of support and thanks from the public.

The #HowAreYouDoing team were available to offer support for staff who just wanted to talk to someone, share their concerns, or to have some help with running staff support groups or debriefs.

Wall of Appreciation in the #HowAreYouDoing hub

Staff Experience Hub

A new staff experience hub on the Lister main corridor (previously known as the HowAreYouDoing hub) opened in November 2020. The hub makes it easier for staff to access wellbeing support, from advice and apps to trauma therapy, whenever required.

#HereForEachOther

The Trust Charity team supported wards and departments with extra items/resources – a wish list was created on Amazon for donations and to ensure items were distributed fairly.

Staff rest, relax and refuel zone

The staff 'rest, relax and refuel' wellbeing zone area at the Lister Hospital was transformed thanks to the generosity of local businesses. As well as new furniture, the area had a new colourful coat of paint to help make the area a more welcoming place for staff to rest, relax and refuel.

Pop up Shop

The new Lister pop-up shop – a 'click and collect' shopping service was set up for staff.

Food boxes containing items such as fruit and vegetables, meat, pasta, bread and milk can be ordered and picked up at the Help NHS Heroes marquee. The boxes offered a stress-free shopping experience exclusively for NHS staff.

Rest area for critical care staff

A new quiet rest area was created where doctors and nurses from Critical Care can relax, when possible, during their busy shifts. MADE.com kindly donated a selection of items including plates and mugs, cutlery, throws, a sofa bed and bean bags for the rest area.

Health@Work support for staff

The Health@Work team offered drop-in sessions for confidential staff support – to listen, and to help staff identify any further support and services they may need.

Crisis support for NHS staff

Body & Soul

London-based charity Body & Soul offered free telephone sessions with any NHS member of staff feeling overwhelmed during the pandemic. The charity has more than 70 fully-qualified and registered volunteer psychotherapists.

New support for staff health and wellbeing

One of the key concerns highlighted by the staff survey and data trends in sickness absence was around improving and supporting the mental health and wellbeing of staff. To enhance the support offered to staff, the Health@Work team identified a new employee assistance provider – Vita Health. They offer staff information, advice and support as well as access to counselling and other therapies, such as cognitive behavioural therapy.

Mental health helpline

The NHS launched a hotline to support and advise healthcare staff during the coronavirus pandemic. Volunteers from charities including Hospice UK, the Samaritans and Shout, listen to concerns and offer psychological support.

Kindness is the key to Mental Health Awareness Week

The wellbeing of colleagues is a top priority for the trust, and we know that it is vital that we create environments where staff feel comfortable to talk about their mental health and know what support is available.

The Health@Work team promoted the importance of being kind to yourself during difficult times. Kindness strengthens relationships, develops community and deepens solidarity. We know that everyone will be facing different emotions and challenges both in relation to their working lives and home lives. It is important that we are there for each other and that everyone feels able to reach out when they need help. The Health@Work team shared information on the mental health services available to staff as well as advice and guidance on looking after their wellbeing. Drop-in sessions were also offered for staff who would prefer confidential staff support.

Support network for shielding staff

A peer support network was set up for shielding staff. It allowed them the opportunity to talk about how they are getting on, speak to other staff in a similar situation and share information about other support networks that could be available for staff having to shield.

Maternity 'wobble' room

A 'wobble room' in maternity has been set up by the professional midwifery advocate team. The team has had a huge impact in providing supportive mechanisms to staff in maternity especially during the COVID-19 pandemic.

The room is a place that staff can go and take a few minutes out of their day to relax and reflect. The 'wobble room' is also used to offer staff individual restorative clinical supervision sessions, which can be done while maintaining social distancing.

Midwives in the Diamond Jubilee Maternity Unit 'wobble room', one of a number of wellbeing areas for staff

COVID-19 Vaccination for staff

A comprehensive COVID-19 vaccination programme has been rolled out to staff and all staff encouraged to have the vaccine. We know that vaccination is key to stem the rising numbers of COVID-19 patients. By getting the jab staff are protecting themselves, each other, their families and our patients.

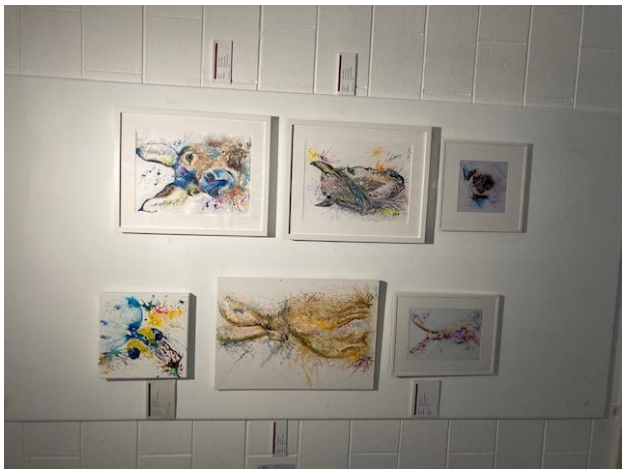
Working with Cavell Nurses' Trust

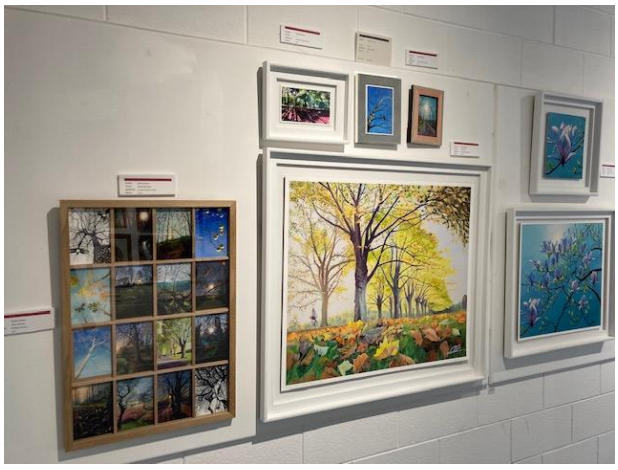
With support from the hospital Charity, the trust became a member of the Cavell Nurses Trust 'Working with' programme. The Cavell Nurses Trust support nursing and midwifery staff when they face a personal crisis such as illness, disability, domestic abuse or pressure from being a carer.

Improving patient and staff wellbeing through art

Artlife has been created to improve the hospital environment, contribute to the health and well-being of patients, visitors, staff and the local community through fine arts, craft, music, creativity and horticulture.

It has been proven that the arts can keep us well, aid our recovery and support longer lives better lived. The Artlife team have opened an art gallery along the Lister hospital corridor for all to enjoy.



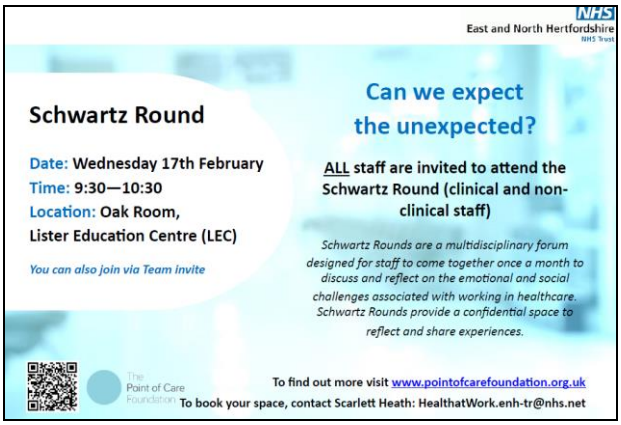


Silent disco in Lister Critical Care Unit

Staff working in the critical care unit have continued to provide exceptional care to critically ill patients during the pandemic. With the help of Silent Noize the Lister ICU silent disco provided a way for staff to unwind.

Schwartz rounds

Regular Schwartz rounds have been set up on topics such as 'how my manager supports me'. These are story telling events that allow all members of teams to come together to tell stories about the emotional and social impact of their roles.



Trust launches wellbeing shared decision-making council

A staff wellbeing shared decision-making council has been launched to help support staff. A high percentage of sickness is due to stress and anxiety-related illnesses and staff who have poor physical or mental health are at increasing risk of making errors. The council will encourage us to start looking out for each other, to have greater awareness of our own level of burnout and to share happiness in the workplace.

Training is available to support staff interested in joining a shared decision making council.

Striving to be first choice employer for multi-professional staff

We continue to aim to be the employer of choice locally, nationally and internationally.

- We have been working hard to fill our vacancies across all staff groups, and we now have 143 more registered nurses in post than we did 12 months ago
- We support our nursing and Allied Health Professional (AHP) students and know they are a vital part of our workforce plan, and we always want them to decide to start their career as a registered professional with us after they have qualified. We run regular symposiums with a variety of different speakers to support and encourage them
- We are starting to undertake work with our communications team to enhance our employer branding to ensure that all of our fantastic work is recognised and known, so that we attract excellent people to join us
- We are focussing more on values within our recruitment processes, giving this equal attention against experience and qualifications, as we know that the right values and behaviours are vital to excellent teamwork
- We have implemented an inclusion ambassador scheme to support our aim for inclusivity for everyone.

International Recruitment- Training and Support

The trust have continued to recruit international nurses to strengthen the nursing workforce. Between April 2020 - March 2021 128 nurses were recruited from the Philippines, India, Zimbabwe, Kenya, Nigeria and Ghana. 65 of these nurses have undergone and passed the Objective Structured Clinical Examination (OSCE) Test of Competence to obtain their Nursing and Midwifery Council (NMC) registration, enabling them to work as Registered Nurses in the UK.

International Nurses outside the Northampton Test centre before undertaking their OSCE

A combination of test centre closures during the initial wave of the pandemic and subsequent restrictions on international travel presented a challenge to the trust with getting these nurses booked onto their OSCE and ensuring efficient and timely progression of this cohort of the workforce to independent clinical practice. As a result the OSCE training delivered has undergone a complete transformation. The nurses are booked onto their exam a couple of days before they arrive in the Trust and receive immediate access to the test centre's learning platform.

The nurses are also utilizing their required isolation period reviewing OSCE training videos and OSCE preparation manuals. Nurse Education has refurbished 2 training rooms into bespoke training facilities not only for nurses undertaking their OSCE but for all clinical skills training.

At present we have a maximum of 12 nurses at any one time undergoing an intense 2 – 3 week programme of training at the end of which they undertake their OSCE exam. This number will increase to 20 to accommodate the further 100 nurses forecasted to join the Trust and who are all required to have passed their OSCE by March 2022.

The Trust is now making best use of the 2 UK mainland test centres, Northampton and Oxford Brookes and are very grateful to the to the Transport team for their continued support with driving nurses to and from the test centres.

The successful OSCE preparation programme continues to provide a comprehensive training, with a subsequent high pass rate of 100% for this period, compared to the national average of 80%.

Feedback from the nurses undertaking their training:

"The two weeks review is very sufficient to learn everything although it is also very important for students to review the videos and materials given prior to formal review sessions. Also, the videos were very helpful. Overall, I had a great time during the review."

"I was really impressed with the OSCE support from the trust especially from the amazing facilitators."

Offering more education and training/ creating a culture that encourages continuous learning and wellbeing

Learning Platform: ENH Academy

The Trust has purchased an IT learning platform system. The platform - ENH Academy - will have all training accessible via this route.

There are numerous benefits of the ENH Academy for the Trust which include a user friendly platform to enable staff to access training more easily, enabling staff to book their own training, managers notifications, confirmation of training booked through the system with candidates receiving reminders to attend the training.

The system also enables subject matter experts to develop their own training for the workforce to access which would be bespoke to the Trust. The first phase of training being developed for the ENH Academy includes Statutory and Mandatory training and Finance training.

In-between training the Nurse Education team are out in the clinical areas supporting the nurses further with their transition to working as Registered Nurses in the Trust.

Training data from March 2020 – February 2021

TSW training – **28** for substantive staff, bank staff and volunteers

Resuscitation/COVID simulation/deteriorating patient – **2654** substantive staff trained

Extra clinical training carried out as outlined in the CPD section.

Apprenticeships

Currently we have 37 different types of apprenticeships being undertaken by staff at the trust. Examples of apprenticeships being undertaken include:

- Accountancy/taxation professional level 7 (degree)
- Coaching level 5
- Project management level 4
- Registered nurse (degree) level 6 (top up)
- HR consultant level 5
- Pharmacy support level 3
- Safety, health and environment level 3

We have members of the senior management team undertaking "Ashridge" Senior leader level 7 apprenticeships both MBA and MBOS.

Maternity Support worker level 3

This is a new opportunity for current band 2 Maternity Support Workers (MSW) to upskill them to obtain the level 3 MSW apprenticeship. The reason we have decided to undertake this apprenticeship is to create a career pathway for them to become (if they wish) midwives. This has been an ICS approach.

Induction

Due to the pandemic the Trust needed to undertake induction for new staff in a different format. Pre-COVID we had induction face to face over 3 days

Day 1 – all staff attended – all day

Day 2 – clinical staff only – all day

Day 3 – clinical staff only – practical sessions (Advanced life support and manual handling) ½ day

During Covid – we changed Day 1 induction to 1 ½ hour via MS Teams, staff are also required to undertake all the mandatory e-learning. Day 2 is condensed into a morning session. Day 3 has remained the same.

CSW Induction

We have created a new Clinical Support Worker (CSW) induction. All new CSW's attend the Trust induction followed by a 3 day programme, this includes practical elements – bed bathing, bed making, commode cleaning. They have classroom session, these sessions range from understanding observations / hydration and nutrition, end of life, diabetes, point of care testing

Moving & Handling training

Moving & handling – level 1: This is a 3 yearly requirement for all Trust staff and has moved from attendance / lecture based training to e-learning since April 2020. This has been further facilitated by the adoption of ENH academy.

Moving & handling – level 2 (Patient handling): Following Health and Safety (HSE) recommendations post inspection a review of manual handling training as it relates to people handling for care within the Trust was carried out in March 2020.

Moving and handling training for people handlers is currently undertaken 2 yearly by clinical staff involved in patient handling and has changed from the previous attendance and participation trainer led course to a competency based training module approach.

The modules focus on key patient handling skills based on the well-established Standard Operating Procedures for patient handling and competent use of equipment required.

The aim of these changes is to enhance the current training and bring this into line with training models which include elements of competency based training. In doing this the Trust will be able to demonstrate and evidence an improvement in the standard and consistency of patient handling training as it relates to the numerous job roles of clinical staff in the Trust.

Employees can use it to provide evidence of manual handling training/patient handling competence when transferring to other departments, areas of the Trust or potentially other organisations.

A comprehensive training needs analysis has been conducted of the current job roles of all the Trust's employees. This identifies those job roles that require the allocation of the competency 'Moving and Handling for People Handlers – 2 yearly'. This has been further analysed to identify those staff requiring competency in using patient hoists and employ the majority of patient handling procedures in their job roles (Maximal handlers) and those staff who do not use patient hoists in their job roles , thereby requiring basic skills only (Minimal handlers). These minimal handlers are predominantly specialist nurses, doctors, theatre staff.

Training content has been divided by modules as follows:

Module C Sit/Stand/Walk – including the falling & fallen patient
Module D Basic seated to seated transfers
Module E Emergency handling situations
Module F Seated to seated transfers using equipment (excluding hoist)
Module G Bed mobility & transfers
Module H Hoisting
Module I Lateral transfers (supine)
Module J Specialised/Urgent need flat lift equipment

The guidance for competency based training is for a ratio of one trainer to 6 delegates. In light of this, and COVID restrictions on practical training sessions, it was possible to introduce a full training programme from August 2020 with adherence to necessary COVIC precautions.

Inspiring and innovating through research and quality improvement

by:

- **Promoting a culture of research and development.**
- **Providing clear guidance and governance that will support continuous quality improvement and research**
- **Developing up-to-date evidence-based best practice.**
- **Providing more learning opportunities – for example, in research coaching and quality improvement methodology.**
- **Encouraging more fellowship opportunities and applications from staff.**
- **Introducing a collaborative approach for research bids that will help advance and improve the health of our population.**

Promoting a culture of research and development

Magnet4Europe

The Trust is one of 14 hospitals in England taking part in the Magnet4Europe study. The study aims to address nurse and doctors' wellbeing, and prevent burnout, by adopting an organization-wide approach to changing working lives. This is an exciting opportunity for ENHT and aligns with Pathway to Excellence, since both are accredited by the American Nurses Credentialing Centre.

Taking place between 2021 and 2023, the implementation of hospital-wide change via a bundle of organizational measures is facilitated by one-to-one twinning with a Magnet© recognized U.S. hospital. The trust has been twinned with Northern Westchester Hospital in New York. As part of this study, inpatient ward staff took part in a survey (and we currently have the highest response rate out of all English hospitals!).

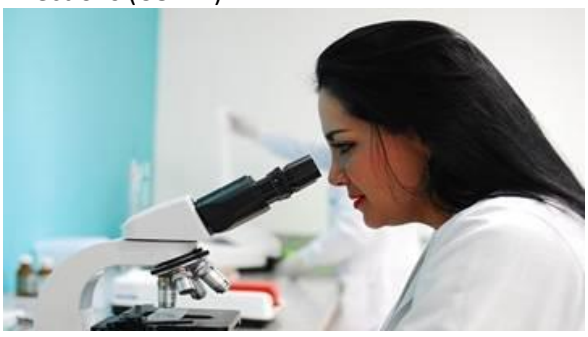
Magnet4Europe involves a usual-practice wait-list cluster randomized trial (RCT) and we will find out soon whether we are in the control arm or the intervention arm. Florence Nightingale Foundation Clinical Professor of Nursing, Natalie Pattison is the Principal Investigator, and the Chief Nurse, Rachael Corser is executive lead.

ANCC Magnet Recognition Program	ANCC Pathway to Excellence Program
. Transformational Leadership . Structural Empowerment . Exemplary Professional Practice . New Knowledge, Innovation and Improvements . Empirical Outcomes	. Shared Decision-Making . Leadership . Safety & Quality . Well-Being . Professional Development

COVID research

Nursing has been prominent with several national studies being led locally by nurses, which have recruited over 700 patients so far. These include: the ISARIC Clinical Characterisation Protocol study – looking at characteristics of people admitted with COVID; this has led to a widely used ISARIC 4C predictive score to determine risk of mortality. GENOMICC – exploring genetic pre-disposition to critical illness through DNA, which has uncovered several genes associated with COVID, and directly led to therapeutic targets for treating COVID.

MERMAIDS-ARI is another study examining gene activity and risk factors in acute respiratory infections (COVID).



The ENHT staff experience has also been captured in the Caring and Learning during the Pandemic (CLAP) study, which was recently published, alongside the national work in SEISMIC, a study looking at safe staffing levels in ICU in the context of COVID.

We are currently developing the next stage of this study, and this is being led nationally by Professor Natalie Pattison.

Prof Natalie Pattison, Principle investigator for the study, Florence Nightingale Foundation Clinical Professor of Nursing

Allied Health Professionals

The therapy service has been working closely with NHS England/Improvement and Kendall Bluck, to establish a workforce planning demand and capacity tool. The model is data driven and evidence based. This is national ground breaking work for the service to have undertaken.

Providing clear guidance and governance that will support continuous quality improvement and research

Research champions

We have resumed the research champion work and also undertaken ward-level teaching to support clinical areas to develop research skills and engage in learning about research. Led by Carina Cruz, we have recently launched lunchtime bite-size sessions for staff to access online.

Learning opportunities

The National Institute of Health Research (NIHR) 70@70 Senior Research Nurse Leader programme is in its second year now and Carina Cruz, Lead Research Nurse and 70@70 nurse, supporting training development and helping to build capacity, working closely with Professor Natalie Pattison.

Research coaching

Lunchtime research coaching sessions have taken place virtually, showcasing current research or methodological teaching and are open to all staff, led by Professor Natalie Pattison.

Shared-decision council in Research

A shared-decision making council for research has been established, with several initiatives underway, including a podcast series, which is led by newly qualified nurse, Gloria Sitakipe.

Research supporting the Clinical Excellence Framework

We continue to support several wards undergoing or preparing for clinical excellence accreditation. We look forward to supporting more areas as the Clinical Excellence Accreditation Framework programme continues at pace.

Patient, Public Involvement panel

The patient, public involvement panel continues to thrive, with presentations around Research and COVID, and they have reviewed and contributed to several studies, including nurse-led work in long-COVID, led by Professor Natalie Pattison.

Service evaluations

Nurses have initiated several service evaluations over the past year, including completing one on Safe practice of personal protective equipment (PPE) in cardiac arrest led by Jen Body.

Ensuring quality and safety

by:

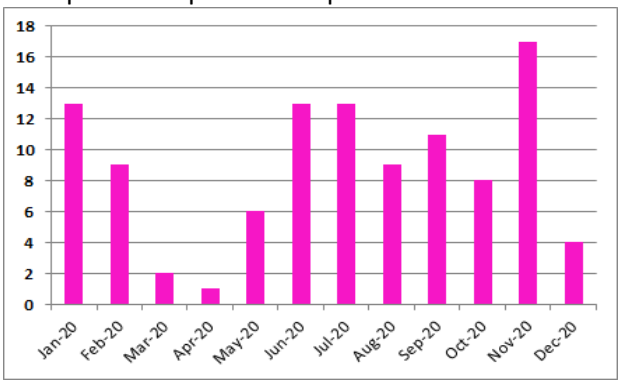
- **Delivering excellent and compassionate care consistently, reflecting the values of the Trust and our professions.**
- **Using our quality dashboard and nursing quality indictors to make informed decisions that will continue to improve patient care.**
- **Making realistic, sustainable and aspirational improvements to quality and safety.**
- **Creating career pathways that will improve our workforce and the care we provide.**
- **Introducing a ward accreditation scheme that will promote and recognise outstanding care.**
- **Using learning from incidents to drive best practice and improvements.**

Delivering excellent and compassionate care consistently, reflecting the values of the Trust and our professions

We aim to provide excellent, compassionate care to our patients, service users and their carers and families and are continually looking to innovate and improve the care we provide reflecting the Trust's PIVOT values.

Accessibility Coordinators

The Accessibility Coordinators at Mount Vernon Cancer Centre (MVCC) have continued to support our most frail and vulnerable patients to access Cancer Services at MVCC during the pandemic. The graph below illustrates the number of patients who have been supported last year and include those with learning difficulties, dementia, drug and alcohol addiction, mental health illness in addition to those with sensory loss. The accessibility coordinators work in partnership with the patient and clinical teams to agree a tailor made pathway to ensure that appropriate adjustments are made to improve the patient's experience.



Number of patients supported by accessibility coordinators to access services at MVCC

Family Liaison Clinician

A new role to keep patients and their families in touch during restrictions on visiting was introduced. The Family Liaison Clinician service (FLiC) comprised of registered nurses redeployed during the COVID-19 pandemic. The service focuses on patients who are unable to communicate directly with their families.

FLiC nurses offer daily update phone calls to families as well as enabling phone and video calls to ensure families can keep in contact. These conversations provide a better understanding of the patient as a person in their normal home environment. Comfort hearts are also provided to the patient and a matching one sent to the family.

Family Liaison Clinician Team

Using our quality dashboard and nursing quality indicators to make informed decisions that will continue to improve patient care

The trust remains committed to supporting the development of analytical capabilities across the workforce. Through measurement for improvement 'bite size' training the staff have been learning how to understand where variation exists in the system; and use their data to proactively drive improvement by reducing the 'unwarranted variation'.

