East and North Hertfordshire NHS Trust
Trust Board Part I (Public Session)

Lecture Theatre, Post Grad Centre, Mount Vernon Cancer Care
6 July 2022 10:30 - 6 July 2022 12:30

AGENDA

#	Description	Owner	Time
1	STANDING ITEMS		
2	Chair's Opening Remarks	Chair	10:30
3	Apologies for Absence		
4	Declaration of Interests	All	
5	Minutes of Previous Meeting For approval 5. Public Board minutes 4 May 22 approved by KM... 7	Chair	
6	Actions Log For information 6. Public Trust Board Actions Log updated from Ma... 21	Head of Corporate Governance	
7	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, stuart.dalton3@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.		10.35
8	Patient Story For discussion	Chief Nurse	10.40

#	Description	Owner	Time
9	Chief Executive's Report For discussion 9. Chief Executive's Report.pdf 23	Chief Executive	10:55
10	Board Assurance Framework For discussion 10. BAF.pdf 25	Head of Corporate Governance	11.05
11	Integrated Performance Report - Finance Update For discussion 11. IPR M02 2022-23.pdf 59	All Exec Directors	11:10
12	STRATEGY & CULTURE		
13	Strategic Transformation Update For discussion 13. Strategic Transformation update.pdf 137	Director of Improvement	11.30
14	System Working and Provider Collaboration (ICS and HCP) Update For discussion 14. System Collaboration Update.pdf 143	Deputy CEO & Director of Finance	11.35
15	Digital Strategy Update For discussion 15. Digital Strategy Update.pdf 149	Chief Information Officer	11.45
16	ASSURANCE AND GOVERNANCE SECTION		
17	Safeguarding and Learning Disability Annual Report (Adult and Children) For noting 17. Annual Safeguarding report 21.22 - final.pdf 157	Chief Nurse	12:00
18	Learning from Deaths Report For noting 18. Learning from Deaths Report (Board) Jun-22 FI... 189	Medical Director	12:05

#	Description	Owner	Time
19	Nursing Establishment Review For approval 19. Establishment Review April 2022.pdf 195	Chief Nurse	12:10
20	Complaints Annual Report For noting 20. 20220624 PACE Annual Report 2021-22.pdf 207	Chief Nurse	12:15
21	Quality Account For noting 21. Quality Account.pdf 225	Chief Nurse	12.20
22	Sub-Committee Reports		12:25
22.1	Finance, Performance and People Committee Report to Board24th May 202228th June 2022 For noting 22.1i. FPPC Board Report 240522 approved by KM... 375 22.1ii. FPPC Board Report 28.06.22- approved by... 379	Chair of FPPC	
22.2	Quality and Safety Committee Report to Board25th May 202229th June 2022 For noting 22.2i. QSC Board Report 250522 approved by PC.... 383 22.2ii. Draft QSC Board Report 290622.pdf 387	Chair of QSC	
22.3	Charity Trustee Committee Report to Board7th June 2022 For noting 22.3. Draft CTC Board Report 7 June 22 (sent to C... 391	Chair of Charity Trustee Committee	
22.4	People Committee Report to Board17th May 2022 For noting 22.4 Draft People Committee Board Report 170522... 395	Chair of People Committee	

#	Description	Owner	Time
22.5	Audit Committee Report to Board20th June 2022 For noting [P] 22.5. Audit Committee Board Report 200622 appro... 399	Chair of Audit Committee	
23	Annual Cycle For noting [P] 23. Draft Board Annual Cycle 2022-23 Final.pdf 403	Head of Corporate Governance	
24	Any Other Business		
25	Date of next meeting 7th September 2022 - Trust Board		

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 4 May 2022 at 10.00am at the Hertford County Hospital, Hertford

Present:	Mrs Karen McConnell	Deputy Trust Chair and Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Dr David Buckle	Non-Executive Director
	Mr Biraj Parmar	Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Dr Michael Chilvers	Medical Director
	Mrs Rachael Corser	Chief Nurse
	Ms Lucy Davies	Chief Operating Officer
From the Trust:	Mr Thomas Pounds	Chief People Officer
	Mr Mark Stanton	Chief Information Officer
Also in attendance:	Mr Stuart Dalton	Trust Secretary
	Mr Richard Hammond	Managing Director Planned Care (Item 20/066)
	Ms Anna Kanengoni	Operating Department Practitioner
	Mrs Catherine Boaden	Senior Operations Advisor
	Julia Smith	Assistant Trust Secretary (Minutes)

No	Sub-No	Item	Action
22/052		**CHAIR'S OPENING REMARKS**	
	22/052.1	The Chair welcomed the Board noting it was the first face to face meeting of the Trust Board in over two years. The Chair welcomed Lucy Davies, the Trust's new Chief Operating Officer to her first Trust Public Board meeting.	
22/053		**APOLOGIES FOR ABSENCE**	
	22/053.1	Apologies were received from: Mrs Ellen Schroder – Trust Chair	
22/054		**DECLARATIONS OF INTEREST**	
	22/054.1	There were no new declarations of interest made.	
22/055		**MINUTES OF PREVIOUS MEETING**	
	22/055.1	The minutes of the previous meeting held on 12 January 2022 were **APPROVED** as an accurate record of the meeting.	

22/056 ACTION LOG

22/056.1 There were no outstanding actions on the Action Log.

22/057 QUESTIONS FROM THE PUBLIC

22/057.1 Dr Alex Wilkinson asked: ENHT is unusual amongst local hospitals in having a smoke-free policy that continues to support smoking with dedicated smoking shelters, but completely bans the use of electronic cigarettes for patients and staff, despite 2021 NICE guidelines recommending nicotine-containing e-cigarettes be made accessible to adults who smoke. Does the Board think it would be a good idea to make the Trust completely smoke-free, whilst allowing the use of e-cigarettes in designated areas?

22/057.2 The Medical Director commented that the Trust allowing smoking in some areas had been a confusing situation and agreed to review the Trust Smoking Policy of how staff and service users could be supported with smoking cessation.

22/057.3 The Medical Director informed the Board that he would create a task and finish group to review the policy. He would include Dr Wilkinson, Occupational Health, expert opinion alongside staff and patient representatives.

22/057.4 The Chief Executive encouraged the inclusion from the Mental Health team and the Ambulance Trust.

22/057.5 It was **AGREED** the Medical Director would provide a progress report at the September Board meeting. **Medical Director**

22/058 STAFF STORY

22/058.1 The Chief People Officer introduced Anna Kanengoni as an Operating Department Practitioner (ODP) for the Trust who had also taken on the responsibilities of being an Inclusion Ambassador and Freedom To Speak Up (FTSU) Champion.

22/058.2 Ms Kanengoni explained to the Board that she was also a Mental Health First Aider. She said she had decided to become a FTSU Champion because she knew there was a lot of work for the Trust to do to encourage staff to speak up. She continued that it was everyone's duty to speak up because all staff had a responsibility for patient safety as well as to bring their "whole-selves" to work.

22/058.3 Ms Kanengoni informed the Board that her responsibility was to support the newly appointed permanent FTSU Guardian, to promote and influence the culture of safety and encourage staff to speak up. She explained to the Board that staff needed to feel supported to share their experiences, concerns and suggest improvements. She said staff were fearful of repercussions if they spoke out, or that no action would be taken and it was the role of the FTSU Champions to sign post staff to the right support, escalate where required and champion Trust values.

22/058.4 Ms Kanengoni explained to the Board that it takes a lot of courage to speak up and it was a privilege to be a part of that journey with her co-workers. She said listening was powerful and when people felt

they were able to speak up in a safe environment and where there would be follow up it promoted good performance. She continued that ensuring all managers had completed the FTSU training would further encourage staff to speak up and to reinforce the culture of the Trust as supportive of a speak up culture.

22/058.5 Mrs McConnell thanked Ms Kanengoni for her passion, commitment and for taking on additional responsibilities. Mrs McConnell agreed that listening was powerful and challenged the Board to ensure their training was complete.

22/058.6 The Chief Executive commented that follow-up, feedback and ensuring actions were completed were important to the culture of speaking up.

22/058.7 Ms Moore asked Ms Kanengoni how much of her time being a FTSU Champion took and asked the Board, how staff could be supported. Ms Kanengoni explained to the Board that her role as an ODP kept her busy during her working day and her additional responsibilities were undertaken in her own time. The Chief People Officer commented that the Trust needed to ensure staff had the permission and capacity to contribute.

22/059 CHIEF EXECUTIVE'S REPORT

22/059.1 The Chief Executive informed the Board that the Prime Minister, Chancellor and Secretary of State for Health and Care had visited the New QEII hospital as they had been interested to understand more about the Community Diagnostic hub and Robotic surgery. He said because of Purdah, the Trust hadn't publicised the visit.

22/059.2 The Chief Executive discussed the front door pressures of the hospital and the Ambulance handover delays. He said the Trust continued to work collaboratively with the East of England Ambulance Service on the rapid release of ambulances. He said the pressures on the Hospital remained high with the Opel level at 4.

22/059.3 The Chief Executive explained to the Board that Covid remained a factor and the Trust was not experiencing a reduction in Covid positive patients. He said the national modelling expected either a significant reduction or a fourth wave. He said the guidance continued to change and would continue to be reviewed by the Chief Nurse and the specialist advisory group along with the IPC team and local plans would be implemented across the Trust.

22/059.4 The Chief Executive informed the Board that the Portering team had been awarded the Team of the Year in the National Portering Awards, he congratulated the team and acknowledged the challenges they faced during the pandemic and how as a team they overcame them.

22/059.5 The Chief Operating Officer explained to the Board that the hospital declaring Opel 4 had been normalised. She said there had been a

good discussion at the Leadership Briefing regarding how the emergency pathway could be supported recognising there would be a lot of System work to do. The Chief Operating Officer continued that there remained high numbers of patients who did not meet the criteria to reside and how this could be addressed through a series of internal actions and good liaison.

22/059.6 Mrs McConnell commented that the Finance, Performance and People Committee had received an update in a deep dive on ED and the teams had shared the mitigating actions they were taking.

22/059.7 Ms Moore commented on how busy the Operational staff were, she reassured the Executive Directors that the Non-Executive Directors continued to offer support.

22/059.8 The Board **RECEIVED** and **NOTED** the Chief Executive Officer's report.

22/060 BOARD ASSURANCE FRAMEWORK

22/060.1 The Trust Secretary informed the Board that he had taken over the management of the BAF.

22/060.2 The Trust Secretary highlighted the intention to brainstorm the BAF with Board members to ensure the 2022/23 BAF accurately reflected the Trust position. He said 8 of the 12 BAF risks were currently rated red and required a review.

22/060.3 The Trust Secretary informed the Board that the score for risk 3 – the Financial Framework risk had increased from 12 to 16 to reflect the significant increase in efficiency requirements for the 2022/23 financial year.

22/060.4 Mrs McConnell discussed risk 12 – the Pandemic risk and the intention to embed it into risk 1 – the Operational Delivery risk. The Chief Nurse confirmed that the narrative needed to be re-articulated as the pandemic had resulted in a more substantial operational risk as well as an ongoing impact. The Medical Director explained to the Board that the risk was multi-faceted affecting patients, workforce, working practices and unknown factors.

22/060.5 The Chief Executive commented that as well as redefining the 2022/23 BAF there were underlying risks on the Corporate Risk Register that needed to be reviewed to identify where else they could be positioned. He said in relation to the ongoing pandemic that there was a risk of another potential outbreak and should be considered on the Corporate Risk Register and the BAF.

22/060.6 The Board **RECEIVED** and **NOTED** the Board Assurance Framework.

22/061 INTEGRATED PERFORMANCE REPORT

22/061.1 The Deputy Chief Executive and Director of Finance introduced the Month 12 Integrated Performance Report and noted that the areas

of focus would be People, Caring, Responsive and Sustainability.

22/061.2 **People**

The Chief People Officer highlighted the following:

22/061.3 There were sustained areas of improving performance although turnover was increasing. Turnover was increasing as the workforce hadn't changed jobs during the two-year pandemic period and moves were now being seen, there had been an increase in retirements including early retirement for reasons of increased work pressures, strain and burn-out which indicated a concerning picture.

22/061.4 The staff survey presented an indication of how staff were feeling. Some staff groups were feeling pressures higher than others.

22/061.5 Work with the ED staff was ongoing to understand how the pressures were manifesting in wellbeing and to provide appropriate support. The leadership model focused on briefing and debriefing sessions. There had been an increased presence from HR business partners, FTSU and clear actions were being taken.

22/061.6 Sickness levels had increased in March. The national picture of sickness absence was centred around mental health and stress but ENHT sickness was short term for respiratory and Covid issues. The levels of sickness were reducing which reflected the local community levels of Covid.

22/061.7 **Safe and Caring**

The Chief Nurse highlighted the following:

22/061.8 Work was underway with Divisional teams to develop a realistic trajectory for recovery for responding to complaints and SI's. This would be reviewed and managed through the Accountability Review meetings.

22/061.9 Two areas of greatest pressure for staff and patients were experience and poor outcomes. There had been a positive reaction to how well the Trust was managing its most unwell patients with good care in the ambulances to ensure patient safety.

22/061.10 Ward areas including Ashwell at Lister hospital and 2 wards at Mount Vernon had received accreditation and ward 11A & B had been the first inpatient area to receive Gold accreditation.

22/061.11 The IPC team and direct care staff had been responsive to new IPC guidelines and their implementation. The new guidelines had been embraced across the Trust with the requirement to live with Covid.

22/061.12 **Responsive**

The Chief Operating Officer highlighted the following:

22/061.13 April continued the trajectory of increasing 12 hour waits for admission and treatment. There remained a level of pressure within the System however, Trusts across the region continued to work

together and share information.

22/061.14 Good work was ongoing to aid the rapid release of ambulances where new assessment and triage areas had provided additional space for assessment.

22/061.15 Work both internally and across the System was underway to review processes and address issues. The Chief Operating Officer raised concern around the level of normalisation of the intensity of pressure. She highlighted the difficulty in discharging patients to an appropriate facility inappropriate presentations to the ED, patients presenting who were more unwell and an increase in Covid admissions. There would be a programme of opening new areas in ED as Capital works were completed which would have a positive impact on patient flow.

22/061.16 Cancer Wait Time performance remained strong with excellent management from the Cancer leadership team.

22/061.17 Referral to Treatment remained steady and there were plans to reduce the 104 week waits to zero by the end of June 2022.

22/061.18 **Sustainability**

The Deputy Chief Executive and Director of Finance highlighted:

22/061.19 The year end accounts had been submitted and were at a pre-audit state. Sign-off by the Auditors was expected at the Audit Committee meeting on 20th June 2022.

22/061.20 The 2021/22 financial year ended with a small surplus as well as full utilisation of the Capital allocation.

22/061.21 The IPR for the new financial year would have a new format using the principles of making data count. The new format would be rolled-out to the Committees at the end of May.

22/061.22 Mrs McConnell commented that the specific areas of the IPR were discussed at Committee level but to bring the whole document together at Board was helpful as it amplified the pressures across the Trust.

22/061.23 Dr Buckle assured the Executive that when the Trust position escalated to Opel 4 that the Non-Executive Directors would continue to provide support where required. He said with the changing IPC guidance different across neighbouring Trusts, the NEDs would welcome a discussion. The Chief Nurse explained to the Board that having run the bed meetings recently whilst the Trust position was Opel 4, there was anxiety around what else the teams could do. The Chief Nurse commented about the changing IPC guidance and informed the Board that the Trust reviewed other regions and used any appropriate learning.

22/061.24 Dr Carter asked that staff exiting the organisation were given structured exit interviews and the results of these were reported to

Board. The Chief People Officer explained to the Board that a great deal of informative data was captured on why staff left and where they moved onto. This would be reported to the People Committee.

22/061.25 The Chief Executive commented that in relation to making data count, there was a national mandate that recovery ensured that health inequalities were not widened and more needed to be done.

22/061.26 The Chief Executive highlighted to the Board that in 26 months the Trust had not had a single case of hospital acquired MRSA, he said the target had been 1.1 and the team had achieved 0 which was an outstanding result.

22/062.27 The Board **RECEIVED** and **NOTED** the Month 12 Integrated Performance Report

22/062.28 **Ambulance Handovers**

22/062.29 The Chief Operating Officer explained to the Board that learning more about how the Ambulance services operated and gaining access to their patient list to understand where there could be diversions to more appropriate settings would make a real difference. She said the team would continue to work closely with the service and pilot new pathways and address the issues that presented at both a System and local level.

22/062.30 Dr Buckle asked about the number of ambulances waiting with patients. The Chief Nurse explained to the Board that the number fluctuated. She said the senior Clinicians examined patients in the ambulance and where appropriate diverted elsewhere based on the consultation and early senior decision making. She assured the Board that the well-being of patients waiting in ambulances was being considered from every angle and by all team members.

STRATEGY AND CULTURE REPORTS

22/063 SYSTEM COLLABORATION UPDATE

22/063.1 The Deputy Chief Executive and Director of Finance highlighted to the Board that there was a lot of work ongoing with System providers and colleagues to expand elective capacity. He said there was potential for significant Capital investment and the Trust would remain actively engaged.

22/063.2 The Deputy Chief Executive and Director of Finance noted the HCP engagement event and informed the Board that there had been good attendance and engagement from Place-based partners. He said the event highlighted the successes and achievements over the past 12 months.

22/063.3 The Deputy Chief Executive and Director of Finance explained to the Board that there remained a lot of work to do around Hospital at Home. He said options for expansion of the provision were being considered and there would be capacity to pump-prime the area.

22/063.4 Mrs McConnel noted the volume of work being done at Executive Director and Trust Chair level and asked if there was more the Non-Executive Directors could do to support the collaboration. The Deputy Chief Executive and Director of Finance explained to the Board that a large part of the collaboration was relationship based and said the NED's would have an impactful role in that area. The Chief Nurse used the example of Ms Moore's involvement in Maternity as a positive force in influencing the Maternity agenda.

22/063.5 The Chief Executive commented that the next steps would be to work through the ICB processes and partnership onboarding which would generate opportunities for the Non-Executive Directors.

22/063.6 The Board **RECEIVED** and **NOTED** the System Collaboration update.

22/064 TRUST STRATEGY UPDATE

22/064.1 The Deputy Chief Executive and Director of Finance explained that the report set out the proposed objectives for the Trust in 2022/23 within the context of the strategic priorities that the Trust Board had agreed as part of its recent strategy refresh. He said it helped develop the case for change with clinical leaders to drive and formulate key programmes. A refined vision and mission would be achieved with four broad strategic themes which had been identified together with high impact objectives for focus over the coming 12 months.

22/064.2 The Chief Executive reflected on the comments from the Board where the strategy had been discussed previously. He said that the Quality theme was ward focused, and the principles should be recognised and reflected across all care settings as well as elective recovery and productivity

22/064.3 Ms Moore commented that the Pathways of Care didn't talk about prevention and asked for the wording to reflect prevention. Ms Moore also asked that the use of acronyms be expanded to ensure it would be easily understood.

22/064.4 Mrs McConnell commented on the objective of reduced vacancy rates and asked whether there should be more emphasis on retention and stated that well-being would be a contributory factor.

22/064.5 The Board discussed the Establishment target and the Chief People Officer explained that an element of this would be flexible and was what was intended to recruit against. He said it could be broken down by recruitable and non-recruitable. If the Non-Executive Directors agreed the principle this section would be re-worded. The Non-Executive Directors **AGREED** the principle. **Chief People Officer**

22/064.6 The Board **RECEIVED** and **NOTED** and **APPROVED** the Trust Strategy subject to the changes discussed in the Private and Public Board meetings

22/065 STAFF SURVEY

22/065.1 The Chief People Officer introduced the report and highlighted:

- This staff survey had been updated in-line with the People promises, measured against them and reviewed how they were being achieved.
- The survey completion period was during a Covid peak where staff had been under sustained pressure, which also reflected in the national results.
- Participation had increased as a percentage of the overall workforce but was not at the level the Trust wanted. Work would be ongoing in relation to engagement and the challenge would be to encourage staff to view completion as a priority amongst their daily pressures.
- The response rate was overall representative of the workforce, there was a high rate of completion in Corporate and Admin staff and lower from Medial and Nursing.
- The Trust result was average across the board.
- There were two areas highlighted of being below average which were being compassionate and inclusive.
- Two areas of significant improvement were raising concerns and safety and harassment.
- Bullying for the Trust had improved to above the benchmark, but Ethnicity remained below.

22/065.2 The Chief People Officer summarised the results as broadly average with areas for improvement. Themes around working flexibly were higher than average for the sector and work was required around compassion and inclusivity.

22/065.3 The Chief People Officer explained to the Board that it was important to engage staff to ensure all staff were aware of the results, what they mean and that it was important to keep communication open. He said this would be done at a local level through team talks as well as an all-staff briefing.

22/065.4 It was **AGREED** that the People Committee would review the detailed analysis of any significant outliers. **Chief People Officer**

22/065.5 The Board **RECEIVED** and **NOTED** the 2021 Staff Survey results.

22/066 ELECTIVE RECOVERY

22/066.1 The Managing Director Planned Care highlighted to the Board that in 2021 the Trust performed well and had exceeded targets in areas across outpatient and day-case inpatients despite Theatre closures.

22/066.2 The Manging Director Planned Care explained to the Board that if

the Trust achieves above the target number of Outpatients, no payment will be received for those over the target. He said the pathway would need to be redesigned to ensure no patient comes to harm or misses out on treatment. He said the QlikView targets had changed to 85% which is what the teams were also working to.

22/066.3 The Managing Director Planned Care explained to the Board that each of the specialties was varied and highlighted Orthopaedics at 56% of previous capacity

22/066.4 The Managing Director Planned Care highlighted the aging Estate in Theatres and issues with ventilation as a risk to recovery, as well as the workforce element.

22/066.5 The Managing Director Planned Care explained to the Board that elective recovery was an ever-changing situation. He said Outpatients overall should achieve 110% with some specialties offsetting others.

22/066.6 The Managing Director Planned Care highlighted the 104 week wait trajectory and informed the Board that plans were in place to achieve zero 104 week waiters by the end of June 2022 from a list of 97.

22/066.7 The Managing Director Planned Care explained to the Board that more work was required in relation to PIFU, he said more specialities would be coming on-line

22/066.8 The Deputy Chief Executive and Director of Finance highlighted the Outpatient follow-up as a significant financial risk.

22/066.9 The Chief Executive commented that another layer of complexity was the Trust activity levels whilst working at a System level. He said ENHT may be asked to support other Trusts across the region which added risk to the recovery schedule.

22/066.10 The Chief Operating Officer asked about the Consultant Connect for PIFU and what it would help the Trust achieve. The Managing Director Planned Care explained to the Board that the specialties on-boarding would help the Trust get to the 5%. Ms Moore commented that PIFU had benefits to capacity issues but prevention, shared communication, shared decision making and monitoring alongside the promise of future services and working with patients differently were key.

22/066.11 Mrs McConnell thanked the Managing Director Planned Care.

22/066.12 The Board **RECEIVED** and **NOTED** the Elective Recovery report.

ASSURANCE AND GOVERNANCE REPORTS

22/067 ANNUAL REPORT and ACCOUNTS, ANNUAL GOVERNANCE STATEMENT and EXTERNAL AUDITOR'S REPORT APPROVAL PROCESS

22/067.1 The Board **RECEIVED**, **NOTED** and **APPROVED** the Approval Process.

22/068 NEW COMMITTEE STRUCTURE

22/068.1 The Board **RECEIVED**, **NOTED** and **APPROVED** the new Committee structure.

22/068 OCKENDEN UPDATE

22/068.1 The Chief Nurse highlighted to the Board the position of the Trust against the current requirements and said 112 of the 122 individual requirements were compliant.

22/068.2 The Chief Nurse informed the Board that the National Chief Midwifery Officer would be visiting the Trust. She said the team were sighted on the key issues and assured the Board that the structure, leadership team and summary reports were in place.

22/068.3 The Chief Nurse informed the Board that the next steps would be a gap analysis against the 15 core recommendations which would be benchmarked and subject to peer-to-peer challenge and review. She said actions were being taken and good governance leadership and reporting structures were in place. The Chief Nurse explained to the Board an update would be presented at the July Board meeting. **Chief Nurse**

22/068.4 The Board **RECEIVED** and **NOTED** the Ockenden update.

22/069 LEARNING FROM DEATHS

22/069.1 The Medical Director explained to the Board that the report needed to be read in conjunction with the IPR. He said there had been a lot of changes in mortality data over the last two months including a mistake in the CHKS data rebase leading to an incorrect HSMR position. He assured the Board that all errors had since been corrected.

22/069.2 The Medical Director informed the Board that the HSMR indicator was where the Trust would expect it to be at 90.38% which positioned the Trust back into the top quartile in-line with other Trusts.

22.069.3 The Medical Director informed the Board that the SHMI in the IPR indicated an increase and assured the Board it was in fact reducing.

22/069.4 The Medical Director explained to the Board that the Elective HSMR was much higher than some of the Trusts peers and therefore had triggered a deep dive into the elective mortality. He said in the reporting period there had been 13 elective deaths and 8 of those were at Mount Vernon Cancer Care and were not elective deaths.

22/069.5 The Medical Director informed the Board that Heart Disease was at the forefront of the clinical coding plan with a six-month project to ensure the coding was as accurate as possible to identify any

changes.

22/069.6 The Medical Director informed the Board that the Sepsis data was historical, and the performance had improved. He said since production of the report the SSNAP rating had also improved from D to C. He continued that the Laparotomy data had not returned to single figures and assured the Board that performance had improved. He said the Trust was still an outlier and the pathway would be reviewed and improvements made.

22/069.7 Mrs McConnell asked if adherence to the Trust HAT process remained an issue. She said with clinical staff rotation how did the reminders that had been issued get communicated to the next rotation. The Medical Director informed the Board that the information formed part of the new intake induction material.

22/069.8 The Chief Executive commented that the avoidable death rating was positive and good to see there hadn't been any. He said there had been a number where the quality of care was rated as poor and asked what the process was to share the learning. The Medical Director said this was covered during the rolling half-day and every rolling half-day commenced with the learning points. The Chief Nurse added that there was also discussion at the MDT.

22/069.9 The Board **RECEIVED** and **NOTED** the Learning from Deaths report.

SUB-COMMITTEE REPORTS:

22/079 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

22/70.1 The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and People Committee meetings held on 30 March 2022 and 27 April 2022.

22/071 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

22/071.1 The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on 29 March 2022 and 29 April 2022.

22/072 AUDIT COMMITTEE REPORT TO BOARD

22/072.1 The Board **RECEIVED** and **NOTED** the summary report from the Audit Committee meeting held on 7 April 2022.

22/073 CHARITY TRUSTEE COMMITTEE REPORT TO BOARD

22/073.1 The Board **RECEIVED** and **NOTED** the summary report of the Charity Trustee Committee meeting held on 7 March 2022.

22/074 EQUALITY AND INCLUSION COMMITTEE REPORT TO BOARD

22/074.1 The Board **RECEIVED** and **NOTED** the summary report from the Equality and Inclusion Committee meeting held on 15 March 2022.

22/075 **ANNUAL CYCLE**

22/075.1 The Board **RECEIVED** and **NOTED** the latest version of the Annual Cycle.

22/076 **DATA PACK**

22/076.1 The Board **RECEIVED** and **NOTED** the Data Pack.

22/077 **ANY OTHER BUSINESS**

22/077.1 No other business was raised.

22/078 **DATE OF NEXT MEETING**

22/078.1 The next Board Development meeting will be held on 8 June 2022.

The next meeting of the Trust Board will be on 6 July 2022.

Karen McConnell
Deputy Trust Chair
May 2022

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

Agenda item: 6

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 6 JULY 2021

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
4 May 2022	22/057.5	Question from the Public	Review the smoking policy with a task and finish group to include Dr Alex Wilkinson, Occupational Health, expert opinions, staff and patient representatives, Mental Health team and the Ambulance Service		Medical Director	September 2022
4 May 2022	22/064.5	Trust Strategy	Re-word the recruitable and non-recruitable establishment section of the strategy document.	June – wording agreed - action closed	Chief People Officer	July 2022
4 May 2022	22/065.4	Staff Survey	People Committee to review the detailed analysis of any significant outliers.	June – added to People Committee annual cycle – action closed	Chief People Officer	July 2022
4 May 2022	22/068.3	Ockenden Update	Undertake a gap analysis against the 15 core recommendations which would be benchmarked against with peer-to-peer challenge and review.		Chief Nurse	September 2022

East and North Hertfordshire NHS Trust

Chief Executive's Report

July 2022

Corporate Update

Congratulations also to our chief nurse, Rachael Corser, who has been appointed as chief nursing officer at the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System. Rachael will take up her post in September 2022.

Congratulations to Nick Carver, former chief executive of East and North Hertfordshire NHS Trust, has been named an Officer of the Order of the British Empire (OBE) in the Queen's Jubilee Birthday Honours, in recognition of his services to the NHS.

Congratulations to Kirit Modi, Chairman of the Lister Area Kidney Patients Association, on being awarded an MBE in the Queen's Jubilee Birthday Honours, in recognition of his long-standing services to organ donation.

Thank You Week

To coincide with the 74th birthday of the NHS, the Trust will hold a weeklong thank you event for our staff in the week beginning 4 July, supported by the hospitals' charity.

Each day has a different theme, including free cake, food trucks and wellbeing sessions throughout the week along with our annual staff awards event taking place on 7 July.

Hospital Update

Our dedicated staff continue to work extremely hard to treat our elective patients and reduce waiting time with investment agreed for the additional capacity with active recruitment into additional posts.

The demand for urgent emergency care continues to be high with high attendances, particularly for walk in patients and staff continue to work extremely hard in managing this on an ongoing basis. This is the picture across the region and the Trust continues to work collaboratively with system partners to look at ways in which this can be best managed.

Covid Update

The NHS incident response was downgraded to Level 3 on 19th May 2022. The Trust currently has 47 Covid-19 positive patients, and this is an increase from the numbers reported in May. Within Hertfordshire we are seeing a slight increase in the incident rate. Staff continue to undertake Lateral Flow Testing (LFT) on a twice weekly basis and to report the results. These tests enable the Trust to detect asymptomatic positive staff and to mitigate further spread of Covid-19.

R&D Update

At the Trust we very much believe in encouraging a research positive culture in order to give patients wider access to clinical research and improve patient care and treatment options. Evidence shows clinically research-active hospitals have better patient care outcomes. There are also sustainability benefits. Research at the Trust is funded by external sources (£3.8m each year) and being research-active also produces cost savings as drugs and other items may be provide free of charge.

The Trust had a high level of research activity in 2021/2 with studies taking place across many specialty areas and 2,350 people took part. The Trust made an important contribution to Covid research and secured an additional £345k funding last year.

We continually ask our patients about their research experience through ongoing surveys. The responses we get are around three main themes: patients really enjoy being in a research study, it gives them hope, and it is satisfying to them because they are helping develop treatments for others. We have a large number of colleagues who are supporting research and we have pockets of research excellence in areas such as cancer, renal and cardiology.

National Award for Midwifery Team

England's most senior midwife has paid a visit to Lister Hospital in Stevenage to present two members of the maternity team with awards – recognising them for going above and beyond.

Katie Chilton, the Trust's director of midwifery, and multiple pregnancy specialist midwife Dionne Thompson both received the accolade – which recognises major contributions to women and the profession.

Midwife Dionne Thompson, who is one of the Trust's ethnic minority ambassadors – was nominated for her pioneering "support of minority ethnic staff and women, challenging inequalities and encouraging information sharing and for colleagues to speak up", and was also praised for being a "magnificent multiple pregnancy specialist midwife".

Congratulations to them both.

Adam Sewell-Jones
Chief Executive

Meeting	Public Trust Board		**Agenda Item**	10
Report title	**Board Assurance Framework (BAF) Risks**		**Meeting Date**	06.07.22
Presenter	Stuart Dalton, Head of Corporate Governance			
Author	Stuart Dalton, Head of Corporate Governance			
Responsible Director	Each of the risks have been reviewed by the lead Director		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

For risk management continuity and good governance, the 2021/22 BAF is presented whilst the 2022/23 BAF is being finalised.

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 – **Appendix C**. The Trust's strategic risks for the Board Assurance Framework 2021/22 are on one page is **Appendix A**. The Trust's strategic priorities and have been mapped to the Trust objectives for 2021/22 providing assurance on the coverage - **Appendix B**.