A new integrated performance report has been designed to support looking at key measures through themes and times series charts (see example below). Triangulation of Nursing Quality Indicators (NQIs) and other data sources is underway to support a more robust Quality and safety dashboard within QlikView sharing platform. This platform allows drilling of quality and safety data to ward and service line level.

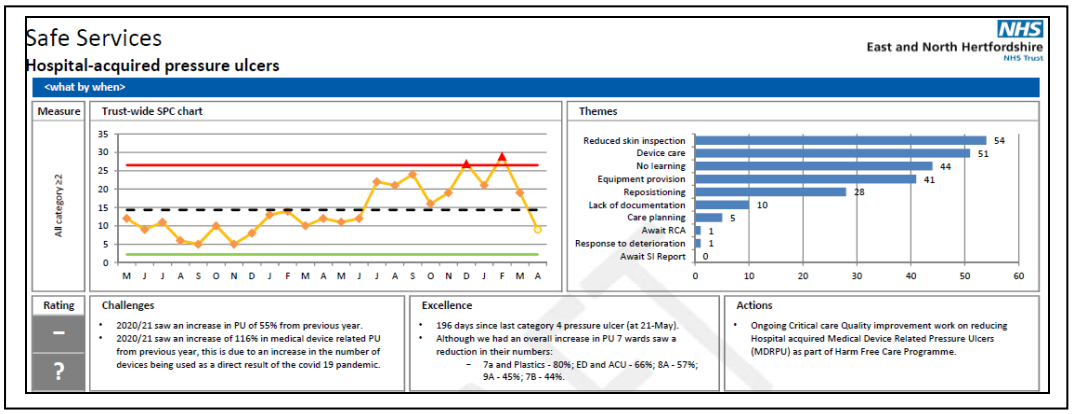
Allied Health Professionals (AHP)

The Ophthalmology AHP team have been working independently in paediatric ophthalmology since 2014 delivering an AHP-led service which significantly reduced waiting times and improved access to the service.

Nursing and Midwifery Quality Indicators:

Our monthly Nursing and Midwifery Quality Indicators report includes key data broken down by ward and division to enable monitoring of:

- Bed numbers
- E-rostering
- Staffing
- Patient safety
- Patient experience

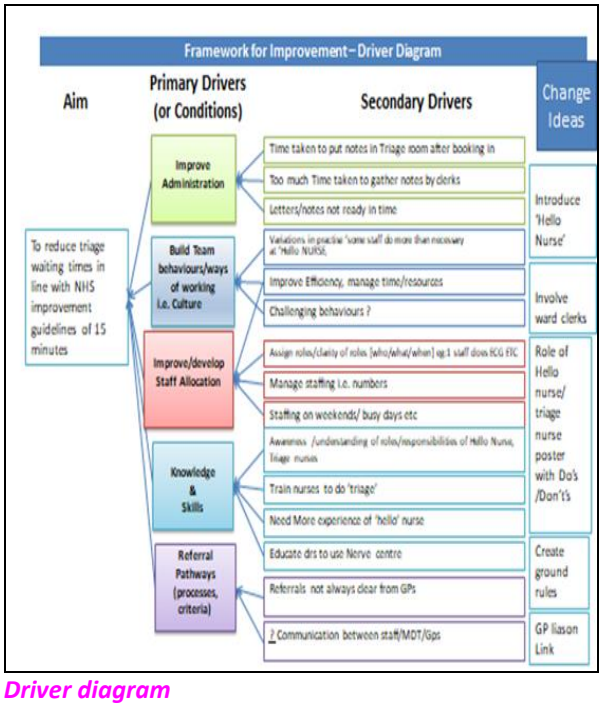


QlikView data

Making realistic, sustainable and aspirational improvements to quality and safety

In November 2019, Ambulatory Emergency Care was transformed, and a higher percentage of patients attending would be 'emergency 'patients either from GP or Emergency Department. This required improvements to key aspects of the service. The team set an aim to align with Emergency Department standards that all patients would be assessed within 15 minutes of arrival.

The baseline performance demonstrated that for the period December 2019-January 2020 the initial triage times were between 20 and 75 minutes. The driver diagram shows the teams aim to improve all triage times to 15 minutes and the identified primary and secondary drivers to target to achieve this improvement:



Driver diagram

New idea tested:
Following consultation with the wider service team members and medical leaders, the team introduced a new 'Hello Nurse' at the point of triage. With continuous review of current and new processes the team worked together to redesign assessment and escalation steps to ensure a safe and more timely triage of patients.

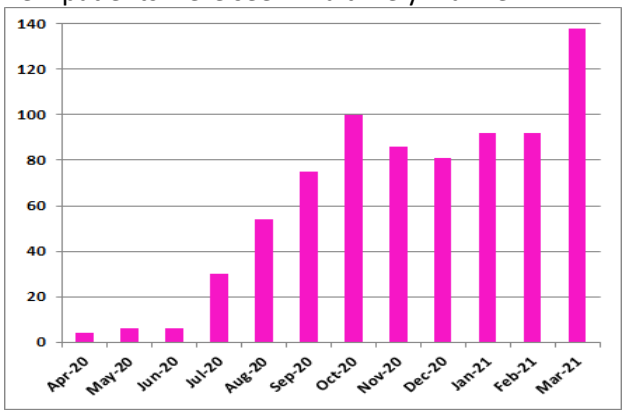
Outcomes:
Patients are now being assessed within 15 - 30 minutes of arrival. This has seen triage times improve from January 2019 at 40-60 mins to March 2020 at 15-25 minutes.

Staff feedback included that they were "proud to be part of a team that could successfully drive service improvements", with the ward clinical leader feeling more accomplished and a more confident clinical leader. Patient feedback included "The service was well timed, with friendly staff who knew what they were doing and explained everything". The project also demonstrated an improvement in Friends and Family Test feedback, with an increase in the proportion of patients that would recommend the service from 94.49% in September 2019 to 100% in February 2020.

Creating career pathways that will improve our workforce and the care we provide

Non-medical prescriber pharmacists

At Mount Vernon Cancer Centre (MVCC), pharmacists provide a wide range of services within the outpatient and inpatient settings to support the cancer patient's journey. The utilisation of non-medical prescriber pharmacists has allowed MVCC to maintain and grow clinic capacity during the pandemic, thereby ensuring existing patients had continued access to care and new patients were seen in a timely manner.



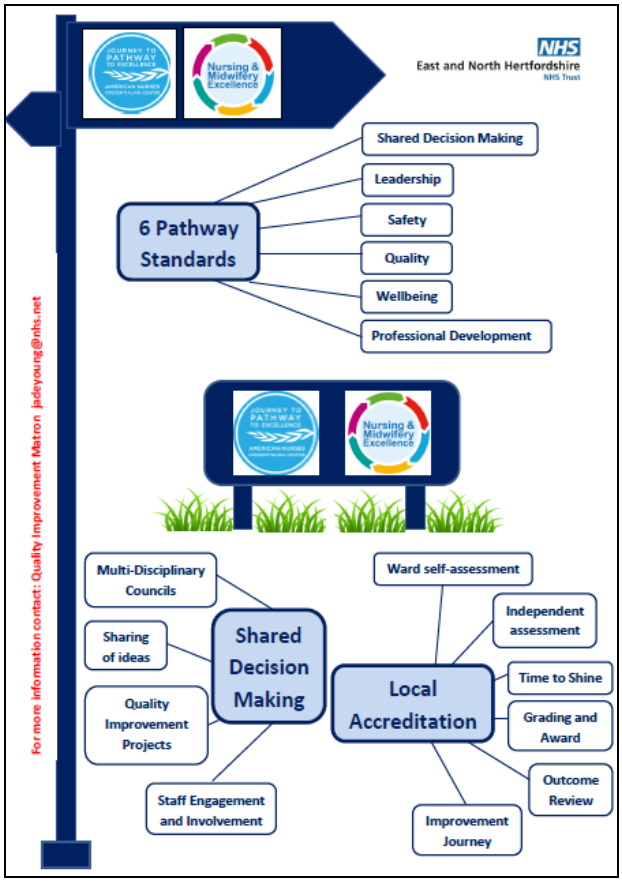
Number of patients seen in non-medical prescriber clinics at MVCC

Introducing a ward accreditation scheme that will promote and recognise outstanding care - Pathway to Excellence®

The trust is one of just 14 trusts across the country, chosen to participate in the Pathway to Excellence® programme. The programme focuses on six pathway standards: shared decision making, leadership, safety, quality, wellbeing and professional development. Pathway to Excellence® is a formal recognition and accreditation of nursing and midwifery excellence that promotes a positive practice environment, and offers proven strategies to ensure that the care that we deliver to our patients is of the highest standard.

The Pathway to Excellence® is made up of three components which come together to demonstrate different ways to support nurses and midwives to influence and effect change:

- Nursing and midwifery excellence – six pathway standards
- Local accreditation
- Shared decision making



Our Clinical Excellence Pathway

Local Accreditation

In July 2020, the trust was delighted to re-launch the Clinical Excellence Accreditation Framework (CEAF) on our wards – this is our local accreditation programme.

The CEAF brings together key measures of nursing/midwifery care to enable a comprehensive assessment of the quality of care provided at ward level. The CEAF enables the trust to reward and recognise excellence in care and supports continuous improvement.

The CEAF aligns with the six pillars within the Nursing, Midwifery and AHP Strategy:

Pillar 1: Developing and strengthening leadership
Pillar 2: Optimising pathways
Pillar 3: Valuing people
Pillar 4: Inspiring and innovating through research and quality improvement
Pillar 5: Ensuring quality and safety
Pillar 6: Partnership working

The CEAF assessment process includes:

- **Baseline/self-assessment** including a staff and volunteer survey, completing the self-assessment templates and preparing a portfolio of evidence
- **Independent assessments** supported by specialist teams e.g. Infection Prevention and Control, Tissue Viability, Pharmacy, Patient and Carer Experience etc.
- **Time to Shine discussion** which is an opportunity for the multi-disciplinary team to share all that they are proud of
- Collating the **evidence and clinical assurance** that fundamental standards are met
- **Credentialing Award panel** where the final award level is agreed

Wards are supported by corporate and specialist teams with their continuous quality improvement programmes.

Our award levels so far:

Gold	Silver
Neonatal Unit	AMU Green
Bluebell Ward	Ward 5B
Swift Ward	Ward 6B
	Ward 7A
	Ward 10B
	Pirton Ward
	Barley Ward

Ward 6B, 8B, 10B and Swift receive their awards – September 2020

Pirton, Barley, Bluebell and 5B receive their awards – October 2020

Shared Decision Making

We have developed our pathway of shared decision making through the introduction of shared decision making councils (SDMC). Shared decision making is a collaborative leadership approach, where our point of care staff are given a platform to get involved with decisions that are being made. We encourage all of our colleagues from a variety of professional backgrounds and bands to join and participate. Members of the shared decision making councils are given the opportunity to have their say on what matters to them, to their colleagues and to their patients. They have the opportunity to network with a multi-professional team, develop leadership skills and to share their learning.

Within the trust we have different types of councils:

- **Ward Councils** – Team members from one ward or department create their own local SDMC and develop improvement initiatives for their areas. They then have the opportunity to share their learning.
- **Themed Councils** - Team members from across the whole trust create a SDMC focussing on a particular theme such as Staff Wellbeing and develop improvement initiatives to share with the trust.
- **Specialist Councils** - Team members from across the whole trust create a SDMC representing a specialist area such as Research and developing improvement initiatives to share with the trust.

Currently within the trust we have six shared decision making councils and the trusts first Leadership shared decision making council. Each council member is given working time to attend the monthly council meetings.

Ward Councils: ♦ Neonatal Unit
Themed Councils ♦ Wellbeing ♦ Reward and recognition ♦ Newly qualified
Specialist Councils: ♦ Research ♦ Pharmacy

Each shared decision making council will nominate a council chair. The council chair is invited to the trusts Leadership Council where they have the opportunity to share their initiatives and outcomes. The Chief Nurse chairs the Leadership Council and provides support to the councils by connecting them with the right people and helping them overcome obstacles. This enables our point of care staff to share their thoughts, feelings and ideas from the 'shop floor' to board level and informs the board of what really matters to our colleagues.

To support the development of shared decision making and all council members the Nursing and Midwifery Excellence team hold a training session once a month: An introduction to shared decision making. This training provides an overview of how shared decision making works and what it looks like, what shared decision making councils are and why the pathway of shared decision making is so important for our trust. The Nursing and Midwifery Excellence team work alongside the Quality Improvement team and Research team who both offer additional support and training for our shared decision making councils.

- **Research Training:** Coaching sessions, Bite-size training and drop in sessions, 1:1 support, Critical appraisal course.
- **Quality Improvement Training:** Bite-size QI, Project Coaching.

Using learning from incidents to drive best practice and improvements

The enabling of round table discussions as an approach to reviewing incidents has afforded opportunities to share good practice across a variety of disciplines like the sharing of virtual clinics to ensure results are reviewed in a timely manner. Patients who are awaiting results are booked into a virtual clinic in a fortnight where results can be reviewed rather than waiting for 6 weeks. This practice was shared by the cardiology team in a thematic review of patients who were awaiting a review of their radiology results. The staff feedback post round table discussions were that often focus has been on individual failure and that at the round table discussions the focus had shifted to a focus on the systems whilst acknowledging failures at the level of individuals.

The After Action Review (AAR) communicates a simple concept in both word and deed, where learning is prioritised over blaming. The maternity team have been successful in supporting staff in implementing welfare, hot and cold debriefs as a process to use following an unexpected/ unanticipated poor outcome where immediate learning, actions and quality improvements are captured. These are currently being rolled out across the Trust with training packages being developed to support staff in facilitating these discussions. AAR creates, is an experience of learning together after difficult experiences that are safe enough to actually allow staff to engage in discussion about creating better ways of working.

The maternity unit conducted a review of their recent incidents to find some common themes that could be converted into quality improvement projects. Through this process the following themes were identified: situational awareness, escalation, and hyponatraemia. They asked themselves some difficult questions as to why previous actions were not working.

They implemented a number of changes which included a new maternity specific fluid balance chart following a quality improvement pathway. Awareness of the escalation process and appropriate escalation promoted using updated human factors/PROMPT training and a quality improvement project to review the current Situation, Background, Assessment, Recommendation (SBAR) format and the updated pathway specific SBAR stickers have been introduced into each area.

Partnership working

by:

- **Improving our engagement with patient experience groups, as well as other local partners.**
- **Encouraging innovation across all levels, from the frontline to wider developments across the Sustainability and Transformation Partnership (STP).**
- **Sharing the Trust's strategy with our partners, making sure our vision aligns with local health priorities.**

Improving our engagement with patient experience groups, as well as other local partners.

We are:

- Recruiting patients and carers to our harm free care and patient and carer experience programmes from diverse backgrounds.
- Designing a patient and carer experience meeting so that it meets the needs of people with learning disabilities so that they can participate in designing service improvements.
- Supporting patients and carers in developing information videos for visiting.
- Running a 'keeping in touch' service which was set up to enable virtual visiting during the period when visiting to the hospital was very restricted and this will continue for people who cannot visit for various reasons.

Sharing the Trust's strategy with our partners, making sure our vision aligns with local health priorities

We:

- Supported training for nursing homes in Hertfordshire around infection prevention control issues and the correct usage of Personal Protective Equipment.
- Work in partnership with services in the community particularly around support for carers.
- Are engaging with community services to support development of the new mental health strategy.

Partnership working with Allied Health Professionals (AHPs)

The trust employs nearly 300 AHP staff spanning nutrition and dietetics, occupational therapy, operating department practitioners, ophthalmology, physiotherapy and radiology. On 14 October 2020 we took the opportunity to celebrate what AHPs do and why their contribution is so valuable.

Across all AHP professions staff work changed considerably during the pandemic in either an extension of responsibility, taking on nursing roles/duties in order to free up the nursing team for redeployment, or in very different roles being redeployed in other areas of the Trust as part of the proning team, the vaccination hub and on critical care.

Working with volunteers

Some examples of how volunteers have helped over the last year:

- Voluntary Services team assisted with the set up and implementation of the Deployment Hub – supporting the recruitment of temporary staff and volunteers over the pandemic.
- Voluntary Services worked closely with community sewing groups in order to make and provide washbags and scrubs for the hospital staff.
- Rolling out the new Response Volunteer model allowing volunteers to book their shifts dependent on their availability each week. On each shift, they are tasked with ad hoc requests from anywhere in need of more support in the hospital.
- Response Volunteers were also used to support the following patient experience initiatives: delivering 'Stay in Touch' letters, helping patients make video calls (aka 'Virtual Visits') with loved ones, delivering patient belongings while visiting was restricted.

- Successful recruitment drive to enrol more Butterfly Volunteers to support dying patients and the End of Life team.
- Reinstating our 'paused' volunteers – inviting over 400 volunteers to return to their supporting roles (ensuring their safety checks are up to date).

Safeguarding Team

The Trust safeguarding team remain active members of the Hertfordshire safeguarding adult board, and children's partnership. Key achievements of our involvement have led to Trust improvements in the following aspect of care:

- Recognising and supporting victims of domestic abuse working in conjunction with Independent Domestic Violence Advisory Services (IDVA). The trust safeguarding team supported 151 victims and 110 children referred to the trust IDVA service in relation to Domestic abuse.
- 400 children and young people had contact with the hospital youth worker
- Recognising the impact of domestic abuse on the family unit, a think family safeguarding response to domestic abuse is now established routine practice.
- Education is delivered to staff on modern slavery to improve recognition of its victims – 29 cases for concerns relating to child exploitation referred to the local authority
- Staff have received improved training on the awareness of financial crime and sign posting of its victims to supportive services.
- Pathway established under the homelessness reduction act for trust staff to sign post and support homeless individuals to access local authority housing services.
- Staff received education on supporting individuals who are self-neglecting and where alcohol or substance misuse is identified as a contributory factor our patients are supported and encouraged to engage with commissioned substance misuse services.
- Staff received support to manage all patients accessing trust services with a learning disability (LD) they work in conjunction with the Health Liaison Team to achieve this. The trust has close links with the HSAB improving health care outcomes group for individuals with a learning disability and learning obtained from LeDeR reviews is incorporated into Trust policy or processes.
- Violent assault dataset implemented with the community safety partnership – to help tackle and reduce serious violence and crime.
- Continued information sharing with Multi Agency Risk Assessment Conference (MARAC) for high risk domestic abuse victims, and introduction of the Multi Agency Child Exploitation (MACE) panel.

Year on year we have seen an increase in safeguarding referrals from our staff in relation to service users this increase demonstrates that our staff are acknowledging and acting on safeguarding concerns and is indicative of an increased awareness achieved through education.

Harmful Sexual Behaviours week ran the week of 28 September 2020. The aim of the week was for the safeguarding team to release their harmful sexual behaviours pathway to use with patients accessing the trust, this piece of work was created by the Safeguarding Team and contributed to by the hospital youth worker.

Promoting the sexual behaviours pathway

Working with the Police

- The trust continues to work in partnership with Hertfordshire Constabulary.
- There is a dedicated Police Community Support Officer based at the Lister Hospital site.
- We have recently launched "Operation Trust" a joint initiative to investigate and support prosecution associated with violence, aggression and antisocial behaviour.
- A joint working group is working to improve the management of patient property within the hospital.

East and North Hertfordshire
NHS Trust

Nursing, Midwifery and Allied Health Professional Strategy 2019-24
Annual Report 2020-21

Published June 2021

East and North Hertfordshire NHS Trust

Agenda item: 19

TRUST BOARD – PUBLIC MEETING – 7 JULY 2021

2020/21 Annual Report on Research at the Trust

Purpose of report and executive summary (250 words max): This report describes the benefit of undertaking research, details the research activities, some of the items of note and current risks related to R&D.		
Action required: For discussion		
Previously considered by: R&D Board 23rd June 2021, Quality and Safety Committee 29th June 2021 (Note: Some amendments have been made from the version submitted to QSC in order to ensure individual patients cannot be identified)		
Director: Medical Director	**Presented by:** Medical Director	**Author:** Associate Director Research & Development
Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites		☒
People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce		☒
Pathways: To develop pathways across care boundaries, where this delivers best patient care		☒
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff		☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term		☒

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

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

2020-21 Annual Report on Research at the Trust v1 dated 30th June 2021

EXECUTIVE SUMMARY

The Trusts seeks to '*enhance patient care and experience through research and innovation'*. This report provides a review from the Research and Development Division covering the period April 2020 to March 2021.

Being research-active is beneficial for patients, staff and Trust. There are significant direct patient and financial benefits for the Trust being research-active and there are a number of indirect and often undescribed benefits such as staff attraction and retention.

Summary 2020/1 has been both a challenging and rewarding year. The Research teams have responded well to the triple challenge of:

- supporting the front line through redeployment,
- delivering research to meet the urgent public health need (Covid), and
- ensuring the safe continuation of treatment for research participants.

2021/2 priorities

1) Identify and share the benefit of our research on patient care and patient pathways through internal and external communication to researchers, staff and Divisions/Specialties.
2) Grow the Trust Patient and Public Involvement activity through the Trust's Patient and Public Involvement in Research Group.
3) Ensure financial visibility and sustainability for research and our research teams and to include the identification / recuperation of all cost savings.
4) Delivery of National Institute for Health Research (NIHR) performance expectations target and other NIHR High Level Objectives.
5) Support Trust staff to gain external funding for research or research-activities and ensure our teams are fully supported through induction, training/development, appraisal and recognition of effort (awards etc.).
6) Support the transfer of Mount Vernon Cancer Centre services and re-align funding from the NIHR accordingly.
7) Establish a functioning Research Office at Lister Hospital.
8) Further develop our working as the co-founder of the East and North Hertfordshire Integrated Care Provider Research Collaboration.
9) Work well with University of Hertfordshire, NIHR (including the Research Design Serviced and the Applied Research Collaboration), the Cambridge Bioscience Campus, Eastern Academic Health Science Network and others to deliver the Trust's research and wider ambitions.

The Board is asked to:

- Note the progress made in delivering the 2020/1 Business Objectives, delivering COVID research and supporting the MVCC transfer.
- Approve the 20201/2 priorities in light of the identified risk.
- Acknowledge and thank all those associated with research (both the delivery and back-office function) for all their hard work and dedication.

1. BACKGROUND

Research supports the Trust vision "**Proud to deliver high-quality, compassionate care to our community"** and is a key enabler for the delivery of the Trust's clinical strategy, (see Tables 1 and 2).

Trust Vision	Proud to deliver high-quality, compassionate care to our community
Strategic Priorities	Quality, People, Pathways, Ease of Use, Sustainability
Values	Patients first, Improvement, Value everybody, Open and honest, Work as a team.
Research Vision	To support high-quality, compassionate care to our community through research and innovation.
Public & Patients	To ensure that the public and patients have the opportunity to contribute to a) the setting of the Trust's research priorities, b) the design of research studies, and c) to take part in wide range of research.
Culture	Well trained and professional staff working within in an environment that is safe, well governed and fit for purpose.
Principal drivers	Public and patient engagement, patient benefit, interested lead researchers, income generation, research metrics

Table 1 Research supports the Trust vision

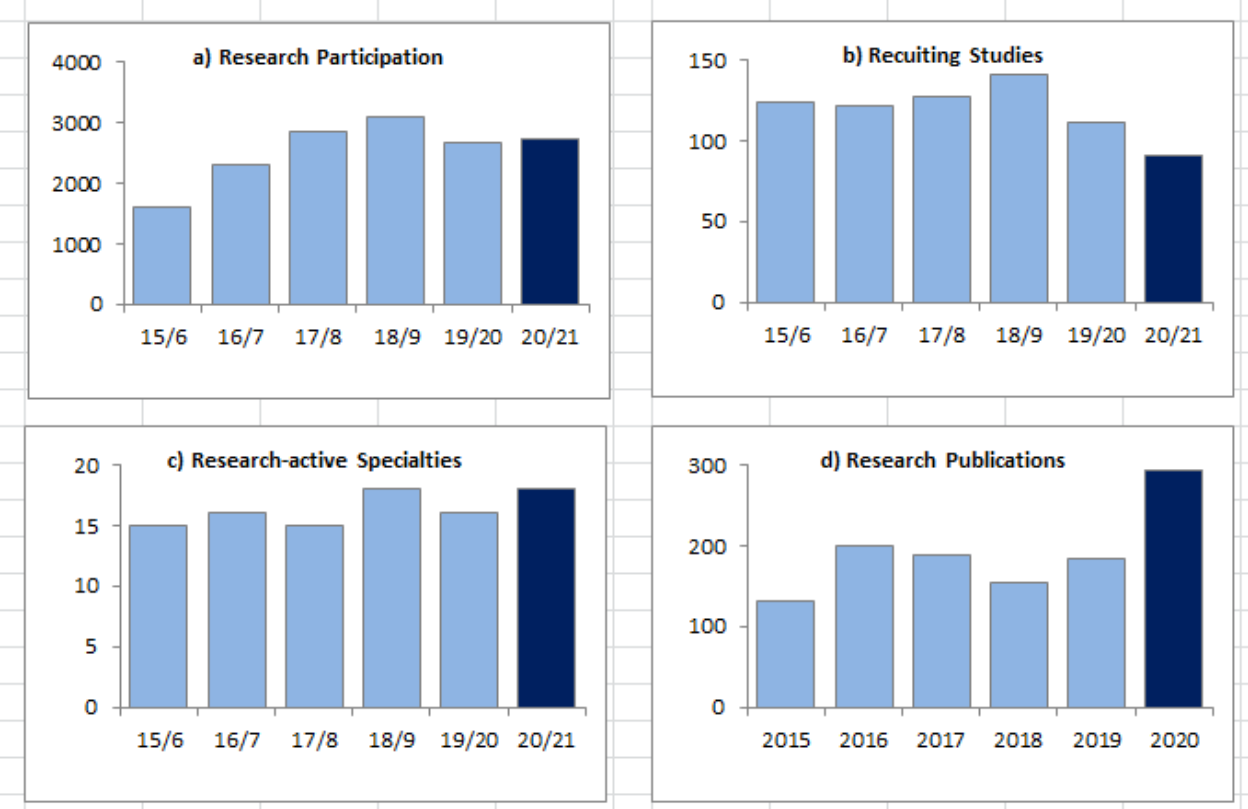
Trust Vision	Proud to deliver high-quality, compassionate care to our community
Deliver high quality care consistently across all of our services in terms of clinical quality, safety and compassion.	• Research-active Trusts deliver better care. • Research participants benefit from an 'enhanced service'.
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.	• Public and patients have the opportunity to contribute to a) the setting of the Trust's research priorities, b) the design of research studies, and c) to take part in wide range of research.
Pursue actively the development of pathways across care boundaries.	• Trust staff develop their own research ideas to improve the local delivery of care.
Create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.	• A research-active Trust helps attract and retain staff. • Well trained and professional staff working within an environment that is safe, well governed and fit for purpose.
Develop a portfolio of services that are financially and clinically sustainable in the long-term.	• Research is entirely externally funded. • Treatment of patients attracts additional income. • Free drugs and other equipment provided. • Research income pays an overhead to the Trust.

Table 2 Research supports the Trust Strategy

2. RESEARCH ACTIVITY

The Trust is proud to be part of the National Institute for Health Research which has a national vision "***to improve the health and wealth of the nation through research***".

During 2020/1 the Trust recruited 2,566 participants to research in 85 unique studies with 4 studies taking place at both Mount Vernon Cancer Centre and the Lister Hospital. Research was led by 41 local leads. Research activity at the Trust over recent years is summarised below and progress against the 2020/1 Research Business Plan is given in Appendix 1.



Figures 1a, b, c, d Research activity over the last 6 years expressed through a) participation, b) recruiting studies, c) research-active Specialties and d) Research Publications.

Research activity covered a range of Specialties as shown below (Table 3) with further details in Appendix 2.

Supporting the proposed transfer of Mount Vernon Cancer Centre services

The Research team has fully supported and completed the due diligence work associated with the proposed transfer of services. Funding has been secured and additional capacity has been put in place to complete those enabling activities that it makes sense to complete prior to a formal 'Go/No Go' decision.

The Lister Research Office is being established so that the Trust has capacity to manage all research responsibilities following the transfer. This is required because currently the Trust's Research Office is mainly located at Mount Vernon and will transfer.

Specialty	Lister (Participants)	Lister (Studies)	MVCC (Participants)	MVCC (Studies)
Anaesthetics	279	2		
Cancer	20	6	287	39
Cardiology	304	8		
COVID-19	925	10		
Diabetes	16	3		
Gastroenterology	81	1		
Health Services Research	126	1	74	1
Paediatrics	68	5		
Plastics	1	1		
Renal	208	9		
Respiratory	169	2		
Urology	8	1		
Total by site	**2205**	**49**	**361**	**40**

Table 3: A summary of research activity in 2020/21 by speciality and site

Providing the research and evidence base for meeting the Covid-19 challenge
During 2020/1 the Trust's Research teams reviewed their research commitments so as to identify how best they could support the response of the Trust and of the nation to Covid-19. Initially all research projects were reviewed to identify which could be paused to enable staff to focus on the nationally prioritised COVID-19 studies or be redeployed to frontline care.

A significant contribution was made to Urgent Public Health COVID-19 Studies as with further details in Appendix 3.

The Trust supported the national research priorities and is proud to be part of the Clinical Research Network in the East of England which performed very well in 2020/1 as illustrated by the highlights below:

- Overall participation in NHS research 122,876 (~3% of the East of England population).
- Overall participation in Urgent Public Health Studies 60,498.
- Overall participation in RECOVERY trial 12.9% of the eligible patients.

Continuation of cancer research
The Trust supports the delivery of cancer research at both the Mount Vernon Cancer Centre and the Lister Hospital. Much of the cancer research continued in 2020/21 and the Trust recorded the second highest recruitment to cancer studies (518 participants) in the East of England after Cambridge University Hospitals NHS Foundation Trust (1,603 participants).

Being ready to support all research to enhance patient experience and outcome
With the pressures of the pandemic beginning to ease and COVID-19 caseloads falling, work is underway to support the recovery of research into other conditions, and to increase the strength of the UK's research base and life sciences sector. This supports the vision set out by the Department of Health and Social Care in the document Saving and Improving Lives: the future of UK clinical research delivery.

Organisational research

The Trust is taking part in the Magnet4Europe study which is an interventional study aimed at redesigning and improving clinical work environment of physicians and nurses to

- improve mental health and wellbeing (e.g. job satisfaction, burn-out, absenteeism, retention, etc.), and
- improve patient safety and patient related outcomes.

The purpose of the study is to determine if redesign of hospital work environments, guided by Magnet® principles, is feasible, effective and sustainable in Europe in improving quality of care and safety, patient satisfaction, and workforce outcomes. This will help us achieve Pathways to Excellence™, which like Magnet®, is accredited by the American Nursing Credentialing Centre. This directly feeds into both the Trust and Nursing strategies, enhances engagement with research Trust wide and also delivers improvements in care.

The Trust has been twinned with Northwell/Northern Westchester Hospital, Mount Kisco, New York.

The Trust has had a 44% response rate from nurses (195) and 10% response rate from doctors (36). We had the highest nurse response rate in the survey for the Group 2 Magnet4Europe Hospitals.

Listening to and acting on the Patient and Research Participant voice

The Trust's Patient and Public Involvement in Research Group ensures that the patient voice is heard and acted on. During 2020/1 the Trust completed the annual research participant survey and a summary of the findings is given below.

Statement	Agreed or strongly agreed
• The information that I received before taking part prepared me for my experience on the study	96% (48 of 50 responses)
• I feel I have been kept updated about the research	70% (33 of 47 responses)
• I know how to contact someone from the research team if I have any questions or concerns	98% (51 of 52 responses)
• The researchers have valued my taking part in the research	92% (48 of 52 responses)
• Research staff have always treated me with courtesy and respect	98% (51 of 52 responses)
• I would consider taking part in research again	85% (44 of 52 responses)

Example qualitative feedback from research participants

I was a research scientist for 10 years so very happy to be involved. I have benefited from research by others to improve treatment, so happy to be involved and help those who follow in future years. It is something positive to come from having prostate cancer.

I received extra care, attention and results. I was informed all throughout the process Nurses on the research programme have been very supportive throughout.

I am very happy with my research experience and can't think of anything that could have improved it.

Some of the many research highlights

Securing additional funds to enable research to take place

- A total of four Consultants received 'Greenshoot' funding from CRN: Eastern to develop research capacity.
- The Trust was successful in a bids to secure £112k and £55k of additional funding from NIHR Clinical Research Network (CRN): Eastern to support the delivery of Covid Research, the development of capacity to support Covid Vaccine research and to support the managed recovery of non-Covid research.

Delivering research and innovation

- The cardiac unit at Lister is the highest global recruiter for EDICA trial (Early detection of myocardial ischaemia in suspected acute coronary syndromes).
- The cancer team at the Lister is the first in Great Britain to open a trial which is comparing a type of targeted therapy with the investigator's choice of chemotherapy for the treatment of high-risk non-muscle invasive bladder cancer.
- The Mount Vernon Urology cancer research team is very proud to be the top recruiters in the UK for two international studies.

Working with partners to deliver research across our local area

- The Trust continues to work with the University of Hertfordshire to support joint research and innovation.
- The Trust co-founded with Hertfordshire Community NHS Trust the East and North Hertfordshire Integrated Care Partnership (ICP) Research Collaboration which aims to establish the local area as a centre of excellence for research.

Producing new knowledge through research and innovation

- The number of research publications was 295 which was higher than previous years. Of these 37 were published jointly with the University of Hertfordshire.
- Supporting innovation - Lightpoint Medical receives CE Mark for world's first approved robotic gamma probe with support from the Trust (more info here).

Transforming the way we treat patients because of research

- Covid research has led to new treatments which are now standard of care e.g. Dexamethasone and Tocilizumab and this saves lives.
- The Mount Vernon Melanoma team are extremely proud of their work on novel therapies and this has included looking at a new drug to treat ocular melanoma. This drug proved to be the first treatment to improve overall survival in this group of patients. With such positive outcome, it has meant that this drug will soon become available through the Early Access Programme.
- At the Lister the gastroenterology team have introduced the use of the Cytosponge™ test to diagnose Barrett's Oesophagus in patients with symptoms such as heartburn. The project aims to diagnose up to 50% of cases of oesophageal cancer earlier, leading to improvements in survival, quality of life and economic benefits for the NHS.

3. GOVERNANCE

The oversight of research is the responsibility of the R&D Board and is led by research Triumvirates at Mount Vernon Cancer Centre and Lister Hospital (which also covers research at Hertford County Hospital and the new QEII Hospital). Each Triumvirate comprises representation from the consultant body, nursing and operational management.

Research at the Trust is supported by a number of well-defined policies, processes and guidance notes to ensure that all research is compliant with national research and ethical standards (e.g. UK Policy Framework for Health and Social Care Research).

The Trust currently has a single Research Office that is mainly based at the Mount Vernon Cancer Centre. A Lister Research Office is being created to ensure that the Trust can maintain capacity to provide oversight, management and governance of research in light of the transfer of MVCC services.

These arrangements ensure that all approved research can meet the requirement of external regulation, so that research is financially sustainable and choices can be made about the allocation of resources to deliver the Trust's overall vision.

4. FINANCES

The Covid outbreak disrupted study activity and diverted staff resources with the reduced activity delivering less income, particularly at the start of the year. Although some costs reduced (e.g. patient travel) the majority of spend was relatively unchanged so the R&D division reported a deficit position. For the first 6 months of the year, this was recovered as part of the Trust's ongoing declaration surrounding the financial impact of COVID. However for the second half of the year, this was accepted as cost as a cost pressure by the Trust.

Both sites continue to work towards increasing commercial income levels to pre-Covid levels.

5. INNOVATION

The Trust has a policy on Innovation (click here) and an Innovation lead. The Trust continues to subscribe to support from Health Enterprise East.

There was a single innovation disclosure in 2020/1.

6. RISK

The transfer of Mount Vernon services poses a risk but this is being well managed by a variety of mitigation measures and not included in the above table.

The following risks have been discussed at the R&D Board:

Issue identified	Impact description	Unmitigated Risk Score (5*5)	Action after discovered	Outcome	Mitigated Risk Score (5*5)
Space	Lack of space to accommodate research staff	Red: high 15	Report to Medical Director.	Temporary space identified at Hertford County Hospital. Research included in Estates vision, Plan to fund raise to extend Lee Haynes Research Institute	Red: high 15
Commercial research income	Research income for 2021/2 not known in detail	Red: high 20	Report to Medical Director	Detailed forecast of income and costs required	Red: high 20

7. SETTING OF THE 2021/22 PRIORITIES

The R&D Board reviewed the progress made in 2020/21 and agreed the setting of the 2021/22 Business Plan.

The broad objective is to implement the Department of Health and Social Care's research strategy Saving and Improving Lives: the future of UK clinical research delivery which seeks to support a 'Managed Recovery' which has the following themes:

- Clinical research embedded in the NHS – to create a research-positive culture in which all health and care staff feel empowered to support and participate in clinical research as part of their job.
- Patient-centered research – to make access to and participation in research as easy as possible for everyone across the UK, including rural, diverse and under-served populations.
- Streamlined, efficient and innovative research – so the UK is seen as the best place in the world to conduct fast, efficient and cutting-edge clinical research.
- Research enabled by data and digital tools – to ensure the UK has the most advanced and data-enabled clinical research environment in the world, which capitalises on our unique data assets to improve the health and care of patients across the UK and beyond.

Specific areas of focus

1) Identify and share the benefit of our research on patient care and patient pathways through internal and external communication to researchers, staff and Divisions/Specialties.
2) Grow the Trust Patient and Public Involvement activity through the Trust's Patient and Public Involvement in Research Group.
3) Ensure financial visibility and sustainability for research and our research teams and to include the identification / recuperation of all cost savings.
4) Delivery of National Institute for Health Research (NIHR) performance expectations target and other NIHR High Level Objectives.

5) Support Trust staff to gain external funding for research or research-activities and ensure our teams are fully supported through induction, training/development, appraisal and recognition of effort (awards etc.).
6) Support the transfer of Mount Vernon Cancer Centre services and re-align funding from the NIHR accordingly.
7) Establish a functioning Research Office at Lister Hospital.
8) Further develop our working as the co-founder of the East and North Hertfordshire Integrated Care Provider Research Collaboration.
9) Work well with University of Hertfordshire, NIHR (including the Research Design Serviced and the Applied Research Collaboration), the Cambridge Bioscience Campus, Eastern Academic Health Science Network and others to deliver the Trust's research and wider ambitions.

8. SUMMARY

2020/1 has been both a challenging and rewarding year. The Research teams have responded well to the triple challenge of:

- supporting the front line through redeployment,
- delivering research to meet the urgent public health need (Covid), and
- ensuring the safe continuation of treatment for research participants.

9. RECOMMENDATIONS

The Board is asked to:

- Note the progress made in delivering the 2020/1 Business Objectives, delivering COVID research and supporting the MVCC transfer.
- Approve the 2021/2 priorities in light of the identified risk.
- Acknowledge and thank all those associated with research (both the delivery and back-office function) for all their hard work and dedication.

Appendix 1: Progress against the 2020/1 Research Business Plan

Details	Review	Status
1) Identify and share the benefit of our research on patients and patient pathways through internal and external communication to researchers, staff and Divisions/Specialties about activity, financial and other relevant information.	• Our attention to identify and share the positive impact of research on patients and pathways has been focussed on COVID-19 research, especially • The Trust's Communications team have ensured that research is included in various internal and external communications. • The Knowledge Centre has a detailed section covering research.	Achieved
2) Grow the Trust Patient and Public Involvement activity through the Trust's Patient and Public Involvement in Research Group ensuring meaningful PPI in all sponsored studies. Align with wider engagement strategy in the Trust	• The Trust ensures appropriate public and patient involvement and engagement for all research. • The Trust has an active Patient and Public Involvement in Research Group. • The Trust annually implements the NIHR Participant in Research Experience Survey and acts on feedback.	Achieved
3) Ensure financial sustainability for research and our research teams and to include the identification / recuperation of all cost savings.	• The 2020/1 year-end position for R&D was negative but this was acceptable as it was accurately forecast and managed by the Trust.	Achieved
4) Delivery of NIHR performance expectations target and other NIHR High Level Objectives in light of the COVID-19 response.	• The Trust is in regular contact with CRN: Eastern to understand how the performance expectations have changed in light of COVID-19. • The Trust had been asked to prioritise Urgent Public Health COVID-19 Studies (including Vaccine research) and to restart NIHR research activities which have been paused due to COVID-19 in accordance with the national 'Restart Framework'.	Achieved
5) Support Trust staff to gain external funding for research or research-activities and ensure our teams are fully supported.	• Colleagues have continued to be supported to submit grant applications. • A Research Team Manual has been written and will provide guidance on how colleagues can be their best professional self.	Achieved
6) Review of office accommodation, in light of COVID-19 and other requirements.	• Location and staff-based risk assessments have been completed in accordance with Trust guidance. • Measures (reviewed weekly) have been put in place to ensure that all colleagues can work safely. • A bid is being made for the Trust Charity to select 'Research Space' as a future major fundraising objective.	Achieved
7) Support the MVCC transfer and establish a Research Office at Lister Hospital.	• The MVCC Transfer task and Finish Group includes research as a separate sub-group. • The Research Office at the Lister is being established.	Achieved
8) Good governance and management of hosted and Sponsored studies.	• Thanks to dedicated staff good governance and management of hosted and Sponsored studies has continued unaffected by COVID-19.	Achieved
9) Further develop the concept of working with others in the East and North Hertfordshire Integrated Care Partnership.	• The Trust is now part of the East and North Hertfordshire Integrated Care Partnership Research Collaboration. • Work to date has been helpful to promote research across the Stevenage area.	Achieved
10) Work well with University of Hertfordshire, NIHR (inc the Research Design Serviced and the Applied Research Collaboration), the Cambridge Bioscience Campus, Eastern Academic Health Science Network and others to deliver the Trust's research and wider ambitions.	• Partnership working with the University of Hertfordshire has continued. • Colleagues continue to seek support from the NIHR Research Design Service. • There are good links with the NIHR Applied Research Collaboration and Eastern Academic Health Science Network.	Partially achieved

Appendix 2a Research Activity in 2020/1 as recorded by the Trust's research information system (Lister)

Trust Specialty	RD Number	Short Title	Site	Research Design	RCT	Commercial	NIHR adopted?	Trust Sponsored?	Participants
Anaesthetic	RD2018-91	PQIP	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	269
Anaesthetic	RD2018-19	CIPHER	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	10
Cancer (Lister)	RD2019-39	IRONMAN	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	8
Cancer (Lister)	RD2012-63	OPTIMA	Lister	Interventional	RCT	Non-Comm	NIHR	Hosted	5
Cancer (Lister)	RD2017-37	SPIT	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	3
Cancer (Lister)	RD2019-19	Commercial in confidence	Lister	Interventional	RCT	Comm	NIHR	Hosted	2
Cancer (Lister)	RD2018-12	ICON9	Lister	Interventional	RCT	Non-Comm	NIHR	Hosted	1
Cancer (Lister)	RD2019-18	Commercial in confidence	Lister	Interventional	RCT	Comm	NIHR	Hosted	1
Cardiology	RD2018-41	VALIDATE-R	Lister	Interventional	Non-RCT	Non-Comm	NIHR	Sponsor	6
Cardiology	RD2019-38	Commercial in confidence	Lister	Observational	Non-RCT	Comm	NIHR	Hosted	57
Cardiology	RD2019-77	Commercial in confidence	Lister	Interventional	RCT	Comm	NIHR	Hosted	12
Cardiology	RD2020-29	Commercial in confidence	Lister	Interventional	RCT	Comm	NIHR	Hosted	10
Cardiology	RD2018-53	Commercial in confidence	Lister	Interventional	RCT	Comm	NIHR	Hosted	5
Cardiology	RD2020-12	FOURIER LEGACY	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	3
Cardiology	RD2019-42	Commercial in confidence	Lister	Observational	Non-RCT	Comm	NIHR	Hosted	1
Diabetes	RD2018-69	OPHELIA	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	12
Diabetes	RD2012-39	ADDRESS-2	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	2
Diabetes	RD2019-12	Commercial in confidence	Lister	Interventional	RCT	Comm	NIHR	Hosted	2
Gastroenterology	RD2020-43	DELTA	Lister	Interventional	Non-RCT	Non-Comm	NIHR	Hosted	81
Health Serv Res	RD2020-14	CLIMB	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	126
Paediatrics	RD2020-20	UKOSS: Flu Pregnancy	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	31
Paediatrics	RD2020-09	CASAP	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	17
Paediatrics	RD2018-44	The Big Baby Trial	Lister	Interventional	Non-RCT	Non-Comm	NIHR	Hosted	14
Paediatrics	RD2017-52	INNODIA	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	4
Paediatrics	RD2019-40	MAGIC	Lister	Interventional	RCT	Non-Comm	NIHR	Hosted	2
Plastics	RD2018-25	DISC	Lister	Interventional	RCT	Non-Comm	NIHR	Hosted	1
Renal	RD2018-88	AV-SONOPATH	Lister	Observational	Non-RCT	Non-Comm	Non-NIHR	Sponsor	2
Renal	RD2018-87	DIMENSION-KD	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	107
Renal	RD2017-94	H4RT	Lister	Interventional	RCT	Non-Comm	NIHR	Hosted	35
Renal	RD2014-37	RaDaR	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	22
Renal	RD2017-20	SIMPLIFIED	Lister	Interventional	RCT	Non-Comm	NIHR	Hosted	12
Renal	RD2007-20	DOPPS	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	11
Renal	RD2019-63	QUALYCARE KIDNEY Study	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	8
Renal	RD2019-74	EMPA-KIDNEY	Lister	Interventional	RCT	Non-Comm	NIHR	Hosted	7
Renal	RD2017-29	Commercial in confidence	Lister	Observational	Non-RCT	Comm	NIHR	Hosted	4
Respiratory	RD2020-05	Lung Exo-DETECT	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	166
Respiratory	RD2018-52	Psychl risk factors of fatigue	Lister	Observational	Non-RCT	Non-Comm	NIHR	Hosted	3
Urology	RD2018-65	CY-ROC	Lister	Observational	Non-RCT	Non-Comm	NIHR	Sponsor	8
Cancer (Brain)	RD2018-73	IPI-GLIO	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	9

Appendix 2b Research Activity in 2020/1 as recorded by the Trust's research information system (MVCC)