Key updates

- The draft 2022/23 BAF has been developed with the Executive and was circulated to Non-Executive Directors on 24 June for consideration.
- The Board on 4 May agreed only the BAF risks owned by a committee should be presented to that lead committee with the goal of increasing focus on the risks owned by each committee and committees have moved to this approach.
- Since it was highlighted that deep dives had been stood down due to COVID and NHSE guidance 'reducing the burden'; FPPC and QSC have resumed their respective programme of deep dives to assist risk/issue assurance and mitigation.
- Two BAF risks have been transferred to newly-formed People Committee as the best-placed lead committee (Risk 2 - workforce model and Risk 9 - staff engagement). The new People Committee will allow more dedicated time for deep dives related to People issues.
- The increased Risk 3 (NHS Financial Framework) score from 12 to 16, presented at May Board, remains highlighted, reflecting the challenging increase in efficiency requirements in 2022/23 and the legacy of COVID remains.
- Risk 1 (operational performance): The recent emphasis has been on the reduction of long waits.
- Risk 4 (Capital Resources): An additional assurance was agreed at June Board Seminar, with a Capital Plan report agreed to be added to the Board agenda going forwards.
- Risk 8 (Safety and learning culture & continuous improvement): There is a clear trajectory in place to close the backlog of complaints and Serious Incidents.
- Risk 10 (Estates): Underlying the risk was a lack of reporting structure within Estates & Facilities. To address this Estates have moved to monthly monitoring via their reporting structure. If the new structures work as anticipated then the risk score should reduce.
- Risk 12 (Pandemic impact on quality of care): Living with Covid guidance has been published.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Management of the BAF and strategic risks is fundamental to good risk management and supporting the delivery of the Trust's organisational strategy. Internal Audit's annual review of the BAF and Corporate Risk Register concluded 'reasonable assurance.'

Risk: *Please specify any links to the BAF or Risk Register*

As documented under each risk	
Report previously considered by & date(s):	
4 May Board	
Recommendation	The Committee is asked to **NOTE** the BAF.

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

Risk Scoring Guide

Risks included in the Risk Assurance Framework (RAF) are assessed as extremely high, high, medium and low based on an Impact/Consequence X Likelihood matrix. Impact/Consequence – The descriptors below are used to score the impact or the consequence of the risk occurring. If the risk covers more than one column, the highest scoring column is used to grade the risk.

Level	Description	Safe	Effective	Well-led/Reputation	Financial
1	**Negligible**	No injuries or injury requiring no treatment or intervention	Service Disruption that does not affect patient care	Rumours	Less than £10,000
2	**Minor**	Minor injury or illness requiring minor intervention <3 days off work, if staff	Short disruption to services affecting patient care or intermittent breach of key target	Local media coverage	Loss of between £10,000 and £100,000
3	**Moderate**	Moderate injury requiring professional intervention RIDDOR reportable incident	Sustained period of disruption to services / sustained breach key target	Local media coverage with reduction of public confidence	Loss of between £101,000 and £500,000
4	**Major**	Major injury leading to long term incapacity requiring significant increased length of stay	Intermittent failures in a critical service Significant underperformance of a range of key targets	National media coverage and increased level of political / public scrutiny. Total loss of public confidence	Loss of between £501,000 and £5m
5	**Extreme**	Incident leading to death Serious incident involving a large number of patients	Permanent closure / loss of a service	Long term or repeated adverse national publicity	Loss of >£5m

Trust risk scoring matrix and grading

Likelihood / Impact	1 Rare (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

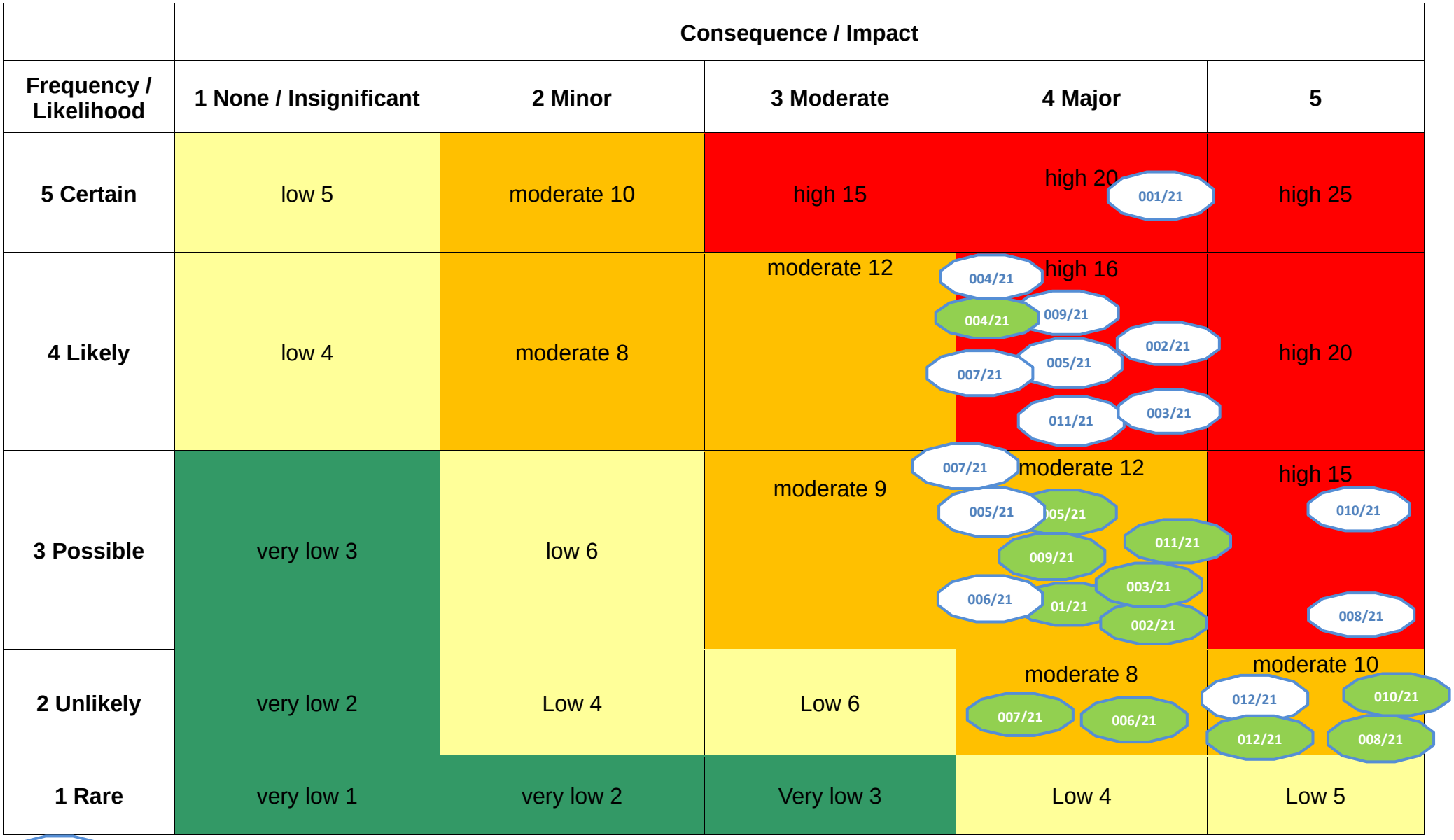
Risk Assessment	Grading
15 – 25	Extreme
8 – 12	High
4 – 6	Medium
1 – 3	Low

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2021/22	Lead Executive	Committee	Current Risk May	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**	**20**	**20**	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	**People**	**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**	**12**	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)	Director of Finance	**FPPC**	**16**	**16**	**16**	**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**	**12**	**12**	**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 Finance	**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	**People**	**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	Director of Estates	**QSC**	**15**	**15**	**15**	**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	Director of Finance	**Strategy**	**16**	16	16	12	12	01.04.20 (TBC)
012/21	Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care	COO/Chief Nurse	**QSC/Board**	**10**	10	10	15	6 (revised May 22)	04.03.20 (April 21)

**Changes to the risk scores discussed at the October Board Committees and approved by Board in November.*

Board Assurance Framework Heat Map – June 2022



REVIEW OF CURRENT STRATEGIC RISKS– MAPPED TO TRUST STRATEGIC PRIORITIES AND 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 *Board approved*

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, 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-22	**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. vi) Increased risk to delivery of the ERF targets. viii) Impact of winter could impact on overall capacity within the hospital Targets set out in the NHSE/I guidance 'delivery plan for tackling the Covid-19 backlog of elective care' Introduction of new Emergency Care Dataset for Urgent and Emergency Care from April 2022.	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 vi) Financial Impact if the Trust does not meet the ERF targets - ERF monies will not be paid. vii) Reputational risk if performance standards are not achieved viii) Risk of winter demand/ illnesses on overall capacity within the hospital	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	5	20	
		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 has robust governance processes in place, including regular meetings, in which quality, safety, performance, transformation, finance and workforce are reviewed. 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 and a 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 take place on monthly basis rotating through each speciality. The Ward refurbishment has now commenced and will have an ongoing impact on bed capacity from this point onwards. The work is phased over a number of years and will impact on different areas at different times.	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. FPC receives and reviews our IPR, performance reports and deep dives at its meetings. Deep dives scheduled for 2022 include cancer, elective recovery, ED performance, stroke and planning for winter. FPC also reviews ED performance and configuration, progress in relation to the endoscopy review and demand and capacity modelling. In addition we have a number of operational groups, meetings and transformation groups at divisional level. Performance relating to ambulance handovers is discussed as a standing agenda item at Trust Board meetings. A revised executive meeting structure means improved visibility of trust wide transformation programmes.	Recovery of our performance continues to be good. Performance against RTT and diagnostics is improving. Deep dives scheduled for 2022 include cancer, elective recovery, ED performance, stroke and planning for winter.		

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 Overall hospital capacity impacted by unprecedented demand for both elective and emergency services.	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 capacity planning initiatives/ transformation with community A4 Ongoing work with system partners to address continuing capacity challenges resulting from unprecedented demand.	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)		Monitored weekly and monthly. Access Manager now in post.	in progress
ii) Continue to engage with our ICS and ICPs. Implement 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)		Workstreams in place tp address ongoing capacity challenge.	in progress
iii) Delivery of the ED reconfiguation programme and SDEC	A1, A3	Unplannned Care Managing Director		Regular ED capital plan and action plan report to FPC . ED Programme board in place - monitoring progress	in progress
iv) Delivery of discharge improvement programme	A4	COO		Discharge improvement update on October agenda for FPPC. Processes regulary reviewed.	in progress
v) Delivery of bed reconfiguration programme	A2., A3	COO/ Director of Estates		Monitored through regular meetings.	in progress
iv) Review delivery performance metrics in line with standards	A1,	COO		New ED standards now in place. Monitoring against them taking place through regular meetings.	in progress
iv) Delivery of elimination of ambulance handover waits	A1,	COO		Action in place including earlier escalation to surge plans	in progress
Summary Narrative:					

July 2021: New guidance has been issued requiring performance to be at 95% against 19/20 activity levels. This will be challenging to achieve, particularly with increasing Covid numbers and a predicted 4th Covid wave. If the system as a whole does not achieve the targets ERF monies will not be paid. Sept 21: Although challenging the Trust has so far performed well against these new standards. As we approach winter, competing pressures and an increase in Covid numbers and a potential decrease in available workforce could make this position harder to sustain'.
October 2021: Risk level reviewed at QSC and FPPC and recommended increasing the risk from 16 to 20; recognising the impact of the current operational performance/ challenges and continued challenges of activity, winter pressures, competing priorities, impact of staff sickness. FPPC recieved a deep dive and assurance on the Discharge Improvement Programme and Winter Planning - including internal and system wide actions/initiatives to support mitigation of the risk. Noting next months deep dive will focus on RTT recovery.
November 2021: The Board considered the requirement to eliminate ambulance handovers and approved the proposed actions. Monitoring will take place through the usual governance processes including the IPR.
December 2021: Impact of the level 4 incident on performance and operational delivery is under close review.Response developed in line with the national guidance.
February 2022: We are closely monitoring the performance of all specialities. We are developing plans to recover elective performance and deliver the targets set out in the February 2022 'delivery plan for tackling the Covid-19 backlog of elective care'. NHSE/I published a 'delivery plan for tackling the Covid-19 backlog of elective care'. The guidance sets out plans for the NHS to return to pre-pandemic performance as soon as possible. The intention is that around 30% more elective activity is delivered in 2024/25 than before the pandemic. Risk rating under review to consider if it can be reduced.
March 2022: Monitoring across all areas in place. Corrective action in relation to activiity and performance being taken as required. Elective recovery summits taking place with planned and unplanned care divisions in March 2022.
May 2022: Monitoring continues across all areas. Plans are in place to continue to deliver elective recovery.
June 2022: Monitoring is ongoing across all areas. Recent emphasis has been on the reduction of long waits. Performance, in this area, has improved.

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:	Jan-22	**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. v) Impact of the pandemic and self isolation guidance on the availability of staff	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. Established Workforce triggers and redeployment processes	i) Care Quality Commission service inspections / TRA's ii) Staffing costs /staff turnover costs iii) Monthly safer staffing reports to QSC Nursing establishment review, Dec 21 Workforce Assurance Framework for winter, Dec 21(N&M)	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	A1 the variation between current staffing arrangements and optimum workforce model is not yet quantified	Green	Effective control is in place and Board satisfied that appropriate assurances are available

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	workforce model is not yet quantified. A2 ability readily monitor capability, specialist skills and risk assessments to maximise using staff flexibly	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. Jan 22: The Staff engagement group has not met in Dec/Jan due to Covid pressures and staff absences and work will reconvene in February	In progress
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	In Progress
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.	In progress
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. Jan 22: Research working group completed and scope report due end January, pilot of flexible working to be identified and run with view to scale up later in 2022 in other areas	In progress
v) delivery of a Education and a capability strategy for the organisation	C1, C2, C3, C4	Chief People Officer		The People Stategy launched in 2019, bringing education, training and Leadership under capability. A number of senior personnel changes and covid has led to a slow and steady implementation of this plan. In June 2021 the Capability strategy was launched, this has been presented to QSC. To deliver against the strategy structural changes remain to be implemented, which are planned for Q4. Currently the service is reliant on a high number of seconded staff to meet demands and there are a small number of staff absent due to long term sickness causing a significant impact on service delivery, particularly in Medical Education. These are hard to fill with bank and senior leaders are having to directly support services. A deep dive into the LDA and education finances is required to ensure in future that activity and payment are met, ensuring quality and value for money Jan 22:New AD commenced in post Jan and this work is now underway	In Progress

Summary Narrative:					
December 2021: Impact of the pandemic and self isolation guidance on the availability of staff. Staff Risk assessments in place in line with national guidance. Workforce triggers and redeployment processes reviewed and ready to stand up when required.					

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-22	**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 efficiency requirement as we enter 2022/23 • Legacy of COVID initiatives still in place but COVID funding reducing by ~58% in 2022/23	• 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 • 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 2022/23 & including ICS developments to FPPC in January 22.	Monthly Finance Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • 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 bed model in place • Internal Audit review programme			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		2022/23 breakeven plan developed and agreed.	
iii) Continue to develop BI and support divisions / directorates using effectively	C1, C4	Director of Finance			
iv) Engagement with Divisions/ Directorates on delivery on financial savings	C5, A4, A5	Director of Finance / Direcotr of Improvement / MD's (Planned ad Unplanned)		CIP plans still in development - enhanced meeting framework to drive identification.	
Summary Narrative:					
October 2021: Risk level reviewed at FPPC and recommended reducing from 16 to 12, taking in to account the current and forecast position including the reports on the H2 Planning Guidance and budget and H2 CIP delivery. December / January/ February: No changes					

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 Stra	**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:	Apr-22	**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 • Weak internal understanding of NHS capital funding arrangements • Poor internal business case development skills • Capital envelopes issued to systems who have authority over how the envelope is distributed to Trusts	• Aged equipments and assets - at or beyond lifespans • Increased associated risks to continuity and reliability of service delivery eg. Radiotherapy • Limited ability to invest in IMT, equipment and service 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 • 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 Plan reports to Board	• 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 2022/23 paper to FPPC in April 22, 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 2022/23 and monitor delivery	C4, A2	Executive	Ongoing	Part of regular finance report to FPPC on a monthly basis with deep dives into specific schemes as required.	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. October 2021: FPPC discussed the risk rating and confirmed it remains a 16; taking into account the longer term position of access to capital . December / January: No changes February: Overall risk assessment considered and agreed remains a 16 due to the level of risks that remain on the corporate risk register related to equipment and estate.

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/ Strategy	**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:	Feb-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.	Disaster recovery - IA - Limited (action plan in place) Cyber Maturity - IA - green except - network security and secure configuration		

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) A3 Clinical engagement and leadership to support developing and embedding the changes	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		Sept 21 update - Delivery in progress. Roadmap has been updated on all workstreams and was presented to the Trust in July 2021. October : KOPS (Keeping our patients safe) launched in October 2021. November 2021: Update on digital strategy presented to Strategy Comm.	In progress
ii) Seek investment through ICS where available	C2	CIO		Sept 21 update - Creation of a business Case to support Digital Aspirant/Unified Technology Digital funding is underway. ICS and regional stakeholders engaged. Other funding oppertunities being actively pursued as they become available.	In progress
iii) Long term Lorenzo strategy/commercials to be finalised	C3	CIO		Sept 21 update- Lorenzo strategy under consideration within the scope of above business case.	In progress
iv) Implementation of a Business partner process (Post Silver)	C4	CIO		Sept 21 update - No update but in progress	In progress
v) Relaunch of EMPA roll out	A1	Deputy Medical Director, Chief Pharmacist and CIO		Sept 21 update - Rollout planning has now commenced. EPMA full rollout delayed.	In progress
vi) recruitment into Chief Nurse Information Officer Role	A3	Chief Nurse	Jan-22	Recruitment commenced August 21 interviews scheduled for end September. October 21: Appointed and due to commence in January 2021.	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 Finance (From August 21)
	Risk Review Date:	Jun-22	**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 effectvely 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 design guidance published June 2021 - ICP governance under development by Impact Group.	in progress

ii) Agree and deliver approach ICP priorities through collaboration - developing risk and benefit sharing	C3, A2	COO/ Director of Finance		ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Bi-lateral work undertaken with HCT on potential models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission at Lister.	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		System partners invited to Trust event with Virginia Mason Institute to explore Quality Management Systems in the NHS. Discussions to continue via the virtual transformation group. HCP virtual transformation team have agreed standardised project reporting templates across Place. Discussions started regarding establishment of an ICS-level improvement network to promote learning and collaboration across both Place programmes and acute network opportunities.	
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		Population health data under development. ICP commenced a health inequalities sub-group to enhance and advice CPEx on health inequalities.	in progress
vi) To review the Trust representation at the revised ICS workstreams for 2021/22	A3	Director of Improvement with COO/ Director of Finance		On hold pending ICS confirmation of 21/22 transformation programmes. Director of Strategy attends ICS Design & Delivery Group to maintain connection with ICS programmes pending confirmation.	Not yet started
Summary Narrative:					

Mar 22 - ongoing work with ICS re elective hub development
Feb 22 - Bid submitted to ICS re development of elective hub at Lister Hospital, incorporating capacity for PAH and WHHT. ICS presenting elective hub concept to Region with exact location to be decided. Ongoing work with system partners to support patient flow into and out of hospital.
Jan 22 - work ongoing re future governance structure of ENH HCP; strategy refresh in final stages; population health steering group helping to provide focus on future service development. CDH work progressing.
Sep 21 - DDoS contributing to development of ICP Strategy; ongoing work on Strategy Refresh, including areas identified for PHM projects; transformation team part of shared project resource on key collaborative ICP projects
Aug 21 - confirmation received of funding for year 1 of CDH; business case for year 2 approved in principle by Execs; work on IBP continues
July 21 - ICP bid submitted for Community Diagnostic Hub at QEII, with pilot in community; helping to build joint working with system partners
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: **new divisional structure and leadership model to further improve service quality** **an inclusive culture in the workplace** **c) Embed and develop the** **e) Progress and develop our equality performance to build** **g) Working with system partners, progress development and delivery of integrated and**	**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:	Feb-22	**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 - Jan 22: Reducing the burden review to Board and Executive	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 - Positive TRA's - Medicine, Surgery, MVCC Medicine, IPC , ED and medicinces management and well led in 2020/21 NHSI/E - positive vists to ED and Assessment and ICP visit (September / October) Internal Audit - BAF and riskreview - reasonable assurance		

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	on going	Compliance and Risk framework combined and priorities drafted. Discussed divisional oversight group in May 21. Sept: Progress report to QSC and reivew of priorites scheduled for October 2021 inline with the new regulation regimes . Internal Audit - reasonable assurance. Summary of work to QSC in March and 2022/23 plan in development	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, ongoing	Board and Board committee review in progress. Review of the new divisional structure against the orginal objectives is in progress for completion at the end of Dec/ jan . Review of governance strucutres as an ICS/ICP commenced.	In progress
iii) Recruitment of new CEO	C5	CPO/Chair	Dec-21	completed - commenced in January 2022. Induction scheduled	completed
iv) Implementation of the Strategic Planning Framework and Integrated Business Plan Structure	C4	Deputy CEO/ Director of Finance		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. September 21: Progress reviewed by Strategy Committee and discussion on system collaboration refered for full Board	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 - scheduled for closure in June 2021; testing compliance. Testing HSE actions; training elements recommenced. . Sept 21: CQC action plans reviewed and closed with divsional boards. On going review of the fundimental standards in place and programme of testing. On going testing in place	In progress
vi) Scope / consider independant well led review in line with the national guiidance	C1	Associate Director of Governance / Deputy CEO		To review with new CEO, and Head of Corporate Services in January - scoping being considered . Internal self assessment commenced.	In progress
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: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030** **c) Embed and develop the new divisional structure and leadership model to further improve service quality** **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**			**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-22	**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 v) increase in activity on some specialities (ED, Assessment, Maternity, Paeds, CCU, Mental Health) post covid vi) Increase in complaints and SIs related to post covid activity and delays in pathways. vii) Fatigued workforce	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 Risk Management Group (new)	ToR, Minutes and papers for the Quailty and Safety Committee Structures Report and deep dives to QSC Internal Audit Programme CQC TRAs and gap analysis Quailty and Safety visits and audit programme Action plans from Mental Health Strategy Group / Discharge Group Maternity surge plan and fortnightly Maternity focus with commissioners, regulators and region LMS - mins and actions (meeting de-escalated) Notes/minutes from Risk Management 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. EoI, OPD Internal Audits 2020/21 reasonable or substancial assurance on Serious incidents, clinical audit, risk management, BAF, compliance framework, health and safety, DSPT, Routine Deep dive review at Audit Committee October 2021. Ockenden response October 2021. Pathways to excellence - ward accreditations Quailty Assurance visits (CCG and Trust) NHSI IPC visit 22.10.21 Stroke, Sepsis and VTE deep dive Feb 22 EOL deep dive May 22		

Gaps in Controls	**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	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	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

C7 VTE compliance C8: Environmental Agency review C9: HTA Notice of Direction February 22	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 A10 Consistancy of meeting the food hygiene standards and routine assurance A11: Evidence of delivery against HTA standards	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 . Chief Nurse and Medical Director strategy session scheduled. Priorities under review including strenghtening the divisional governance structures - sessions scheduled for February / March	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. Compliance and risk framework reviewed. Monthly review of fundimental standards recommenced. Review of divisional action place in progress and governance, compliance, cqc communcation plan in place with supporting materials . January _ QAV visits focusing on safety and wellbeing	in progress
iii) Implemention of patient safety strategy priorities	A2, A3, A5, A7	Patient Safety Specialists		Quailty and safety digital update to QSC Sept 21. Annual cycle of deep dives to the committee reviewed.	in progress
iv) Implementaiton of End of Life strategy and priorities	A8	Medical Director		Review against new guidance in progress for consideration by EoL strategy group.	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		Mental health strategy in development. System working to develop local solutions to support acute patients awaiting inpatient beds. Remains an area of focus- interanlly and externally	In progress
vi) Implementaion of pathways to excellence	A3, A5	Chief Nurse		Programme recommenced.	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		Progress under currently review to support the increased volum due to Covid.	In progress
iv) Review complaints process and oversight in line with PHSO guidance and increases following COVID	C3	Chief Nurse		Responding to complaints remains a focus. Interium addiitional resources in place to support recovery plan. Recruitment of new Head of Patient Experience in progress; interviews Sept.	In progress
vii) Complete Gap analysis on GIRFT reports and develop and monitor action plans	C1	Medical Director		Report to QC sept 21	in progress
viii) Review the quailty and safety metrix ward to board with BI	A9	Associate Chief Nurse		work in progress and compliance team also reviewing compliance and assurance data sets . Exploring different systems to support greater visibilty of ward to board reporting - Implementation of Inphase to commence in April 2022	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 . Sept 21: Technical solution completed at end August to enable Datix to complete confirguations. User testing to commence in Oct. Review of programm timetime commenced and to be agreed in October. October 2021: claims module went live in October. Anticipate programme to deliver the rest of the modules in Q4.	In progress
x) Implementation of new cleaning contract and active monitoring of the standards	C7, A10	Director of Estates		Supporting implementation of the new cleaning contract and cleaning standards. Contract monitoing, training, early escalation in plan. Further challenged by the increased levels of activity. October 21: Internal IPC / environmental supportive audits in place.	In progress

xi) Delivery of HTA compliance against standards	C8, A11	COO		Action plan in place, supported by project manager, steering group and workstreams. Full refurbishment of the Mortuary scheduled to commence 7 March 2022 - works commenced	In progress
Summary Narrative:					

October 21: Routine deep dive review at Audit Committee October 2021, Discussion on the impact of the backlog of activity , current activity pressures and changes to pathways in the context of quailty and safety. Assurance given on the actions being taken. Also discussed Medical Director and Chief Nurse holding joint strategic session for their senior teams. This will include review of quality and safety priorities, maximising working together and supporting the divisions effectively and streamlining meeting structure where possible.
June 22: There is a clear trajectory in place to close the backlog of complaints and Serious Incidents. Patient Safety Specialists are becoming more embedded in the organisation. Exec Committee supported a revised risk management approach to tackle risk inflation (staff over-inflating the risk score for corporate risks).

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 best in the health service workplace** **c) Embed and develop the new** **d) Create a health and well-being offer that is amongst the** **e) Progress and develop our equality performance to build an inclusive culture in the**	**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:	Dec-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 Equality 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 rolled 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	in progress

ii) Develop improved education and training offer for all staff groups.	C2	Chief People Officer	Oct-21	Capability strategy developed to support all staff groups across the organisation. Now developing further the delivery of the roadmap	in progress
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. Head of People Culture in post from 1.6.2021 working on a culture plan aligned to the Trust People Strategy. Allocation of time agreed by the Board for Staff Network Chairs, job purpose and descriptions being finalised for existing chairs. A Staff Network Chair's Away Day was held on 12.7.2021 where the group worked on objectives and outcomes over the next 12 months.	in progress
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	in progress
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	in progress
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	in progress
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. Business case approved by Executive committee to support new structure October 21: Fulltime FTSUG appointed and should commence in the new year. Our Trust has been chosen to take part in a pilot project on Inclusive Freedom to Speak up; workshops in place for October/November.	in progress
Summary Narrative:					

July 21: All interventions in place are highlighting particular areas of concern across the organisation, and interventions are being streamlined around these areas to maximise impact. A multi-disciplinary task and finish group is being set up including senior staff from the departments affected to implement the work.

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

Strategic Aim: 1. Quality: 5. Sustainability:

Strategic Objective: **direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic** **a)Develop a new strategic b)Safely restore capacity, and operational and**	**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-22	**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 Internal Audit - PAM (limited assurance) - report to QSC and Audit committees			

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	COMPLETED
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 September 21. Estates Strategy completed December 2021	COMPLETED
iii) Space Utilisation review and implement governance of decision making	C7	Director of Estates and Facilities	Dec-21	Systems for the management of space being investigated and compared. Investment required to implement Space Utilisation Group (SUG) is now established with standard agenda, terms of reference (clear process), and risk-log. Group meets once a month, is chaired by Director of Estates & Facilities, membership /attendance is good.	COMPLETED
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		Head of Compliance now in post, developing / implementing guideline for governance, control requirements and responsibiliies for all critical systems and functions. Feeding into the Premises Assureance Model (PAM). Estates Compliance monthly meeting in process of being established. Estates Compliance Meeting established, meetings are now scheduled 2nd Wednesday of each month, standard agenda, terms of reference, with the Head of Compliance as Chair. Agenda includes update on all critical functions, including monitoring of actions plans against AE Audits. A Compliance Report is updated on a monthly basis and tabled at the Estates & Facilities Board Meeting. Monitoring of action plans in place, monitoring via monthly Estates Compliance Group and quarterly critical area safety groups. Majority of compliance areas due for annual audit, when assurance levels will be assessed and revised by Authorised Engineer's. Poor trust engagement flagged with Ventilation / Decontamination Group Meetings at Health & Safety, Fire and Security Meeting. Decontamination - gap analysis has now been completed with AE (Decon), AP (Decon) and Head of Compliance. Briefing paper has been produced to highlight gaps and risks of Trust Decontamination management. Paper gone to TIPCOG, on to TIPC week commencing 21st March. Ventilation - gap anaylysis also to be undertaken. Medical Gas Safety Group (MGSG) is progressing well against AE Audit Action Plan, good robust effective monitoring of plan by well attended Trust MGSG. Trust Decontamination Group new chair - Richard Hammond (Deputy COO planned care). Meetings to move to quarterly, handover meeting scheduled between estates (AP / Compliance Lead) mid May. Medical Gas Action Plan (BOC & AE Annual Audit) to be tabled FRiday 20th May Med Gas Safety Group Meeting. Decontamination Action Plan to be tabled at next Trust Decontamination Group Meeting on 16th June. Trust Ventilation Safety Group Action Plan finalised (AE Audit / Plan verification reports), monitoring in progess.	In progress **COMPLETED**
v) Complete the PAM gap analysis	A3, C2, C6	Director of Estates and Facilities	Dec-21	Compliance manager recruited and will prioritise this audit. PAM gap analysis is underway, supported by TIAA external PAM Audit. TIAA PAM process assurance audit is now completed. Compliance Manager has updated audit with management response/action - briefing paper has been tabled at Decembers H&S, F,S Group and Q&S Committee. Gap analysis is completed, updating action plan in progress. Note - this is significant exercise requiring trust-wide engagement to provide supporting evidence of process. On-going updating of PAM Action Plan - also acts as PAM Library - directory collating file-pathways for all documents / evidence. Actual PAM submission due end of July. Team aiming for end of May submission date. PAM update paper provided for Audit Committee, next steps completed PAM SAQ master spreadsheet 27th June. PAM sign-off with Kevin Howell 5th/6th July, official upload submission 15th July. Final Report to E&F Board 19th July.	In progress COMPLETED
vi) Review mechanisms of oversight of complaince across all sites to ensure effective	C1, C3, C5, A1	Director of Estates and Facilities		Estates Compliance monthly meeting in process of being established. Estates Compliance monthly meeting now established. To inlcude over-sight of all E&N Herts sites. Agenda includes all E&Nherts sites. Included in ToR's. All E&Nherts sites added to Critical Function Safety Group meeting standing agendas.	COMPLETED / on-going monitoring
vi)					
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 Finance
	Risk Review Date:	Mar-22	**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 failure 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 MVCC - Weekly ENHT, UCLH and NHSE Director level call in place and monthly Tripartite meeting in place to monitor delivery of the Strategic Review against plan - Fortnightly Due Diligence governance meeting in place (NHSE, UCLH, ENHT, HHT) - 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, NHSE Critical Infrastructure Review in place underpinned by action plans & risk register - MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG, HHT and UCLH) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility	- Regular reports to Strategy Committee and the Board - Status reporting through ENHT Steering Committee - July 21 - Audit Committee Deep Dive	- 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. - June 2021 - East of England Clinical Senate review of proposals; informal feedback from review team has been positive - Sept 2021 - UCLH Expression of Interest submitted to DHSC, with support from ENH Trust Board, seeking route to capital as part of new hospitals programme		

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	
	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
ii) Provide input and support as relevant to NHSE activities to access capital	A1	Deputy CEO/Director of Finance	Ongoing	- Input provided to capital paper shared with NHSE Finance colleagues - Input and support provided for UCLH Expression of Interest in capital as part of DHSC new hospitals programme	In progress
iii) Chief Executive briefing of regional team to support activities in relation to access capital	A1	CEO	Ongoing	- Briefing of Regional Director NHSE/I East of England	In progress
iv) Support public consultation process through effective development and execution of ENHT communications and engagement plan	A1	SRO (Deputy CEO/Director of Finance)	TBC	- Planning to start once timing of Public Consultation is clearer, dependent on capital assurance	Not yet started
v) Finalise assessment of ENHT stranded costs	A2	Deputy CEO/Director of Finance	May-21	- Initial Financial Impact Assessment of MVCC Transfer on ENHT has been developed; detailed analysis completed. To be refreshed as required over time	Complete
vi) Negotiate settlement with NHSE to address ENHT stranded costs	A2	Deputy CEO/Director of Finance	Jul-21	- Review of stranded costs agreed with NHSE mid June 2021	Complete
vii) Lead definition and execution of plans to reshape corporate departments to deliver target reductions in corporate overheads	A2	Director of Finance	01/03/2022 Ongoing - dates to be realigned with earliest possible transfer date (subject to timing of confirmation of capital availability)	- Meetings held in May at which Corporate Directors shared their plans	In progress
viii) Seek assurance from UCH of commitment to resourcing and plans at programme governance forums	A3	Programme Director – MVCC Transfer	May-21 Ongoing - dates to be realigned with earliest possible transfer date (subject to timing of confirmation of capital availability)	- 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	Complete In progress
ix) Lead the programme-level development of transition and decoupling plans to identify corporate and divisional resources required to implement transition	A4	Programme Director – MVCC Transfer	Ongoing - dates to be realigned with earliest possible transfer date (subject to timing of confirmation of capital availability)	- Prior to confirmation from NHSE supporting work at risk, initial transfer and transition/de-coupling activities underway	In progress
Summary Narrative:					

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.