Trust Specialty	RD Number	Short Title	Site	Research Design	RCT	Commercial	NIHR adopted?	Trust Sponsored?	Participants
Cancer (Breast)	RD2012-63	OPTIMA	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	10
Cancer (Breast)	RD2018-40	A-BRAVE	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	3
Cancer (Breast)	RD2019-08	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	1
Cancer (GI)	RD2016-66	PLATO	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	4
Cancer (Gynae)	RD2018-42	CENTURION	MVCC	Interventional	Non-RCT	Non-Comm	NIHR	Hosted	5
Cancer (Gynae)	RD2018-26	DICE	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	5
Cancer (Gynae)	RD2019-50	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	4
Cancer (Gynae)	RD2017-98	COMICE	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	3
Cancer (Gynae)	RD2018-12	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	2
Cancer (Gynae)	RD2018-32	COPELIA	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	2
Cancer (Gynae)	RD2018-75	PEACOCC	MVCC	Interventional	Non-RCT	Non-Comm	NIHR	Hosted	2
Cancer (Gynae)	RD2016-07	RaNGO	MVCC	Interventional	Non-RCT	Non-Comm	NIHR	Sponsor	5
Cancer (Head/Neck)	RD2019-33	Commercial in confidence	MVCC	Observational	Non-RCT	Comm	NIHR	Hosted	2
ancer (Head/Neck)	RD2019-81	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	2
Cancer (Lung)	RD2019-06	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	3
Cancer (Lung)	RD2019-21	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	1
Cancer (Renal/Melaa	RD2017-44	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	1
Cancer (Renal/Melaa	RD2018-50	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	1
Cancer (Renal/Melaa	RD2018-56	DANTE	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	1
Cancer (Renal/Melaa	RD2019-16	CAcTUS	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	1
Cancer (Renal/Melaa	RD2016-56	PRIMM	MVCC	Observational	Non-RCT	Non-Comm	NIHR	Sponsor	6
Cancer (Renal/Melaa)	RD2018-07	RAMPART	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	2
Cancer (Urology)	RD2012-40	PACE	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	21
Cancer (Urology)	RD2018-10	PIVOTAL BOOST	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	5
Cancer (Urology)	RD2019-14	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	5
Cancer (Urology)	RD2016-92	POPS	MVCC	Interventional	RCT	Non-Comm	NIHR	Hosted	2
Cancer (Urology)	RD2019-15	Commercial in confidence	MVCC	Interventional	RCT	Comm	NIHR	Hosted	2
Cancer (Urology)	RD2018-43	Q-ABC	MVCC	Observational	Non-RCT	Non-Comm	NIHR	Hosted	1
Cancer (Urology)	RD2019-68	Commercial in confidence	MVCC	Interventional	Non-RCT	Comm	NIHR	Hosted	1
Health Serv Res	RD2020-14	CLIMB	MVCC	Observational	Non-RCT	Non-Comm	NIHR	Hosted	74
Supportive Oncology	RD2018-74	EORTC Comp Eval UK	MVCC	Observational	Non-RCT	Non-Comm	NIHR	Hosted	32
Supportive Oncology	RD2013-50	Generic EORTC QOL	MVCC	Observational	Non-RCT	Non-Comm	NIHR	Hosted	20
Supportive Oncology	RD2020-03	EORTC Breast Cancer	MVCC	Observational	Non-RCT	Non-Comm	Non-NIHR	Hosted	9
Supportive Oncology	RD2020-37	EORTC Quality of Life Gastric	MVCC	Interventional	Non-RCT	Non-Comm	NIHR	Hosted	8
Supportive Oncology	RD2019-32	14-39 years with cancer	MVCC	Observational	Non-RCT	Non-Comm	NIHR	Hosted	6
Supportive Oncology	RD2018-72	BRITER	MVCC	Observational	Non-RCT	Non-Comm	NIHR	Hosted	5
Supportive Oncology	RD2018-52	Psych risk factors of fatigue	MVCC	Observational	Non-RCT	Non-Comm	NIHR	Hosted	4

Key to the Tables

- RCT = Randomised Controlled Trial. A study in which a number of similar people are randomly assigned to 2 (or more) groups to test a specific drug, treatment or other intervention. One group (the experimental group) has the intervention being tested, the other (the comparison or control group) has an alternative intervention, a dummy intervention (placebo) or no intervention at all. The groups are followed up to see how effective the experimental intervention was. Outcomes are measured at specific times and any difference in response between the groups is assessed statistically. This method is also used to reduce bias.
- Commercial = Funded by a commercial company (note title not provided as Commercial in confidence).
- Hosted = Research Sponsored by another organisation. In this context the Sponsor is the organisation or partnership that takes on overall responsibility for proportionate, effective arrangements being in place to set up, run and report a research project. All health and social care research should have a sponsor. This includes all research that involve NHS patients, their tissue or information
- Interventional = Interventional studies are designed to evaluate the direct impacts of a risk factor on a disease by applying an intervention to the subjects in an experimental group and prospectively comparing the effects with a control group.
- Observational = Observational studies are studies where the exposure you are evaluating is not assigned by the researcher. This means that no randomization occurs as part of the study and therefore the selection of subjects into the study and analysis of study data must be conducted in a way that enhances the validity of the study.
- CI = Chief investigator. The chief investigator is the overall lead researcher for a research project. In addition to their responsibilities if they are members of a research team, chief investigators are responsible for the overall conduct of a research project.
- PI – Principal Investigator - An individual responsible for the conduct of the research at a research site. There should be one PI for each research site. In the case of a single-site study, the chief investigator and the PI will normally be the same person.

Appendix 3: COVID-19 Research for the period Mar 20 to May 21

Title	Description	Details
ISARIC Clinical Characterisation Protocol (UKCCP) for Severe Emerging Infection - tier 0 (RD2020-15) Local lead Prof Natalie Pattison	Rapid, coordinated clinical investigation of patients with confirmed novel coronavirus infection - involving data only.	Opened 12th March 2020, recruited 632 patients
RECOVERY trial - Randomised Evaluation of COVID-19 Therapy (R&D2020-18) Local lead Dr Pietro Ferranti	Randomised controlled trial to assess suggested treatments. New arms being added. Can enter patients at the weekend.	Opened 7th April 2020, recruited 83 patients
RECOVERY-RS Respiratory Support (R&D2020-23) Local lead Dr Alison McMillan	Comparison of ventilation methods: Continuous positive airway pressure, High flow nasal oxygen or Standard care.	Opened 11th May 2020, recruited 4 patients
GenOMICC (R&D2020-22) Local lead Prof Natalie Pattison	Study to identify the specific genes that cause some people to be susceptible to specific infections / severe injury.	Opened 30th April 2020, recruited 63 patients
MERMAIDS (R&D2020-26) Local lead is Carina Cruz	EuROpean study of MAjor Infectious Disease Syndromes (MERMAIDS): Acute Respiratory Infections in Adults?	Opened 24th July 2020, recruited 8 patients
Remote ischaemic conditioning in COVID-19 (R&D2020-24) Local lead Prof Diana Gorog	Can remote ischaemic conditioning reduce inflammatory markers in COVID-19 patients?	Opened 14th July 2020, recruited 2 patients
CLARITY (R&D2020-48) Local lead Dr Johanne Brooks	ImpaCt of bioLogic therApy on saRs-cov-2 Infection and immuniTY.	Opened 26th Oct 2020, recruited 81 patients
Pregnancy and Neonatal Outcomes in COVID-19 (R&D2020-51) Local lead Dr Rabia Zilll-e-Huma	To better understand how COVID-19 affects early pregnancy, fetal growth, prematurity and virus transmission to the baby.	Opened 01/12/2020 Recruited 31 patients
HICC (R&D2021-08) Local Lead Dr Alex Wilkinson	Investigating and characterising primary and secondary immunodeficiency.	Opened 23/02/2021 Recruited 5 patients
CoV-2 antibody (RD2021-15) Local Lead Dr Enric Vilar	SARS CoV-2 antibody responses in immunocompromised patients.	Opened 4th March 2021, recruited 51 patients
UKOSS Pandemic Influenza in Pregnancy (adapted for COVID19) Local lead Dr Rabia Zilll-e-Huma	Study about all pregnant women admitted to hospital who are COVID-19 confirmed.	Opened 1st May 2020 recruited 31 patients
The CLAP study (**Caring and Learning during the pandemic in critical care**) Local lead Prof Natalie Pattison	This study explored frontline NHS staff experiences of working in critical care during the first wave of the COVID-19 pandemic.	Opened 1st May 2020 recruited 10 patients

The Trust has recruited 1001 participants to Covid-19 studies (83 to RECOVERY) and has supported the development of new treatments–many thanks to all patients, staff and others who made this possible.

East and North Hertfordshire NHS Trust

Agenda Item: 20.1 a)

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021
FINANCE, PERFORMANCE & PEOPLE COMMITTEE – MEETING HELD ON 26 MAY 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the FPPC meeting of 26 May 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Trust Secretary

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

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

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING – 26 MAY 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 7 JULY 2021

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

Finance Report Month 1

The FPPC considered the key points in relation to financial performance for month 1. Inpatient activity was 85%-95% of pre-Covid levels with the average length of stay for inpatients increasing and an upsurge of activity in ED now exceeding 2019/20 levels. The Committee discussed the new framework for income which was based on a system target. There was currently limited visibility of system wide performance but greater clarity was expected by the time of the next meeting.

The Committee also discussed the balance between bed numbers and staffing numbers, which would remain under review by the Committee.

Budget Update Funding

The FPPC noted that the draft budget was signed off by FPPC in April 2021 but remained a draft submission as the framework for the second half of 2021/22 was not yet available. It was anticipated that some CIP delivery would be required in the second half of the year and it was acknowledged this would require a cultural shift from the arrangements in place for 2020/21.

Procurement Transformation

The Committee received the procurement transformation update. The transfer of Princess Alexander Hospital NHS Trust and Hertfordshire Partnership Foundation Trust to Hertfordshire Procurement on 1 April 2021 had been successful. The savings to the Trust created by the transfer will be monitored over the next eighteen months.

The FPPC were advised that a new Director of Procurement has been appointed and will start in September 2021.

Population Health Potential

The FPPC considered the report on population health potential. Analysis will be carried out on the demographics within the Trust's catchment area which equates to approximately 450,000 people. It is expected that there will be more patients over 60 years of age and less patients under 60 years of age in the future which will require forward planning of services in elderly care.

The Committee noted the implications of the data for people living within the area serviced by East and North Hertfordshire NHS Trust's hospitals. Further work will be carried out on analysing this data in the coming months and through working with the ICP and ICS.

Finance Training Material

The FPPC discussed the new finance modules on the learning management system. These will equip non-finance budget holders with the skills to better understand financial matters. The training is tailored to the Trust and provides relevant examples.

People Performance Report Month 1

The FPPC received the new People Performance summary report for month 1, which included the Equality and Inclusion dashboard which will be reviewed at the Equality and Inclusion Committee meetings.

The FPPC observed that vacancy rates were at a historic low at the end of March. Temporary staffing usage reduced by 27% as a result of a reduction in bank hours utilised, due to the increased availability of substantive staff.

The new ENH Academy system will enable better analysis of staff training compliance. All training data is now held in one central place.

The FPPC observed that there was a small increase in sickness absence in April and that stress and anxiety may be the cause of some of this absence. Therapy sessions have been set up for staff and funding has been provided for wellbeing and compassionate conversations. Line managers will be asked to attend training on effectiveness of one-to-one conversations focussing on wellbeing.

Staff Engagement and Experience

The FPPC received a presentation regarding staff engagement and experience, with reference to the results of the staff survey. Work is underway to address areas of concern with an initial plan to improve the engagement score from 6.9 to 7. A new Head of People Culture and an Associate Medical Director for Culture have been appointed and will be working collectively and cohesively across the Trust to address the staff survey results.

Resourcing Update

The FPPC observed that the Trust has recruited four hundred new starters in the last quarter. The trajectory of a low vacancy rate is anticipated to continue to the end of the year. Funding has been agreed for one hundred international recruits between now and December 2021.

Performance Report Month 1

The FPPC considered the key points in relation to operational performance for month 1. ED performance was 82.9%, which was a decrease compared to the previous month, with zero twelve hour waits. There has been an increase in mental health patients affecting patient flow and further discussions with system partners were planned.

The Committee considered the improvement of stroke performance against the previous month. There had been a need to utilise ring fenced stroke beds for non-stroke patients, however there was no detrimental effect on the stroke patients who continued to receive the same care as if they had been in stroke beds.

The Committee considered the increase in ambulance offloading waiting times which will be considered in more detail through a deep dive later in the year.

Bed Plan

The FPPC received the summer bed plan noting that a winter bed plan will be available in September 2021. It was reported that there were more beds than required in April and May, and this had been addressed in the bed plan that has been created for June onwards.

Board Assurance Framework

The Committee considered the Board Assurance Framework. The Equality and Inclusion Committee risk is now referenced under risk 9.

Karen McConnell
Finance, Performance and People Committee Chair
May 2021

East and North Hertfordshire NHS Trust

Agenda Item: 20.1 b)

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021
FINANCE, PERFORMANCE & PEOPLE COMMITTEE – MEETING HELD ON 30 JUNE 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the FPPC meeting of 30 June 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Trust Secretary

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

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

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING – 30 JUNE 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 7 JULY 2021

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

People Report Month 2

The FPPC received the People Performance summary report for month 2. A small increase in vacancies were reported in comparison to the previous month. It is anticipated that performance should be maintained below the target vacancy rate of 3% up to September 2021. There has been an increase in the desire for work/life balance being the primary reported reason for individuals leaving the organisation.

There was positive feedback on the new ENH Academy learning platform since its introduction in April. A Grow Together module was launched on ENH Academy, focussing on career conversations, performance, objectives and talent management.

The Committee also discussed the process for increasing the workforce establishment.

A Head of Culture has been appointed and will be focussing on cultural change. 150 training sessions on compassionate conversations are being rolled out to middle managers across the organisation. Reciprocal mentoring is being developed with ENHT being one of four organisations selected within the region.

A paper on E-Roster will be brought to the July FPPC meeting for discussion.

Health and Wellbeing

The FPPC received the Staff Wellbeing update which provided an overview of the support the Trust has provided to date and the support planned for the remainder of the year.

Uptake on reflective space sessions has been slow, however those who have used it have given positive feedback on how valuable they have been.

The Committee requested a report regarding the alignment of wellbeing initiatives in the second half of the year.

Medical Workforce Overview

The FPPC received a Medical Workforce overview highlighting medical workforce activities from January 2021 to June 2021. The report was comprehensive and the direction of travel was welcomed by the Committee.

It was noted that high cost locums usage has reduced by 56%.

The Committee discussed the possibility of university affiliation. It is unlikely that the Trust will meet the stringent research criteria to have university status, however recognition as a teaching hospital could be pursued which should have a positive impact on recruitment and retention. It was noted this would be discussed further at the September Strategy Committee meeting.

Nursing Establishment Review

The FPPC were presented with a Nursing Establishment review which was undertaken in April 2021. This has been presented to the Executive Committee and QSC before being considered by the FPPC due to the financial investment required.

The Committee approved the proposal for consideration by the Trust Board (see agenda item 13).

Finance Report Month 2

The FPPC noted ENHT is reporting against a break-even plan for April to September 2021. There was a break-even position in month and the Trust is reporting a £0.2m surplus year to date. The reported position includes a £4.3m estimate of income earnt as part of the Elective Recovery Framework. Ongoing Covid inefficiency costs have now been incorporated into business as usual budgets for the first half of 2021/22.

The FPPC considered the key points in relation to financial performance for month 2 and considered the key risks to achieving breakeven for the year. Work to ensure the Trust would be able to deliver a cost improvement programme in the second half of the year has commenced.

The Committee discussed the capital available to the Trust and the risk arising from not replacing equipment that is old or broken. It was agreed that a paper regarding the equipment replacement schedule and associated risks and potential mitigation will be discussed at the September FPPC meeting.

Costing Assurance Audit and Action Plan

The Committee were presented with an overview of the 2019/2020 costing assurance audit and the actions to address issues raised. An audit was carried out in February 2021 with a draft assurance report provided in May 2021. The auditors will issue an assurance report to NHS England and Improvement with a draft copy provided to the Trust for factual accuracy check prior to issue. Work continues to ensure improvements are made.

Predictive Analytics Development

The FPPC received an update on the current status, issues arising and future work plan for the Predictive Analytics project. It was explained that machine learning is a process of incorporating past and current information to assist in making predictions and also learning from predictions. Predicting future healthcare outcomes with high accuracy can significantly improve patient experience and operational and financial efficiency. The Committee noted recent work that had taken place to predict ED attendances and the predictive analytics roadmap moving forward. The findings to date were promising.

Performance Report Month 2

The FPPC considered the key points in relation to operational performance for month 2 with A&E performance being 84.06% with zero twelve hour trolley waits.

The Trust's 62 day cancer performance for April was 91.12%. There were 4 pathways over 104 days for 62 day screening. Good progress continues on the speciality cancer action plans with all plans being reviewed and updated weekly.

The FPPC noted that ED performance showed a slight improvement compared to the previous month, despite an increase of 8% of non-elective attendances. 'Not admitted' pathways remain strong. The Trust is working with the Emergency Care Improvement Support Team (ECIST) to improve discharges.

The Committee learned that stroke performance had been disappointing. There will be a deep dive for Stroke performance in July 2021.

The Committee observed that although there was an increase in ambulance handovers above 30 minutes, there was significant improvement on delays over 60 minutes. This is despite an increase of 6.5% in ambulance arrivals in ED. The new ambulance offload area currently under development will improve performance in offloading patients.

RTT and DM01 Deep Dive

The Committee received a presentation on the waiting list position and key issues and risks. The Committee was informed that the various PTL types were above the target size and received an update on the prioritisation process. The report included details of the governance and oversight arrangements in relation to waiting lists and next steps to address the issues. Steps included supporting patients to wait well, system wide working, addressing health inequalities and future pathway analysis and redesign together with steps to ensure effective management of the PTLs such as online training modules. The Committee requested a regular update on the position.

Board Assurance Framework

The FPPC considered the Board Assurance Framework which will be presented to the Trust Board in July 2021 once updated to reflect the deep dives and discussed at FPPC.

Regarding the capital risk the Committee noted the mitigations in place with a plan to reduce the risk score to 16. This was approved by the Committee. There has been significant improvement of overdue risks across the organisation. A risk management training module will be added to ENH Academy.

Vascular Outline Business Case

The FPPC considered the Vascular Network outline business case, setting out the transformation required for vascular services across Hertfordshire and West Essex Integrated Care System.

The Committee discussed the revenue implications and how these could be mitigated. FPPC endorsed the OBC for approval by the Trust Board. The full business case will be presented at FPPC in July.

Karen McConnell
Finance, Performance and People Committee Chair
June 2021

East and North Hertfordshire NHS Trust

Agenda Item: 20.2

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021

STRATEGY COMMITTEE – 22 JUNE 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Strategy Committee meeting held on 22 June 2021. The report includes details of any decisions made by the Strategy Committee under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of Strategy Committee	**Presented by:** Chair of Strategy Committee	**Author:** Trust Secretary

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

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

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STRATEGY COMMITTEE – 22 JUNE 2021

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

The following Non-executive Directors were present:
Karen McConnell (Strategy Committee Chair), Biraj Parmar (Associate Non-Executive Director), Ellen Schroder (Trust Chair) and Jonathan Silver (Non-Executive Director).

The following core attendees were present:
Sarah Brierley (Director of Strategy), Martin Armstrong (Director of Finance and Deputy CEO) (for Strategic Planning Framework discussion), Michael Chilvers (Medical Director), Mark Stanton (Chief Information Officer), Kevin O'Hart (Director of Improvement), Kevin Howell (Director of Estates and Facilities), Thomas Pounds (Chief People Officer), Rachael Corser (Director of Nursing)

MATTERS TO BE REFERRED TO THE BOARD
No specific issues were referred to the Board.

MATTERS CONSIDERED BY THE COMMITTEE:

STRATEGIC PLANNING FRAMEWORK
The Committee received an update on the progress with the strategic planning framework refresh. The workshops with each of the clinical specialties have now taken place with some follow up workshops planned. Consideration will be made of how best to reflect the patient voice in the discussions. The next steps involve challenge, options appraisal and prioritisation and for the Board to formulate their views based on the findings. The Committee welcomed the update and noted the progress to date and future plans.

ENABLING STRATEGIES:
SUSTAINABILITY STRATEGY PROGRESS REPORT
The Committee received the draft Green Plan which identified the status of the Trust in terms of NHS sustainability targets, summarised the areas of focus and set out the aims, objectives and delivery plans for sustainable development to 2024. The Committee noted that the Trust is likely to be below the target required for carbon reduction rates in the next three to five years. It was felt that COVID has added to the delay in achieving the target as the baseline has changed.

The Strategy Committee were updated on some of the positive actions currently being taken which would also improve the carbon footprint including reducing the length of hospital stays and minimising readmission.

The Committee noted that the success of the strategy involved the education and engagement of staff and public and heard there is a keenness from staff in relation to engagement around this issue.

The Green Plan was supported for submission to the Board for approval.

ESTATES STRATEGY DEVELOPMENT
The Strategy Committee received and noted an update on the estates strategy highlighting where the Trust is now, where it wants to be and how to achieve this. Establishing a baseline, reviewing space utilisation, linking with clinical strategy, and planning were key to achieving the targets.

STRATEGIC PROJECTS:
VASCULAR SURGERY NETWORK UPDATE
The Committee received the updated OBC for the vascular surgery project and after some discussion regarding the internal funding element, agreed to support the OBC for consideration at the Finance, Performance and People Committee.

MVCC TRANSFER PROGRAMME
The Strategy Committee noted the overview provided and discussed the risks regarding the MVCC Transfer Programme.

ICS PATHOLOGY PROCUREMENT
The Committee noted the update regarding the ICS Pathology Procurement. A four to six week delay to the programme was noted.

SYSTEM COLLABORATION
The Committee received an update on the latest work in relation to system collaboration within the ICS and ICP.

NHSE/I INTEGRATED CARE SYSTEMS DESIGN FRAMEWORK
A paper was received by the Committee on the new ICS Design Framework released by NHSE/I which outlined the key features and responsibilities for the ICS NHS Body, ICS Partnership Providers within this framework.

BOARD ASSURANCE FRAMEWORK
The Strategy Committee noted the latest version of the Board Assurance Framework and the risks that had been assigned to that Committee. Further discussion in relation to the digital risk was planned for the next meeting.

Karen McConnell
Strategy Committee Chair

June 2021

East and North Hertfordshire NHS Trust

Agenda Item: 20.3 a)

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 25 MAY 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 25 May 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary

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

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

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QUALITY AND SAFETY COMMITTEE MEETING – 25 MAY 2021

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 7 JULY 2021

The following Non-Executive Directors were present:

Ellen Schroder, Peter Carter, Val Moore, David Buckle

The following core attendees were present:

Michael Chilvers, Rachael Corser, Julie Smith, Tom Pounds

Matters Considered by the Committee:

Mental Health Patients (Deep Dive)

The Chief Nurse delivered a presentation to the QSC regarding the challenges the Trust was facing in terms of mental health patients. There remained national pressure on mental health beds and the additional resource required to support mental health patients also had an impact on the flow of other patients through the organisation. The Committee discussed the next steps that were planned and the importance of system working to find a solution to the issues.

Infection Prevention and Control Report

The Committee received the IPC report covering Month 1 2021/22. The majority of metrics were in a good position and there had been no definite or probable Covid cases recorded in April.

Safer Staffing Report

The Safer Staffing Report for Month 1 was received and considered by the Committee. Key points discussed included:

- The Trust saw an overall increase in sickness levels, but a decrease in Covid related absences in April.
- The Trust has seen an increase in the number of patients requiring mental health care.
- The percentage of Black rated shifts had reduced from 5% in March to 3% in April.