July 21 - Strategic Review Programme Board: Confirmation that due to continued uncertainty regarding route to capital, earliest feasible transfer date is now October 2022. In light of the delays, an MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG and HHT) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility. ENHT refresh of scenario analysis in light of the delays, for discussion at July Audit Committee. Government announcement w/c 12th July regarding DHSE competition to fund 8 new hospitals, with Expressions of Interest due early September.

Sept 21 - Expression of Interest in capital for re-provision of MVCC Services was submitted by UCLH to DHSC on 08/09. ENH Trust Board supported the submission (discussed at 01/09 Private Board).
The first MVCC Service Sustainability Group meeting took place 06/09, comprising NHSE, ENHT, UCLH, THH and ENH CCG, to review the sustainability dashboard which will be produced monthly. The Group will next meet in November unless there is an urgent requirement to meet sooner.

Jan 22 - Awaiting feedback following UCLH Expression of Interest in DHSC new hospitals programme for re-provision of MVCC Services. Indications are that short-list of projects to be funded will be published in late spring/early summer. In the meantime UCLH continue to progress their reprovision Business Case and have flagged an expected increase in costs. The second quarterly meeting of the MVCC Service Sustainability Group took place 22/11, to review the Sustainability Dashboard, with no areas requiring escalation.

Mar 22 - Strategic Review Programme Board: Continue to await feedback from the DHSC National Hospital Programme for the re-provision of MVCC Services. The third quarterly meeting of the MVCC Service Sustainability Group took place 01/02 to review the Sustainability Dashboard, with no areas requiring escalation. Hilary Finegan joined the trust 01/03 as MVCC Transfer Programme Director, following the departure of Joanna Osbourne.

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

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

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 progress development and delivery of integrated and collaborative services, making them easier to use for patients **g) Working with system partners,**

Source of Risk:	External/ Civil Contingencies Act	**BAF REF No:**	012/21
Risk Open Date:	04-Mar-20	**Executive Lead/ Risk Owner**	**Chief Operating Officer/ Chief Nurse**
Risk Review Date:	Jun-22	**Lead Committee:**	**QSC/ Board**

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**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Covid 19 outbreak/pandemic - impact of varients nationally and world wide -Lifting of the national restrictions. Approach now is 'living with Covid-19' and guidance has been issued to support this. ii) Potential increased need of respiratory and critical care beds iv) Enactment of the Civil Contingency Act v) Insufficent capacity for the increased demand - including ED and assessment , side room capacity and readiroom capacity vi) Likelihood of future surges / increase in covid numbers resulting in an increase in Covid numbers and hospitalisations, ventilated patients and a decrease in available workforce. vii)Future Covid surges combined with a decrease in available workforce could have a negative impact on staff resilience viii) Impact of winter could impact on overall capacity within the hospital ix) Living with Covid guidance now available. Risk score has been updated to reflect this.	i) Risk of staff unable to attend work - due to ~~self isolation or~~ covid 19 positive.Risk assessments due to the changes in isolation rules to ensure vulnerable patients are not at risk. 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 v) Risk of financial impact if regulatory requirements are not achieved vi) Risk of winter demand/ illnesses on overall capacity within the hospital vii, Increasing Urgent and Emergency Care pressures impacting on overall capacity within the hospital	**Inherent Risk** (Without controls):	5	4	**20**	
		Residual/ Current Risk:	5	2	10	
		Target Risk:	3	2	6	

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 - Strategic, Tactical and Operational (Gold , silver, bronze) Command structures reviewed/adapted to ensure continued support to organisation / major incident Communication plan - internal and external Linked into and represented at Local and National resilience fourms/ communications/ conference calls Emergency Preparedness, Resilience and Response Committee - Chaired by Managing Director for Unplanned Care 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 Staff well being programme and deployment / reassignment processes - flexible (workforce triggers in place) Monitoring, review and recording of all national guidance and directives received 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 and fast tracked Point of Care Tests are available for all staff who are critical for a service to continue following a rsik assessment and Executive Director sign off or available to all via the national portal. Staff vaccine hub and vaccination programme currently the covid vaccination hub 'mothballed' Visitors Policies - including agreed triggers if changes required.	COVID dashboard Weekly Audits on environmental, IPC, H&S and social distancing Action Log/ Minutes from Strategic (GOLD), Tactical (Silver) and COVID SAG Trust Communications Visitors Roadmap task and finish group convened to meet the national recommendations for visiting in a safe enviroment.	Compliant with Emergency Planning Core standards 2021/22. (We will submit evidence to demonstrate compliance with the 2022/23 standards later this year).	Report to QSC given.	
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 being exposed to Covid-19 postive people especially with the rise in asymptomatic cases. C3. Possibility of visitors being exposed to Covid-19 postive people especially with the rise in asymptomatic cases. 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,lifting of national requirement to isolate if positive and reduced testing availability 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 surges on capacity and staffing ~~C10 – Overall hospital capacity limited by winter pressures. Winter initiatives agreed to provide additional capacity.~~ C10. Overall hospital capacity impacted by unprecedented demand for emergency and elective care.	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 A4 ~~Implementaion of winter initiatves~~ Redi rooms to prevent further infection and bed closures	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

Jan-22	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		July 2021: Awaiting national guidance Sept 21: Covid boosterand flu vaccination programme in place ready to commence in October 21. Vaccination Programmes commenced. November 21: review of mandatory vaccination programme May 22: will comply with any future guidance.	In progress
iv) Monitoring of triggers to enable responsivness and 'unflat packing' of COVID response if/when required.	C9	COO / Emergency Planning	On going	July 2021: Command and Control structures reviewed - GOLDnow meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. Specialty working groups include - Critical care surge (adults/children), Paeds, Respiratory, Renal, Maternity. October 21: review of the triggers commenced to ensure they remain fit for purpose. Command structure ready to increase freqency if/when required. December 2021: Surge plans and triggers under review	In progress
iv) Implementaion of lessons learnt from previous COVID surges (internal and system)	C7, A1	COO / Emergency Planning	on going	July 2021: Command and Control structures reviewed -Workstreams, task and finish groups and surge plans - reviewed and stood up. Reviewing and preparing taskteam / deployment in readiness to respond.	In progress
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. Assessment for the 2021 standards completed and compliant.	completed
~~vi) Monitoring implemention of winter initiatives (links to risk 1, operational delivery)~~	~~C10, A4~~	~~COO~~		~~see risk 1 performance - Mini nightigale (Additional surge capacity) programme - work in line with national guidance~~	
vi) Working with system partners (including primary care, EEAST, acute care, community and locak authority) to address flow through the system.	C10	COO	Ongoing	Regular cross system meetings/ conversations to review approach and alteratives. Discharge workshop help in April 2022.	In progress.
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. July 2021: Command and Control structures reviewed - GOLD now meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. October 2021: Review of operational triggers and strucutre to support escalation commenced (taking into account the winter pressures) . December 2021 : Frequency of Gold/ Silver incident meetings reviewed and increased in frequency. Review of task and finish groups to support level 4 incident response locally and in line with national requirements. Risk assessment process introduce to support staff return to work in line with National Guidance. February 2022: Successful project to ensure the mini nightingale surge unit for general and acute beds was ready to mobilise at the beginning of February if required. This was fortunately not required and has been stood down. March 22: Although the rates of covid have increased in the hospital and locally, this has not led to increased numbers in CCU, RSU or deaths. **May 2022 -** Our organisational response to the pandemic remains strong, with measures in place should numbers increase. Trust response agreed to the Living with Covid guidance. Target risk score updated following this guidance.
June 2022, NHS incident level is at level 3, Hertfordshire Strategic Cooridnation Group and Tactical Coordination Group 'battle rhytmn' is monthly and the Trust has reduced the Strategic Gold to Monthly,bi-weekly for Tactical and Covid Specialist Advisory Group meetings.

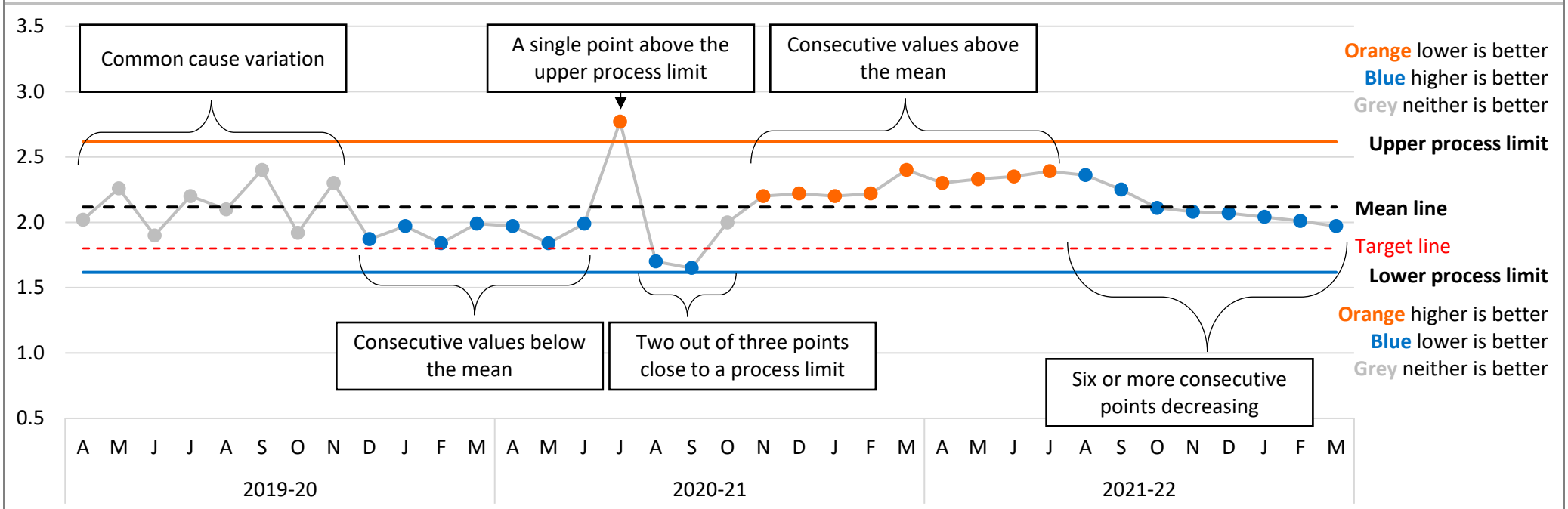
Integrated Performance Report

Month 02 | 2022-23

	P	?	F
H / L	0	4	3
	5	35	5
H / L	5	11	7

Data correct as at 24/06/2022

How to interpret a Statistical Process Control (SPC) Chart



Variation

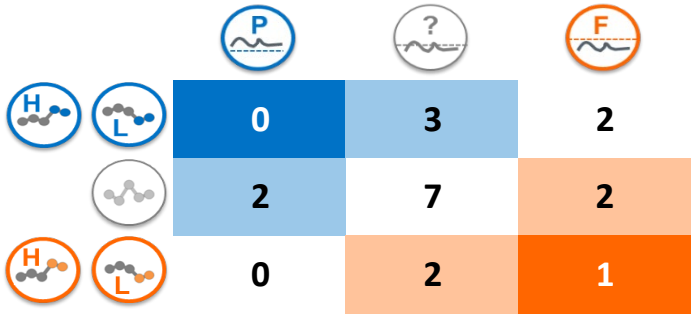
H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

Assurance

F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

Safe Services

Month 02 | 2022-23



Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	May-22	n/a	1,130			Common cause variation No target
	Serious incidents in-month	May-22	0	6		?	Common cause variation Metric will inconsistently pass and fail the target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	May-22	0	0	L	?	No hospital-acquired MRSA since Jan-20 Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	May-22	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	May-22	0	6		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	May-22	0	2	H	?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	May-22	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	May-22	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	May-22	0	0	L	?	No hospital-acquired CPOs since Jun-20 Metric will inconsistently pass and fail the target
	Hand hygiene audit score	May-22	80%	92.9%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	May-22	n/a	77.3%			Common cause variation No target
	Staff shortage incidents	May-22	n/a	24			Common cause variation No target

Safe Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	May-22	n/a	0.90			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	May-22	n/a	0.90			Common cause variation No target
Deteriorating Patients	Reliability of observations (4-hour)	May-22	n/a	71.1%			Common cause variation No target
	Reliability of observations (1-hour)	May-22	50%	38.1%	L	F	One point below the lower process limit Metric will consistently fail the target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	May-22	95%	77.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	May-22	95%	38.5%	H	F	Eight points above the mean Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	May-22	95%	82.7%	H	?	Eight points above the mean Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	May-22	95%	67.1%	H	F	Eight points above the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	May-22	85%	65.4%	L	?	Two points below the lower process limit Metric will inconsistently pass and fail the target
	VTE risk assessment for stage 2, 3 and / or 4	May-22	85%	42.4%		F	Common cause variation Metric will consistently fail the target
	Correct low molecular weight heparin prescribed and documented administration	May-22	85%	83.8%		P	One point below the lower process limit Metric will consistently pass the target
	TED stockings correctly prescribed and documentation of fitted	May-22	85%	51.5%		?	Common cause variation Metric will inconsistently pass and fail the target

Safe Services

Summary

East and North Hertfordshire NHS Trust

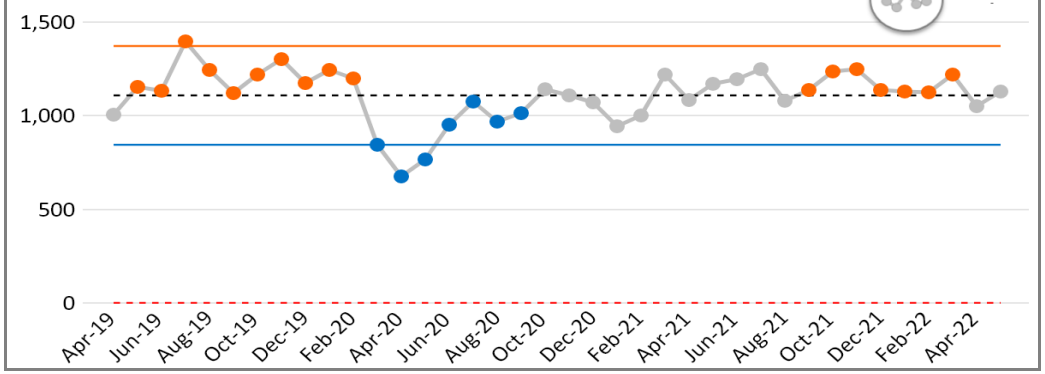
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
HATs	Number of HAT RCAs in progress	May-22	n/a	74			two points above the upper process limit No target
	Number of HAT RCAs completed	May-22	n/a	14			Common cause variation No target
	HATs confirmed potentially preventable	May-22	n/a	0			Common cause variation No target
PU	Pressure ulcers All category ≥2	May-22	0	16			Common cause variation Metric will consistently fail the target
Patient Falls	Rate of patient falls per 1,000 overnight stays	May-22	n/a	4.0			Common cause variation No target
	Proportion of patient falls resulting in serious harm	May-22	n/a	1.8%			Common cause variation No target

Safe Services

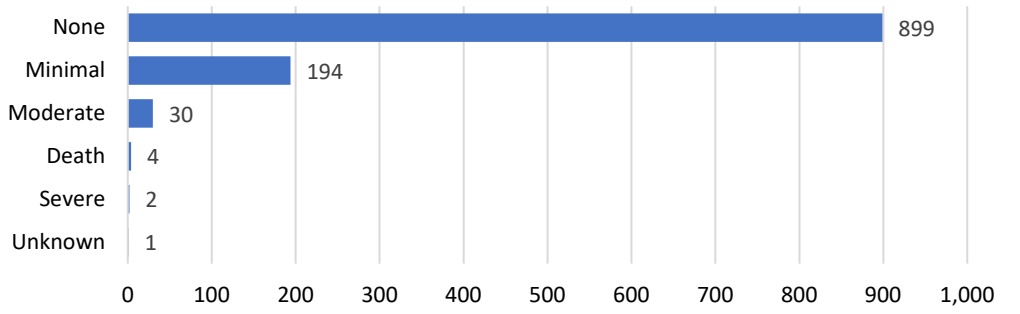
Patient Safety Incidents

East and North Hertfordshire NHS Trust

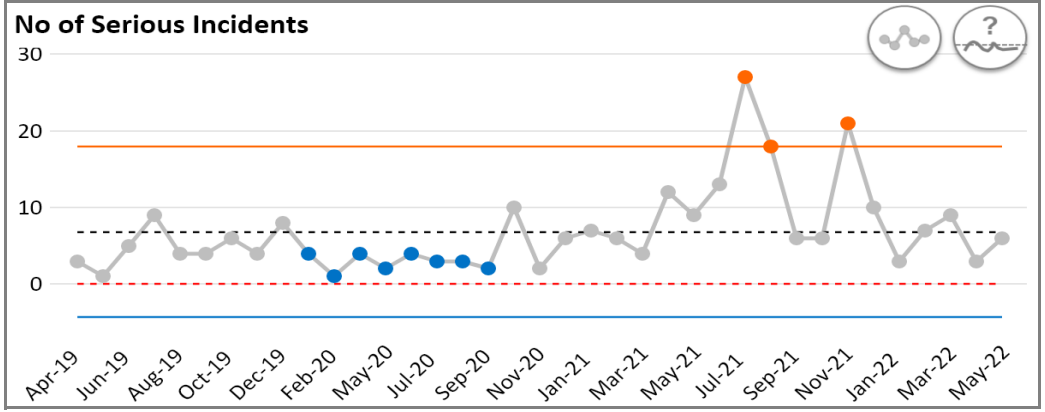
Total incidents reported



Number of incidents by level of harm



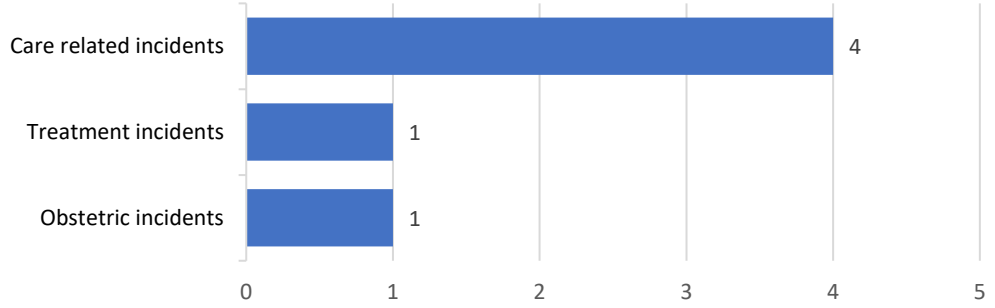
No of Serious Incidents



Key Issues and Executive Response

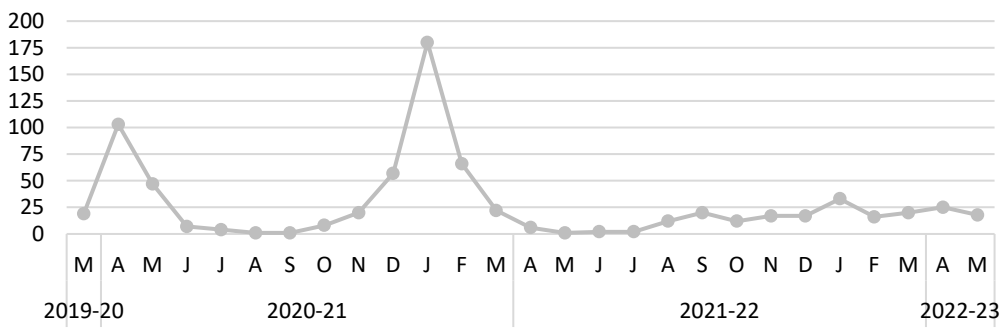
- Common cause variation seen in the number of incidents reported.
- 97% of incidents reported resulted in no or low harm (this is in-line with previous months).
- Common cause variation in the number of SIs declared each month.
- Agreement of ToR at the beginning of an investigation, identification of key issues and the continuation of embedding the roundtable discussions have made a positive impact on the SI investigation process. This is evident in the reduction of amendments within reports at the executive sign-off stage.
- Ongoing review and prioritising of overdue SIs with commitment from Divisions to support timely approvals.

Themes

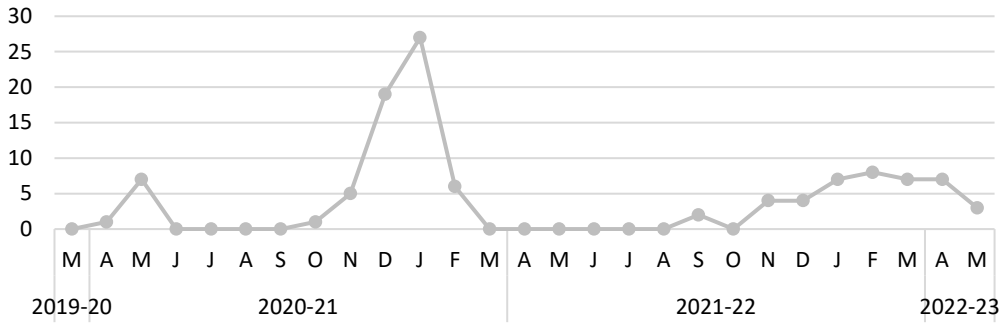


East and North Hertfordshire NHS Trust

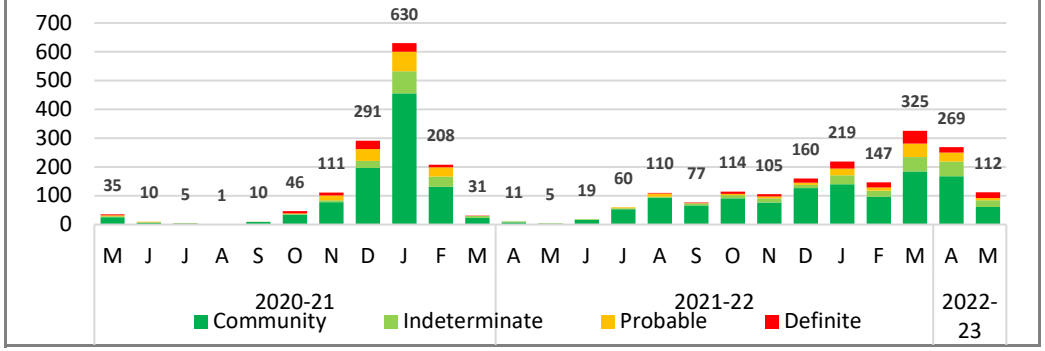
Number of deaths from COVID-19



Number of deaths from hospital-acquired COVID-19



COVID-19 cases by category

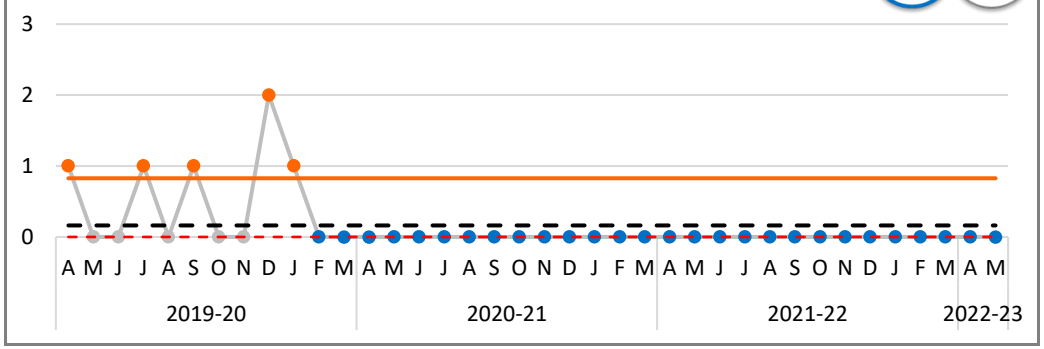


Key Issues and Executive Response

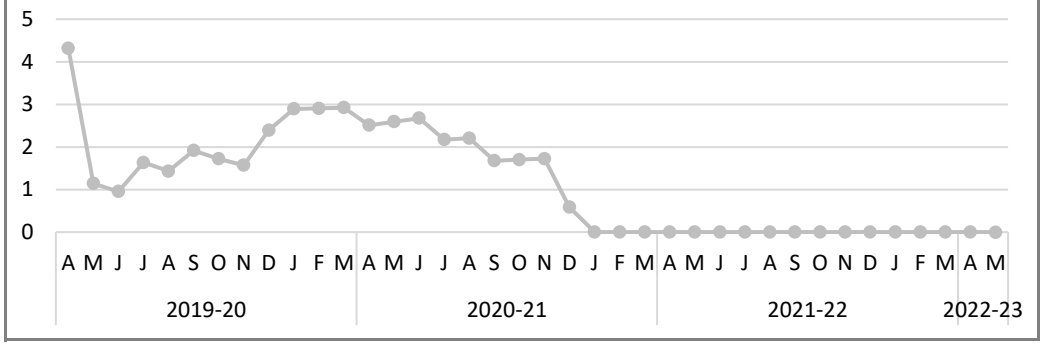
- A reduction in COVID cases were seen in May, the total number was 112. 28 of these cases were contributed to probable or definite hospital-onset COVID.
- Sadly 18 patients died with a diagnosis of COVID in May, and 3 of these cases were related to hospital-onset COVID.
- All deaths undergo a structured care review to capture learning from deaths within the hospital. Any deaths related to hospital onset COVID shall be prioritised for discussion in the trust serious incident review panel.
- An outbreak has occurred in 1 clinical area in May and some clinical areas have seen increased prevalence of hospital-onset COVID.
- The trust continues to deliver a clinical specialist COVID advisory group where all new national and local guidance is reviewed, and plans agreed to implement accordingly.
- The trust has no general visiting restrictions in place, special consideration is given to visiting within outbreak areas or patients with vulnerable needs.

Measure	Site	Assurance		Narrative
Water Safety	Lister Site		**Reasonable assurance**	• A Responsible Person has not been appointed, this is a requirement of the HSE Approved Code of Practice, L8. • Policy in place with Water Safety Plan procedures currently being drafted. • An Authorising Engineer [Water] and an Authorised Person [Water] have been appointed. • A second Authorised Person [Water] has been assessed and recommended for appointment. • Competent Persons training has been completed in readiness for formal appointments. • Water Safety Group & operational sub-groups established. • Water safety risk assessments are up to date. • Control schemes documented at all Trust sites. • The programme of planned maintenance & monitoring at Lister Hospital is ongoing and up to date and demonstrates high levels of compliance with the control scheme. • The Trust has some very old water distribution infrastructure. A risk-based plan is required for future replacement & upgrades. • Work continues to engage with our colleagues & partners at each of the satellite premises to provide assurance that the relevant processes & procedures are in place for water safety.
	Satellite premises		**Limited assurance**	
Ventilation	Lister Site		**Limited assurance**	• There is a policy and limited procedures in place. These require updating. • An Authorising Engineer [Ventilation] and an Authorised Person [Ventilation] have been appointed. • Competent Persons training has been completed in readiness for formal appointments. • Ventilation Safety Group [VSG] meetings have been scheduled. • Critical ventilation systems are verified annually; inspection findings are reported to the VSG; • The Trust has some very old assets/AHU in poor condition. A risk-based plan is required for future replacement & upgrades. • The programme of planned maintenance of ventilation systems is ongoing and up to date. • Satellite premises have not been assessed separately from the Lister site at this time.
	Satellite premises		**To be confirmed**	
Decontamination	Lister Site		**Limited assurance**	• Richard Hammond has been nominated “Decontamination Lead” for the Trust, awaiting appointment by the Chief Executive Officer. • The Trust Decontamination Policy requires review. This should include a full review of roles & responsibilities. • An Authorising Engineer [Decontamination] has been appointed. • A Trust Decontamination Group [TDG] has been set up. A Terms of Reference has been drafted and submitted for consultation. • An Estates Manager (Decontamination) role has been employed to undertake the Authorised Person [Decontamination] duties, however this role has yet to be formally appointed by the AE[D]. • Initial AP[D] training has started and due for completion September 2022. • The AE[D] has completed an audit / gap analysis which identified opportunities for improvement. An action plan is to be developed to address these items. • The AE[D] has completed the JAG IHEEM audit for endoscope decontamination facilities, which identified the lack of a permit to work system. A permit-to-work system has been devised and an SOP drafted and submitted to the TDG for approval. • Satellite premises have not been assessed separately from the Lister site at this time.
	Satellite premises		**To be confirmed**	

Hospital-acquired MRSA - number of incidences in-month



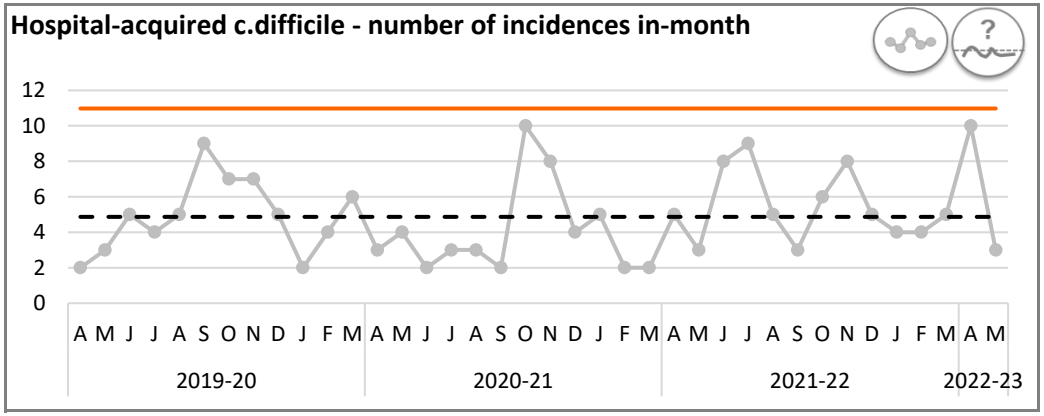
Hospital-acquired MRSA - rate per 100,000 bed days - rolling 12-months



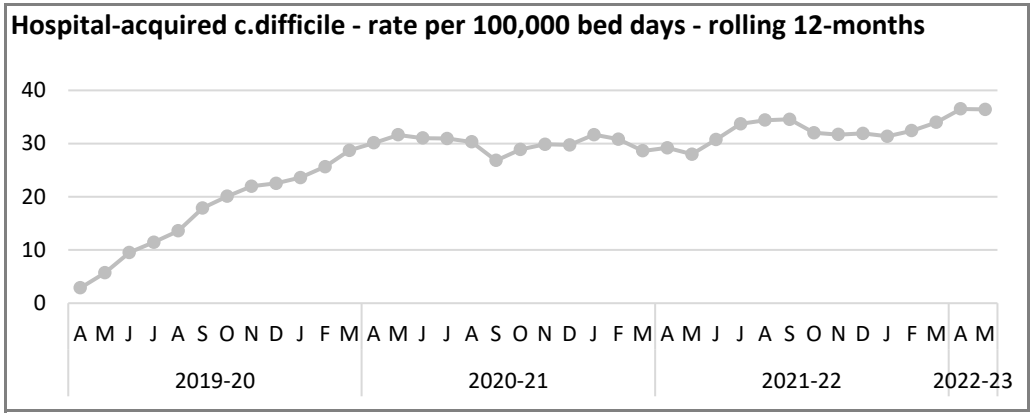
Key Issues and Executive Response

- The Trust continues to report 0 hospital-acquired infections (HCAI) MRSA blood stream infections (BSIs) against the annual target of 0.
- The Trust reported 3 hospital-acquired Clostridium Difficile Infection (CDI) for the month of May.
- The Trust has reported 13 in 2022 - 2023 to date against the annual target of 59, which is slightly below trajectory.
- The IPC team and the clinical practice team has been working with the wards to identify gaps/learning though audits and post infection reviews (PIRs).
- A further 10 cases have been successfully appealed and the Trust position for April 2021- March 2022 is now 49 HCAIs, the UKHSA HCAI DCS is still reporting 65 HCAIs. However, UKHSA HCAI DCS team have informed the Trust they are happy for cases which were successfully appealed to be deleted. The IPC are currently reviewing the process.