The Committee also discussed the positive position in terms of recruitment and retention, with a better trajectory than forecast and 0% vacancies for band 5 nurses.

Clinical Audit and Effectiveness Year End Report

The Committee received the Clinical Audit and Effectiveness Year End Report 2020-21. The number of audits required to be completed had continued to increase and the Trust had maintained a similar performance compared to previous years despite the impact of the Covid pandemic. The Committee noted the report.

Clinical Harm Reviews Update

The Committee discussed the latest position in relation to the clinical harms review process. The Trust's PTL was above the target level but work was underway to reduce the size, with all 17 theatres now reopened. The Committee noted that patients continued to be categeroised according to clinical need, and this would now be extended to diagnostics patients. The Committee discussed the process and timing in relation to clinical harm reviews. This would continue to be monitored. The Committee also discussed the role of the system and the potential for mutual aid.

Maternity Reports

The Chief Nurse presented the following maternity related reports:

- Continuity of Carer Action Plan

It was reported that the first action on the continuity of carer action plan regarding continuity of carer trajectories and financial implications was slightly behind schedule but recruitment was continuing. A joint bid as part of the LMS had been submitted for additional funding.

- Maternity Safety Highlight Report

It was reported that there were no particular concerns requiring escalation from the latest maternity safety highlight report.

- Neonatal Nursing Workforce

It was reported that some small changes in relation to the neonatal workforce were proposed and were being worked through. The report included an action plan regarding the neonatal workforce for sign-off.

- Safety Action 4 – Anaesthetics Clinical Services Accreditation Standards Compliance

It was reported that the Trust was compliant against ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6.

- Safety Action 6 – Saving Babies Lives Care Bundle Compliance

This report provided an update on the Saving Babies Lives Care Bundle 2 and included the commitment to facilitate local, in-person, foetal monitoring training when this is permitted.

- Maternity Serious Incident Report

The Committee noted the latest report regarding maternity serious incidents.

Compliance Report

The latest compliance report was considered by the Committee. It was noted that the CQC strategy for 2021 was due to be published at the end of May and further TRA visits were planned.

The Committee also noted the changed timeline in relation to approval of the Quality Account. This was now due to be submitted by 30 June and the final draft would be presented to the next meeting of the QSC for approval. Initial contact had been made with the key stakeholders involved with the process.

Board Assurance Framework

The Committee received and noted the latest version of the BAF. The refresh of the BAF for 2021/22 was underway and the updated version would be ready for the next meeting.

The Committee noted the following reports:

- **Integrated Performance Report and Quality and Safety Dashboard**
- **Maternity Dashboard and Report on Maternity Services Assessment and Assurance Tool**
- **Escalation reports from the Clinical Effectiveness Committee and Quality Safety Forum.**

Peter Carter
Quality and Safety Committee Chair
June 2021

East and North Hertfordshire NHS Trust

Agenda Item: 20.3 b)

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 29 JUNE 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of the 29 June 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Trust Secretary

Trust priorities to which the issue relates:		**Tick applicable**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our	☒
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 – 29 JUNE 2021

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 7 JULY 2021

The following Non-Executive Directors were present:

Ellen Schroder, Peter Carter, David Buckle (up to and including Clinical Harm Review Update)

The following core attendees were present:

Michael Chilvers, Rachael Corser, Julie Smith, Tom Pounds

Matters Considered by the Committee:

Quality and Safety Report (Month 2)

The Committee received the latest edition of the Quality and Safety Report. It was reported that the Infection, Prevention and Control, Safer Staffing, Compliance and Risk papers would be summarised in this report in the near future. The Committee noted that serious incidents would be clustered together by themes in the future to enable timely discussion and to decide actions that need to be taken to address any issues.

Infection, Prevention and Control

The Committee received the latest IPC report. It was noted that there had been 2 indeterminate hospital onset COVID cases and 4 community onset COVID cases reported in May.

Safer Staffing Report

The Committee noted the latest Safer Staffing Report and there were no issues escalated to the Committee. It was noted that there was a positive position in terms of the recruitment campaign.

Clinical Harm Reviews

The Committee received an update regarding the clinical harm review process. It was noted there was acceleration in the number of patients being treated and an improvement was seen in the number of patients at over 18 and 52 weeks being treated between April and June. The Committee also discussed the challenges in the specialties.

Learning from Deaths Report

The Committee received the learning from deaths report. The Committee heard the HSMR had remained stable and is in the first quartile nationally and that SHMI is also stable, in the 'better than expected' band. Crude mortality is 1.51% for the 12 month period to April 2021 compared to 1.25% for the latest 3 years.

Incidents and Inquests Report

The Committee noted the Incidents and Inquests Report which provided information around reported patient safety incidents by division, level of harm and category. The Committee observed the increase in incidents around violence, aggression and mental health.

Maternity Reports:

The Committee was advised that the NHSR submission is a board statement confirming the Trust is satisfied with evidence provided in relation to the 10 safety standards. The Trust will be declaring full compliance against each of the 10 standards. Following a meeting with the CCG they support the Trust's declaration of compliance. The QSC endorsed the submission.

Compliance Report

The Committee noted the latest compliance update. It was reported that quality assurance visits had now restarted and a monthly audit on fundamental standards of care had also commenced, starting with Duty of Candour. It was noted that the Trust is continuing the programme of CQC TMAs with maternity, outpatients and end of life being covered over the next few months.

Risk Report

The Quality and Safety Committee received the risk report and noted a 16% improvement of risk reviews since the last reporting period. It was noted that some of the newer risks were still subject to test and challenge through the divisional governance structures. The Committee heard that a risk management learning module would be added onto the ENH Academy to support the teams.

Emergency Preparedness

The Committee received and noted the progress against the Emergency Preparedness Resilience and Response programme and the readiness of the Trust for business continuity events and major incidents. It was noted that the Trust remains fully compliant against the NHS England EPRR Core Standards Assurance rating.

Board Assurance Framework

The Committee noted the latest edition of the Board Assurance Framework. Following discussion and consideration of other reports presented within the meeting, the Committee agreed to reduce the risk rating for Risk 12 - Pandemic from a 15 to 10 and the risk rating for Risk 10 - Estates from a 20 to 16.

Estates and Facilities Annual Assurance Report

The Committee received the Estates and Facilities Annual Overall Assurance Report which identified the level of assurance that currently exists within the estates and facilities team with regard to statutory compliance items.

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

Annual Statement of Fire Safety

The Committee approved the Annual Statement of Fire Safety and noted the improvements that had been made and the work that will be undertaken over the next year.

Grow Together – ENH Academy Launch

The Committee received an update on the recently launched Grow Together component of the ENH Academy which would assist in career conversations and opportunities for pathways to development.

Nursing Establishment Review

The Committee noted the paper and the key recommendations from the review and agreed these would have a positive impact on the workforce.

The QSC approved the Nursing Establishment Review for consideration by the Trust Board (see agenda item 13).

Quality Account Annual Report

The Quality and Safety Committee approved the Quality Account 2020/21 for submission and publication and noted the stakeholder (CCG, Healthwatch and Hertfordshire County Council) comments at the end of the document.

R&D Annual Report

The Committee received the 2020-21 Annual Report on Research at the Trust. This would be referred to the Trust Board for discussion due to time constraints at the meeting.

Safeguarding Children and Adults Annual Report

The Committee received a presentation from the Head Nurse from Safeguarding on the Safeguarding Children and Adults Annual Report which highlighted the achievements in 2020/21 and the priorities for 2021/22. The Committee noted there had been high increases across all areas of safeguarding during the last year due to COVID, particularly around domestic abuse. The Committee recognised the work the Safeguarding team had undertaken during an incredibly difficult year.

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

Nursing and Midwifery Strategy Progress Review (Annual Review)

The Committee received and noted the Nursing, Midwifery and Allied Health Professionals Strategy 2019-24 Progress Report for April 2020 – March 2021 and recommended it be presented to the Trust Board for discussion due to time constraints at the meeting.

The Committee noted the following reports:

- Integrated Performance Report
- Maternity and Neonatal Dashboards

Peter Carter
Quality and Safety Committee Chair
June 2021

Agenda Item: 20.3.1

TRUST BOARD – 7 JULY 2021

Infection Prevention & Control Report – May 2021

Purpose of report and executive summary (250 words max): To inform the Board of infection prevention and control performance for the period of 01-31 May 2021.		
Action required: For information		
Previously considered by: **QSC – 29.06.21**		
Director: **Director of Nursing & Infection Prevention & Control**	**Presented by:** **Director of Nursing & Infection Prevention & Control**	**Author:** **Lead Nurse Infection Prevention & Control**

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

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

011/18: There is a risk that the Trust is not always able to consistently embed a safety culture and evidence of continuous quality improvement and patient experience

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

Failure to act upon outcomes may increase risk to patients and staff and place the Trust at risk of breaching registration requirements set out in the Health & Social Care Act 2008.

Risk of not delivering on national targets for MRSA bacteraemia & Clostridium *difficile* and potential loss of income. For 2020-21, the ceiling for Hospital Onset MRSA bacteraemias remains at zero. The *Clostridium difficile* ceiling target for the Trust has been set at 52 cases for Hospital Onset Healthcare Associated and Community Onset Healthcare Associated cases.

Risk of not maintaining the reduction of surgical site infection (SSI) rates to the national benchmark in the three categories of orthopaedic procedures which are subject to surveillance. Actions being taken include a deep dive into all identified SSI cases to ensure all learning points are identified and addressed, auditing against national (NICE) guidance and taking measures preventing unnecessary theatre staff movement.

Infection Prevention and Control Board Report Objectives & Outcomes: May 2021

Executive Summary	**Key messages**	The month of May saw a total of 6 COVID-19 inpatients, with no outbreaks. The IPC team supported the staff as the Trust continues the period following the latest peak of cases, whilst continuing to manage full recovery of services. The IPC team continues to reinvigorate the audit programme, joining ward team times, visiting clinical areas for review, and providing specific support. The STP collaborative work has continued with meetings to discuss a strategy for common reporting standards, and planning for the ICS working is due to come into effect April 2022. The Trust identified two positive COVID-19 patient with the Delta variant (1 ED & 1 inpatient) **COVID-19 Nosocomial Infections** The number of nosocomial infections recorded in May: ▪ Hospital-Onset Indeterminate Healthcare-Associated - 2 ▪ Hospital-Onset Probable Healthcare-Associated cases - 0 ▪ Hospital-Onset Definite Healthcare-Associated cases - 0 ▪ **IPC Highlights** ▪ The IPC team celebrated with the Trust by creating awareness for the International Hand Hygiene day on the 5th May, with the theme “Make one change” at the Charity corner. In this same week the IPC team ran a successful National Glove awareness week. These events were supported by Gama, Ecolab and the Trust charity. ▪ The IPC team stepped up their visits to the external sites to support, audit, and train. ▪ The hand hygiene competency and audit training continued for clinical and non-clinical colleagues. ▪ From this month (May 2021) the Trust will be reporting healthcare associated bacteremia in accordance with the updated PHE DCS mandatory surveillance guidance: HOHA, COHA, and COCA. There is no change to C.difficile reporting.	

IPC Covid Updates

Covid-19 nosocomial infections and update

From the 14th May 2020 the NHSE/I introduced mandatory surveillance for nosocomial Covid-19 infection. Surveillance covers inpatients only and no targets have been set.

The four categories are:

- Community-Onset: First positive specimen date 2 days or less after admission
- Hospital-Onset Indeterminate Healthcare-Associated: First positive specimen date 3-7 days after admission
- Hospital-Onset Probable Healthcare-Associated: First positive specimen date 8-14 days after admission
- Hospital-Onset Definite Healthcare-Associated: First positive specimen date 15 or more days after admission

In May, the Trust reported:

May	Specimen Date / Days post admission	Total for 01/03/2021 - 31/03/2021	Total to date (from 14/05/20)
Community Onset	[<=2]	4	**990**
HO Indeterminate	[3-7]	2	**151**
HO Probable	[8-14]	0	**165**
HO Definite	[>=15]	0	**89**
	TOTAL	**6**	**1,395**

Hospital-Onset Probable and Definite Healthcare-Associated Covid-19 | Data SitRep for East and North Hertfordshire Trust December 2020, January 2021, February 2021, and March 2021 bed occupancy per 100,000 days

Dec-20		
Type	Total	Rate
Def	28	159.02
Prob	39	221.49
Total	67	380.51

Jan-21		
Type	Total	Rate
Def	30	167.52
Prob	68	379.70
Total	98	547.22

Feb-21		
Type	Total	Rate
Def	9	55.64
Prob	32	197.83
Total	41	253.47

Mar-21		
Type	Total	Rate
Def	1	5.58
Prob	0	0.00
Total	1	5.58

	Water Safety	**Lister Site Reasonable Assurance**  **Satellite Premises Limited Assurance** 	▪ Policy in place with Water Safety Plan procedures currently being drafted; ▪ An estates Authorised Person [AP] for water services has been appointed, competent person training is to be scheduled in readiness for appointments; ▪ A Responsible Person has not been appointed, this is a requirement of the HSE Approved Code of Practice, L8; ▪ Water Safety Group & the Water Safety Operational Group (sub-group) established; ▪ The water safety risk assessments that underpin the control scheme have been reviewed and work is now underway to implement the risk minimisation actions identified; ▪ Work is continuing to ensure that our primary and supplementary control systems (i.e. temperature & chlorine dioxide respectively) meet required standards. Aging infrastructure and natural seasonal variations in water supply temperature mean that water temperatures cannot always be maintained within recommended limits, however, cold water temperatures have improved following the seasonal shift in source water temperature. Regular monitoring shows that chlorine dioxide dosing systems are working within specification; ▪ The programme of planned maintenance and monitoring is ongoing and up to date; Work continues to engage with our colleagues & partners at each of the satellite premises and obtain evidence that the relevant processes & procedures are in place for water safety.	
	Ventilation	**Limited Assurance** 	There is a policy & limited procedures in place. These require updating and then vetting by the Authorising Engineer [Ventilation]; ▪ An Authorised Person [Ventilation] has been appointed; ▪ Competent Persons training has been scheduled in readiness for formal appointments;The Trust has some very old assets/AHU in poor condition. A risk-based plan is to be formulated for the future maintenance and /or replacement of these; The programme of planned maintenance and verification of AHUs & associated systems is ongoing and up to date; Satellite premises have not been assessed separately from the Lister site at this time.	

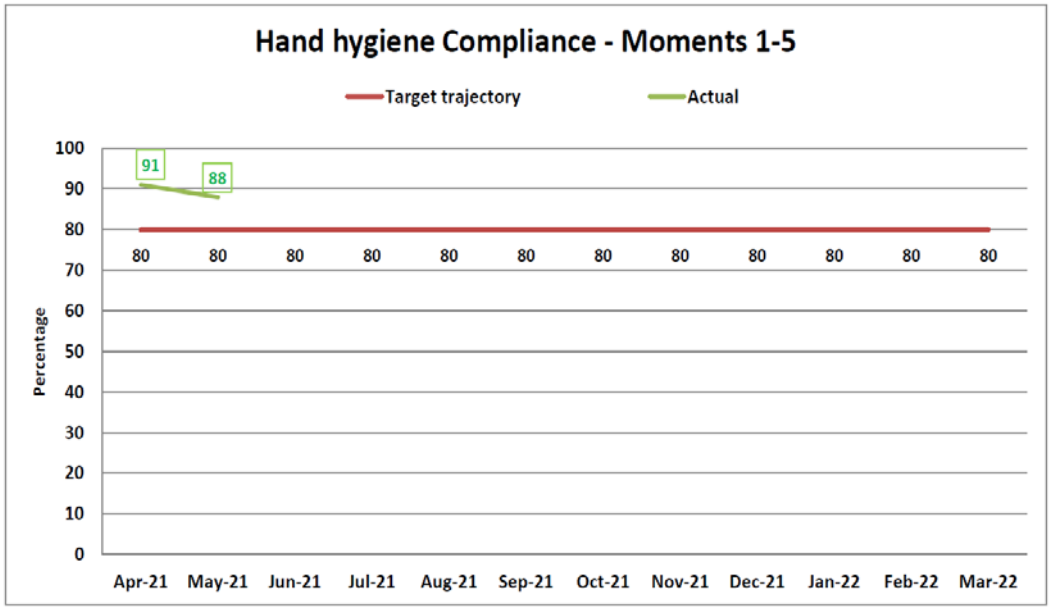
	Decontamination	**Lister Site**  **Limited Assurance** **Satellite Premises** To Be Confirmed	▪ The Trust Decontamination Policy requires review. This should include a full review of roles & responsibilities; ▪ The position of "Decontamination Lead" for the Trust remains un-appointed, this is a requirement under the Department of Health HTM [Health Technical Memoranda] series guidance; ▪ Estates have appointed Mark walker of Deconcidal as the Authorising Engineer for Decontamination; ▪ A Decontamination Safety Group has been set up and the inaugural meeting was held 11 May 2021. A Terms of Reference has been drafted and submitted for consultation; ▪ An Authorised Person [AP] Decontamination role has been appointed the within estates management team, however, further appointments are necessary to provide the post holder with the resource to fully undertake the AP [Decontamination] duties. The AE [D] has completed an audit / gap analysis which identified a number of opportunities for improvement. An action plan is to be developed to address these items.	
HCAI SURVEILLANCE	**C.difficile**	3 Hospital Onset Healthcare Associated (HOHA) case and 0 Community Onset Healthcare Associated (COHA) cases in May. Year to date position is 8 reported cases (HOHA / COHA) against the ceiling target of 52 cases for 2021-22. Benchmarking data for May is not available.		
	MRSA bacteraemias	0 Hospital Onset and 0 Community Onset bacteraemia in May. Year to date position is 0 Hospital Onset cases and 0 Community Onset cases. Benchmarking data for not available.		
	MSSA bacteraemias	0 Hospital Onset MSSA bacteraemia in May. Year to date position is 1 Hospital Onset cases (no target set). Benchmarking data for May is not available.		
	Gram negative bacteraemia: **National monitoring and reduction programme for E.*coli*,**	0 Hospital Onset Healthcare Associated (HOHA) and 1 Community Onset Healthcare Associated (COHA) *E.coli* bacteraemia in May. Year to date position is 1 Hospital Onset cases and 1 Community Onset cases. (No target set). Benchmarking data for May not available.		
		0 Hospital Onset Healthcare Associated (HOHA) and 0 Community Onset Healthcare Associated (COHA) *Pseudomonas aeruginosa* bacteraemia in May.		

	***Pseudomonas aeruginosa, Klebsiella species*.**	Year to date position is 1 Hospital Onset case and 0 Community Onset cases. (No target set). Benchmarking data for May not available.	
		0 Hospital Onset Healthcare Associated (HOHA) and 1 Community Onset Healthcare Associated (COHA) *Klebsiella* bacteraemia in May. Year to date position is 0 Hospital Onset case and 1 Community Onset cases. (No target set). Benchmarking data for May not available.	
	Carbapenemase Producing Organisms (CPO)	0 new inpatient cases and 0 new outpatient cases identified in May. Year to date position is 0 inpatient cases and 0 outpatient case (no target set). ICNet has been configured to provide alerts to the IP&C Team when known CPO-positive patients are readmitted to ensure prompt isolation.	
	Surgical Site Infection	The infection rate for Total Knee Replacement in Oct-Dec 2020 was 0%, giving an overall rate of 0.6 % for the last 4 quarters for which data has been provided. This is above the national benchmark of 0.5%. This remains above the national benchmark of 0.5% and the Trust remains an outlier. Data is being reviewed by the Orthopaedic surgical leads. Work is being carried out to strengthen the processes of monitoring patients, surveillance and supporting the orthopaedic teams to improve outcomes.	
		The infection rate for Total Hip Replacement in Oct-Dec 2020 was 0%, giving an overall rate of 0.9 % for the last 4 quarters for which data has been provided. This is above the national benchmark of 0.6%	
		The infection rate for Repair to Fractured Neck of Femur in Oct-Dec 2020 was 0%, giving an overall rate of 1.0% for the last 4 quarters. This is below the national benchmark of 1.1%.	
AUDITS	**High Impact Interventions (HII)**	HII audit scores in May recorded on IQVIA by ward nursing teams met the agreed standards except: - Intravascular Devices (Target: 95%, May: 89.70%) - Urinary Catheter Care (Target: 95%, May: 56.35%) - Inpatients Environment Peer audit – Overall (Target: 95%, May: 89.57% %) - Inpatients Environment - Peer Audit - Ward Environment (Target: 95%, May: 94.74% %) RAG rating based on scores meeting or exceeding the agreed standards in 4 out of 7 categories monitored. These HIIs have improved however, this will continue to be a focus with senior leadership teams until standards are raised throughout the organisation and the support is given where needed.	
ANTIMICROBIAL STEWARDSHIP	**Antimicrobial CQUINs**	The 2 antimicrobial CQUINs planned for 2020-21 have been cancelled due to the Covid-19 pandemic.	
	Antimicrobial review	Target to maintain 90% compliance for review of antibiotics within 72 hrs for all inpatients to 90%. Compliance to be monitored at least every 2 months by Pharmacy team. 2021-22: April 85%, May 91%	

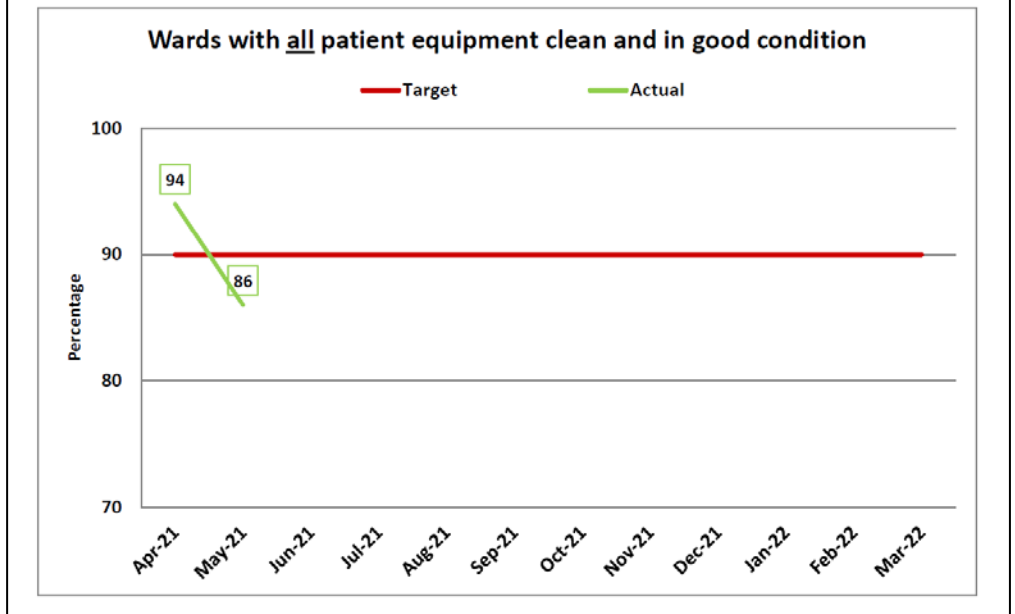
Note: RAG ratings are based on performance against set targets, previous year's performance or PHE benchmarking data, as specified.

IP&C Improvement Plan Trajectories

Hand hygiene



Inpatient Environment: Patient equipment cleanliness & condition



Audit scores are extracted from the IQVIA database of Trust-wide audits.