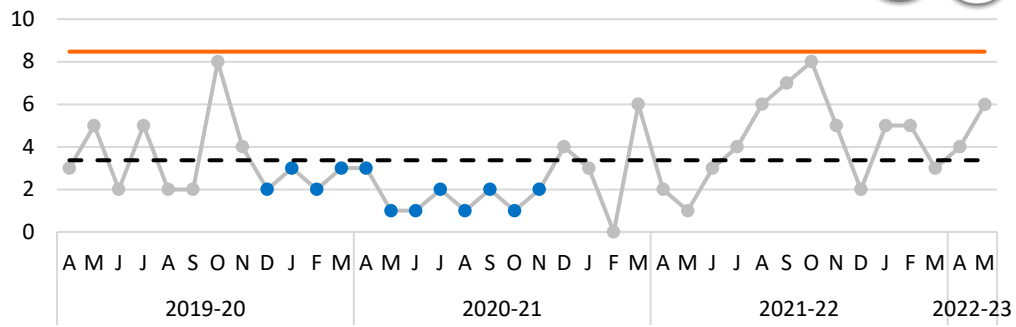
Hospital-acquired c.difficile - number of incidences in-month



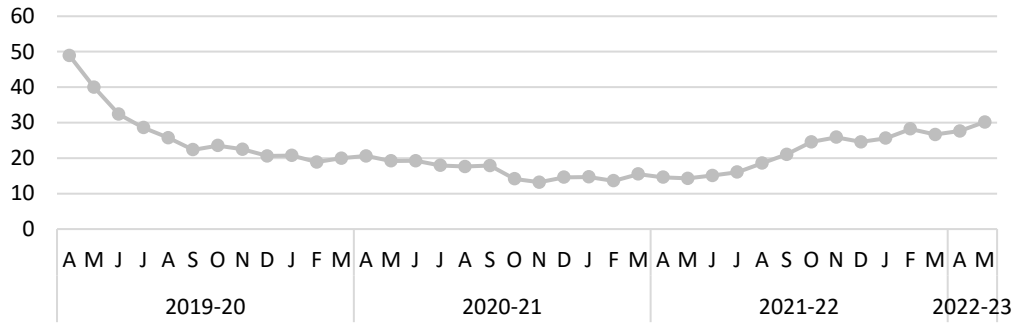
Hospital-acquired c.difficile - rate per 100,000 bed days - rolling 12-months



Hospital-acquired e.coli - number of incidences in-month



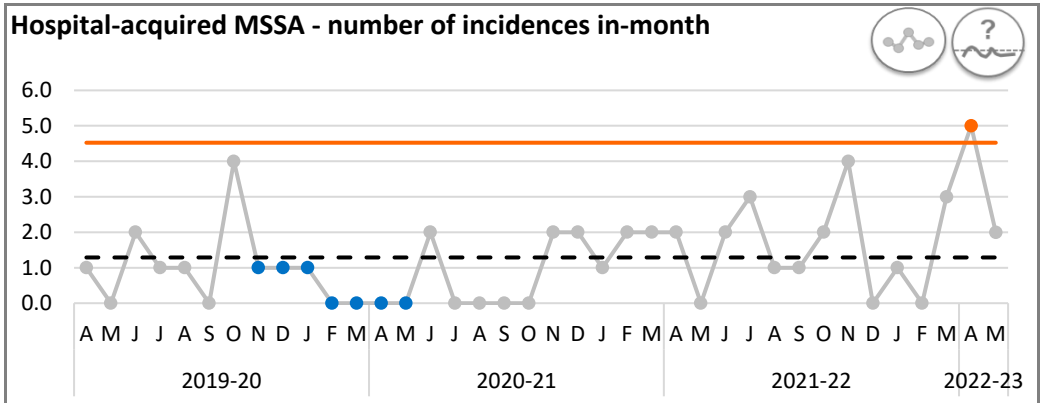
Hospital-acquired e.coli - rate per 100,000 bed days - rolling 12-months



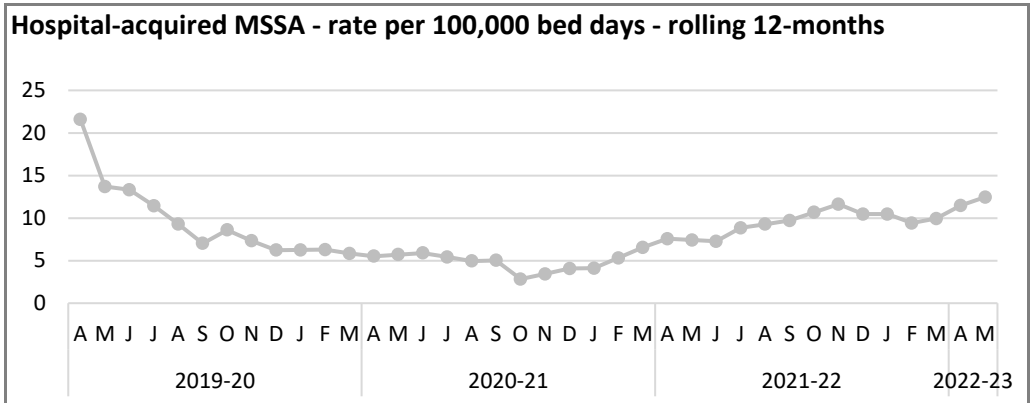
Key Issues and Executive Response

- The Trust reported 4 HCAIs E.coli BSIs for the month of May.
- The Trust has reported a total 8 HCAIs in 2022 - 2023 to date against the annual target of 46, which is slightly above trajectory.
- The IPC team are currently in the process of reviewing all 51 HCAI E.coli BSIs for 2021 - 2022, with 4 being already presented to the panel. Lessons learnt will be circulated to the divisions.
- IPC are currently working with the Lead Urology Nurse Practitioner to digitalise the Catheter Care plan and relaunch the Catheter passport.
- The Trust reported 2 HCAIs MSSA BSIS for the month of May.
- The Trust has reported at total of 7 HCAIs in 2022 - 2023 to date, no target has been set for MSSA, therefore is non-applicable.
- A process is in place to review the Pre-operative skin preparation for several orthopaedic procedures, which will be presented at The Trust Infection Prevention Control Operational Group (TIPCOG).

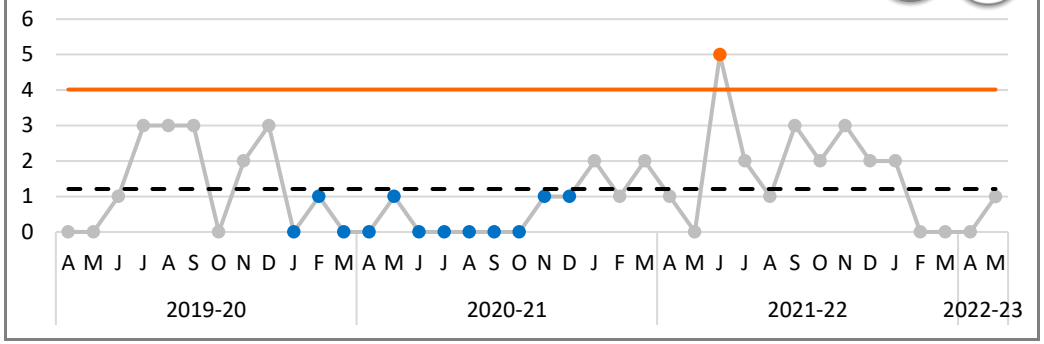
Hospital-acquired MSSA - number of incidences in-month



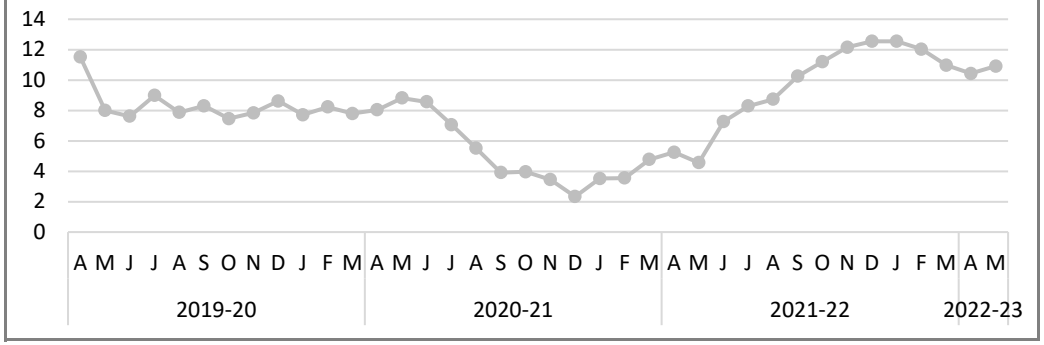
Hospital-acquired MSSA - rate per 100,000 bed days - rolling 12-months



Hospital-acquired klebsiella - number of incidences in-month



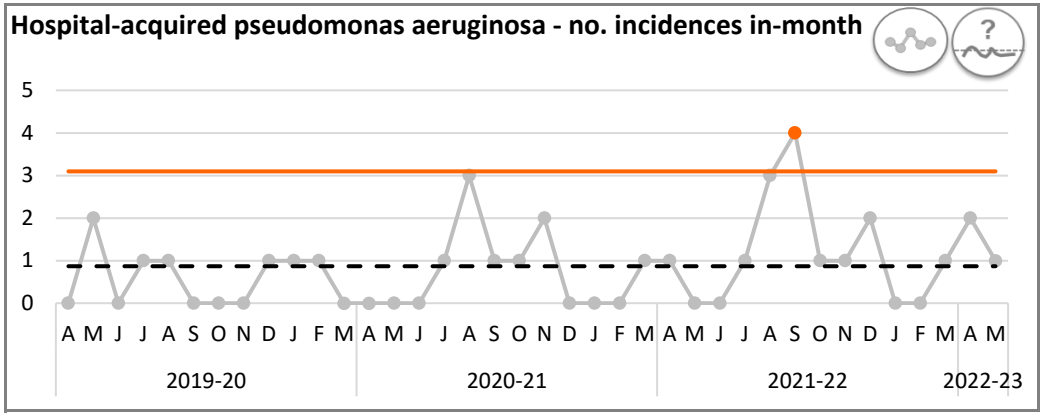
Rate of incidences per 100,000 bed days - rolling 12-months



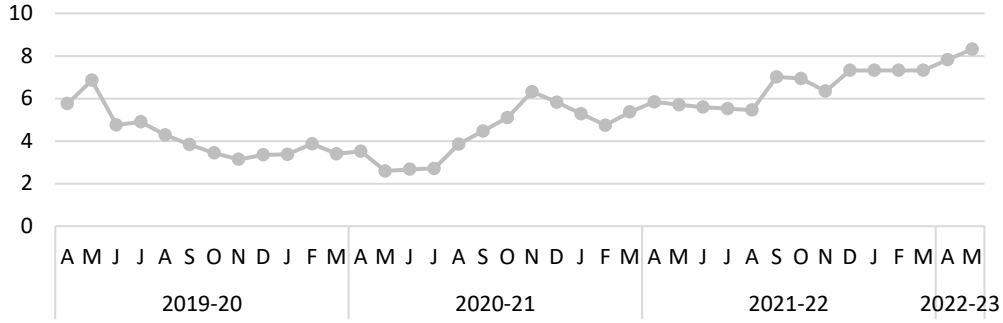
Key Issues and Executive Response

- The Trust reported 1 HCAI Klebsiella BSIs for the month of May.
- The Trust has reported a total of 1 HCAI Klebsiella BSIs in 2022 - 2023 to date against the annual target of 22, which is below trajectory.
- The Trust reported 1 HCAI pseudomonas aeruginosa BSIs for the month of May.
- The Trust reported a total of 3 HCAI pseudomonas aeruginosa BSIs in 2022-2023 to date against the annual target of 11, which is slightly above trajectory.
- The Trust Clinical Practice Teams for both Planned Care and Unplanned Care are in the process of working with the operational teams to create bespoke audits for aseptic non touch technique (ANTT).

Hospital-acquired pseudomonas aeruginosa - no. incidences in-month

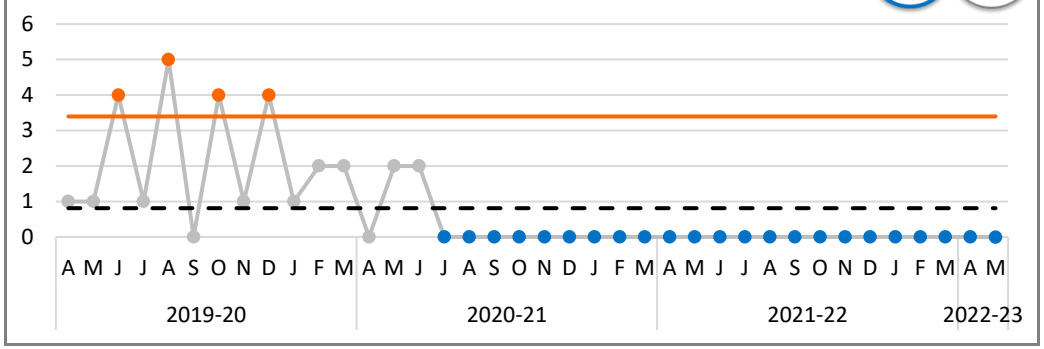


Rate of incidences per 100,000 bed days - rolling 12-months

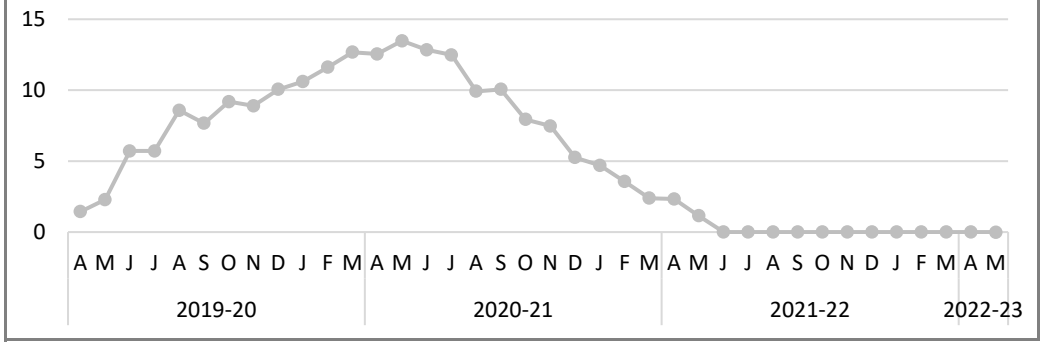


East and North Hertfordshire NHS Trust

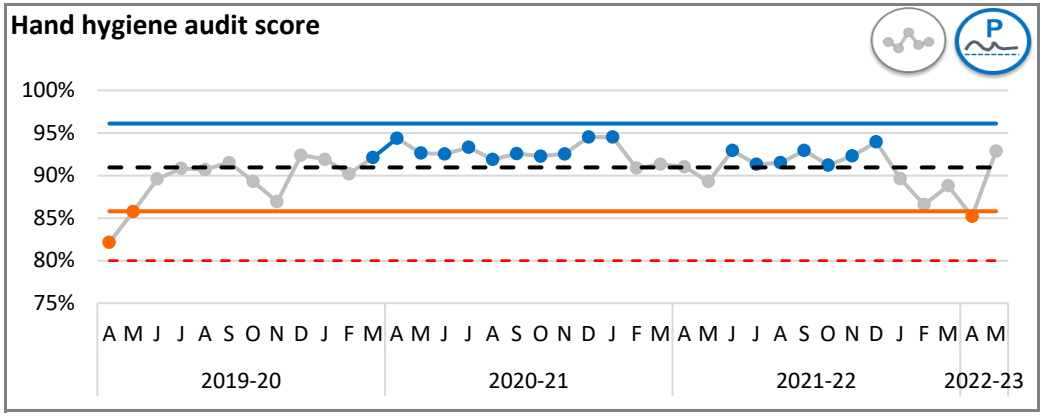
Hospital-acquired Carbapenemase Producing Organisms (CPOs)



Rate of incidences per 100,000 bed days - rolling 12-months

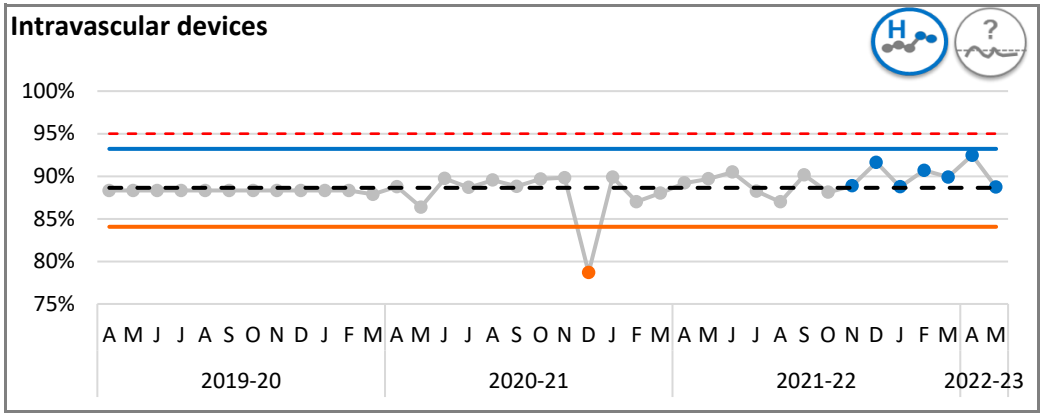


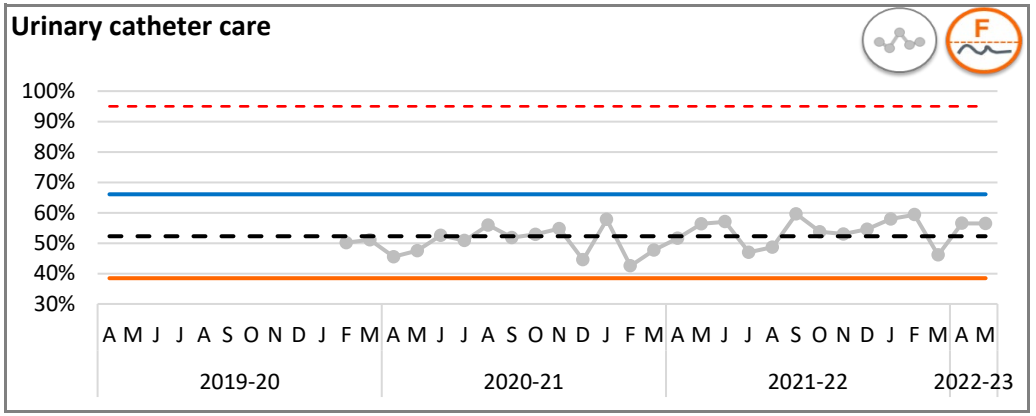
Hand hygiene audit score

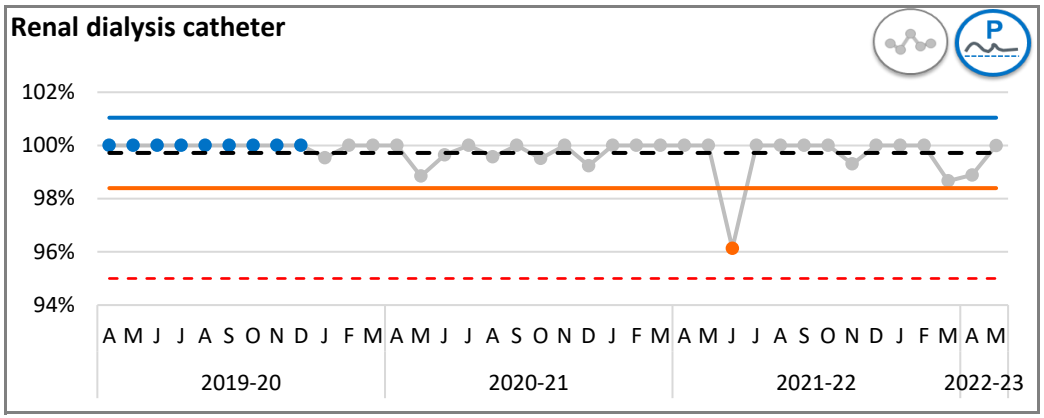


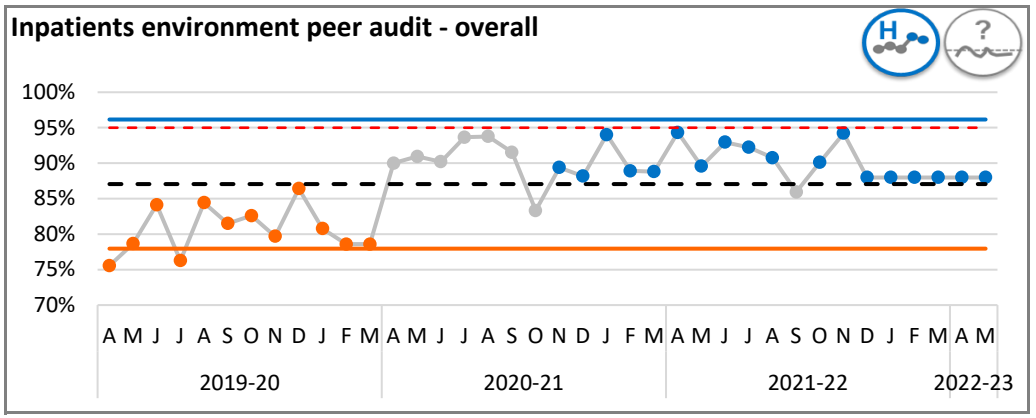
Key Issues and Executive Response

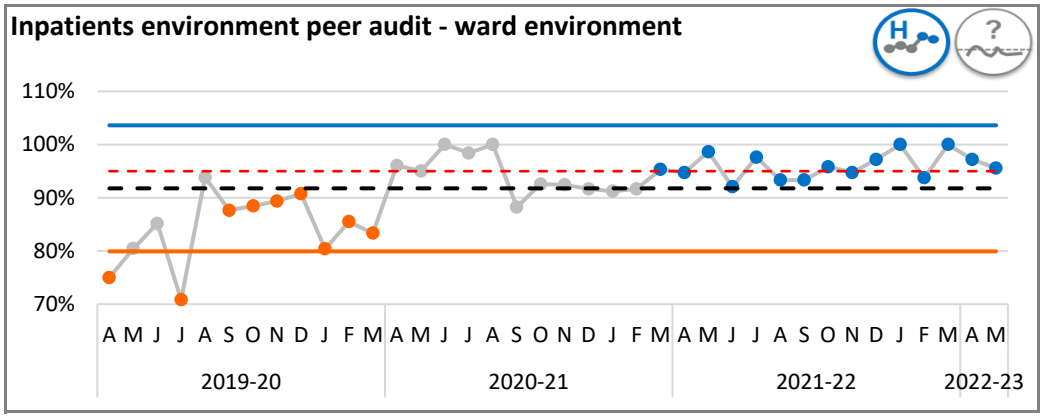
- The Trust has identified 0 HCAIs CPO infections in May.
- There has been an increase of CPO infections in recent months within the region.
- The Trust took part in the National CPE Point Prevalence survey to support better understanding of the data around CPO.
- The Trust has seen a significant improvement throughout the Trust for Hand hygiene, IPC will continue to carry out hand hygiene competency training.

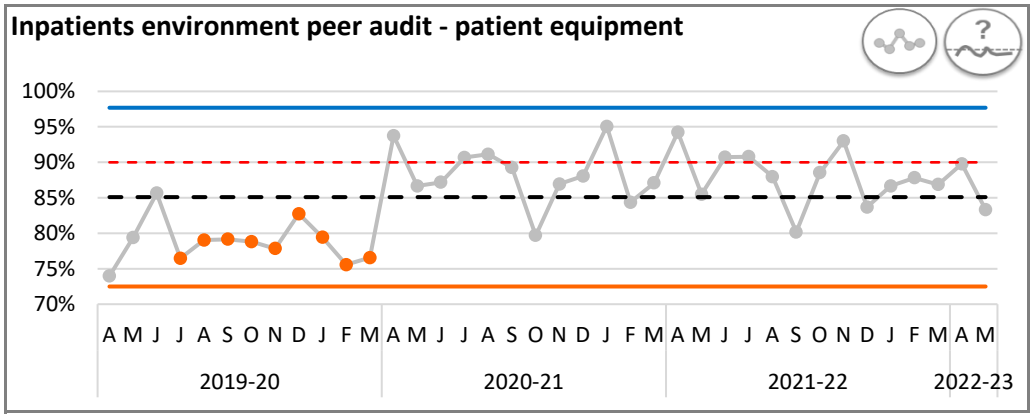

Intravascular devices
100%
95%
90%
85%
80%
75%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2019-20
2020-21
2021-22
2022-23


Urinary catheter care
100%
90%
80%
70%
60%
50%
40%
30%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2019-20
2020-21
2021-22
2022-23


Renal dialysis catheter
102%
100%
98%
96%
94%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2019-20
2020-21
2021-22
2022-23

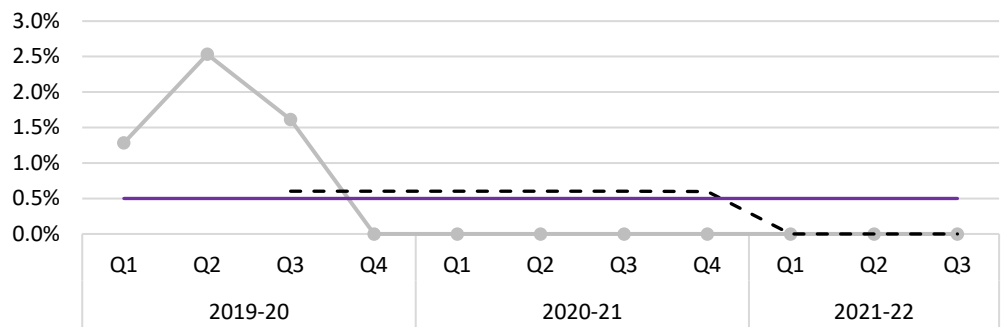

Inpatients environment peer audit - overall
100%
95%
90%
85%
80%
75%
70%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2019-20
2020-21
2021-22
2022-23


Inpatients environment peer audit - ward environment
110%
100%
90%
80%
70%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2019-20
2020-21
2021-22
2022-23

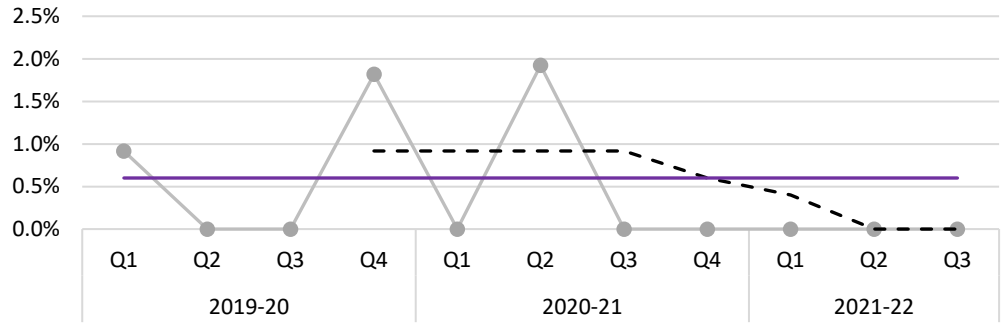

Inpatients environment peer audit - patient equipment
100%
95%
90%
85%
80%
75%
70%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M
2019-20
2020-21
2021-22
2022-23

East and North Hertfordshire NHS Trust

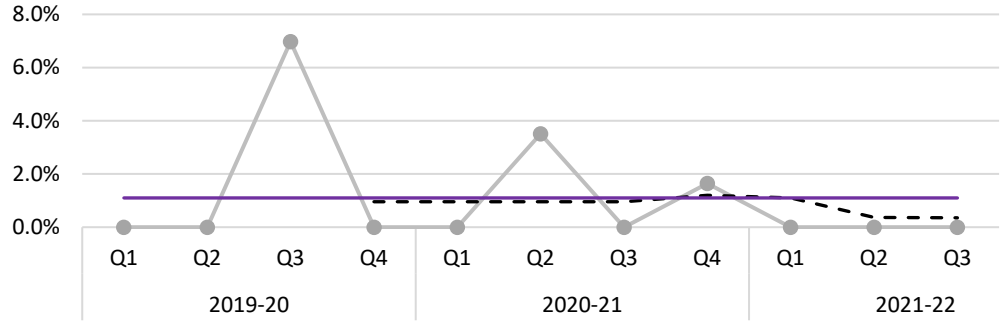
Surgical Site Infections - Total Knee Replacements



Surgical Site Infections - Total Hip Replacements



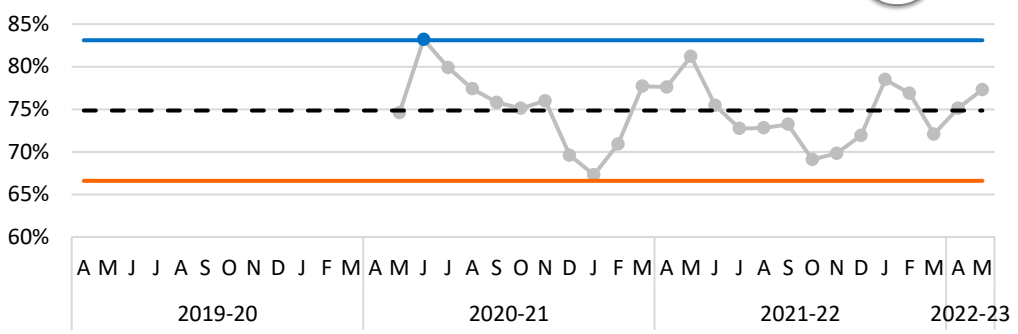
Surgical Site Infections - Fractured Neck of Femur



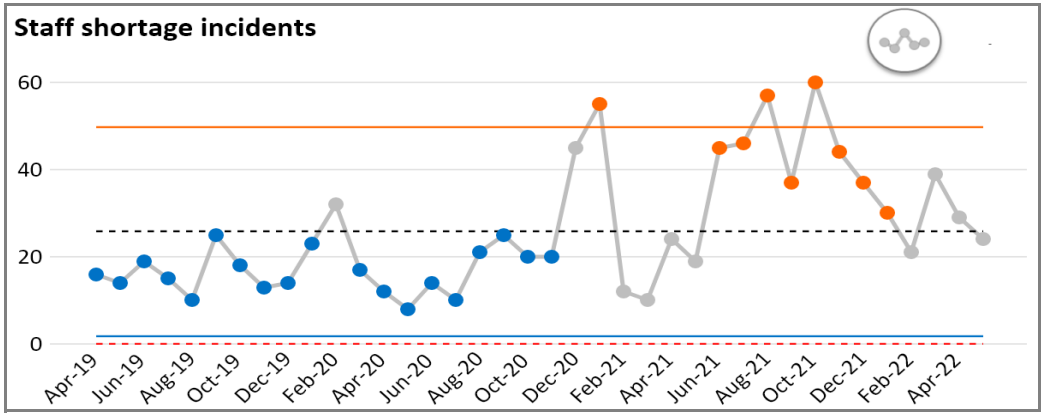
Key Issues and Executive Response

- SSI figures over the last 4 periods (December 2020 – December 2021) show an overall reduction in infection rates in all three categories monitored (Total Knee Replacement (TKR), Total Hip Replacement (THR) & Repair of Fractured Neck of Femur (NOF), compared to the 2014 - 2019 figures.
- The TKR infection rate remains at 0.0% in October – December 2021 and the overall rate for the past 4 periods (October 2020 – October 2021) remains at 0.0%. This is below the national benchmark of 0.5%.
- There were 0 THR infections in October – December 2021, which gives an infection rate of 0%. The THR rate over the last 4 quarters (October 2020 – October 2021) has remained at 0.0%, which is below the national benchmark of 0.6%.
- The NOF infection rate for October – December 2021 remains at 0.0% and the rate for the last 4 quarters (October 2020 – October 2021) remains at 0.4%, which is below the national benchmark of 1.1%.
- A quality improvement project, led by the Unplanned Care Division, should begin when COVID-19 numbers allow the relevant stakeholders to be involved.
- Thus far, the most common causative organism is Staphylococcus aureus. The Unplanned Care Division has been asked to review the MSSA pre-operative screening process and eradication therapy for all patients to run in parallel with our MRSA detection.
- The pre-operative skin preparation agent of choice will be presented at the product selection group by the Pre-Operative Assessment team.
- A new position of Enhanced Recovery Nurse is being explored and they will play a vital role in enabling patients to contact a medical professional who is comfortable reviewing wounds, rather than having to attend their Primary Care Practitioner.

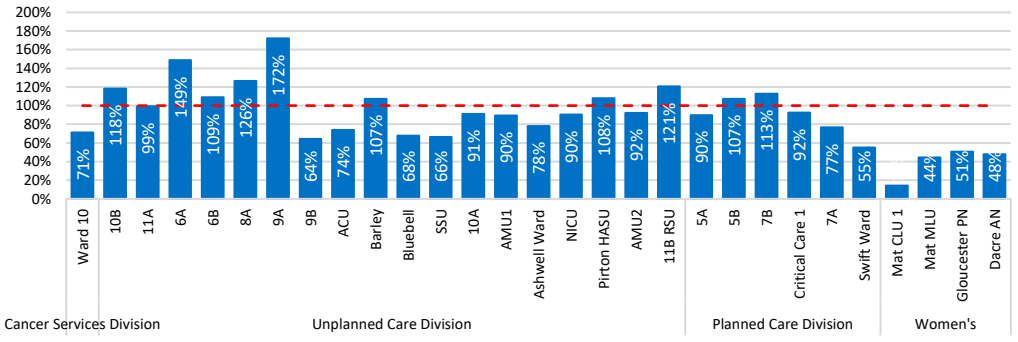
Safer Staffing - Overall fill rate



Staff shortage incidents



Safer Staffing - Supervisory Shift Report - Apr-22



Key Issues and Executive Response

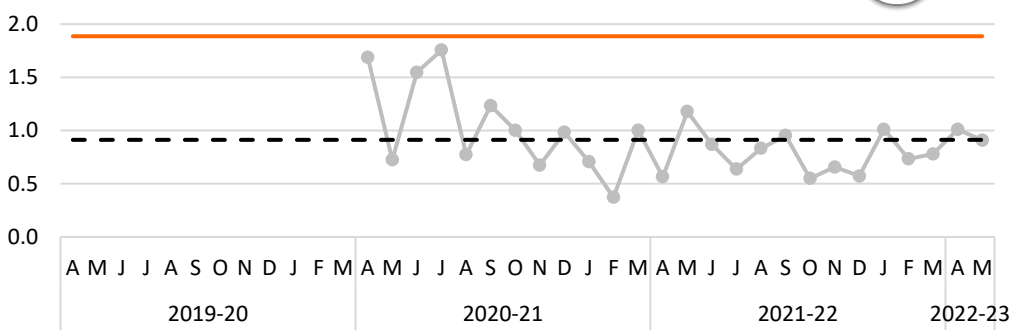
- Fill rates increased overall in May (decrease in CSW fill at night). CHPPD remains static at 7.4. Although we had a slight increase in fill rate we continue to see use of additional beds on Barley, Pirton and Ashwell.
- The number of staffing shortage Datix has reduced for the month of May. Successful international recruitment has delivered a positive RN position. There are still challenges around Clinical support worker recruitment leaving shortfalls in most areas. NHSP CSW development programme has been commenced to support the CSW gaps and a HCSW focus group has been set up.
- Flexible Pool and Rapid Response pools are utilised to support short notice sickness and drop out. If unable to cover all the shortfalls shifts are released to agency on agreement by the head of nursing at the safer staffing meetings.
- Ward managers are rostered 75% supervisory time to provide adequate leadership and support for their department. As part of the safer staffing mitigation ward managers are utilised if supervisory and moved into the clinical numbers when shortfalls happen, or acuity increases. The supervisory shift report shows the amount of supervisory time each department delivered for the month; the supervisory time managers have taken for the month of May has improved across most wards.

Safe Services

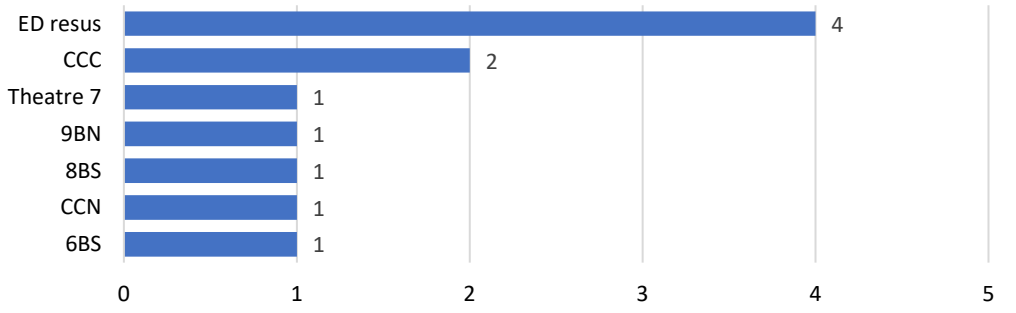
Cardiac Arrests

East and North Hertfordshire NHS Trust

Number of cardiac arrest calls per 1,000 admissions



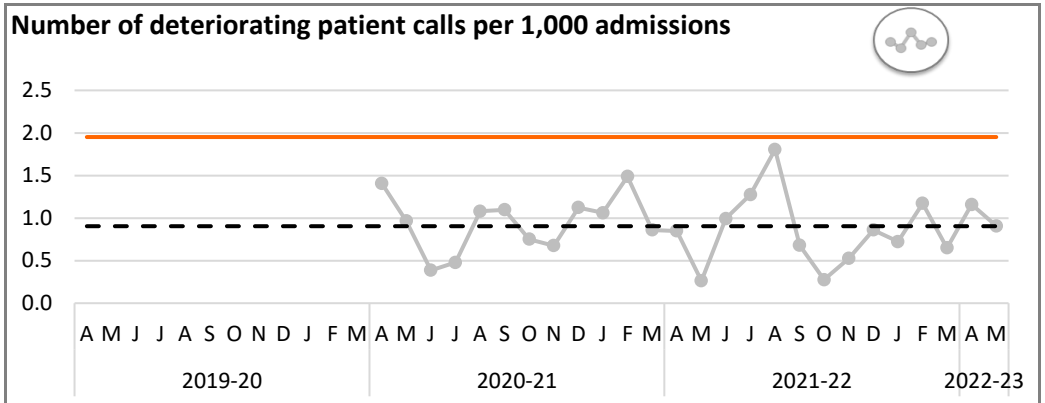
Number of cardiac arrest calls by location - May-22



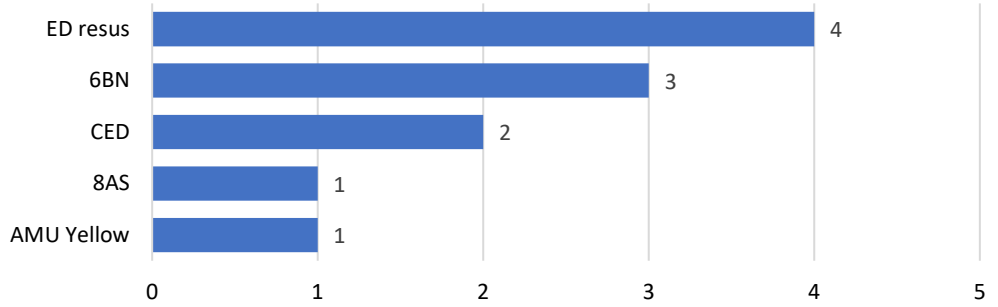
Key Issues and Executive Response

- The trust cardiac arrest rate remains below the national average at 0.9 per 100 admissions.
- Human Factors project has been approved for Launch in July to examine the influencing factors that affect the recognition and management of the deteriorating patient.
- ReSPECT work continues across E&N Herts, this work is done in collaboration with palliative care teams to support the quality of recognising and supporting end of life clinical presentations.

Number of deteriorating patient calls per 1,000 admissions

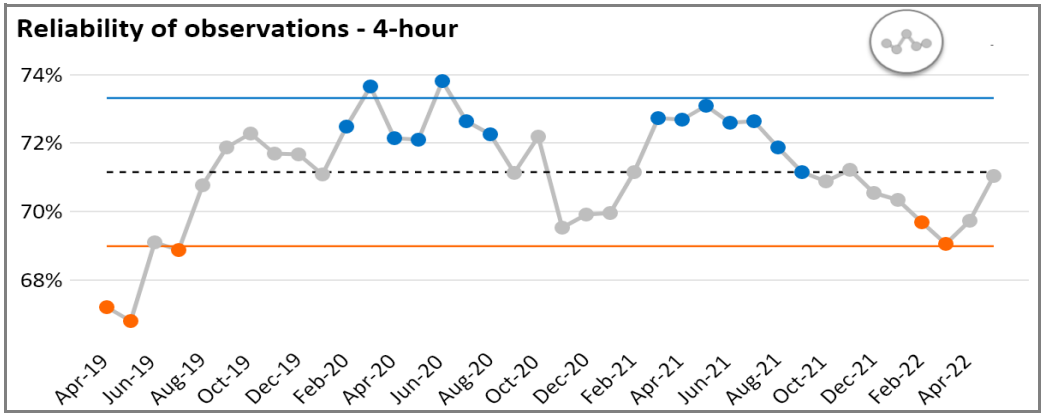


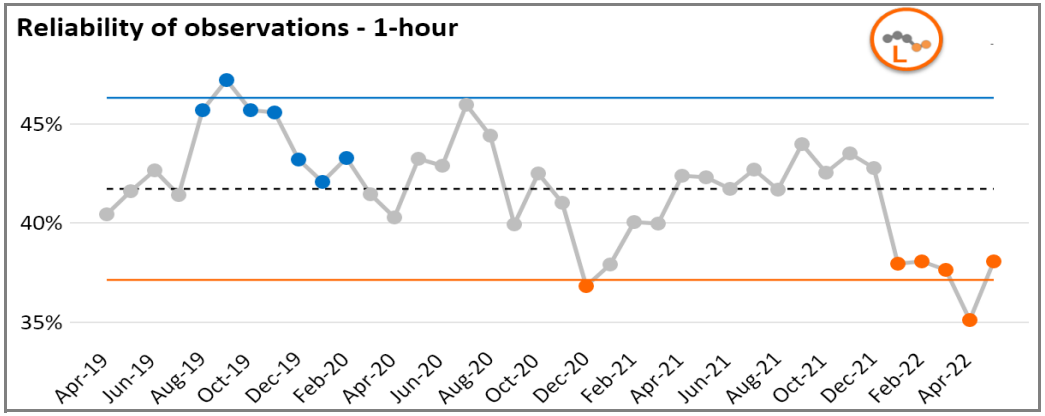
Number of deteriorating patient calls by location - May-22



Safe Services

Deteriorating Patients

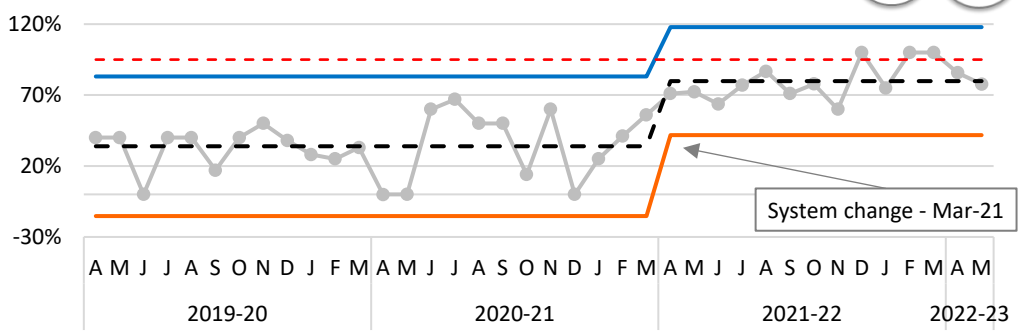




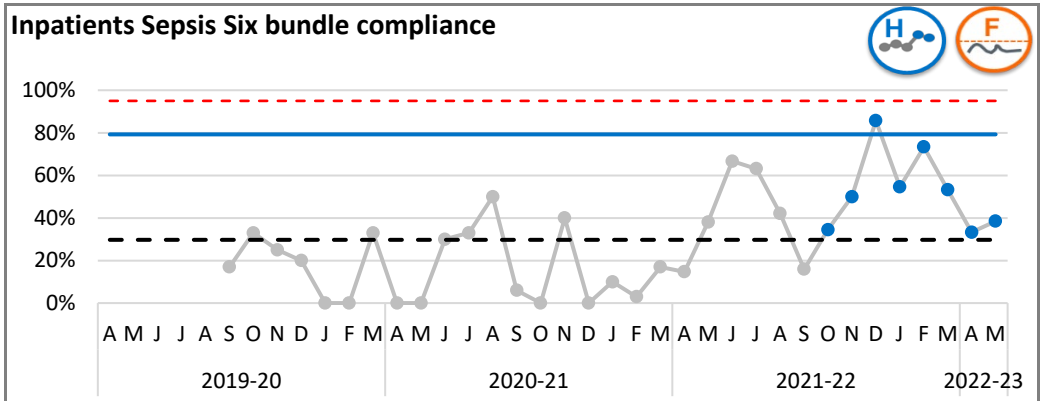
Key Issues and Executive Response

- Continued theme around short staffing versus increased acuity of patients/Opel statuses causing pressure on discharges and flow on wards.
- Audits undertaken leading to imminent launch of project to streamline and support ward level procurement of equipment (non-digital) to undertake physiological observations on patients. This is being managed by QI team and CCOT.
- NEWS2 training now live in the Academy.
- Ward teaching project completed by CCOT with themes fed back. Themes being used to commence work with wards to improve knowledge of the 'whys/hows' of taking observations and prioritisation of jobs - especially at times of short staffing /increased Opel pressures.
- CSW training using BEACH (Bedside Emergency Assessment Course for Healthcare staff). It is recognised that CSW's are now undertaking most of our physiological observations therefore we hope to embed the knowledge/understanding the importance of timely observations and escalation and give them a basic ABCDE of altered physiology leading to deterioration.

Inpatients receiving IVABs within 1-hour of red flag



Inpatients Sepsis Six bundle compliance



Themes

Sepsis IP	2021-22										2022-23	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	69%	89%	53%	52%	54%	54%	85%	70%	79%	75%	55%	93%
IV antibiotics	64%	77%	87%	73%	72%	72%	100%	75%	100%	100%	86%	83%
IV fluids	80%	83%	86%	64%	60%	60%	100%	71%	67%	80%	50%	90%
Lactate	75%	79%	53%	46%	52%	52%	85%	70%	62%	55%	50%	86%
Urine measure	70%	79%	42%	16%	59%	59%	82%	67%	58%	50%	42%	60%

Key Issues and Executive Response

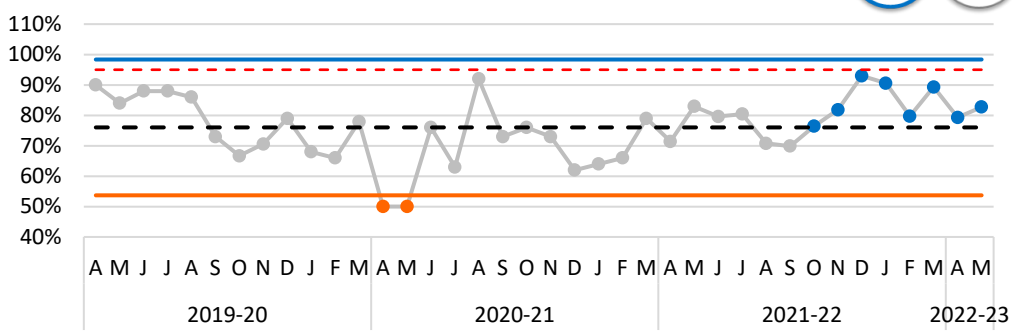
Themes

- Significant increase in compliance to blood culture collection, IV fluid administration, and lactate measurement within the hour of Red Flag Sepsis Triggers.
- IV antibiotics administration has remained within the target of less than 60 minutes from Red Flag Sepsis Triggers.
- The Sepsis Team started to have weekend shifts from 08:00 to 18:00 to support a 7-day cover and assist the ED and IP areas in the delivery of Sepsis 6.

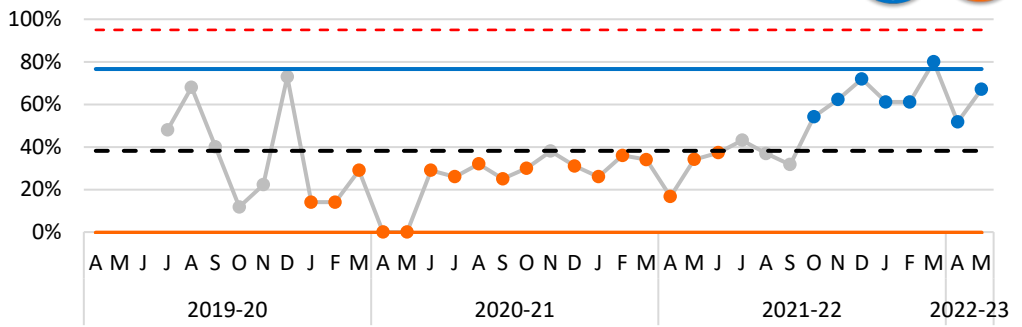
Response

- The Sepsis Team is still continuously running virtual Sepsis Teaching to IP areas.
- The Sepsis Team has completed the Sepsis E-Learning to be uploaded in the ENH Academy and is now awaiting full approval.
- The Sepsis Team will start a face-to-face Fluid Balance Teaching to IP wards.
- The team will start making a quick video regarding fluid balance and sent it to the Clinical Practice Team to be converted into a QR code for quick access.

ED attendances receiving IVABs within 1-hour of red flag



ED attendance Sepsis Six bundle compliance



Themes

Sepsis ED	2021-22										2022-23	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Oxygen	90%	95%	100%	100%	95%	94%	100%	95%	100%	100%	100%	100%
Blood cultures	86%	78%	74%	52%	88%	93%	95%	88%	93%	90%	86%	89%
IV antibiotics	80%	80%	71%	73%	76%	82%	93%	91%	80%	89%	79%	83%
IV fluids	85%	78%	77%	64%	85%	98%	98%	98%	86%	90%	95%	86%
Lactate	92%	92%	94%	46%	80%	76%	93%	100%	87%	98%	87%	97%
Urine measure	49%	48%	45%	45%	64%	71%	76%	61%	76%	90%	69%	79%

Key Issues and Executive Response

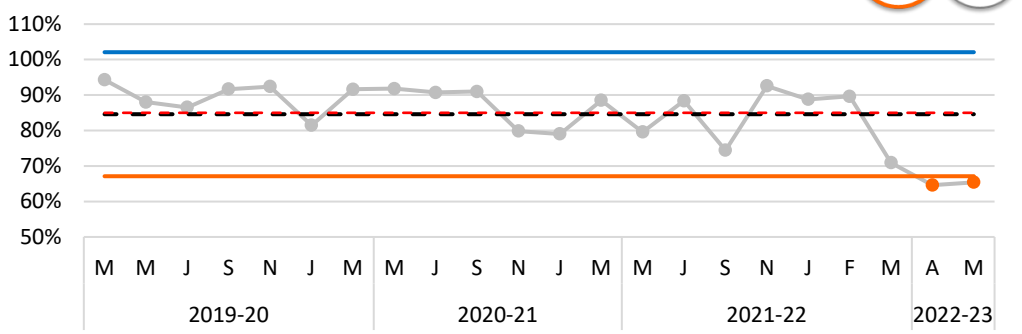
Themes

- IV antibiotic administration has remained within the target time of less than or within 60 minutes from Red Flag Sepsis Triggers.

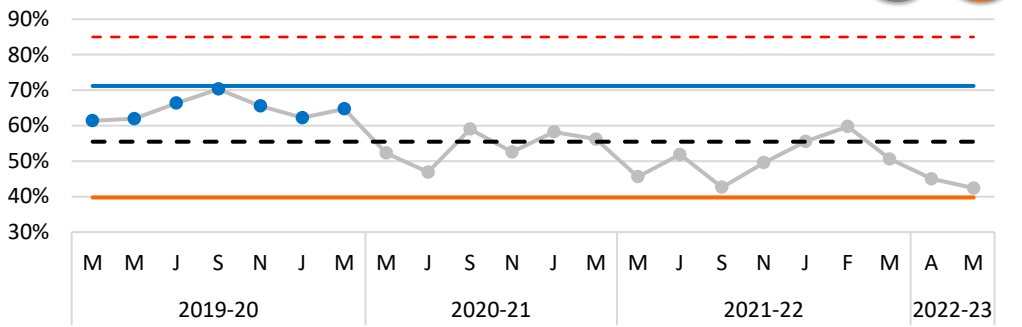
Response

- The team is in communication with Practice Development Nurse (PDN) of ED and trainings are in place for newly qualified staff. The team is still waiting for confirmation from the ED Practice Development Team.
- The Sepsis Team has been continuously supporting ED by being clinically visible when a Septic patient is identified.
- The team assists the staff in completing the Sepsis 6 within an hour.

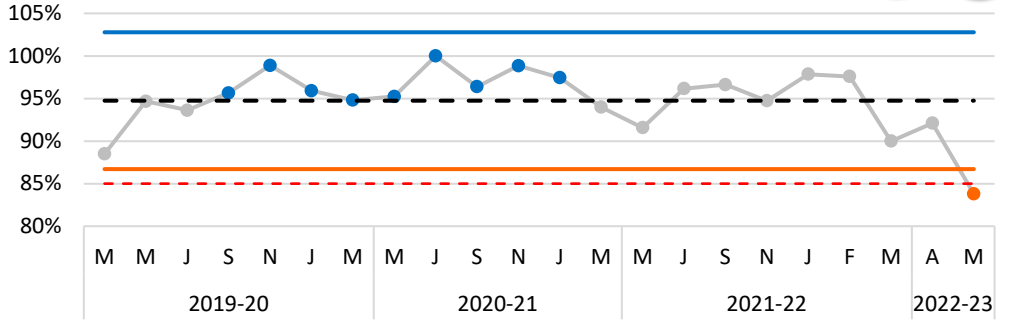
VTE risk assessment stage 1 completed



VTE risk assessment for stage 2, 3 and / or 4



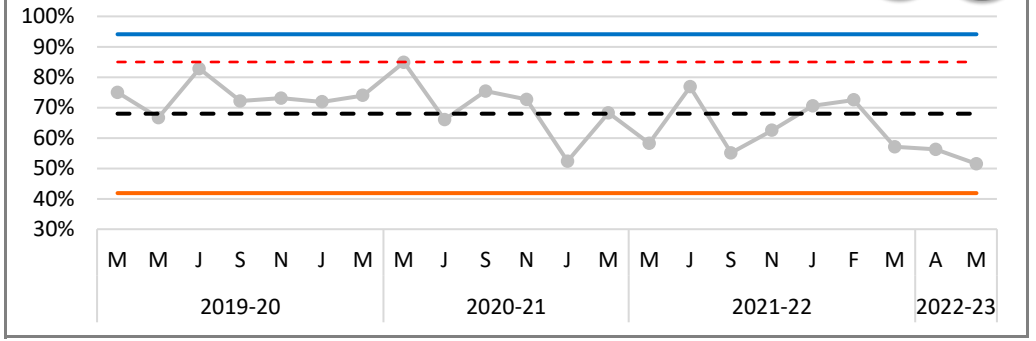
Correct low molecular weight heparin prescribed & documented



Key Issues and Executive Response

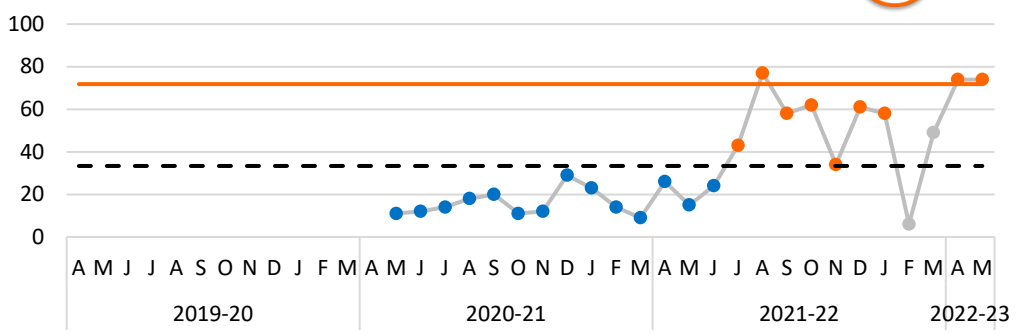
- ePMA rolled out across all adult in-patient medical and surgical wards during March 2022. From April 2022 data demonstrates full impact of the roll out on VTE risk assessments.
- Continue work on embedding ePMA into clinical practice & the utilisation of the clinical indicator page within Lorenzo.
- Review the possibility of digital VTE assessment flags in NerveCentre.
- Establish if retrospective data capture from Lorenzo is possible for improved audit data.
- Review VTE digital options appraisal at 3 months post ePMA.
- Progression towards the appointment of a VTE consultant - strengthen clinical leadership.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Continue to monitor training figures for VTE and report the results at Thrombosis Action Group .
- Continue the on-going ward focused quality improvement work.
- Continue to improve patient engagement and review VTE patient information during admission and on discharge.

TED stockings correctly prescribed and documentation of fitted

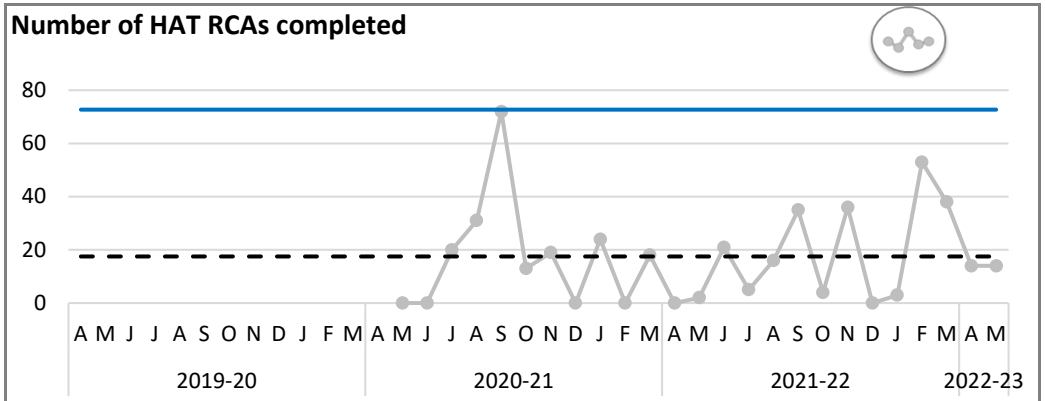


Hospital-Acquired Thrombosis (HAT)

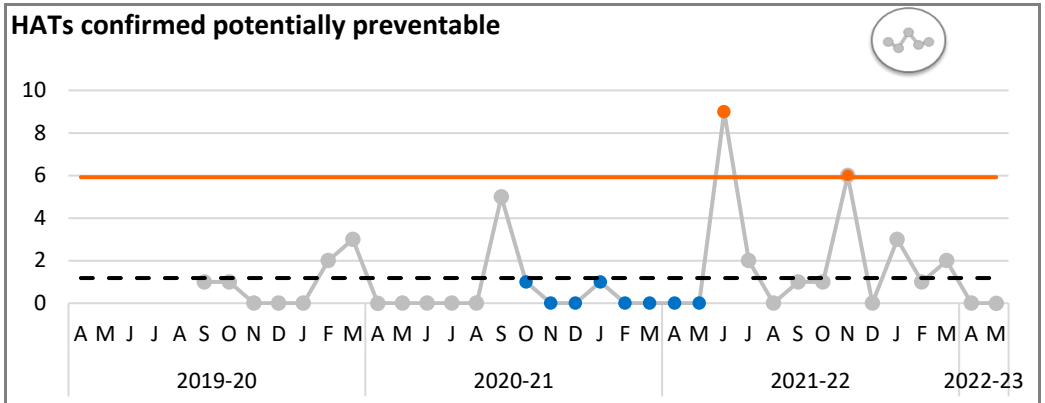
Number of HAT RCAs in progress



Number of HAT RCAs completed



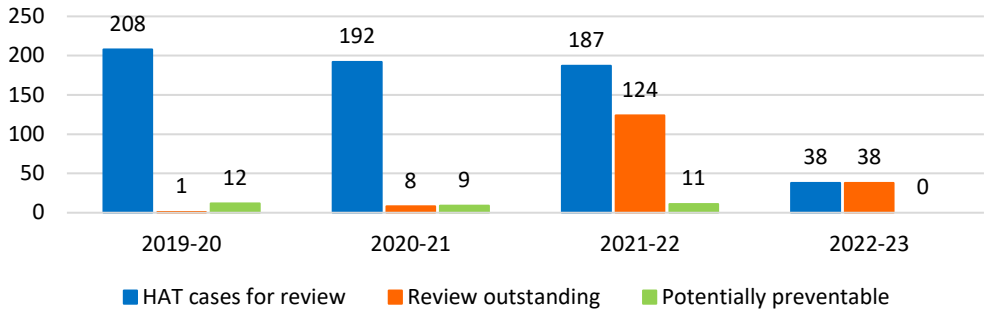
HATs confirmed potentially preventable



Key Issues and Executive Response

- Cleared the backlog of outstanding HATs requiring review, this has contributed to increased number of HAT RCAs in progress and therefore increased the number that have been completed.
- Expect the monthly variation to narrow now the backlog of RCAs has been cleared.
- Rapid review of HATs has allowed learning to be identified quicker and actions implemented in a timelier manner.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Continue progression towards a VTE/Thrombosis consultant - strengthen clinical leadership.

Annual HAT review prevalence

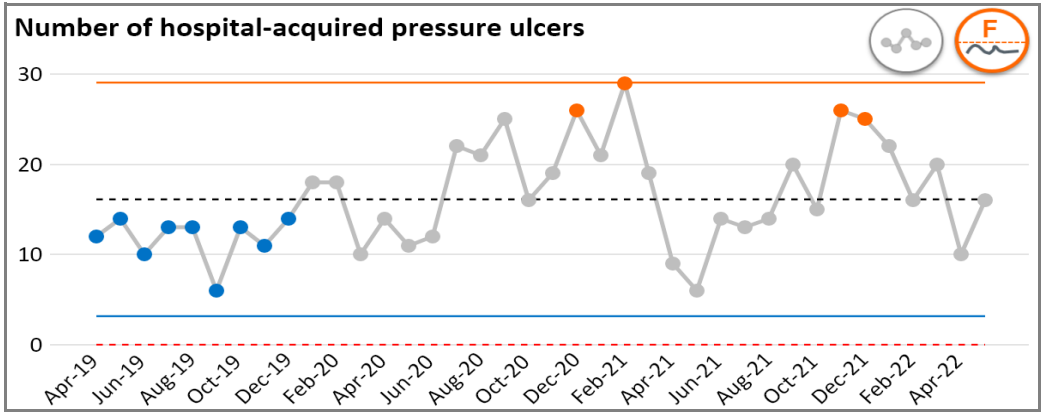


Safe Services

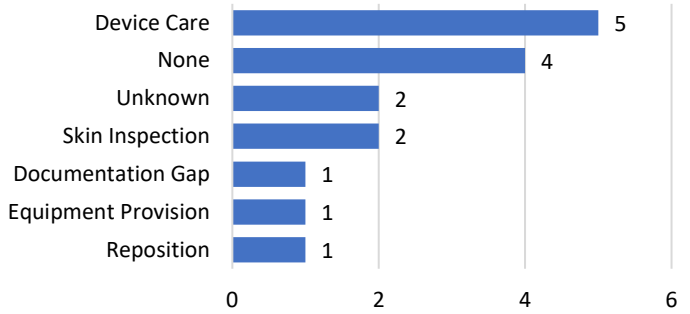
Pressure Ulcers

East and North Hertfordshire NHS Trust

Number of hospital-acquired pressure ulcers



Themes - May-22



293

days since last category 4

as at 24/06/2022

Key Issues and Executive Response

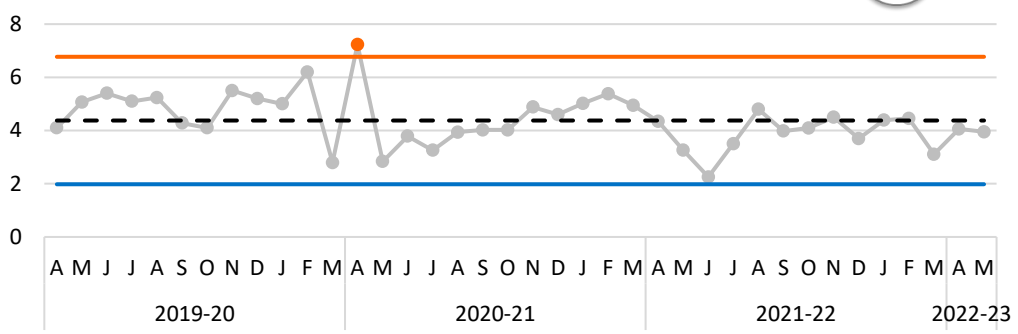
- Completion of digital waterlow assessment within 6 hours of admission is an improvement priority
- Lack of repositioning as main theme of learning reviews.
- TVN working supporting the design and implementation of pressure ulcer documentation to be digitalised.
- TVN auditing staff knowledge check of PU prevention, focusing on wards with highest number and then expanding to other areas.
- Focus on decreasing the number of heel SDTI.