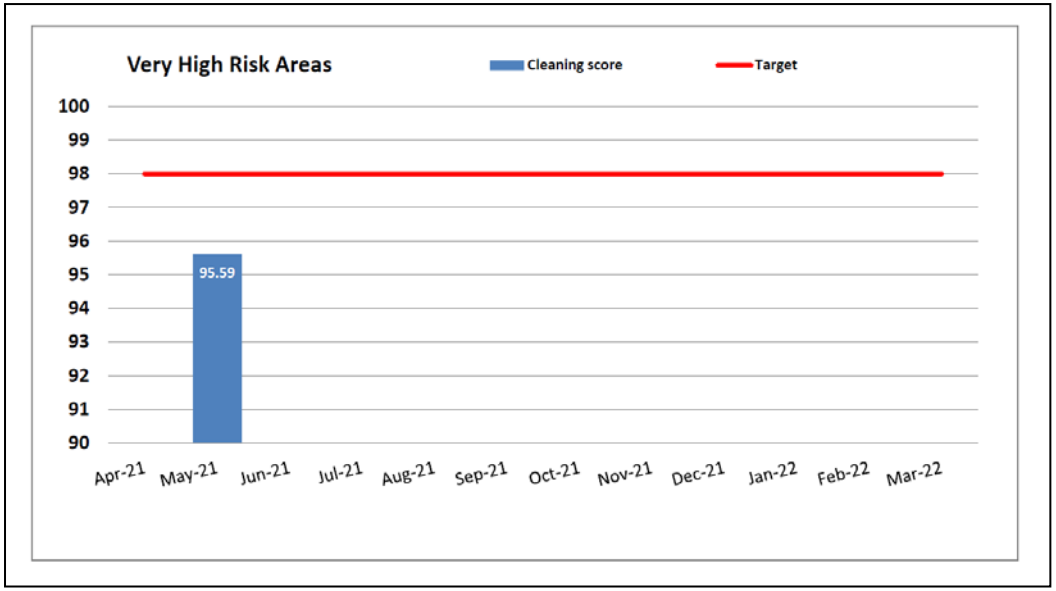
Hand Hygiene audits cover the World Health Organisation (WHO) Moments 1-5 see below:

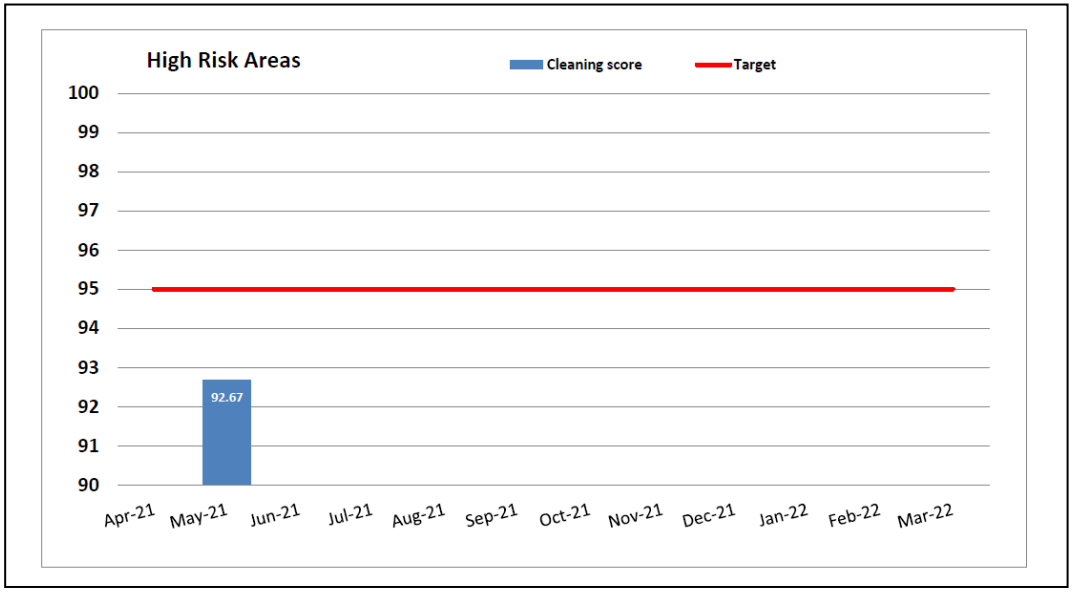
1. Before patient contact
2. Before clean/aseptic procedure
3. After exposure to body fluids
4. After patient contact
5. After contact with patient surroundings

From November 2019, cleanliness of commodes/other patient equipment and equipment condition is recorded as a single combined score which shows the percentage of wards with all commodes and other patient equipment clean, labelled as clean and in good condition.

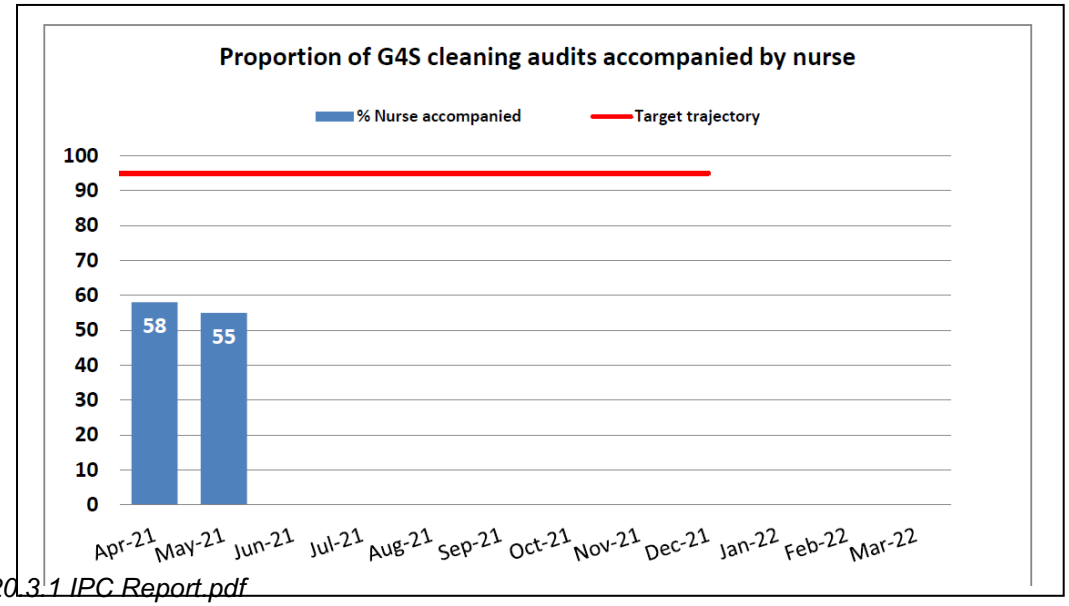
Cleaning audits: First time audit pass rates for very high risk and high risk areas

Note: Cleaning audit scores for very high risk areas and high risk areas for April are unavailable due to Mitie being unable to access G4S data.

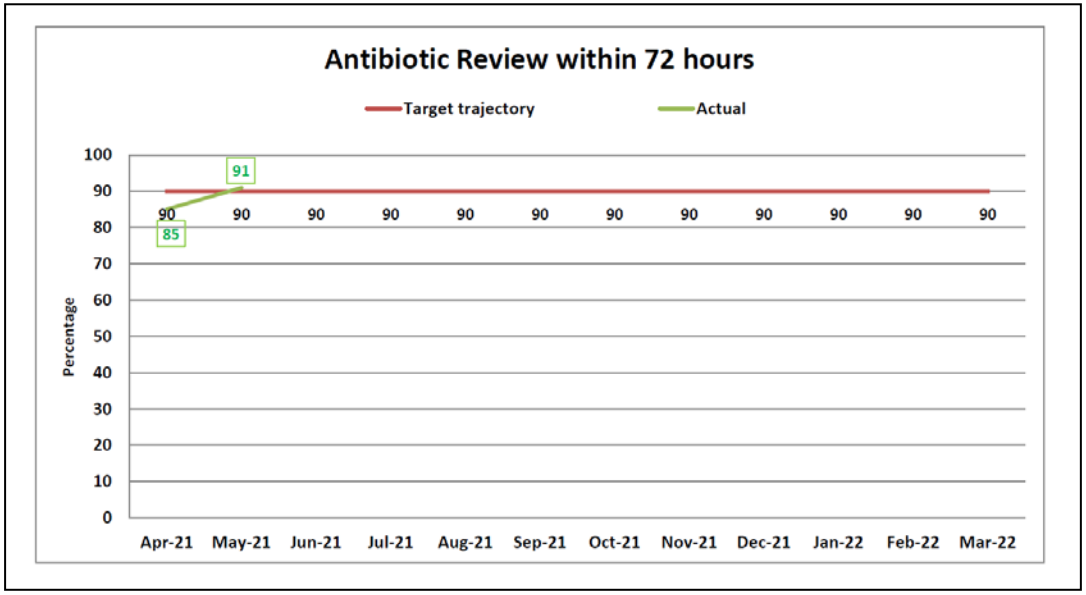




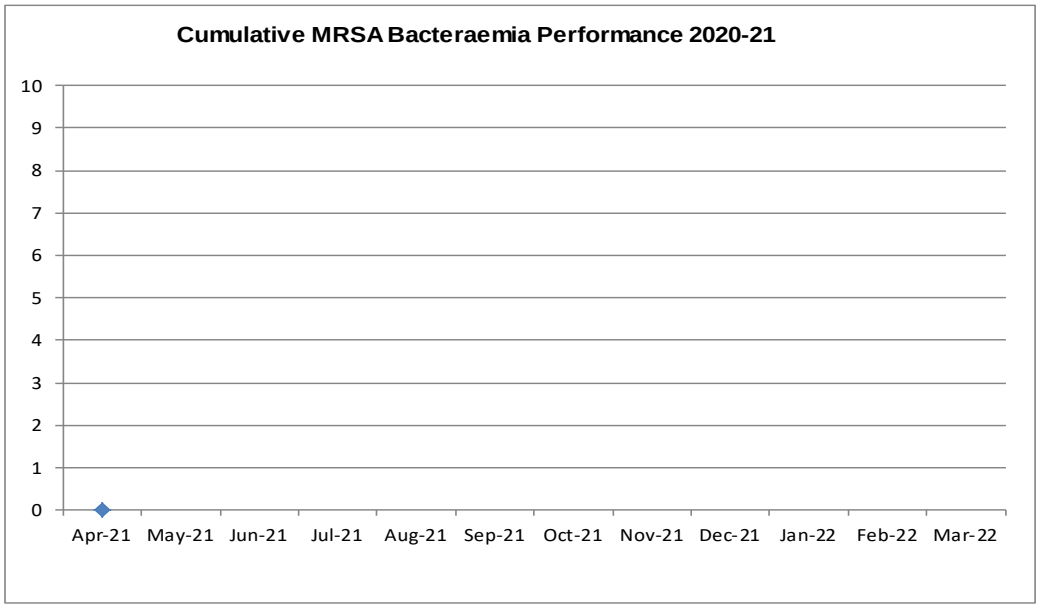
Cleaning audits: Attendance by nursing staff

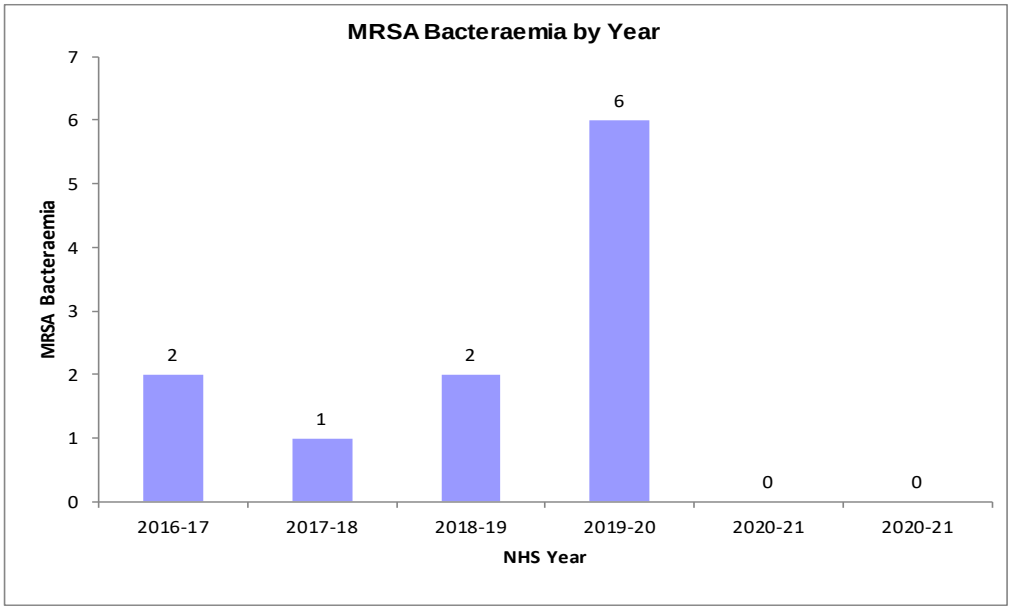


Antimicrobial stewardship



MRSA BACTERAEMIA – HEALTHCARE ASSOCIATED





MRSA Bacteraemia by Division

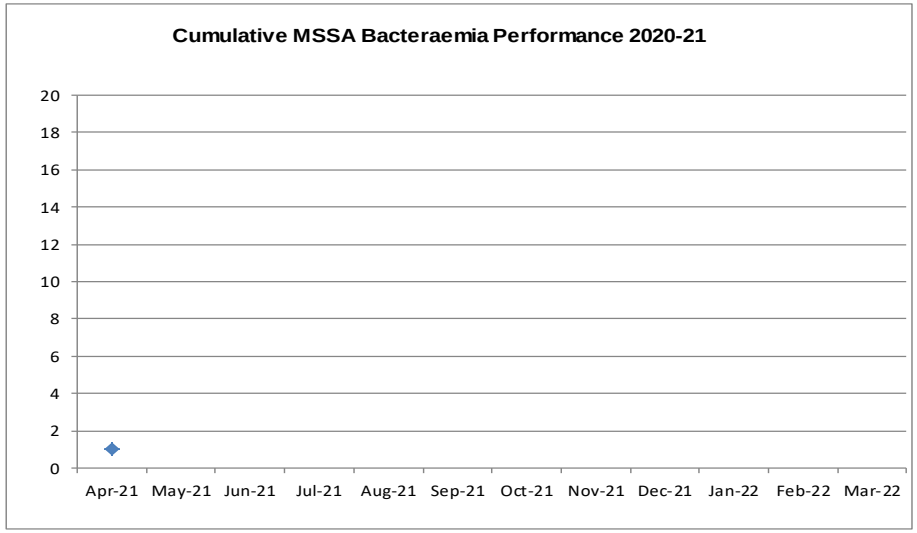
Division	2020-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021-22
Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Medicine	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Surgical	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Women & Children	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Grand Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

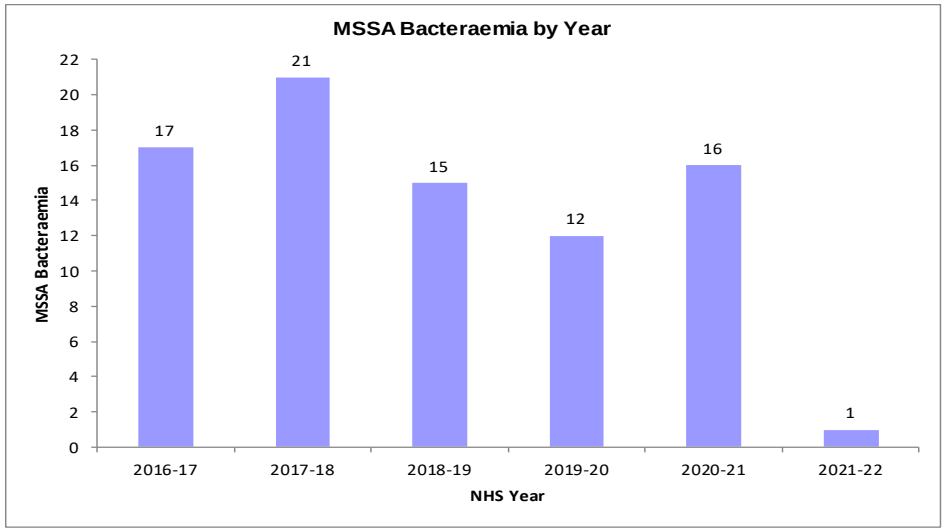
MRSA bacteraemias reporting requirements, allocation process for 2021-22

For 2021-22, MRSA bacteraemias cases reported to the Healthcare Associated Infection Data Capture System (HDCS) are assigned as follows:

- **Hospital Onset Healthcare Associated (HOHA):** Detected in hospital 3 or more days after admission (previously 4 or more days after admission)
- **Community Onset Healthcare Associated (COHA):** Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 28 day

MSSA BACTERAEMIA - HEALTHCARE ASSOCIATED





Healthcare Associated MSSA Bacteraemia by Division

Division	2020-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021-22
Cancer	0	0	0											0
Medicine	10	1	0											1
Surgical	5	0	0											0
Women & Children	1	0	0											0
MVCC	0	0	0											0
Grand Total	16	1	0											1

MSSA bacteraemias reporting requirements, allocation process for 2021-22

For 2021-22, MSSA bacteraemias cases reported to the Healthcare Associated Infection Data Capture System (HDCS) are assigned as follows:

- **Hospital Onset Healthcare Associated (HOHA):** Detected in hospital 3 or more days after admission (previously 4 or more days after admission)
- **Community Onset Healthcare Associated (COHA):** Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 28 day

MSSA – PHE Benchmarking Data

Public Health England

MSSA

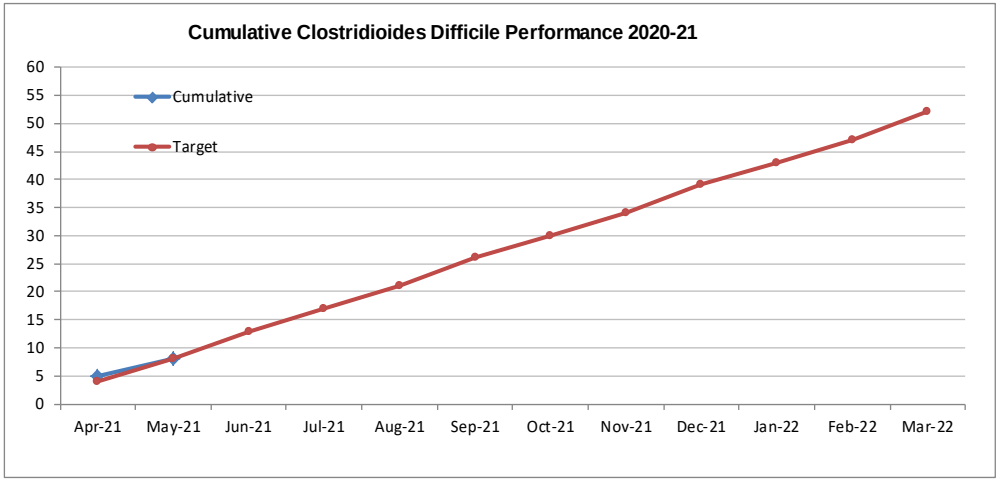
Count of all Hospital-Onset cases identified by acute trust per month

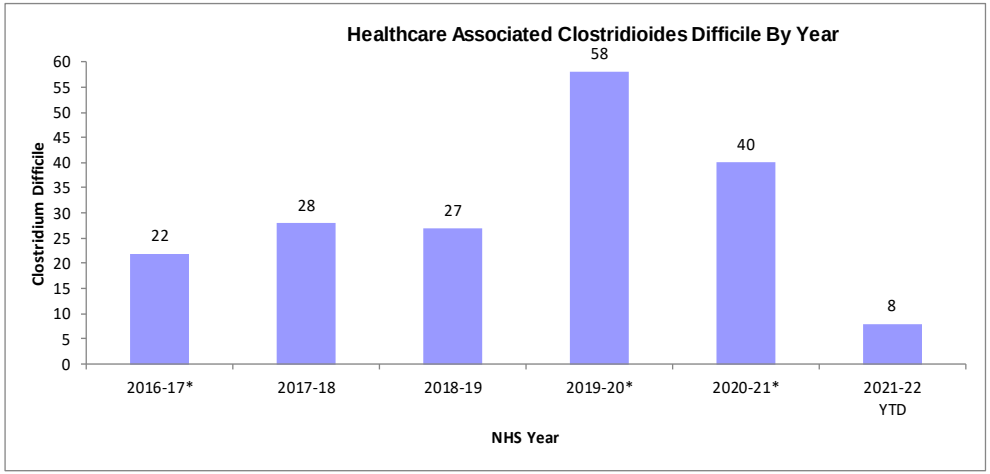
Trust Code	Acute Trust Name	Trajectory	2020 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2021 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	3	1	2	3									9
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0									0
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0	2	0	1									3
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	2	0									2
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	1	5	1	1									8
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	1	1									2
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	2	0	1	1									4
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	1	2	0									5
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	1	1	1	0									3
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	3	3	1									7
RGN	North West Anglia NHS Foundation Trust	N/A	2	2	1	0									5
RGM	Royal Papworth NHS Foundation Trust	N/A	1	0	0	0									1
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	2	0	1									4
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	0	0	2									3
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	0	0	0									1
RGR	West Suffolk Hospitals NHS Trust	N/A	1	0	0	1									2
	East of England Total	**N/A**	**16**	**17**	**14**	**12**									**59**
	England Total	**N/A**	**167**	**210**	**239**	**253**									**869**

Hospital-Onset rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020 April	May	June	July	Aug	Sept	Oct	Nov	Dec	2021 Jan	Feb	Mar	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	15.73	5.08	10.49	15.23									11.61
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	0.00	7.31	0.00	3.66									2.79
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	12.70	0.00									3.12
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	3.08	14.92	3.08	2.98									6.07
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00	8.63	8.35									4.24
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	11.08	0.00	5.54	5.36									5.45
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.75	6.65	13.75	0.00									8.45
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	7.24	7.00	7.24	0.00									5.34
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0.00	11.22	11.59	3.74									6.65
RGN	North West Anglia NHS Foundation Trust	N/A	8.67	8.39	4.34	0.00									5.33
RGM	Royal Papworth NHS Foundation Trust	N/A	20.37	0.00	0.00	0.00									5.01
RQW	Princess Alexandra Hospital NHS Trust	N/A	8.68	16.79	0.00	8.40									8.53
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	8.28	0.00	0.00	16.03									6.11
RWG	West Hertfordshire Hospitals NHS Trust	N/A	5.57	0.00	0.00	0.00									1.37
RGR	West Suffolk Hospitals NHS Trust	N/A	9.24	0.00	0.00	8.94									4.54
	East of England Total	**N/A**	**5.63**	**5.79**	**4.93**	**4.09**									**5.11**
	England Total	**N/A**	**5.76**	**7.01**	**8.24**	**8.44**									**25.51**

CLOSTRIDIOIDES DIFFICILE – HEALTHCARE ASSOCIATED





Healthcare Associated Clostridioides Difficile by Division

Division	2019-20	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021-22
Cancer	0	0	0											0
Medicine	28	5	3											8
Surgical	8	0	0											0
Women & Children	4	0	0											0
MVCC	0	0	0											0
Grand Total	40	5	3											8

C.difficile reporting requirements, allocation process and ceiling targets for 2021-22

For 2021-22, *C.difficile* toxin positive cases reported to the Healthcare Associated Infection Data Capture System (HDCS) are assigned as follows:

- **Hospital Onset Healthcare Associated (HOHA):** Detected in hospital 3 or more days after admission (previously 4 or more days after admission)
- **Community Onset Healthcare Associated (COHA):** Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 4 weeks
- **Community Onset Indeterminate Association (COIA):** Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 12 weeks but not the most recent 4 weeks
- **Community Onset Community Associated (COCA):** Detected in the community (or within 2 days of admission) when patient has not been an inpatient in the Trust in the previous 12 weeks.