Safe Services

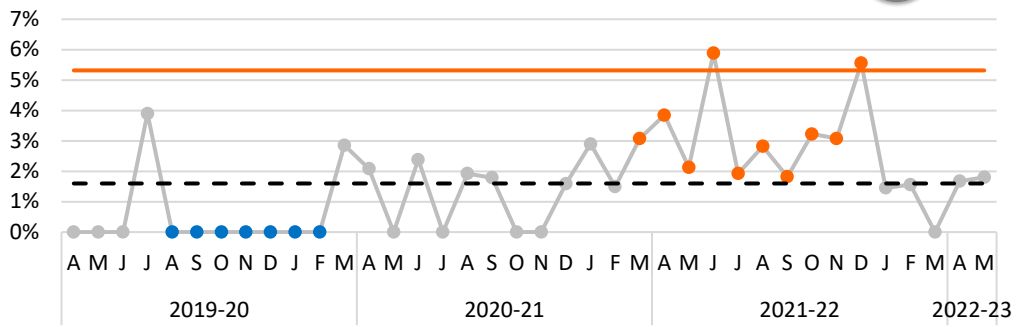
Patient Falls

East and North Hertfordshire NHS Trust

Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm

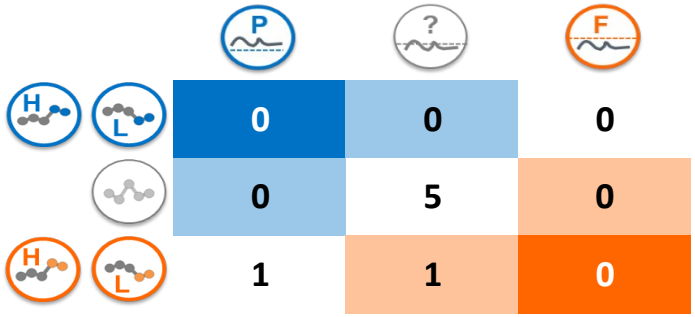


Key Issues and Executive Response

- Inpatient falls data remains to show common cause variation.
- Learnings identified from round table discussion ongoing.
- Falls training being arrange with doctors and AHP, supporting wards with baywatch compliance.
- QI in AMU1 ongoing. We are currently finalising falls poster to be trialled in AMU1 as part of the project.
- Falls prevention documentation currently being pilot looking at trust-wide launch in July.

Caring Services

Month 02 | 2022-23



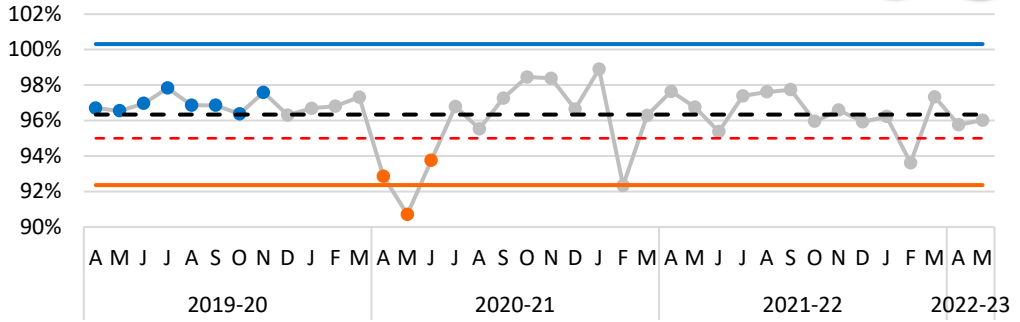
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Friends and Family Test	Inpatients positive feedback	May-22	95%	96.0%			Common cause variation Metric will inconsistently pass and fail the target
	A&E positive feedback	May-22	90%	90.0%			Nine points below the lower process limit Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	May-22	93%	100.0%			Metric unsuitable for SPC analysis
	Maternity Birth positive feedback	May-22	93%	95.2%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Postnatal positive feedback	May-22	93%	93.3%			Common cause variation Metric will inconsistently pass and fail the target
	Maternity Community positive feedback	May-22	93%	100.0%			Metric unsuitable for SPC analysis
	Outpatients FFT positive feedback	May-22	95.0%	96.5%			Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	May-22		267			Common cause variation No target
Complaints	Number of written complaints received in-month	May-22		35			Common cause variation No target
	Number of complaints closed in-month	May-22		96			Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	May-22	75%	93.3%			Two points below the lower process limit Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	May-22	80%	55.2%			Six points below the mean Metric will inconsistently pass and fail the target

Caring Services

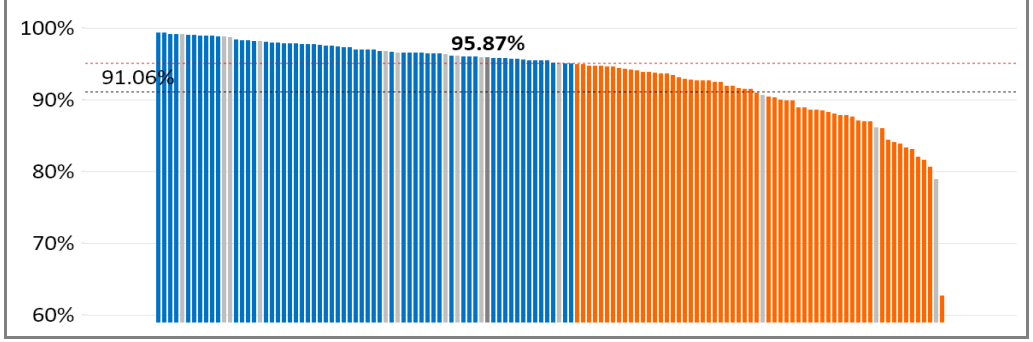
Friends and Family Test

East and North Hertfordshire NHS Trust

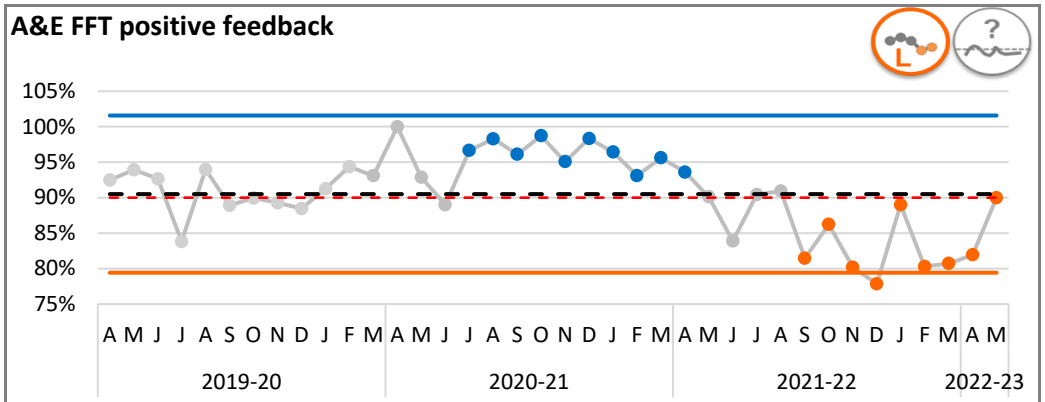
Inpatients FFT positive feedback



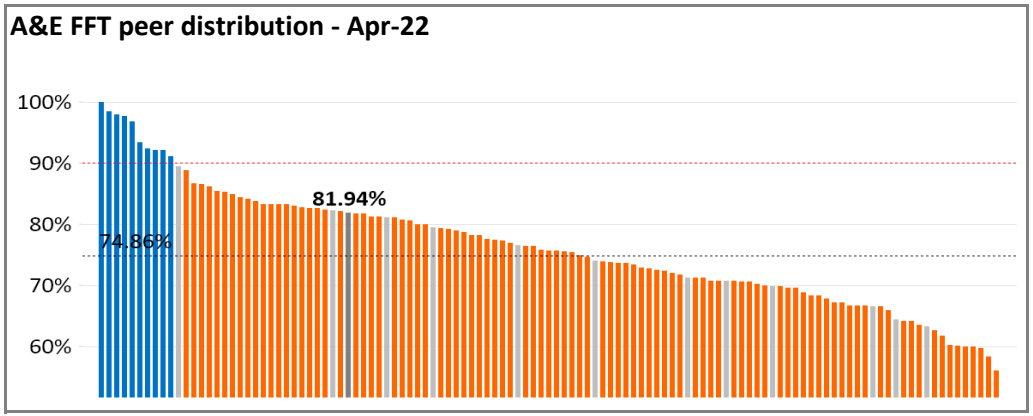
Inpatients FFT peer distribution - Apr-22



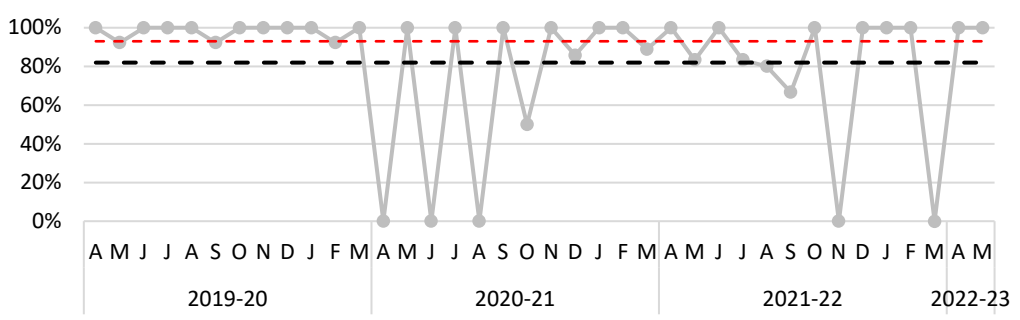
A&E FFT positive feedback



A&E FFT peer distribution - Apr-22



Maternity Antenatal FFT positive feedback



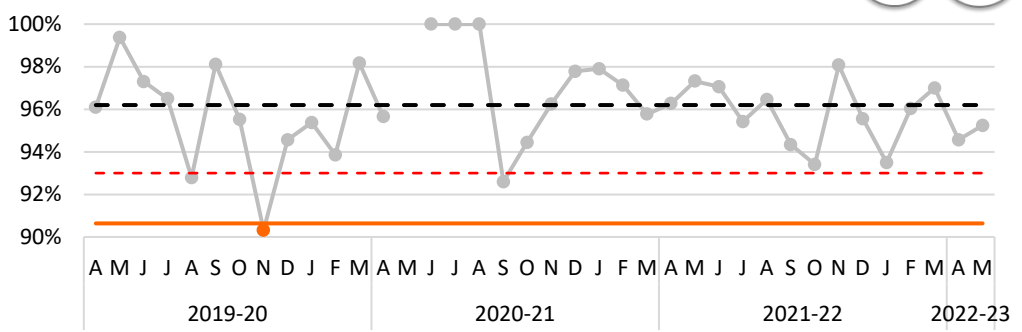
Maternity Antenatal FFT peer distribution - no ENHT data in Apr-22

Caring Services

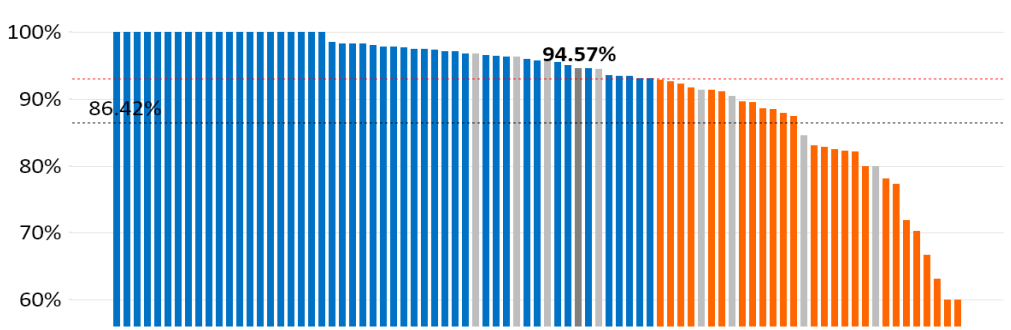
Friends and Family Test

East and North Hertfordshire NHS Trust

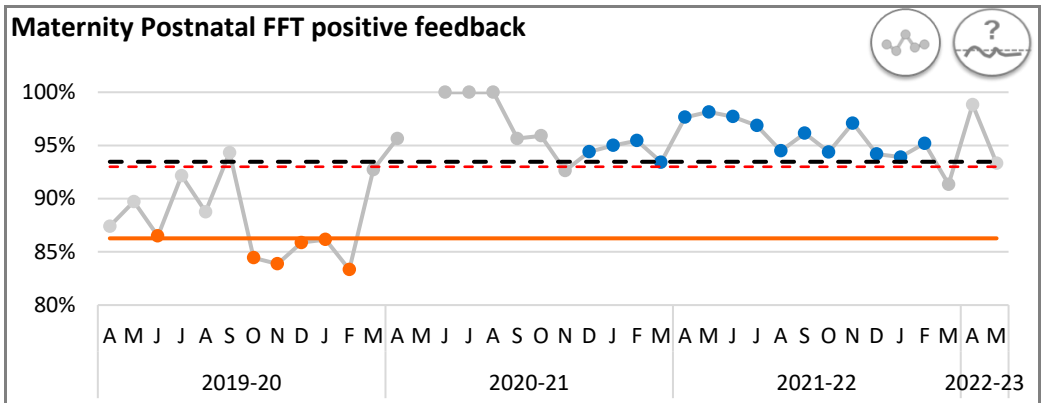
Maternity Birth FFT positive feedback



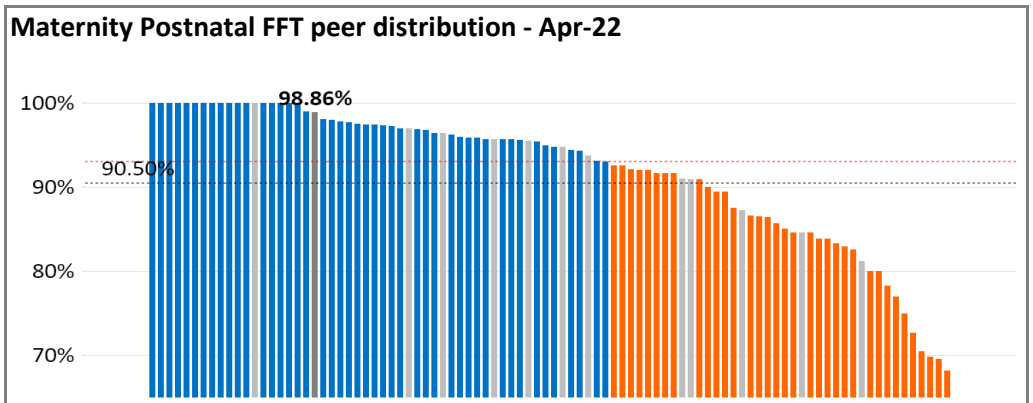
Maternity Birth FFT peer distribution - Apr-22



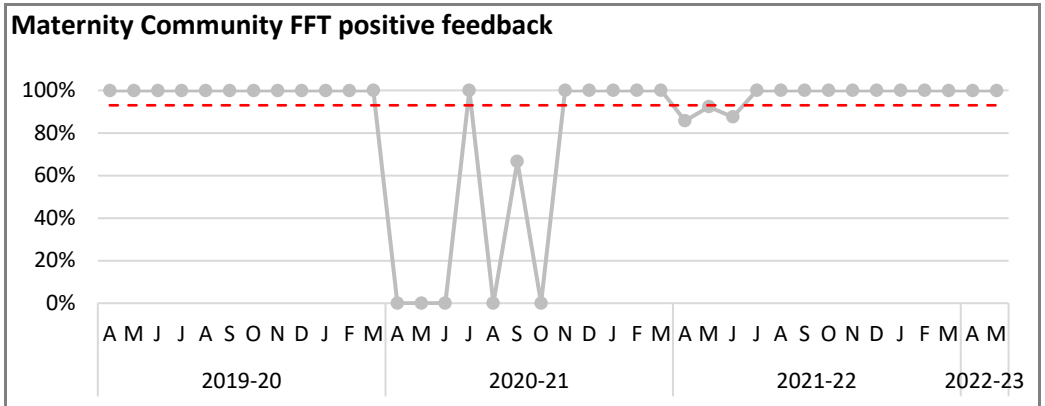
Maternity Postnatal FFT positive feedback



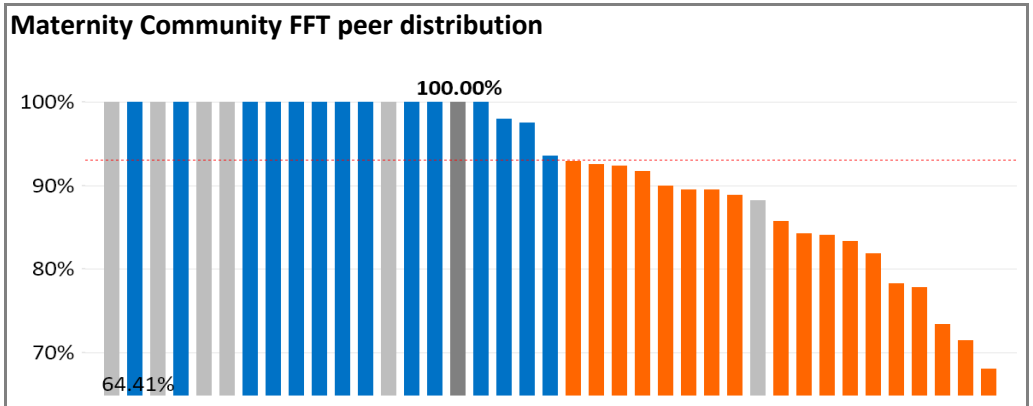
Maternity Postnatal FFT peer distribution - Apr-22



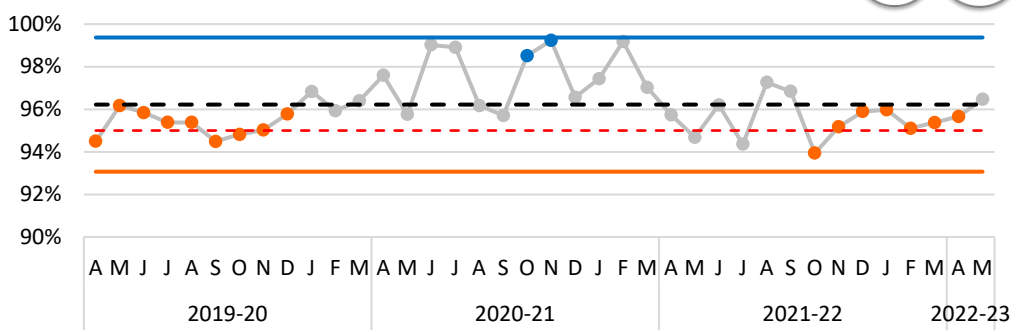
Maternity Community FFT positive feedback



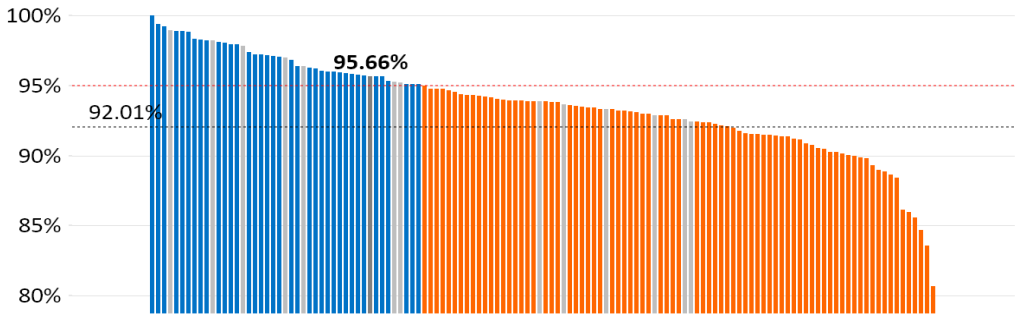
Maternity Community FFT peer distribution



Outpatients FFT positive feedback



Outpatients FFT peer distribution - Apr-22



Key Issues and Executive Response

Excellence

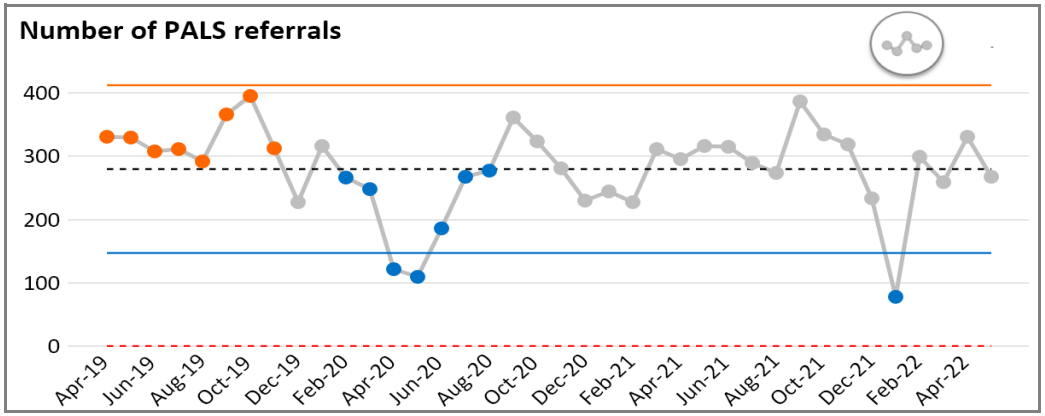
- IQVIAs contract ends the 30th June and as such all feedback will be transferred over to ENHance (InPhase), which will allow services to review their feedback in an easier dashboard.

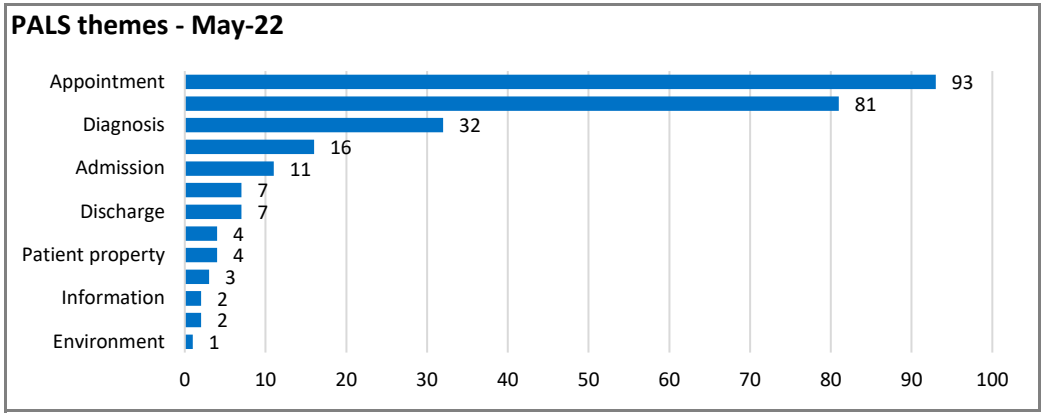
Challenges

- Continuing to promote the surveys to all who use our services.

Actions

- Looking into SMS FFT surveys being sent, if this is feasible by ENHance and what the costs would be.
- Working with communications to see if QR codes can included in discharge letters etc.





Key Issues and Executive Response

Excellence

- Team continue to manage the large number of queries.

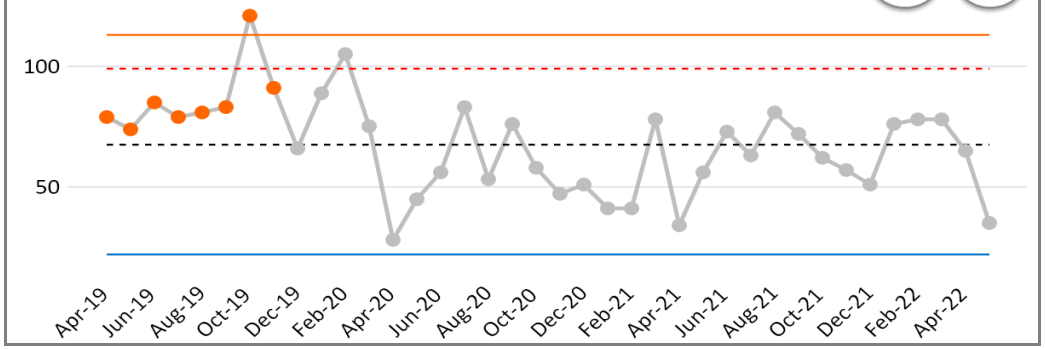
Challenges

- Reduced workforce capacity within the PALS team.
- High volume of concerns around appointments, delays and waiting lists.
- Unable to manage the amount of traffic in generic inbox - 14 working days has been set as a response time and has been included in the automatic email response.
- PALS concerns raised around my planned care and the wrong times on the website compared to the times they are being told.

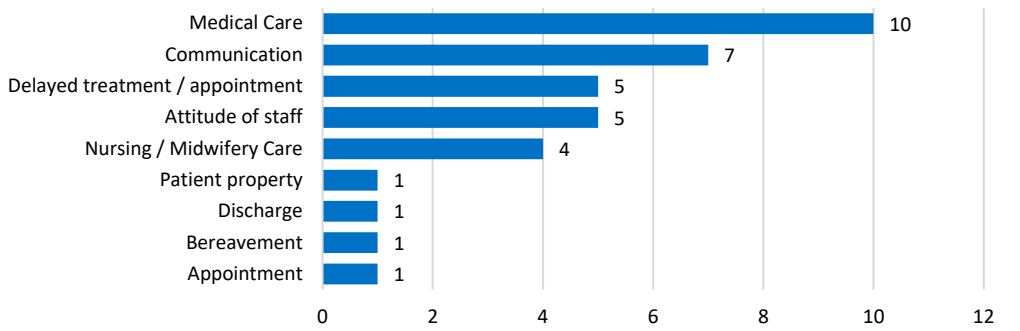
Actions

- Continue to promote staff to resolve concerns in the first instance instead of passing straight over to the PALS team.
- Explore further with the team who manage my planned care data within the Trust.

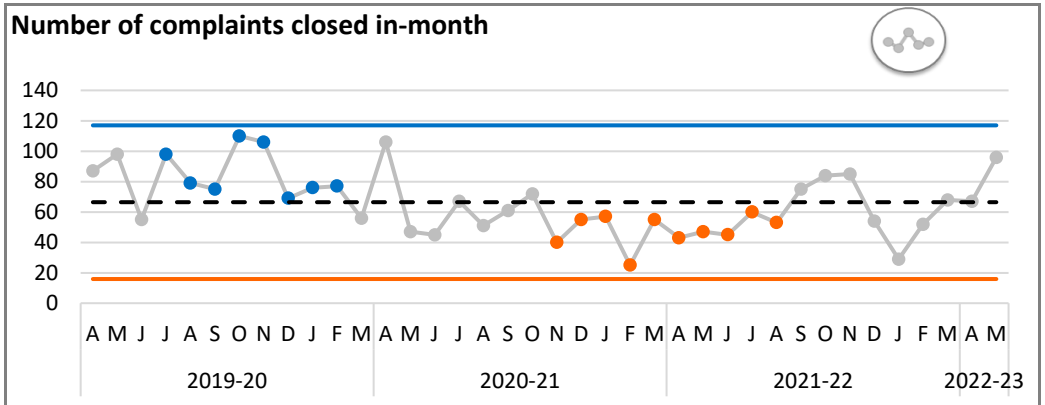
Number of written complaints received



Complaints themes - May-22



Number of complaints closed in-month



Key Issues and Executive Response

Excellence

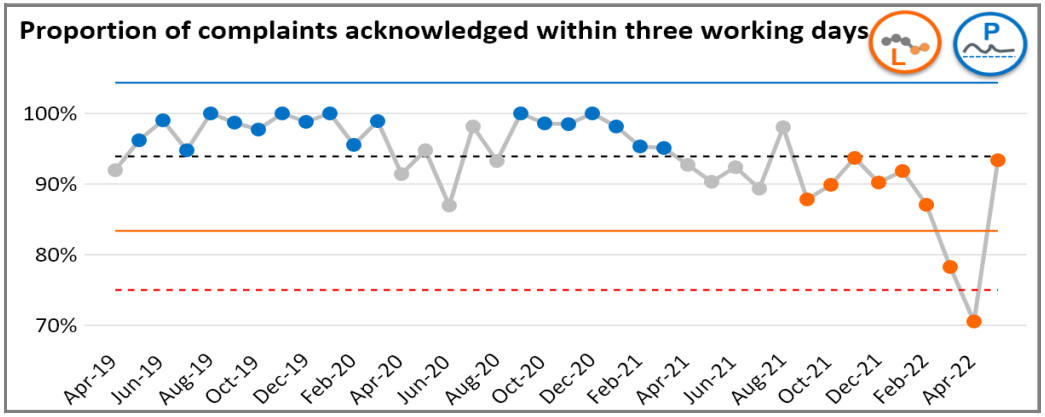
- Acknowledgment response rate has increased to the Trusts target, and the team will continue to strive to 100% compliance.
- 96 formal complaints closed in-month.

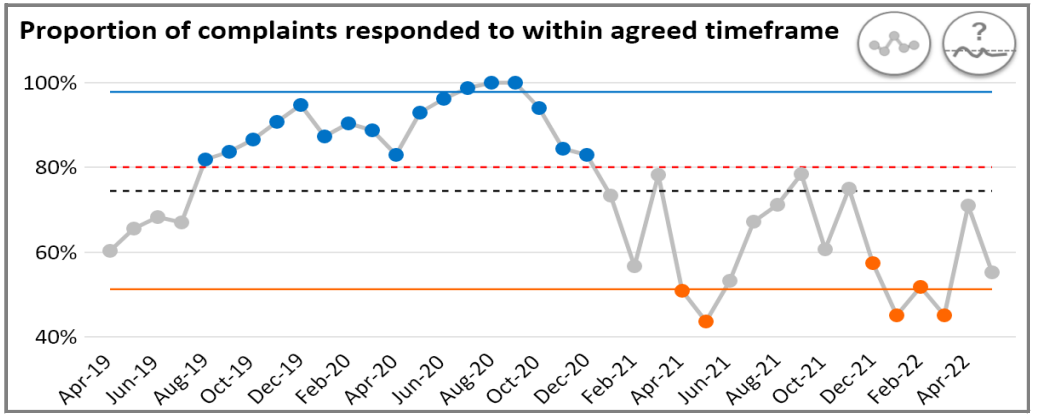
Challenges

- Reducing the number of outstanding complaints responses is a priority. The team are balancing resolving the older complaints with also responding to the newer ones promptly.
- Delays within divisions with completing investigations.
- Two complaints handlers' secondments are now ending - capacity in the team being reviewed.
- The delay in complaints going to SIRP for review - complainants unhappy with the wait for a way forward.
- The number of complaints responded to within the timeframe has decreased due to older cases taking priority to close.

Actions

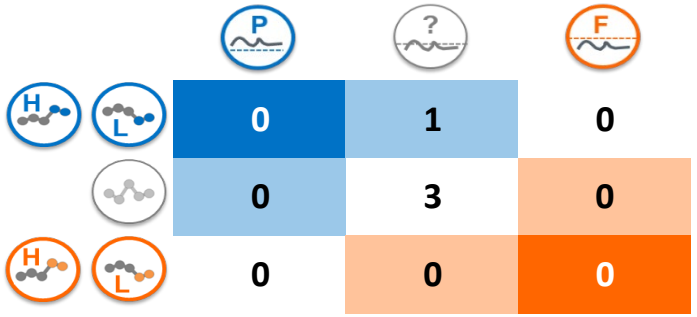
- Team continues to prioritise oldest complaints, with escalation reports being sent to divisions.
- New SIRP spreadsheet will be created to monitor cases closer and escalate on a weekly basis.