The ceiling target remains at 52 cases for 2021-22.

C.difficile – PHE Benchmarking Data

Public Health England

Clostridioides difficile

Count of all Healthcare Associated cases identified by acute trust per month

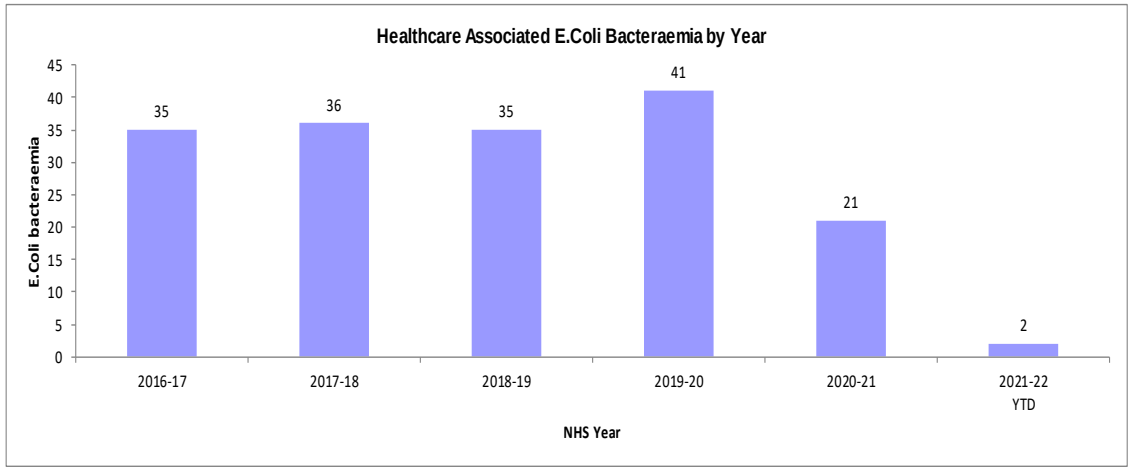
Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	51	1	2	3	6									12
RC1	Bedford Hospitals NHS Trust	14	0	1	1	0									2
RGT	Cambridge University Hospitals NHS Foundation Trust	95	4	3	5	5									17
RWH	East & North Hertfordshire NHS Trust	52	3	4	2	3									12
RDE	East Suffolk & North Essex NHS Foundation Trust	107	9	7	4	6									26
RGP	James Paget University Hospitals NHS Foundation Trust	24	2	1	0	2									5
RC9	Luton & Dunstable Hospital NHS Foundation Trust	19	4	4	3	6									17
RQ8	Mid Essex Hospital Services NHS Trust	83	2	2	2	2									8
RD8	Milton Keynes Hospital NHS Foundation Trust	22	1	0	1	3									5
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	35	4	8	9	10									31
RGN	North West Anglia NHS Foundation Trust	68	3	6	6	7									22
RGM	Royal Papworth NHS Foundation Trust	11	0	1	0	1									2
RQW	Princess Alexandra Hospital NHS Trust	27	1	2	1	4									8
RAJ	Southend University Hospital NHS Foundation Trust	51	8	4	8	5									25
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	44	2	3	5	6									16
RWG	West Hertfordshire Hospitals NHS Trust	34	3	2	0	6									11
RGR	West Suffolk Hospitals NHS Trust	20	2	1	3	5									11
	East of England Total	**757**	**49**	**51**	**53**	**77**									**230**
	England Total	**TBC**	**410**	**521**	**580**	**662**									**2173**

Healthcare-Associated rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	21.40	5.24	10.15	15.73	30.45									15.48
RC1	Bedford Hospitals NHS Trust	10.00	0.00	8.36	8.64	0.00									4.25
RGT	Cambridge University Hospitals NHS Foundation Trust	28.60	15.11	10.97	18.89	18.28									15.79
RWH	East & North Hertfordshire NHS Trust	25.30	19.05	24.58	12.70	18.44									18.74
RDE	East Suffolk & North Essex NHS Foundation Trust	25.70	27.75	20.89	12.33	17.90									19.71
RGP	James Paget University Hospitals NHS Foundation Trust	18.60	17.25	8.35	0.00	16.70									10.61
RC9	Luton & Dunstable Hospital NHS Foundation Trust	8.70	22.16	21.44	16.62	32.16									23.16
RQ8	Mid Essex Hospital Services NHS Trust	42.00	13.75	13.30	13.75	13.30									13.52
RD8	Milton Keynes Hospital NHS Foundation Trust	13.30	7.24	0.00	7.24	21.01									8.90
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	11.30	15.46	29.92	34.78	37.40									29.46
RGN	North West Anglia NHS Foundation Trust	26.00	13.01	25.18	26.02	29.38									23.46
RGM	Royal Papworth NHS Foundation Trust	19.20	0.00	19.71	0.00	19.71									10.02
RQW	Princess Alexandra Hospital NHS Trust	17.60	8.68	16.79	8.68	33.59									17.07
RAJ	Southend University Hospital NHS Foundation Trust	29.10	55.02	26.62	55.02	33.28									42.28
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	29.70	16.56	24.04	41.40	48.08									32.58
RWG	West Hertfordshire Hospitals NHS Trust	15.10	16.72	10.79	0.00	32.36									15.08
RGR	West Suffolk Hospitals NHS Trust	15.80	18.48	8.94	27.71	44.70									24.99
	East of England Total	**TBC**	**17.25**	**17.37**	**18.66**	**26.23**									**19.91**
	England Total	**TBC**	**14.14**	**17.38**	**20.00**	**22.09**									**18.42**

E.COLI BACTERAEMIA – HEALTHCARE ASSOCIATED

The Trust does not have specific targets at present. However, a number of strategies are being introduced in the Trust to minimise cases, including initiatives to reduce hospital acquired pneumonias (HAP) and catheter associated urinary tract infections (CAUTI). There is a whole health economy approach to reducing Gram Negative bacteraemias and the Trust is participating in this programme. A focus of this approach is to reduce Urinary Tract Infections (UTI), including participation in a CCG-led project to improve hydration. The IP&C Team will explore how ICNet can be used to support a process to identify and investigate catheter-associated UTIs which are related to E.coli bacteraemias.



Healthcare Associated E.Coli Bacteraemia by Division

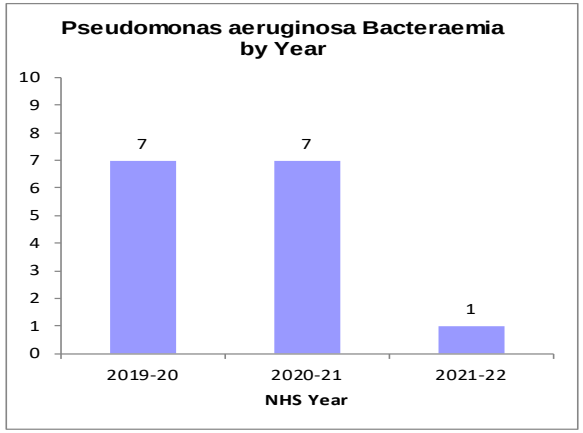
Division	2020-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021-22
Cancer	0	0	0											0
Medicine	12	0	1											1
Surgical	4	1	0											1
Women & Children	5	0	0											0
MVCC	0	0	0											0
Grand Total	21	1	1											2

E.coli bacteraemias reporting requirements, allocation process for 2021-22

For 2021-22, E.coli bacteraemias.cases reported to the Healthcare Associated Infection Data Capture System (HDCS) are assigned as follows:

- **Hospital Onset Healthcare Associated (HOHA):** Detected in hospital 3 or more days after admission (previously 4 or more days after admission)
- **Community Onset Healthcare Associated (COHA):** Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 28 days

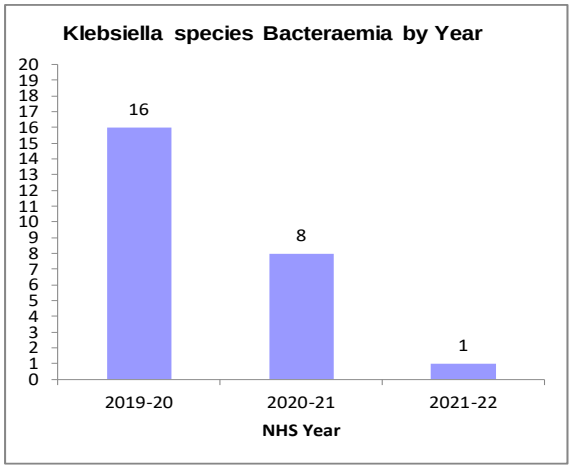
PSEUDOMONAS AERUGINOSA BACTERAEMIA – HEALTHCARE ASSOCIATED



Healthcare Associated Pseudomonas aeruginosa Bacteraemia by Division

Division	2020-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021-22
Cancer	1	0	0											0
Medicine	4	1	0											1
Surgical	2	0	0											0
Women & Children	0	0	0											0
MVCC	0	0	0											0
Grand Total	7	1	0											1

KLEBSIELLA SPECIES BACTERAEMIA – HEALTHCARE ASSOCIATED



Healthcare Associated Klebsiella species Bacteraemia by Division

Division	2020-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021-22
Cancer	1	0	0											0
Medicine	4	0	0											0
Surgical	3	0	1											1
Women & Children	0	0	0											0
MVCC	0	0	0											0
Grand Total	8	0	1											1

Pseudomonas aeruginosa and *Klebsiella species* bacteraemia **reporting requirements, allocation process for 2021-22**

For 2021-22, *Pseudomonas aeruginosa* and *Klebsiella* species bacteraemia cases reported to the Healthcare Associated Infection Data Capture System (HDCS) are assigned as follows:

- **Hospital Onset Healthcare Associated (HOHA):** Detected in hospital 3 or more days after admission (previously 4 or more days after admission)
- **Community Onset Healthcare Associated (COHA):** Detected in the community (or within 2 days of admission) when patient has been an inpatient in the Trust in the previous 28 day

E.coli – PHE Benchmarking Data

Public Health England

Escherichia coli

Count of all Hospital-Onset cases identified by acute trust per month

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	4	5	8	3									20
RC1	Bedford Hospitals NHS Trust	N/A	0	1	0	0									1
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	4	10	7	8									29
RWH	East & North Hertfordshire NHS Trust	N/A	3	1	1	2									7
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	3	0	8	6									17
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	4	3	3									11
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	2	3	6									11
RQ8	Mid Essex Hospital Services NHS Trust	N/A	2	1	4	1									8
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	1	1	1	2									5
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	5	1	10	7									23
RGN	North West Anglia NHS Foundation Trust	N/A	4	5	2	7									18
RGM	Royal Papworth NHS Foundation Trust	N/A	1	1	0	1									3
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	1	1	2									5
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	0	2									3
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	3	1	2									6
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	1									1
	East of England Total	**N/A**	**29**	**37**	**49**	**53**									**168**
	England Total	**N/A**	**367**	**425**	**478**	**515**									**1785**

Hospital-Onset rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	20.98	25.38	41.96	15.23									25.79
RC1	Bedford Hospitals NHS Trust	N/A	0.00	8.36	0.00	0.00									2.12
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	15.11	36.55	26.44	29.24									26.94
RWH	East & North Hertfordshire NHS Trust	N/A	19.05	6.15	6.35	12.29									10.93
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	9.25	0.00	24.67	17.90									12.89
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	8.63	33.40	25.88	25.05									23.34
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	10.72	16.62	32.16									14.98
RQ8	Mid Essex Hospital Services NHS Trust	N/A	13.75	6.65	27.49	6.65									13.52
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	7.24	7.00	7.24	14.00									8.90
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	19.32	3.74	38.64	26.18									21.86
RGN	North West Anglia NHS Foundation Trust	N/A	17.35	20.98	8.67	29.38									19.20
RGM	Royal Papworth NHS Foundation Trust	N/A	20.37	19.71	0.00	19.71									15.03
RQW	Princess Alexandra Hospital NHS Trust	N/A	8.68	8.40	8.68	16.79									10.67
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0.00	8.01	0.00	16.03									6.11
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	16.18	5.57	10.79									8.22
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	8.94									2.27
	East of England Total	**N/A**	**10.21**	**12.60**	**17.25**	**18.06**									**14.54**
	England Total	**N/A**	**12.65**	**14.18**	**16.48**	**17.18**									**15.13**

Pseudomonas aeruginosa – PHE Benchmarking Data

Public Health England

Pseudomonas aeruginosa

Count of all Hospital-Onset cases identified by acute trust per month

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	1	1	1									3
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0									0
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	2	4	2	4									12
RWH	East & North Hertfordshire NHS Trust	N/A	0	0	0	1									1
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	1	0	0	2									3
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	1	0									1
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	1	0									1
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	2	0	0									2
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	1	1									2
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	1	0	3	1									5
RGN	North West Anglia NHS Foundation Trust	N/A	0	0	0	1									1
RGM	Royal Papworth NHS Foundation Trust	N/A	0	0	1	0									1
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	1	0	0									1
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	0	0	3									4
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	0									0
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0									0
	East of England Total	**N/A**	**5**	**8**	**10**	**14**									**37**
	England Total	**N/A**	**89**	**110**	**94**	**123**									**416**

Hospital-Onset rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0.00	5.08	5.24	5.08									3.87
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	7.55	14.62	7.55	14.62									11.15
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	0.00	0.00	6.15									1.56
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	3.08	0.00	0.00	5.97									2.27
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0.00	0.00	8.63	0.00									2.12
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0.00	0.00	5.54	0.00									1.36
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0.00	13.30	0.00	0.00									3.38
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0.00	0.00	7.24	7.00									3.56
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	3.86	0.00	11.59	3.74									4.75
RGN	North West Anglia NHS Foundation Trust	N/A	0.00	0.00	0.00	4.20									1.07
RGM	Royal Papworth NHS Foundation Trust	N/A	0.00	0.00	20.37	0.00									5.01
RQW	Princess Alexandra Hospital NHS Trust	N/A	0.00	8.40	0.00	0.00									2.13
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	8.28	0.00	0.00	24.04									8.14
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
	East of England Total	**N/A**	**1.76**	**2.73**	**3.52**	**4.77**									**3.20**
	England Total	**N/A**	**3.07**	**3.67**	**3.24**	**4.10**									**3.53**

Klebsiella species – PHE Benchmarking Data

Public Health England

Klebsiella species

Count of all Hospital-Onset cases identified by acute trust per month

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	1	4	3	2									10
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	1									1
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	10	2	4	6									22
RWH	East & North Hertfordshire NHS Trust	N/A	0	1	0	0									1
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	2	3	1	3									9
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	0	2	1									4
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	1	0	2	1									4
RQ8	Mid Essex Hospital Services NHS Trust	N/A	4	1	1	1									7
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	0	1	0									3
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	2	2	1	1									6
RGN	North West Anglia NHS Foundation Trust	N/A	3	2	2	0									7
RGM	Royal Papworth NHS Foundation Trust	N/A	4	0	2	0									6
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	0	2	0									3
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0									0
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	1	1	2									5
RWG	West Hertfordshire Hospitals NHS Trust	N/A	1	0	1	2									4
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0									0
	East of England Total	**N/A**	**33**	**16**	**23**	**20**									**92**
	England Total	**N/A**	**301**	**236**	**213**	**253**									**1003**

Hospital-Onset rate per 100,000 occupied bed days

Trust Code	Acute Trust Name	Trajectory	2020									2021			Total
			April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	5.24	20.30	15.73	10.15									12.90
RC1	Bedford Hospitals NHS Trust	N/A	0.00	0.00	0.00	8.36									2.12
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	37.77	7.31	15.11	21.93									20.43
RWH	East & North Hertfordshire NHS Trust	N/A	0.00	6.15	0.00	0.00									1.56
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	6.17	8.95	3.08	8.95									6.82
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	8.63	0.00	17.25	8.35									8.49
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	5.54	0.00	11.08	5.36									5.45
RQ8	Mid Essex Hospital Services NHS Trust	N/A	27.49	6.65	6.87	6.65									11.83
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	14.47	0.00	7.24	0.00									5.34
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	7.73	7.48	3.86	3.74									5.70
RGN	North West Anglia NHS Foundation Trust	N/A	13.01	8.39	8.67	0.00									7.46
RGM	Royal Papworth NHS Foundation Trust	N/A	81.47	0.00	40.74	0.00									30.05
RQW	Princess Alexandra Hospital NHS Trust	N/A	8.68	0.00	17.35	0.00									6.40
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0.00	0.00	0.00	0.00									0.00
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	8.28	8.01	8.28	16.03									10.18
RWG	West Hertfordshire Hospitals NHS Trust	N/A	5.57	0.00	5.57	10.79									5.48
RGR	West Suffolk Hospitals NHS Trust	N/A	0.00	0.00	0.00	0.00									0.00
	East of England Total	**N/A**	**11.62**	**5.45**	**8.10**	**6.81**									**7.96**
	England Total	**N/A**	**10.38**	**7.87**	**7.34**	**8.44**									**8.50**

Carbapenemase Producing Organisms

Carbapenems are a class of broad spectrum intravenous antibiotics reserved for serious infections or when other therapeutic options have failed. One of the most concerning groups of Carbapenem Resistant Enterobacteriaceae (CRE) are those organisms which carry a carbapenemase enzyme that breaks down carbapenem antibiotics. This type of organism is called Carbapenemase Producing Enterobacteriaceae or Organism (CPE/CPO) and it has caused most outbreaks worldwide.

The ICNet system was fully implemented in June 2019 and has been configured to enable prompt identification and isolation of readmitted patients previously identified as positive for CPO.

Carbapenemase-Producing Organisms - 2021-22

Division/Dept		2021-22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021-22
INPATIENTS	Renal Ward - Lister	0	0	0											
	Medicine	0	0	0											
	Surgery	1	0	0											
	W&C	2	0	0											
	MVCC	0	0	0											
RENAL DIALYSIS UNITS	Lister	0	0	0											
	L&D	0	0	0											
	Harlow	0	0	0											
	St Albans	0	0	0											
	Bedford	0	0	0											
OUTPATIENTS	Lister	1	0	0											
	QEII	0	0	0											
	HCH	0	0	0											
	MVCC	0	0	0											
TOTAL (TRUST PATIENTS)		4	0	0											

0

GP Patient Specimens		0	0	0											

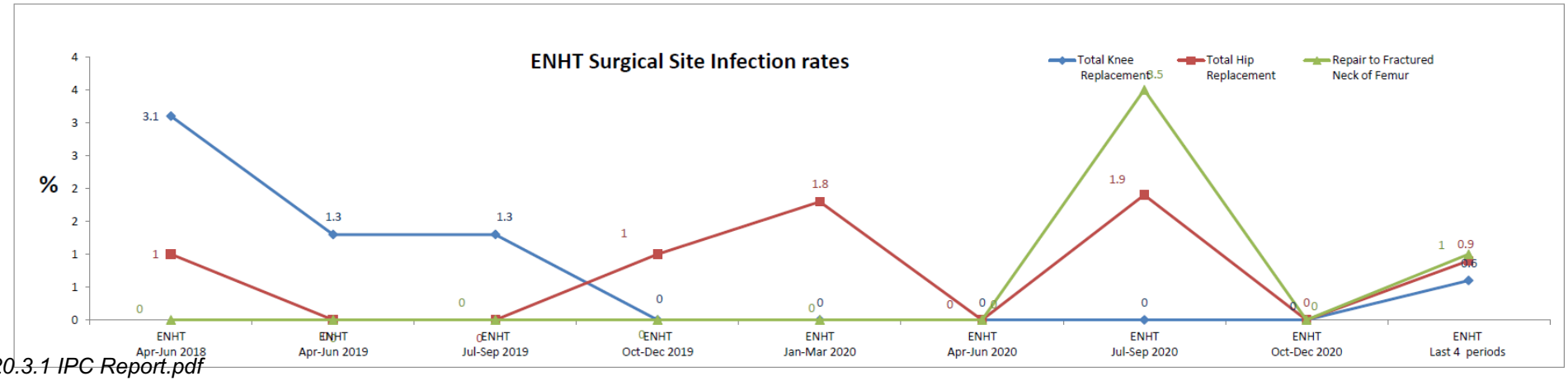
Surgical Site Infection Rates-

A retrospective review of the SSI data has revealed that the cases highlighted below have been identified after the initial quarterly data was submitted and signed off. The Trust proactively review the following procedures: Total Knee Replacement (TKR), Total Hip Replacement (THR), and Repair Fractured Neck of Femur (NOF) for SSIs. These are implant procedures the Trust carries out surveillance of, for up to a year and any SSIs developed within that year will be associated with the initial procedure and can be added to/removed from the PHE Surgical Site Infection Surveillance data accordingly.

SSI figures over the last 4 periods (Jan 2020 – Dec 2020) show an overall reduction in infection rates in all three categories monitored (Total Knee Replacement, Total Hip Replacement & Repair of Fractured Neck of Femur), compared to the 2014-15 figures. There were no TKR in Apr-Jun 2020 due to COVID the TKR infection rate in Jan-Mar 2020 – Oct- Dec 2020 was 0% but the overall rate for the past 4 periods is 0.6%. This is above the national benchmark (0.5%) and the Trust remains an outlier. There was 0 THR infection in Oct-Dec 2020, which gives an infection rate of 0% due to the reduced number of operations carried out. The THR rate over the last 4 quarters is 0.9% which is above the national benchmark (0.6%). For the NOF, the rate for Oct- Dec 2020 was 0% and the rate for the last 4 quarters is 1.0%. This is below the national benchmark (1.1%)
SSI surveillance resumed from April 2019, having been suspended from July 2018 due to staffing issues. Most recent results for Oct-Dec 2020 are included below.

Surgical Site Infection rates	Apr-Jun 18 ENHT	Apr-Jun 19 ENHT	July-Sep 19 ENHT	Oct-Dec 19 ENHT	Jan-Mar 20 ENHT	Apr-Jun 20 ENHT	July-Sep 20 ENHT	Oct-Dec 20 ENHT	* Last 4 periods ENHT	National Benchmarks 2014-2019
Total Knee Replacement	**3.1%**	**1.3%**	**2.5%**	**1.6%**	**0%**	**0%**	**0%**	**0%**	**0.6%**	**0.5%**
TKR infections / ops	3 / 98	1 / 78	2 / 79	1 / 62	0 / 48	0 / 0	0 / 16	0 / 40	1 / 166	
Total Hip Replacement	**1%**	**0.9%**	**0%**	**0%**	**1.8%**	**0.0%**	**1.9%**	**0.0%**	**0.9%**	**0.6%**
THR infections / ops	1 / 105	1 / 109	0 / 106	0 / 101	1 / 55	0 / 6	1 / 52	0 / 150	2 / 218	
Repair Fractured Neck of Femur	**0%**	**0%**	**0%**	**7%**	**0%**	**0%**	**3.5%**	**0%**	**1.0%**	**1.1%**
#NOF infections / ops	0 / 56	0 / 47	0 / 53	3 / 43	0 / 30	0 / 55	2 / 57	0 / 68	2 / 210	

*** The last 4 quarters for which data has been collected are considered most useful for identifying trends, due to the comparatively small no. of operations per quarter**
ENHT participation was suspended between July 2018 & March 2019 inclusive so there is no data for that period.