Proportion of complaints acknowledged within three working days
L
P
100%
90%
80%
70%
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22


Proportion of complaints responded to within agreed timeframe
?
100%
80%
60%
40%
Apr-19
Jun-19
Aug-19
Oct-19
Dec-19
Feb-20
Apr-20
Jun-20
Aug-20
Oct-20
Dec-20
Feb-21
Apr-21
Jun-21
Aug-21
Oct-21
Dec-21
Feb-22
Apr-22

Effective Services

Month 02 | 2022-23



Effective Services

Summary

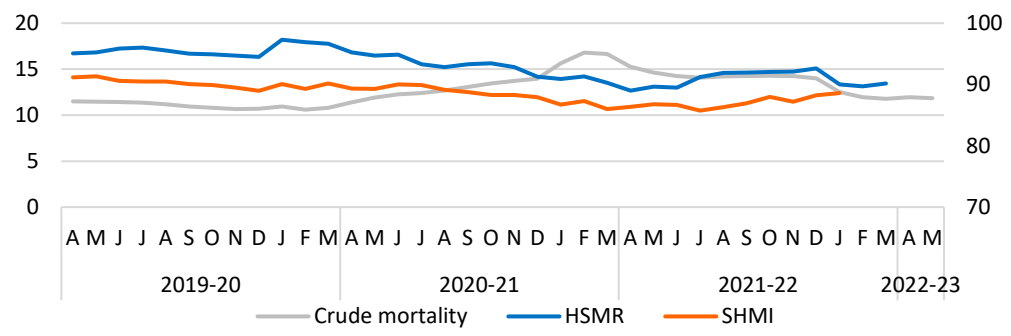
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Mortality	Crude mortality per 1,000 admissions In-month	May-22	12.8	11.0			Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	May-22	12.8	11.8			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Mar-22	100	96.8			Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Mar-22	100	90.2			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Jan-22	100	91.1			Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Jan-22	100	88.6			Rolling 12-months - unsuitable for SPC
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Apr-22	n/a	640			Eight consecutive points below the mean No target
	Rate of emergency re-admissions within 30 days of discharge	Apr-22	9.0%	7.2%			Ten consecutive points below the mean Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Apr-22	n/a	79.2%			Common cause variation No target
	Individualised care pathways	Apr-22	n/a	31			Common cause variation No target

Effective Services

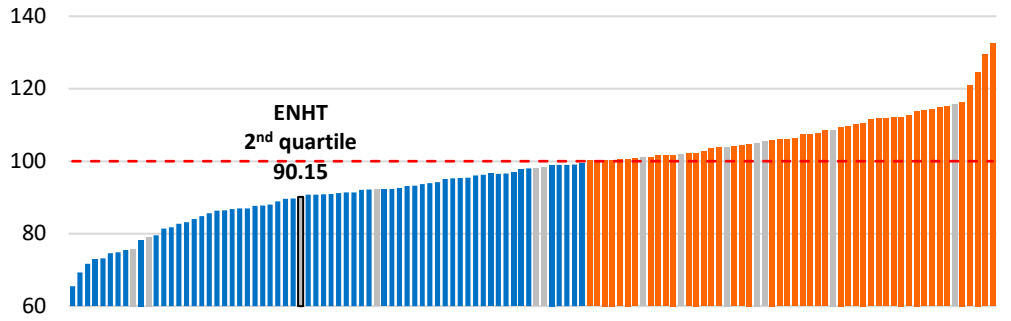
Mortality Summary

East and North Hertfordshire NHS Trust

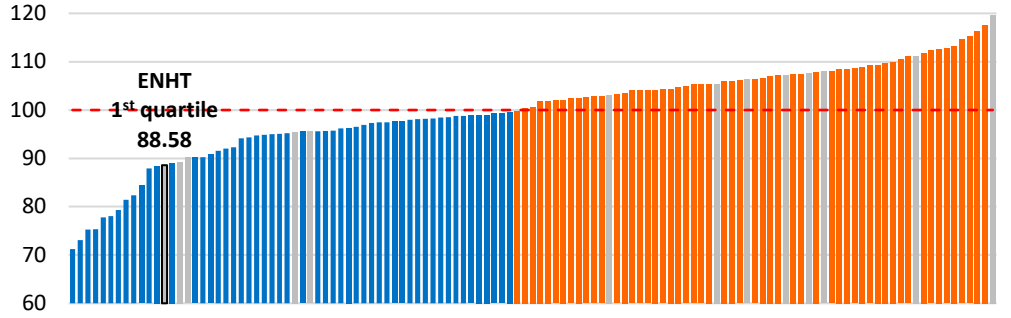
Mortality metric comparison - rolling 12-months



HSMR peer distribution - Mar-22



SHMI peer distribution - Jan-22



Key Issues and Executive Response

COVID-19

- To date CHKS analysis of our COVID-19 mortality has shown the Trust to be centrally placed in comparison to the national peer group with mortality tracking in line with the national trend.
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital.

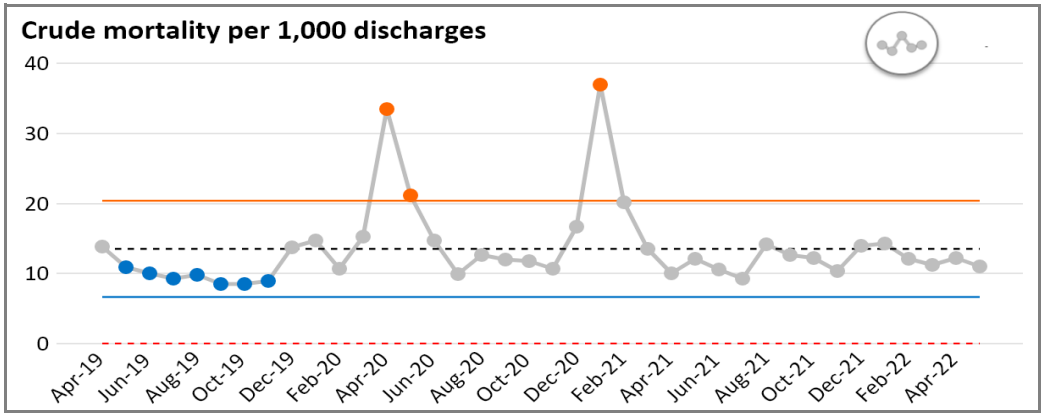
Learning from Deaths

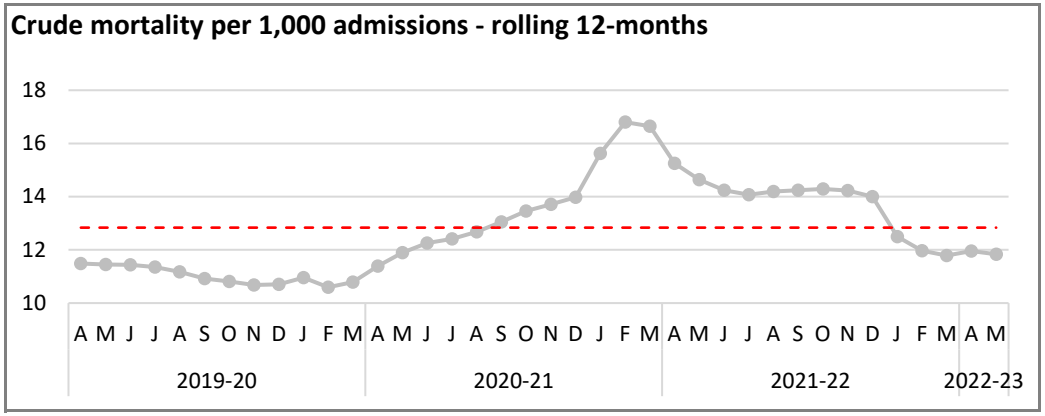
- Reforms are underway regarding the Trust's learning from deaths framework, including the adoption of a SJR Plus Review format, developed by NHSE/I's 'Better Tomorrow' platform. Reforms will include the reduction in the number of reviews undertaken, with the focus being on gaining richer learning from the process.
- The SJR Plus review format, soon to be adopted by the Trust, is very different to our existing review tool. Its adoption provides an opportunity to revisit our boarder learning from deaths processes, to take into account recent and imminent changes in the fields of scrutiny, quality and governance, including the introduction of the Medical Examiner function and the forthcoming introduction of the new PSIRF approach to patient safety. Further news will follow over the coming months.

Mount Vernon

- The secession of MVCC as part of the Trust, will affect both our HSMR and SHMI. In preparation for the split, we will shortly begin to report these metrics showing the anticipated effect of the loss of MVCC.

Crude Mortality





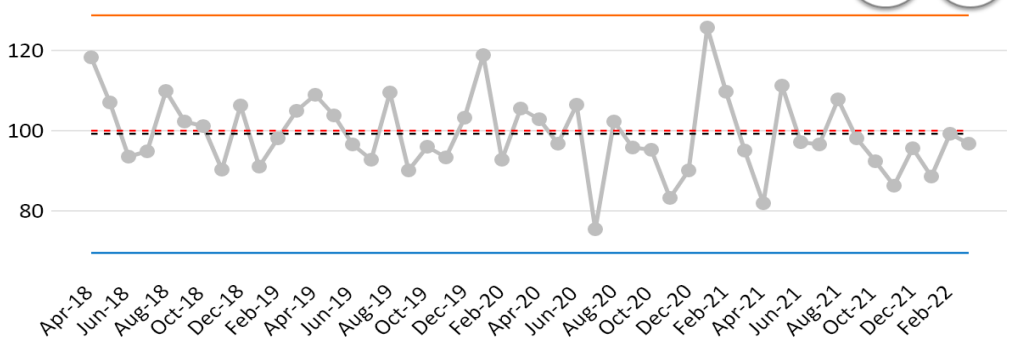
Key Issues and Executive Response

- Crude mortality is the factor with the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric.
- The general improvements in mortality prior to the COVID-19 resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work. Of particular importance has been the continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average, with rolling 12-month crude consistently tracking below national.

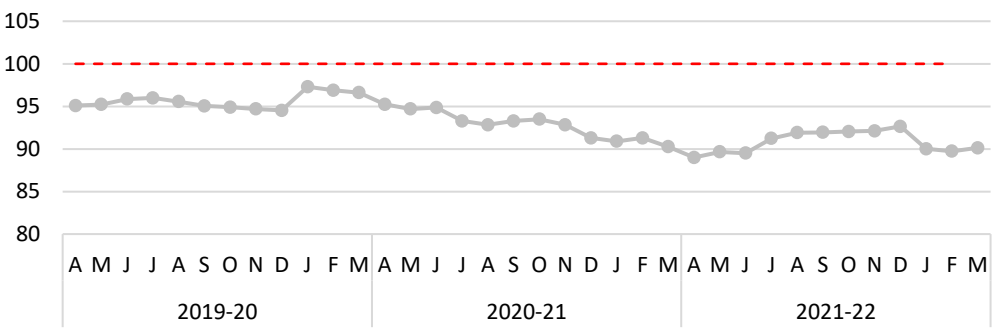
Effective Services

Hospital Standardised Mortality Ratio (HSMR)

HSMR - Hospital Standardised Mortality Ratio



HSMR - rolling 12-months



HSMR - mortality alerts Mar-21 to Feb-22

CCS Group	Deaths	Value	Alert	Description
101 - Coronary atherosclerosis and other heart disease	10	376.1	R	3-sigma breach in Mar-22

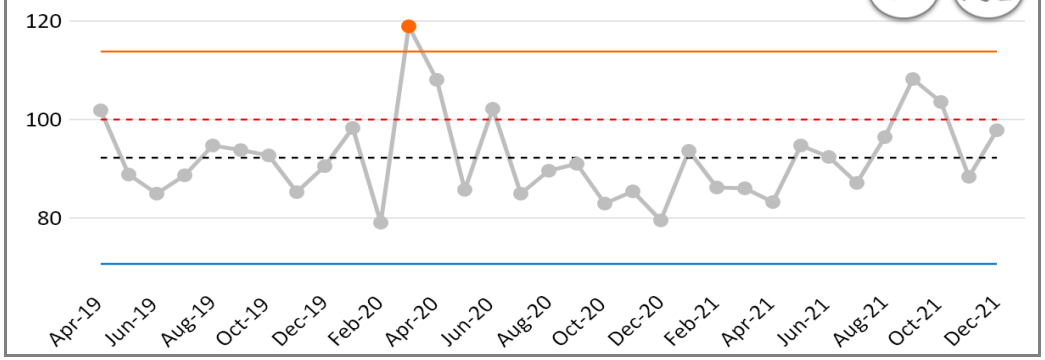
Key Issues and Executive Response

- The latest CHKS refresh providing rolling 12-month data to March 2022 shows a slight increase in HSMR from 89.72 to 90.15.
- Rolling 12-month HSMR has remained stable.
- Following the National Hip Fracture Database 3SD outlier alert for #NOF mortality (for the period Jan-Dec 2020) work has continued on the remedial action. The Service reports that a key remaining impediment to improvement is timely access to theatre. Following escalation to the Quality & Safety Committee, a multidisciplinary meeting, led by the Medical Director, is planned for early July.
- Unfortunately, the National Hip Fracture Database has yet to update its risk adjusted mortality beyond December 2020, making the impact of our improvement work unclear.
- The Head of Coding has confirmed that the coding of the deaths underpinning the HSMR CUSUM alert for coronary atherosclerosis was correct. At May Mortality Surveillance Committee it was agreed that coding of this diagnosis group would continue to be monitored by Cardiology/Head of Coding on a monthly basis, with an update to the Committee in 6 months.

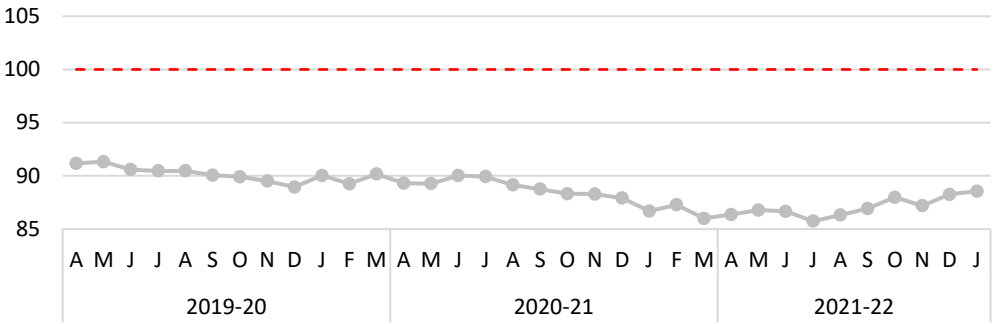
Effective Services

Summary Hospital-level Mortality Index (SHMI)

SHMI - Summary Hospital-level Mortality Indicator



SHMI - rolling 12-months



SHMI - mortality alerts Feb-21 to Jan-22

SHMI Group	Deaths	Value	Alert	Description
58 - 101: Coronary atherosclerosis and other heart disease	10	267.36	R	3-sigma breach in Jan-22
61-104: Other and ill-defined heart disease	2	856.5	R	3-sigma breach in Jan-22
87 - 143: Abdominal hernia	11	256.3	R	3-sigma breach in Jan-22
107 - 197: Skin and subcutaneous tissue infections	30	178.0	R	3-sigma breach in Jan-22
108 - 198, 199, 200: Skin disorders	27	239.0	R	3-sigma breach in Jan-22

Key Issues and Executive Response

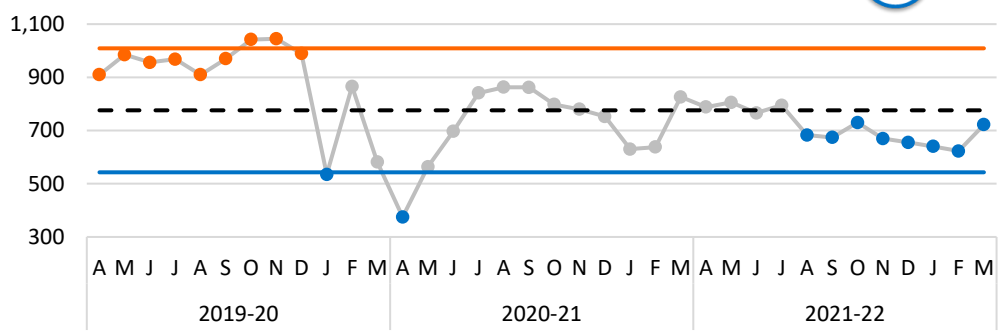
- The latest in-month position for January 2022 reported by CHKS shows common cause variation.
- Latest published rolling 12-month SHMI to January 2022, shows a marginal increase from 88.26 to 88.58.
- While there has been a gradual upward trend in the rolling 12-month SHMI position over recent months, the metric remains stable and in the 'lower than expected' range.
- All SHMI alerts are discussed by the Mortality Surveillance Committee.
- They are considered in conjunction with other metrics and current performance information.
- Where further review is deemed appropriate, this starts with a Coding review. The detail of this is used to determine the need for further action, potentially involving a clinical review of the deaths underpinning the alert, or joint remedial work between coding and the clinical specialty.

Effective Services

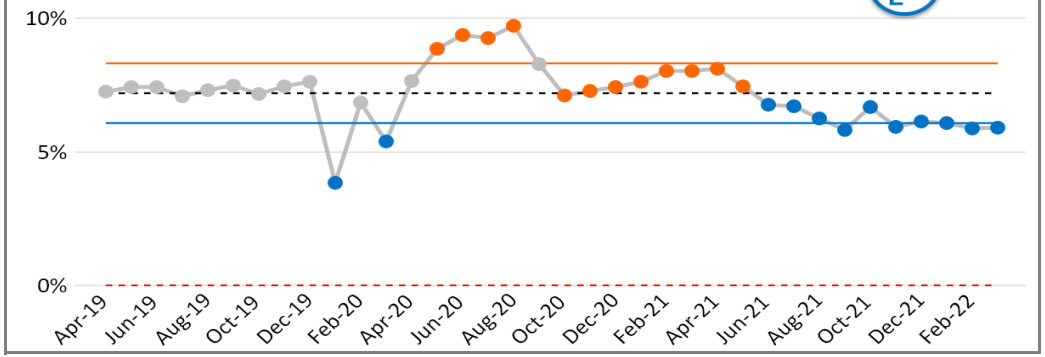
Emergency Re-admissions

East and North Hertfordshire NHS Trust

Number of emergency re-admissions within 30 days of discharge



Emergency re-admissions within 30 days



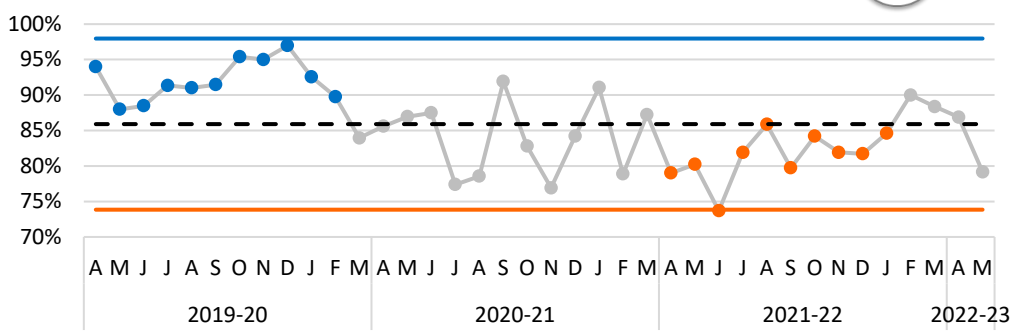
Key Issues and Executive Response

- The Trust's re-admission rate has generally been consistent with national performance.
- Recent months have seen performance improve, with the Trust consistently tracking below the national average.

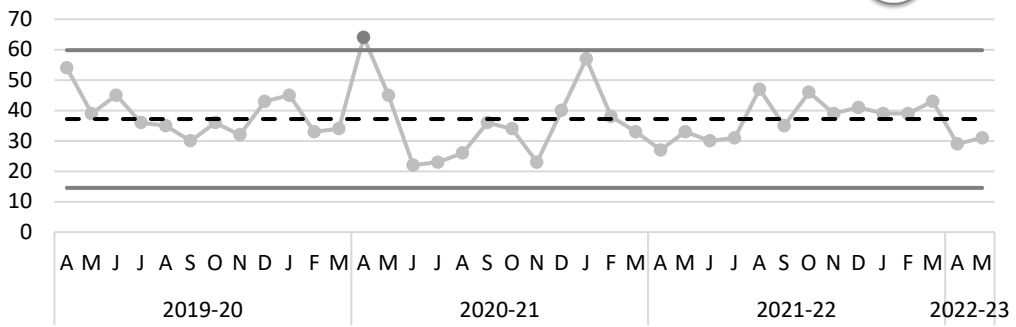
Effective Services

Palliative Care

Patients with whom their preferred place of death was discussed



Individualised care pathways

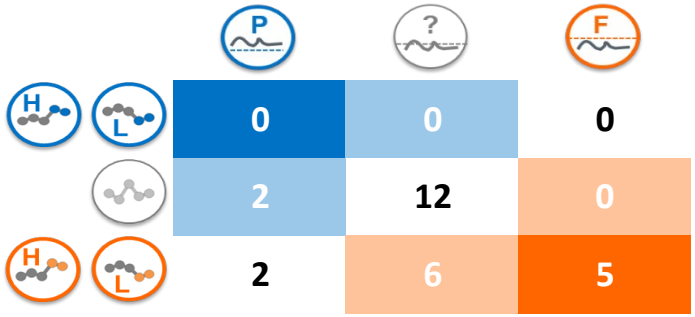


Key Issues and Executive Response

- The data provided shows that the portion of patients with whom their preferred place of death has been discussed, which had declined during 2020-21. This had been increasing but has recently dipped. The rate currently stands at 79.2%.
- It should be noted that currently only the Palliative Care team collect preferred place of death data, meaning that this figure does not represent the Trust as a whole. Work is on-going to address this.
- The incidence of individualised care pathways has remained relatively stable but has recently dipped marginally below the mean.

Responsive Services

Month 02 | 2022-23



Responsive Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	May-22	95%	66.36%			Nine points below the lower process limit Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	May-22	2%	8.71%			Nine points above the upper process limit Metric will inconsistently hit and miss the target
	Percentage of ambulance handovers within 15-minutes	May-22	65%	5.60%			Twelve points below the lower process limit Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	May-22	80%	56.60%			Thirteen points below the mean Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	May-22	240	198			Nine points above the upper process limit Metric will consistently pass the target
	Average (mean) time in department - admitted patients	May-22	tbc	603			Nine points above the upper process limit No target
	Clinically ready to proceed	May-22	tbc	tbc			Pending data
	Critical time standards	May-22	tbc	tbc			Pending data
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18-weeks from referral	May-22	92%	56.9%			Nine points below the lower process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	May-22	1%	47.0%			Six points above the upper process limit Metric will consistently fail the target

Responsive Services

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	Two week waits for suspected cancer	Apr-22	93%	90.95%	L	P	One point below the lower process limit Metric will consistently pass the target
	Two week waits for breast symptoms	Apr-22	93%	81.82%	L	?	One point below the lower process limit Metric will inconsistently hit and miss the target
	28-day faster diagnosis	Apr-22	75%	68.70%		?	Six points below the mean Metric will inconsistently hit and miss the target
	31-days from diagnosis to first definitive treatment	Apr-22	96%	97.67%		?	Common cause variation Metric will inconsistently hit and miss the target
	31-days for subsequent treatment - anti-cancer drugs	Apr-22	98%	100.00%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - radiotherapy	Apr-22	94%	100.00%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - surgery	Apr-22	94%	100.00%		?	Common cause variation Metric will inconsistently hit and miss the target
	62-days from urgent GP referral to first definitive treatment	Apr-22	85%	86.02%		?	Common cause variation Metric will inconsistently hit and miss the target
	Patients waiting no more than 104-days from urgent GP referral to first definitive treatment	Apr-22	0	5.0		?	Common cause variation Metric will inconsistently hit and miss the target
	62-days from referral from an NHS screening service to first definitive treatment	Apr-22	90%	100.0%		?	Common cause variation Metric will inconsistently hit and miss the target
	62-days from consultant upgrade to first definitive treatment	Apr-22	n/a	84.0%			Common cause variation No target

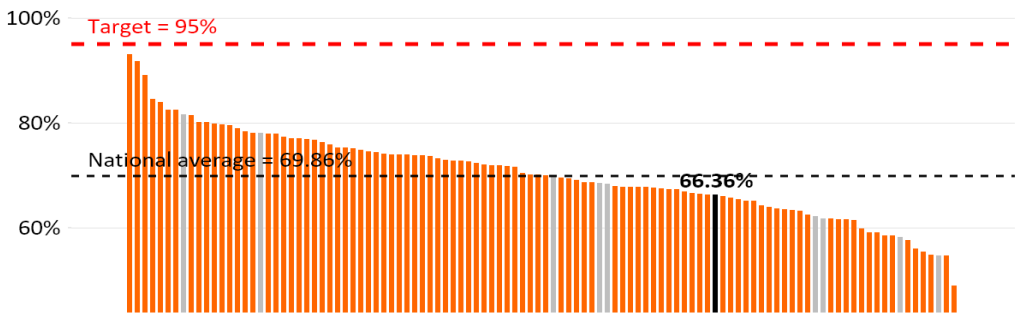
Responsive Services

Summary

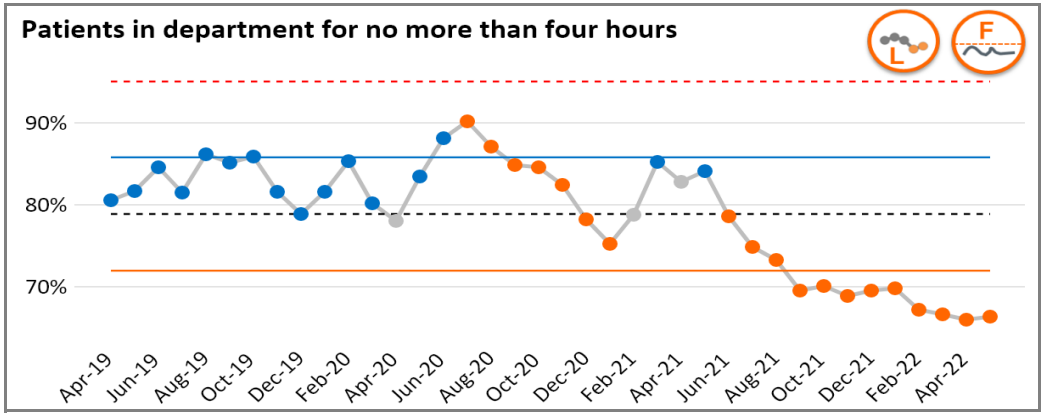
East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	May-22	A	D			
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	May-22	80%	60.0%			One point below the lower process limit Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED	May-22	63%	8.2%			Two point below the lower process limit Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	May-22	63%	8.3%			Three points below the lower process limit Metric will inconsistently hit and miss the target
	Number of confirmed Strokes in-month on SSNAP	May-22	n/a	74			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	May-22	80%	84.0%			Common cause variation Metric will inconsistently hit and miss the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	May-22	50%	58.7%			Common cause variation Metric will inconsistently hit and miss the target
	Scanned within 12-hours - all Strokes	May-22	100%	97.3%			Common cause variation Metric will inconsistently hit and miss the target
	% of all stroke patients who receive thrombolysis	May-22	11%	17.8%			Common cause variation Metric will inconsistently hit and miss the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	May-22	70%	61.5%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with JCP	May-22	80%	76.1%			Common cause variation Metric will inconsistently hit and miss the target
	Discharged with ESD	May-22	40%	35.6%			One point below th elower process limit Metric will inconsistently hit and miss the target

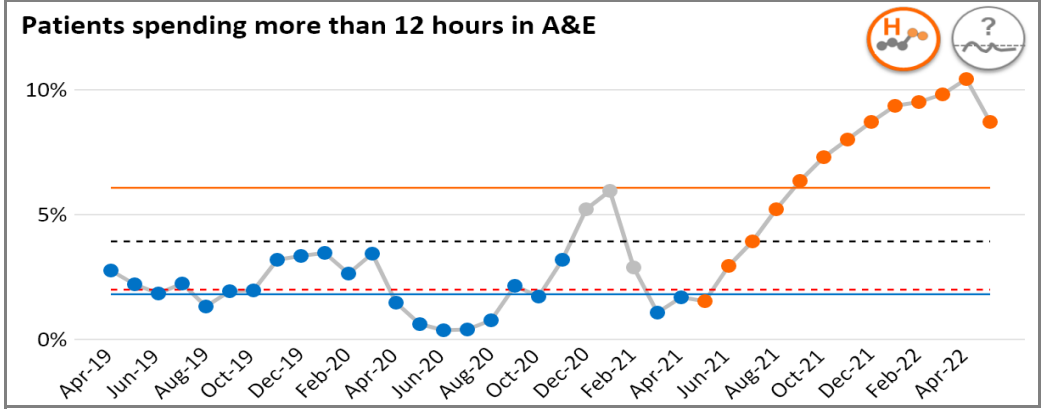
Patients waiting no more than 4-hours in ED peer distribution - May-22



Patients in department for no more than four hours



Patients spending more than 12 hours in A&E



Key Issues and Executive Response

- Demand on the emergency department and urgent treatment centre remains higher than pre Covid and demonstrated an increase compared to last month.
- The proportion of 4+ hour waits and 12+ hour waits remains uncomfortably high.
- Patients not meeting the criteria to reside (previously known as Medically Optimised) remained high at over 1,000 bed-days per month, often numbering as many as 90 per day.
- Minimal improvement in the number of patients that were discharged under the virtual hospital service.

Actions

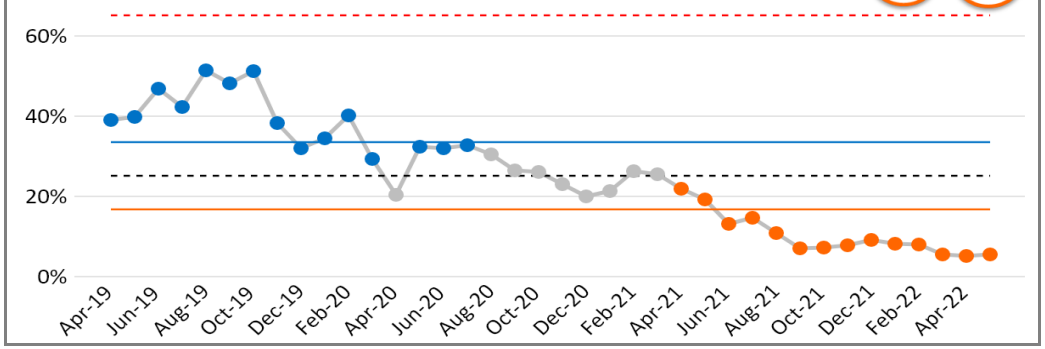
- The clinical decision unit and commenced in mid-June with a post ED cohort pilot commencing in early July. The purpose of the pilot is to provide immediate flow out of ED in the mornings whilst discharges are coordinated. Unfortunately, these two initiatives were delayed due to an internal critical incident.
- These key actions are expected to have a positive impact on length of stay within the emergency department as well as other key emergency standards such as ambulance handover and the 4-hour standard.