High Impact Intervention Audit Scores

High Impact Interventions	2020-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD 2021-22	Target	Amber
Hand Hygiene (MOMENTS 1-5)	92.58%	91.15%	87.92%											89.33%	80.00%	70.00%
Intravascular Devices	88.46%	89.20%	89.70%											89.47%	95.00%	80.00%
Urinary Catheter Care	51.12%	51.62%	56.35%											54.26%	95.00%	80.00%
Renal Dialysis Catheter	99.70%	100.00%	100.00%											100.00%	95.00%	80.00%
Inpatients Environment Peer Audit (Overall)	90.11%	94.34%	89.57%											91.89%	95.00%	80.00%
Inpatients Environment - Peer Audit - Ward Environment	93.98%	95.31%	94.74%											95.04%	95.00%	80.00%
Inpatients Environment Peer Audit (Patient Equipment - Cleanliness & Condition)	87.64%	94.24%	85.52%											89.79%	90.00%	75.00%

Audit scores are extracted from the IQVIA database of Trust-wide audits.

Hand Hygiene audits cover the World Health Organisation (WHO) Moments 1-5 see below:

1. Before patient contact
2. Before clean/aseptic procedure
3. After exposure to body fluids
4. After patient contact
5. After contact with patient surroundings)

East and North Hertfordshire NHS Trust

Agenda Item: 20.4

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021

AUDIT COMMITTEE – MEETING HELD ON 4 JUNE 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Audit Committee meeting of the 4 June 2021 to the Board.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of AC	**Presented by:** Chair of AC	**Author:** Trust Secretary

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

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

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

AUDIT COMMITTEE MEETING – 4 JUNE 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 7 JULY 2021

The following Non-Executive Directors were present:
Jonathan Silver (Chair), Karen McConnell, Bob Niven

External Audit Reports:

External Audit Progress Report

The Committee received a progress report from the External Auditors regarding the planned audit approach for the year ended 31 March 2021. The work remained ongoing and the Committee noted the key points from the report.

The Committee was reminded that the Trust had enacted the option to extend the deadline for submission to 29 June 2021 and that the Board had granted delegated authority to the Audit Committee to approve the annual report and accounts at its meeting on 5 May 2021.

Once finalised, the completion report would be circulated to senior management and Audit Committee members.

Draft Letter of Representation

On the basis of the work completed to date and subject to a satisfactory final audit completion report, the Audit Committee received and approved the draft letter of representation.

Final Accounts 2020-21

The Audit Committee received the final draft of the Trust Accounts 2020-21. An earlier iteration had been reviewed and discussed at an informal meeting between Non-Executive Directors and Trust officers previously. It was confirmed there had been no material changes from the version considered at that meeting.

On the basis of the work completed to date and subject to a satisfactory final audit completion report, the Trust Accounts 2020-21 were approved.

Draft Annual Report and Annual Governance Statement 2020-21

The Audit Committee received the draft Annual Report and Annual Governance Statement 2020-21. Earlier versions of these documents had also been discussed at the informal meeting between Non-Executive Directors and Trust officers. It was noted that the main matters that had been outstanding at that point had now been resolved.

On the basis of the work completed to date and subject to a satisfactory final audit completion report, the Trust Annual Report and Annual Governance Statement 2020-21 were approved.

Internal Audit Reports:

Internal Audit Annual Report and Head of Internal Audit Opinion

The Committee received the Internal Audit Annual Report and Head of Internal Audit Opinion. The opinion provided was:

TIAA [the Trust's internal auditor] is satisfied that, for the areas reviewed during the year, East and North Hertfordshire NHS Trust has reasonable and effective risk management, control and governance processes in place. Not having completed all of the planned work due to the global Covid-19 pandemic has not impacted on our overall assessment.

This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried our during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by the East and North Hertfordshire NHS Trust from its various sources of assurance.

Internal Audit Update and Action Tracker
Three internal audit reports had been finalised since the previous meeting, as follows:

- Data Quality – Friends and Family Test – Reasonable Assurance
- Compliance Framework – Reasonable Assurance
- Long Stay Reviews and Discharge Management – Reasonable Assurance

The Committee noted the key findings and discussed the target dates for actions arising from the audits, some of which were considered potentially too optimistic.

The Committee also reviewed the latest edition of the internal audit actions tracker. Whilst the total number of actions due had reduced from the previous meeting, it was noted that there were a number of actions that had been open for in excess of a year. It was requested that work was undertaken to review the actions and ensure they remain appropriate in advance of the next meeting of the Committee.

Local Counter Fraud Annual Report
The Committee received the Counter Fraud Annual Report 20/21, which provided a summary of the work undertaken by the Trust's Senior Anti-Crime Manager during the year and was intended to provide assurance against the NHS Counter Fraud Authority assurance areas.

The Committee noted that the Counter Fraud Functional Standard Return submission had been completed and rated the Trust as green in five components and amber in eight components, with zero areas rated as red. The Committee discussed steps to improve the performance for next year's return.

Other Reports:

Fixed Asset Verification Progress Report
A report regarding progress made on the fixed asset verification was received by the Committee. The exercise had begun following a recommendation arising from a previous external audit to carry out a full asset verification exercise and to update the fixed asset register accordingly. This was a significant task and whilst there had been factors affecting the speed of work, the verification exercise was now complete. The Committee thanked the team for their work to complete the exercise and ensure more robust processes were in place moving forward.

Board Assurance Framework 2021/22
The Committee was informed that the review of the BAF for 21/22 was underway and the updated version would be considered at the next round of Board sub-committees later in the month.

The Committee considered a proposed schedule for deep dives related to the BAF risks. The Committee was asked to provide feedback outside of the meeting for the schedule to be finalised before the next meeting.

Cyber Security Report
The Committee received the latest update regarding the Trust's cyber security position. The Committee noted the recent issue affecting the Irish health service and discussed the Trust's position in terms of cyber security alerts, patching, the data security and protection toolkit submission and priorities for 2021/22.

Quality Account Progress Update
It was reported that the deadline for submission of the Quality Account had been confirmed as 30 June. The Committee noted the planned timeline for production of the report. The Quality and Safety Committee would be asked to approve the final version at their meeting on 29 June.

Jonathan Silver
Audit Committee Chair
July 2021

East and North Hertfordshire NHS Trust

Agenda Item: 20.5

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021
CHARITY TRUSTEE COMMITTEE – MEETING HELD ON 7 JUNE 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the CTC meeting of 7 June 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of CTC	**Presented by:** Chair of CTC	**Author:** Trust Secretary

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

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

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CHARITY TRUSTEE COMMITTEE – 7 JUNE 2021

SUMMARY TO THE TRUST BOARD MEETING HELD ON 7 JULY 2021

The following members were present: Bob Niven (Chair), Ellen Schroder (Trust Chair), Val Moore (Non-Executive Director), David Buckle (Non-Executive Director), Sarah Brierley (Director of Strategy) and Rachael Corser (Chief Nurse)

Key decisions made under delegated authority:
The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its Terms of Reference:

Approval for expenditure over £5,000
The Committee discussed the following applications for expenditure over £5,000:

Proposal	Cost	Outcome
Children's: Raise funds for two Rhino portable sensor trolleys for three areas. This is portable sensory equipment.	£10,000	Approved
Cancer: Convert the wheelchair storage room into a waiting room by removing folding doors and replacing with glass panel.	£6,558	Approved
Research: Feasibility Randomised Study – Definitive (chemo) radiotherapy versus primary surgery and post-operative radiotherapy in advanced oral cavity squamous cell cancer. There is an upper limit of £50,000 from the John Bush fund. The remainder of the money is requested from the CTC.	£78,846.41	Approved subject to confirmation that adequate governance processes are in place regarding the development of the proposal.

Matters Arising
The CTC discussed the increasing number of requests for funding and the logistical challenge of managing these applications at the CTC meetings. It was proposed that the CTC meetings should be split into two sections. The first half will be an approval section to ensure approvals are provided with the appropriate time needed and the second half will be the strategic and governance section of the meeting. This suggestion was supported by the Committee.

The Committee also discussed the possibility of increasing the threshold of approvals to £10,000. This was supported in principle with a caveat that the threshold could be reduced if appropriate, and an increase would first require the Trust Board to authorise a change to the Trust's Standing Orders and Standing Financial Instructions when it considers the annual review in November.

Investment Portfolio
The advisors from Rathbones presented a report on the Charity's investment portfolio and factors affecting its performance, including worldwide economic recovery, inflation and the UK market. The Trust's Charity portfolio return since 30 November was 9.5%. Performance is ahead of the benchmark and the long term target.

Charity Highlight Report
The CTC received the Charity Highlight Report, which provided an appraisal of income generation, an update on branding and marketing, details on the new capital appeal (the Sunshine appeal), an update on charity expenditure, detail of the risk register entries in relation to the Charity and assurances regarding the impact of the MVCC transfer.

Regarding the Sunshine appeal, the CTC was informed that a fundraising committee will be set up to oversee the appeal. Some feasibility work remained outstanding and any issues identified would be escalated to the CTC.

Regarding branding, it was reported that the current Trust Charity logo will be phased out, introducing a new logo. The main reason is because the type face is not easily accessible and dated. The CTC reviewed the proposals and approved a new logo.

The Committee requested an update on the development of the Charity's strategy be included in future reports.

Charity Finance Report
The Committee received the finance report. The year end income was £1.7m against a revised income budget of £1.4m (excluding gift in kind). Income was £357k above a revised budget mainly due to legacy income. Expenditure was in line with the revised plan.

The pandemic had an impact on income streams, however there was a strong level of corporate giving. Gift in kind income was almost £500k with a large volume of gifts received.

The CTC also received an update on the year to date position.

Major Project Update
The Committee received an update on the 'Here for Each Other' project. A significant amount of the staff funding had been allocated for improving staff rest areas. The first phase of furniture will be arriving this week with all deliveries expected by the end of July.

Charity Investment Procurement
The CTC received details of the timeline for the retendering of the Charity's investment advisors. The Trust Board would be asked to approve the awarding of the contract at its meeting in September.

Any Other Business
The CTC considered a fundraising appeal for two interactive floors in the children's department of approximately £10,000 each. Ongoing revenue implications will be explored before a final decision is made. Further detail would be circulated to the CTC members outside of the meeting.

Bob Niven
Chair of the Charity Trustee Committee
June 2021

East and North Hertfordshire NHS Trust

Agenda Item: 20.6.1

TRUST BOARD - PUBLIC SESSION – 7 JULY 2021
EQUALITY & INCLUSION COMMITTEE – MEETING HELD ON 18 MAY 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the Equality and Inclusion meeting of 18 May 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of E&IC	**Presented by:** Chair of E&IC	**Author:** Trust Secretary

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

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

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

EQUALITY AND INCLUSION COMMITTEE MEETING – 18 MAY 2021
SUMMARY TO THE TRUST BOARD MEETING HELD ON 7 JULY 2021

The following Non-Executive Directors were present:
Biraj Parmar (Chair), Ellen Schroder (Trust Chair), Bob Niven and Val Moore

Draft Terms of Reference and Annual Cycle of Business
This being the first meeting of the Equality and Inclusion Committee meeting, the Committee reviewed the draft Terms of Reference and discussed the purpose of the Committee, the membership and proposed annual cycle of business. Some minor changes were discussed and agreed.

The draft Terms of Reference are attached as Appendix A for approval by the Trust Board.

EDI Dashboard
The Equality and Inclusion Committee reviewed the EDI dashboard which provided a snapshot of key measures and KPIs regarding equality and inclusion. The dashboard is still under development and will be developed further to include information regarding patients as well as staff. To enable this, a task and finish group will be set up to support the development of the dashboard.

It was found that a significant percentage of staff do not disclose personal information such as any disabilities they may have or their ethnicity. The Committee is keen to ensure that staff are comfortable in disclosing such information and the Committee discussed ways to improve the capture of such data.

The Committee welcomed the first iteration of the dashboard and agreed there was further work required in relation to data collection and meaningful analysis in order for the dashboard to be used as a useful and relevant means of monitoring progress.

Developing our Networks
The ED&I Manager presented a detailed report regarding the development of the Staff Networks. The Networks were formed by staff groups with protected characteristics as defined by the Equality Act 2010. The networks have grown in one year from an involvement of 20 people to memberships of 200+ people. It was highlighted that to increase the size and ambition of the networks, engagement is needed at all levels and the efforts of the Chairs of those networks are crucial in encouraging people to join and participate. The possibility of additional resources to support the groups would also be explored at future committee meetings.

Reciprocal Mentoring
The East and North Hertfordshire NHS Trust is one of 42 trusts that are looking to be early adopters of reciprocal mentoring. This differs from traditional mentoring and focusses on partnerships of pairs of people who will have an opportunity to learn from each other and this information can be used to improve inclusion throughout the Trust. The Committee considered whether this scheme could include patients as well as staff and there was discussion about how to use the scheme in the most effective way. The Committee is supportive of the approach in principle and requested further detail be provided at a future meeting.

Recruitment Update
An update was provided in relation to the Inclusion Ambassador scheme that was introduced last year to address under representation in BAME employees at band 8A and above. The scheme focuses on providing support to ensure that BAME applicants are not disadvantaged in any way throughout the recruitment process. 11 individuals have been trained as Inclusion Ambassadors, and have supported the majority of appointments at Band 8A and above. However, the availability of Inclusion Ambassadors has been a challenge and, as a result, more Inclusion Ambassadors are being trained. The Committee also discussed the next steps, such as attempting to increase the overall number of applications from under-represented groups, and widening the scope of the Inclusion Ambassador scheme to include bands below 8A, to include other protected characteristics as well as earlier involvement in the recruitment and selection process.

Biraj Parmar
Equality & Inclusion Committee Chair
June 2021

EQUALITY & INCLUSION COMMITTEE

TERMS OF REFERENCE

1. Purpose

The purpose of the Equality and Inclusion Committee (EIC) is to provide assurance to the Board that appropriate arrangements are in place to improve equity and inclusion for our patients and people. Through this work the Committee will play a key role in ensuring the Trust delivers sustainable improvements.

The Committee's work will:

- Maintain an overview of the development and maintenance of the Trust's short, medium and long term inclusion strategy for our people and patients.
- Provide scrutiny of inclusion performance against agreed KPIs.
- Oversee risk management for the duties of the Committee.
- Collaborate with our local partners across the county, ICS and East of England to improve inclusion for all.

The Committee will be notified of any development relating to the Hertfordshire and West Essex Integrated Care System that may impact on the work of the Committee.

Further detail regarding the duties of the Committee is set out under section 6.

2. Status & Authority

The committee is constituted as a formal Committee of the Trust Board and is authorised by the Board to investigate any activity within its terms of reference.

It is authorised to seek any information it requires and all employees are directed to co-operate with any request made by the Committee.

The Committee has the authority to set up and oversee subgroups for specific inclusivity programmes. These will report directly to the Committee.

3. Membership

Three non-executive directors, one of whom will be nominated as Chair.

Core Attendees:

Chief People Officer
Medical Director (as the named executive Board member responsible for tackling health inequalities)
Deputy Chief People Officer
Deputy Director of Finance
Managing Director – Unplanned care
Managing Director – Planned care
Head of People Culture
Equality, Diversity and Inclusion Lead

Attendees

Executive network sponsors
Staff network chairs
Trust Secretary
ICS partners, such as contribution from the Public Health team, and Inclusion leads in HCT/HPFT as required.

Other staff will be invited to attend to present an item to the committee or to support their personal development with the prior agreement of the Committee Chair.

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

4. Quorum

Two Non-Executive Directors and two core attendees one of whom should be either

- Chief People Officer or their nominated deputy
- Medical Director or their nominated deputy.

5. Frequency of meetings

The Committee will normally meet every 2 months. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

All attendees are expected to attend each meeting or to send a nominated deputy when they are unable to do so.

6. Duties

The Committee will oversee the delivery of the following priorities with an emphasis on continuous improvement. Any additional or amended priorities will be recommended to the Board for approval.

1. Deliver better health outcomes for our whole community, and actions to reduce health inequalities
2. Improve access and experience for our patients
3. Ensure a representative and supported workforce
4. Ensure inclusive leadership
5. Ensure that the culture of the organisation supports and improves inclusion
6. Improve data collection, use and reporting in relation to equality and inclusion
7. Devise and monitor appropriate KPIs for equality and inclusion to enable effective scrutiny of delivery against the equality and inclusion priorities
8. Ensure compliance with legislative and governing body requirements.
9. To monitor and review risks for the areas relevant to the Committee's duties and escalate to the Trust Board where required.

7. Reporting arrangements

The committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board, Executive Team and Executive Directors for these groups / individuals to take appropriate action.

The Committee will work closely with other Trust Board subcommittees as required, in particular the Finance, Performance and People Committee and Quality and Safety Committee.

8. Process for review of committees work including compliance with ToR

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

- The Committee's report to Trust Board
- An annual evaluation of the Equality and Inclusion Committee and review of its terms of reference.

9. Support

The Trust Secretary will ensure the committee is supported administratively and advise the Committee on pertinent areas.

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

Agenda item: 21

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 7 JULY 2021

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

No actions outstanding

Draft Board Annual Cycle 2021-22

Notes regarding the annual cycle:

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

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

Draft Board Annual Cycle 2021-22

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

Draft Board Annual Cycle 2021-22

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

Draft Board Annual Cycle 2021-22

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

DATA PACK

Contents

1. Data and Exception Reports:

FFT

2. Performance Data:

CQC Outcomes Summary

1. Data and Exception Reports:

FFT

Friends and Family Test - May 2021

APPENDIX 1

Inpatients & Day Case	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No of Patients eligible to respond
5A	NP	NP	0	0	0	0	0	0	0	242
5B	95.83	4.17	17	6	0	0	1	0	24	61
6A	90.48	4.76	30	8	2	2	0	0	42	74
6B	100.00	0.00	2	0	0	0	0	0	2	55
7A	90.48	4.76	16	3	1	0	1	0	21	52
7B	86.36	0.00	6	13	3	0	0	0	22	165
8A	100.00	0.00	44	35	0	0	0	0	79	78
8B	NA	NA	0	0	0	0	0	0	0	0
9A	89.47	0.00	11	6	2	0	0	0	19	53
9B	100.00	0.00	29	11	0	0	0	0	40	47
10A	90.00	0.00	14	4	2	0	0	0	20	30
10B	NP	NP	0	0	0	0	0	0	0	66
11A	97.65	0.00	36	47	2	0	0	0	85	71
11B	90.91	0.00	4	6	1	0	0	0	11	7
ICU1	0.00	33.33	0	0	0	1	0	2	3	3
ICU2	NA	NA	0	0	0	0	0	0	0	0
SSU	NP	NP	0	0	0	0	0	0	0	99
ACU	96.00	0.00	19	5	1	0	0	0	25	69
AMU1	NA	NA	0	0	0	0	0	0	0	0
AMU2	100.00	0.00	4	0	0	0	0	0	4	48
Ashwell	89.47	0.00	11	6	2	0	0	0	19	48
Barley	85.71	0.00	4	2	0	0	0	1	7	36
Pirton	100.00	0.00	17	5	0	0	0	0	22	50
Swift	100.00	0.00	42	14	0	0	0	0	56	156
Day Surgery Centre, Lister	100.00	0.00	17	2	0	0	0	0	19	319
Day Surgery Treatment Centre	96.92	0.00	60	3	2	0	0	0	65	219
Endoscopy, Lister	98.40	1.20	238	8	1	2	1	0	250	693
Endoscopy, QEII	98.00	0.00	45	4	0	0	0	1	50	56
Cardiac Suite	100.00	0.00	35	0	0	0	0	0	35	71
MEDICINE/SURGERY TOTAL	96.63	0.87	**701**	**188**	**19**	**5**	**3**	**4**	**920**	**2868**
Bluebell ward	97.62	0.00	37	4	1	0	0	0	42	71
Bluebell day case	NA	NA	0	0	0	0	0	0	0	0
Neonatal Unit	97.83	0.00	39	6	1	0	0	0	46	86
WOMEN'S/CHILDREN TOTAL	97.73	0.00	**76**	**10**	**2**	**0**	**0**	**0**	**88**	**157**
MVCC 10 & 11	100.00	0.00	7	5	0	0	0	0	12	33
CANCER TOTAL	100.00	0.00	**7**	**5**	**0**	**0**	**0**	**0**	**12**	**33**
TOTAL TRUST	96.76	0.78	**784**	**203**	**21**	**5**	**3**	**4**	**1020**	**3058**

Inpatients/Day by site	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister	96.66	0.84	732	194	21	5	3	3	958	2969
QEII	NA	NA	45	4	0	0	0	1	50	56
Mount Vernon	100.00	0.00	7	5	0	0	0	0	12	33
TOTAL TRUST	**96.76**	**0.78**	**784**	**203**	**21**	**5**	**3**	**4**	**1020**	**3058**

Accident & Emergency	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister A&E/Assessment	89.71	2.86	123	34	12	1	4	1	175	10513
QEII UCC	94.12	5.88	8	8	0	1	0	0	17	5047
A&E TOTAL	**90.10**	**3.13**	**131**	**42**	**12**	**2**	**4**	**1**	**192**	**15560**

Maternity	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. eligible to respond
Antenatal	83.33	16.67	4	1	0	1	0	0	6	457
Birth	97.32	0.89	81	28	1	1	0	1	112	437
Postnatal	98.15	1.85	74	32	0	2	0	0	108	437
Community Midwifery	92.31	7.69	10	2	0	0	1	0	13	525
MATERNITY TOTAL	**97.07**	**2.09**	**169**	**63**	**1**	**4**	**1**	**1**	**239**	**1856**

Outpatients	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses
Lister	95.15	3.64	111	46	1	5	1	1	165
QEII	100.00	0.00	30	9	0	0	0	0	39
Hertford County	100.00	0.00	80	15	0	0	0	0	95
Mount Vernon CC	87.22	6.02	91	25	7	5	3	2	133
Satellite Dialysis	97.37	1.32	63	11	1	1	0	0	76
OUTPATIENTS TOTAL	**94.69**	**2.95**	**375**	**106**	**9**	**11**	**4**	**3**	**508**

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

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 New Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 23 - 25 & 30 – 31 July 2019. The well led inspection took place from 10 – 11 September 2019. The Use of Resources inspection, which is led by NHS Improvement took place on 6 August 2019.

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

At **Lister Hospital** CQC inspected:

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

At the **New QEII Hospital** CQC inspected:

- Urgent Care Centre
- Outpatients

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

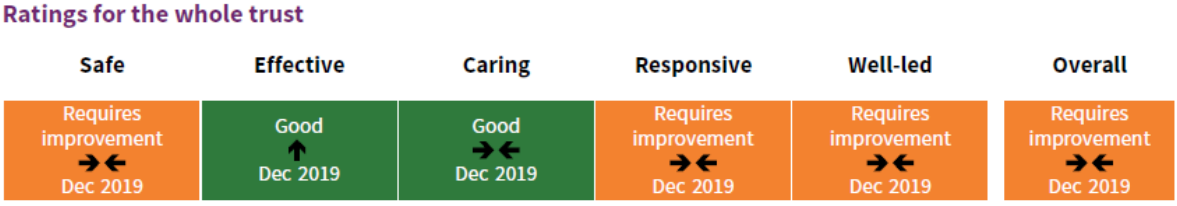
- Medicine (MVCC)
- Radiotherapy (MVCC)
- Outpatients

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

Summary of the Trust's Ratings

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

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



	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