Responsive Services

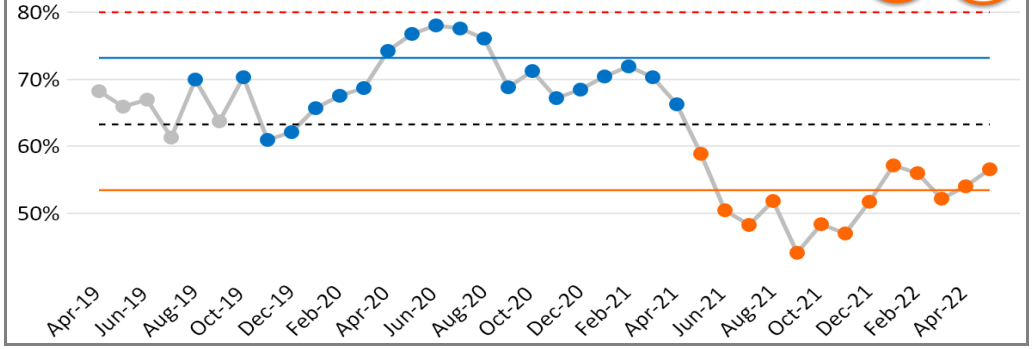
Emergency Department New Standards

East and North Hertfordshire NHS Trust

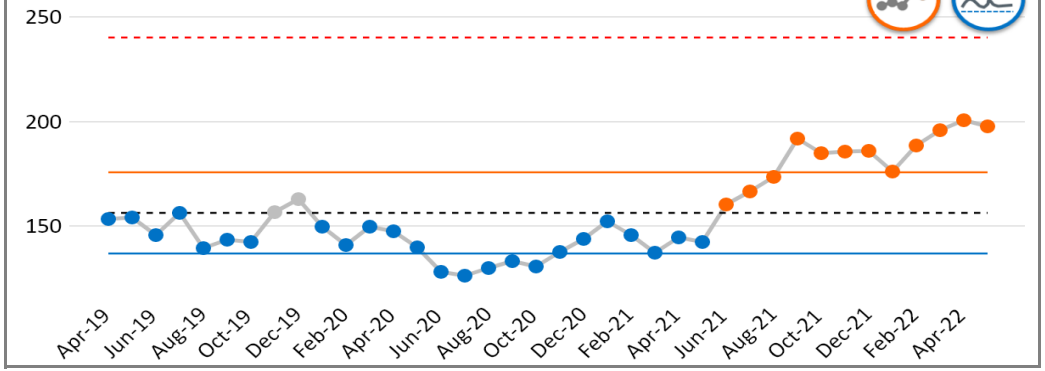
Percentage of ambulance handovers within 15 minutes



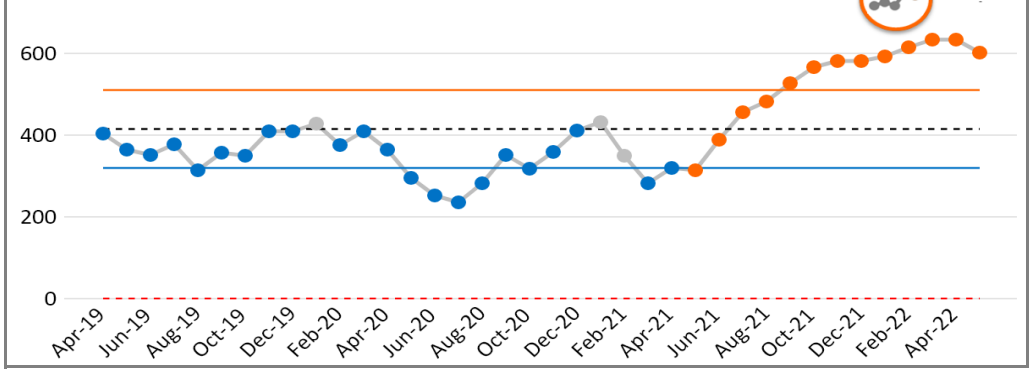
Time to initial assessment - percentage within 15 minutes



Average (mean) time in department - non-admitted patients



Average (mean) time in department - admitted patients



Clinically ready to proceed

Placeholder

Critical time standards

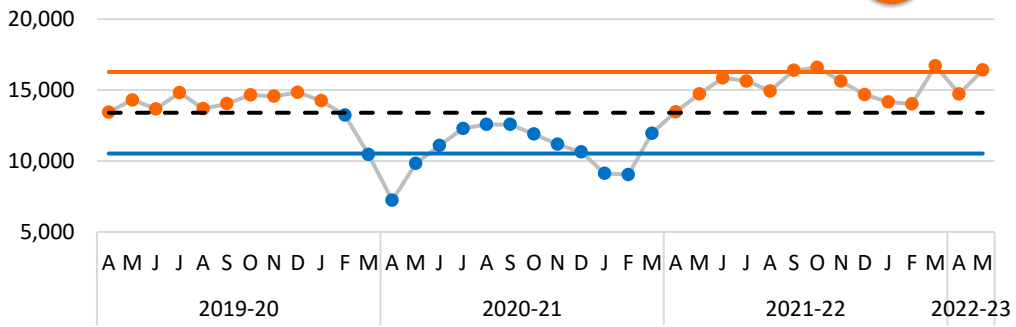
Placeholder

Responsive Services

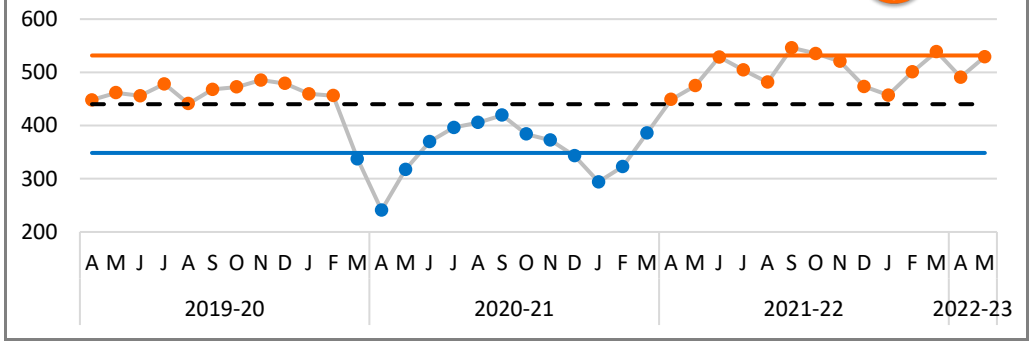
Emergency Department Supporting Metrics

East and North Hertfordshire NHS Trust

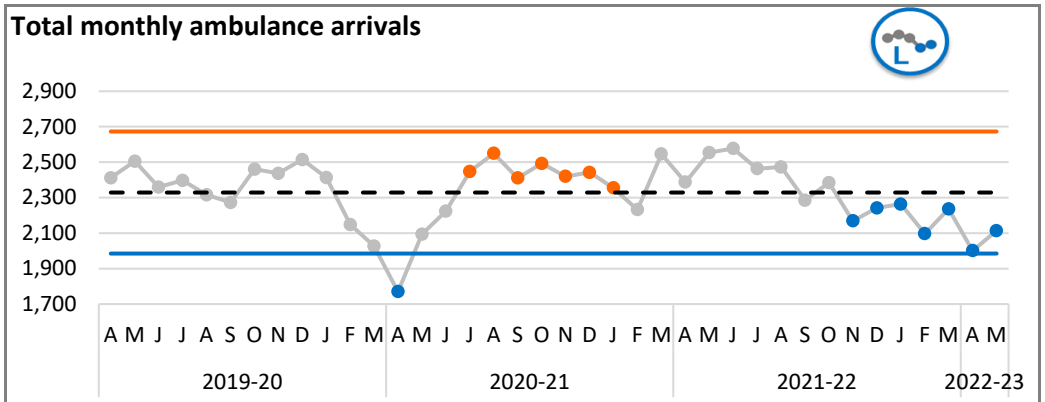
Total monthly attendances



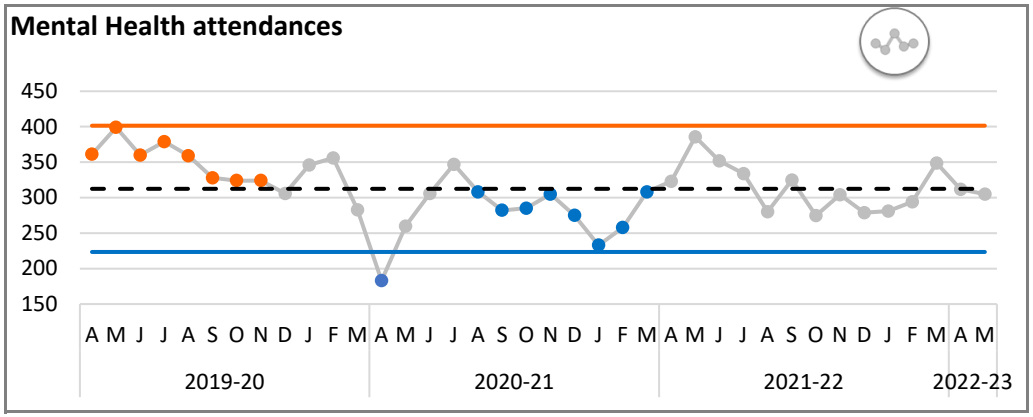
Average daily attendances



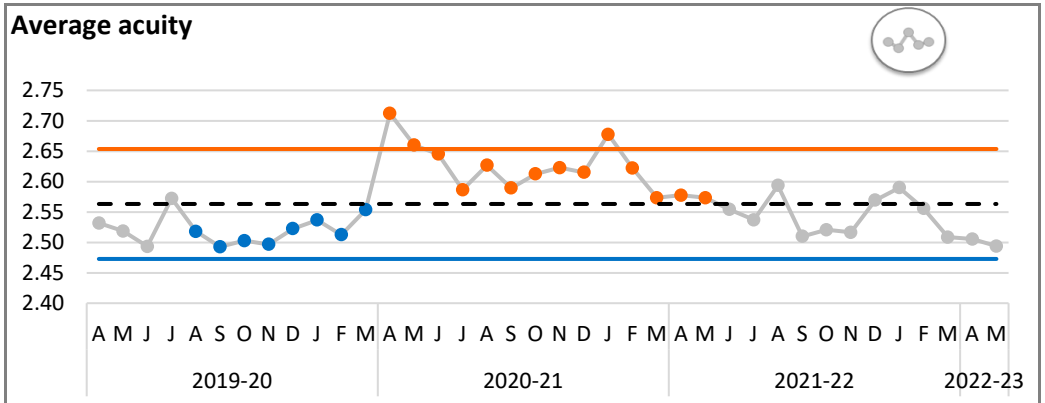
Total monthly ambulance arrivals



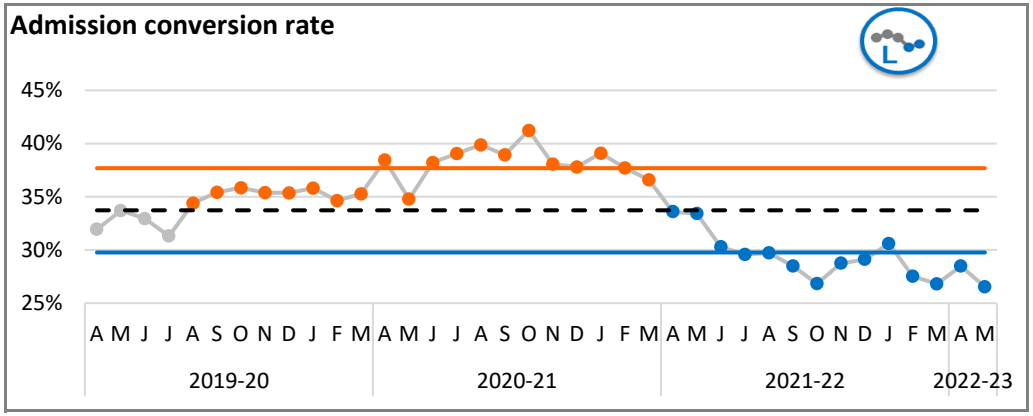
Mental Health attendances



Average acuity



Admission conversion rate

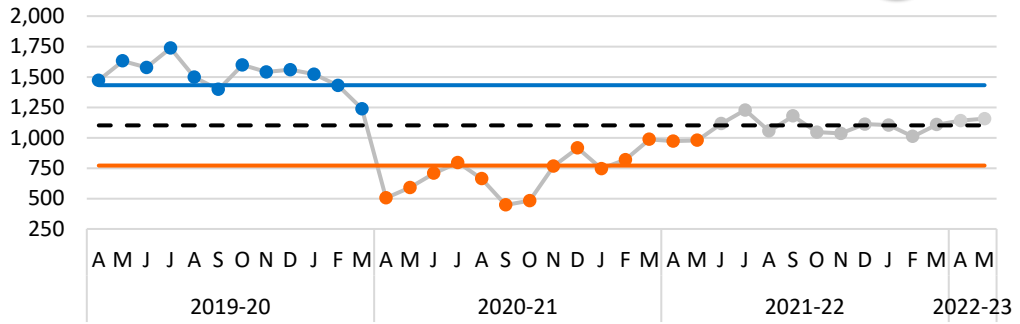


Responsive Services

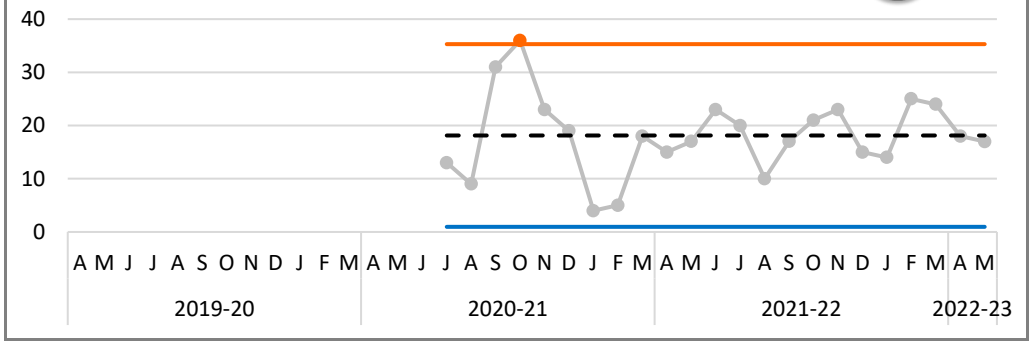
Emergency Department Supporting Metrics

East and North Hertfordshire NHS Trust

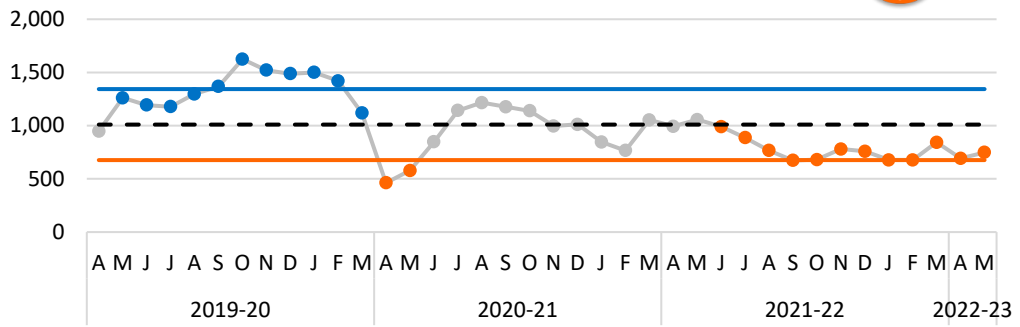
Same Day Emergency Care attendances



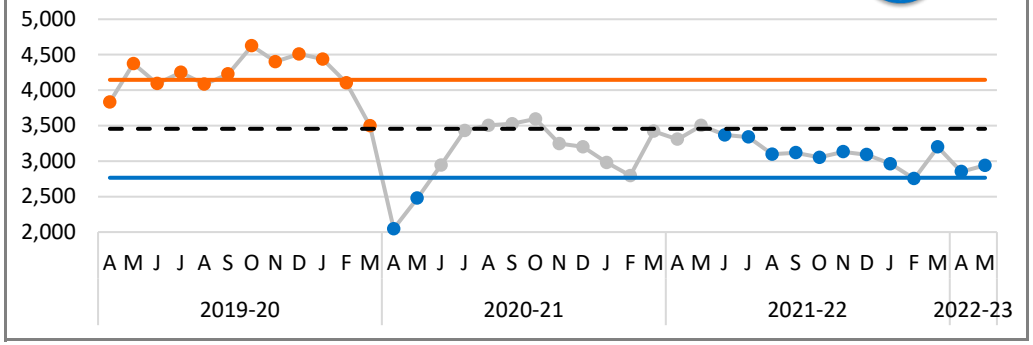
Frailty



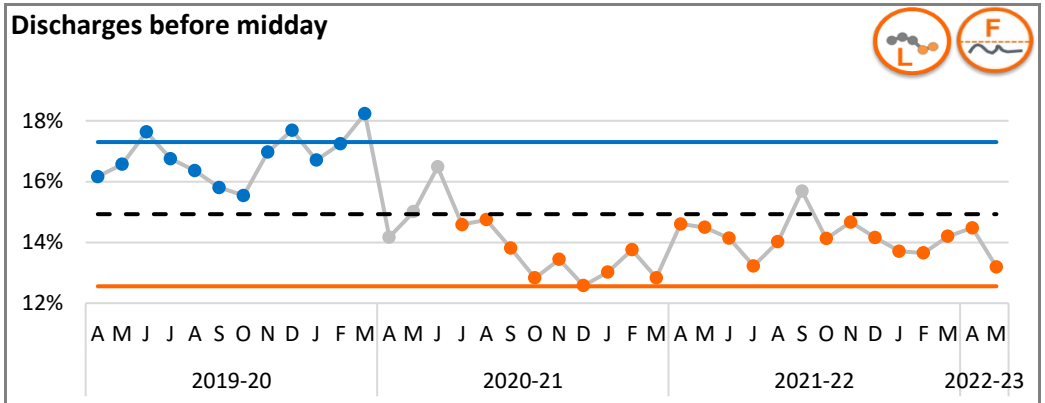
Non-elective zero-day length of stay



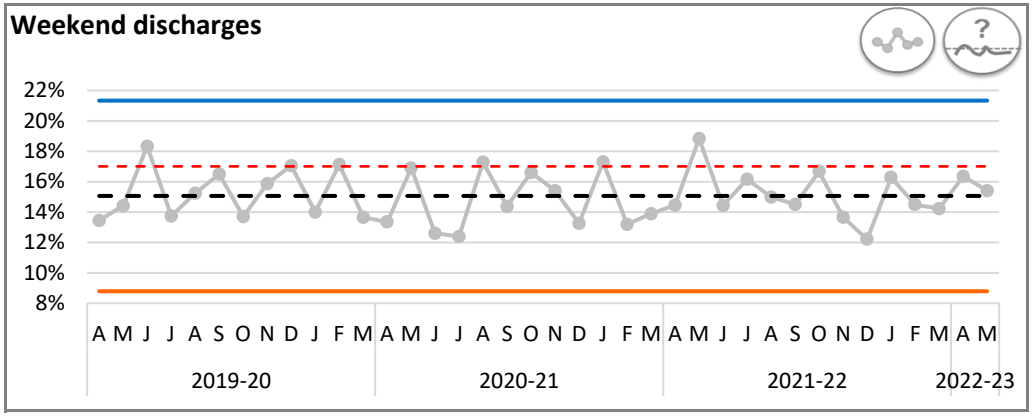
Total non-elective inpatient spells



Discharges before midday



Weekend discharges

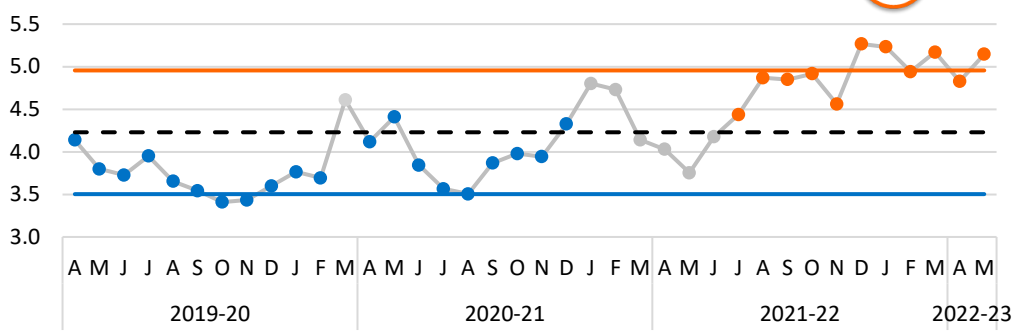


Responsive Services

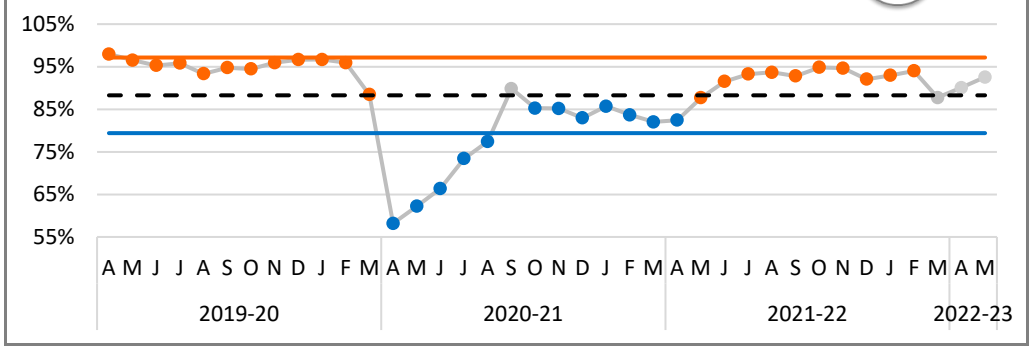
Emergency Department Supporting Metrics

East and North Hertfordshire NHS Trust

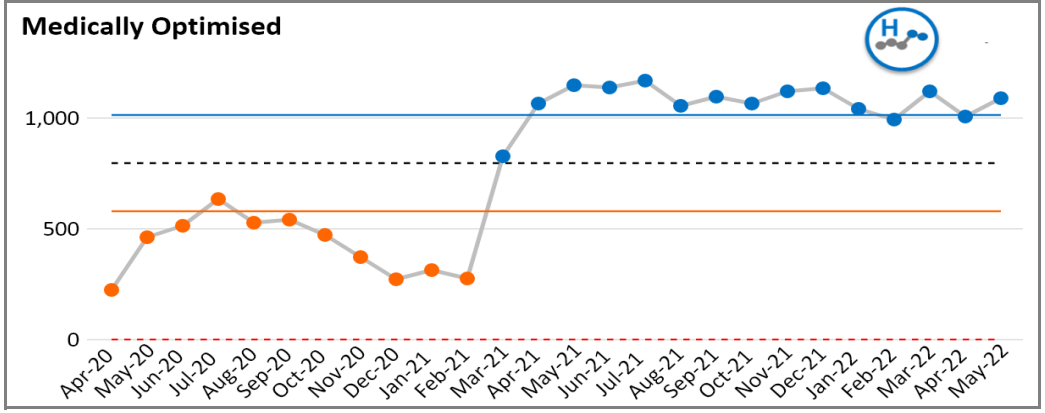
Non-elective average length of stay



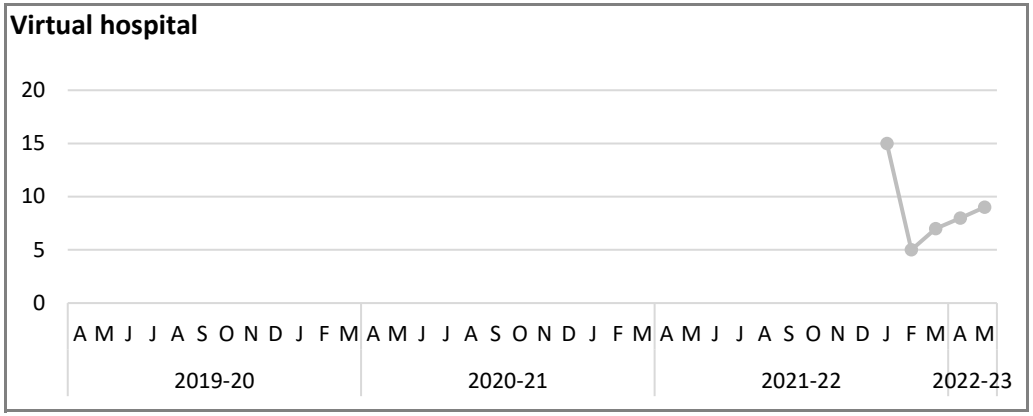
Bed occupancy



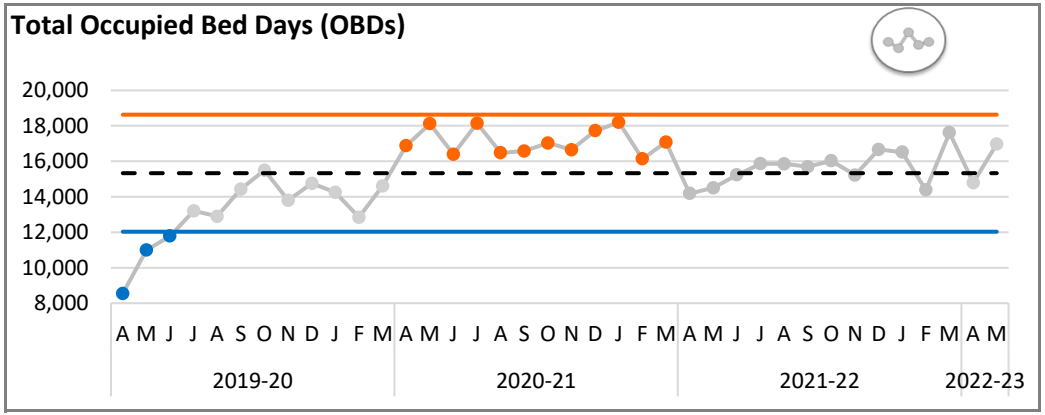
Medically Optimised



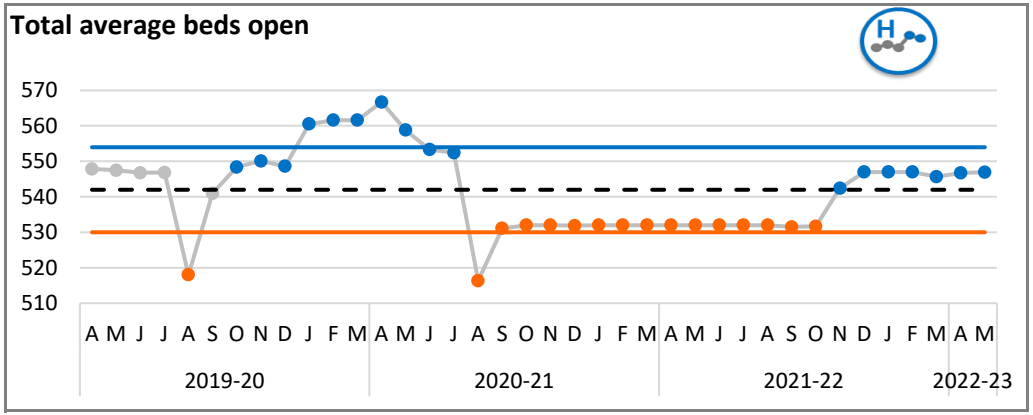
Virtual hospital



Total Occupied Bed Days (OBDs)



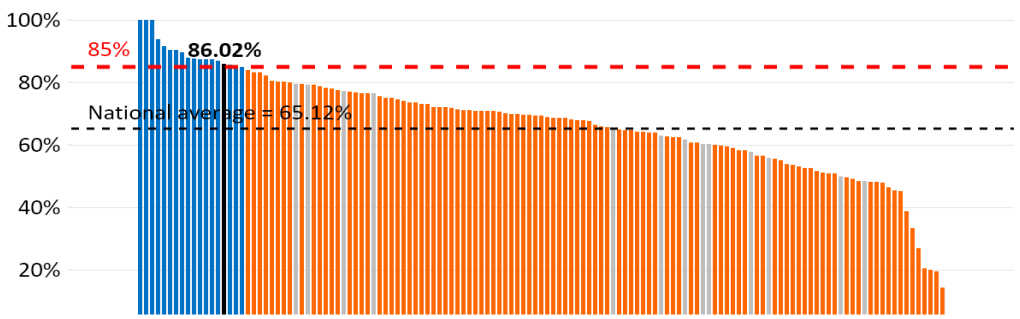
Total average beds open



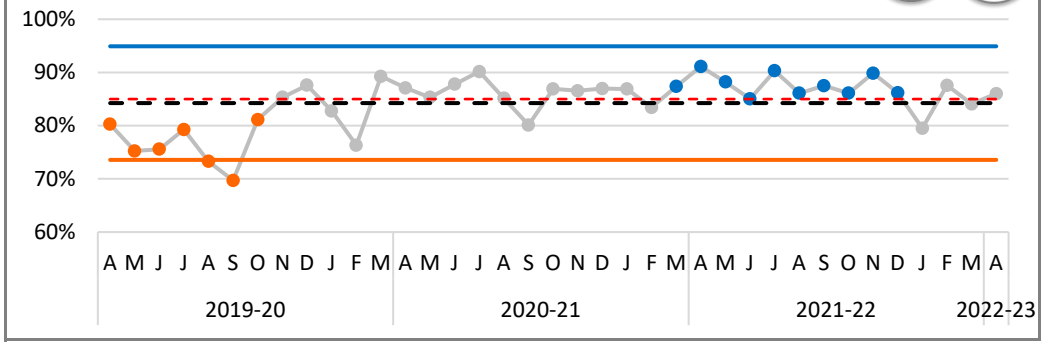
Responsive Services

Cancer Waiting Times

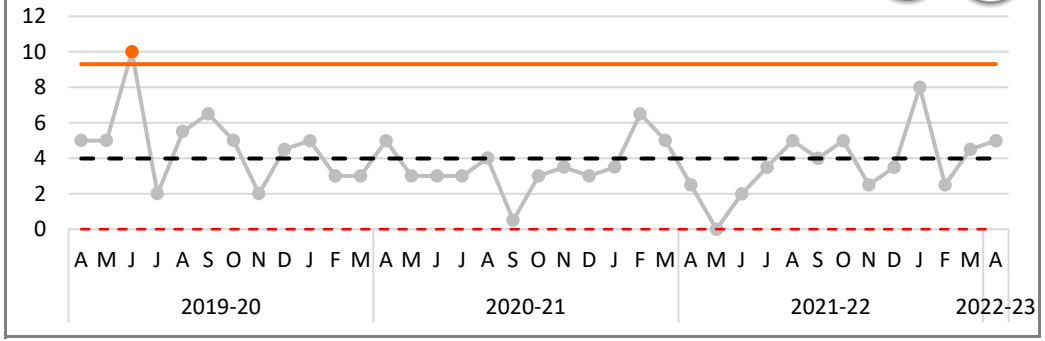
62-days GP referral to treatment peer distribution - Apr-22



62-days from urgent GP referral to first definitive treatment

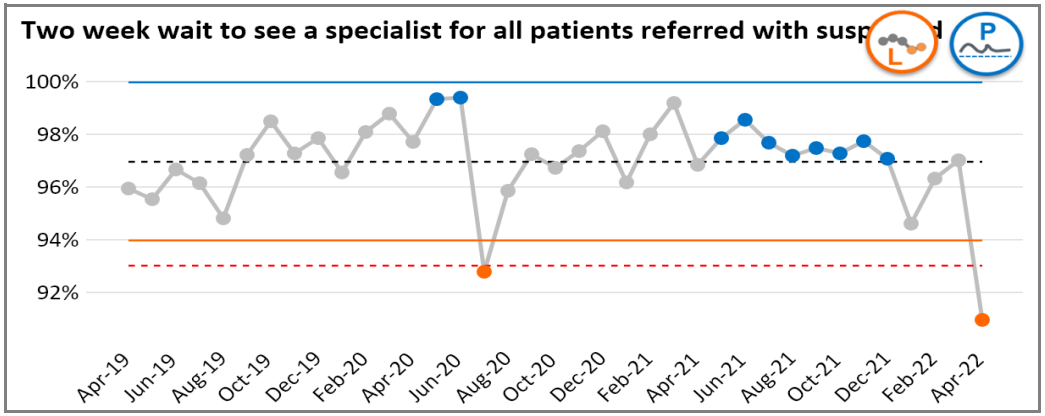


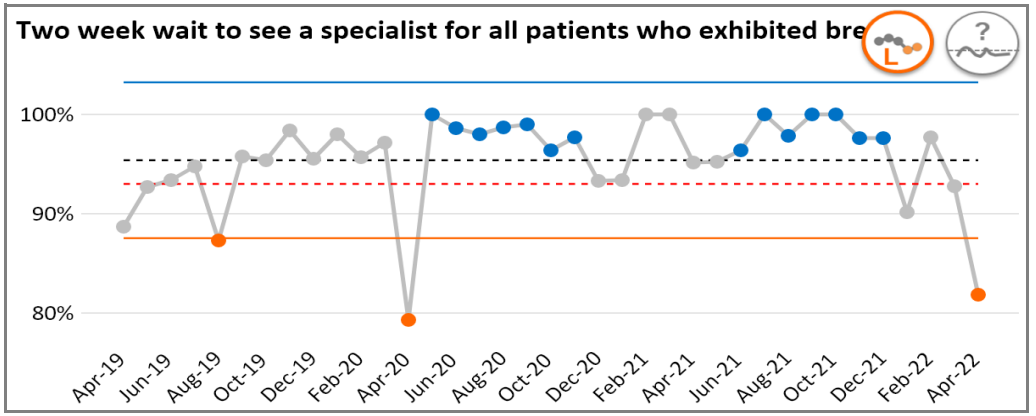
No more than 104-days from urgent GP referral to first definitive treatr

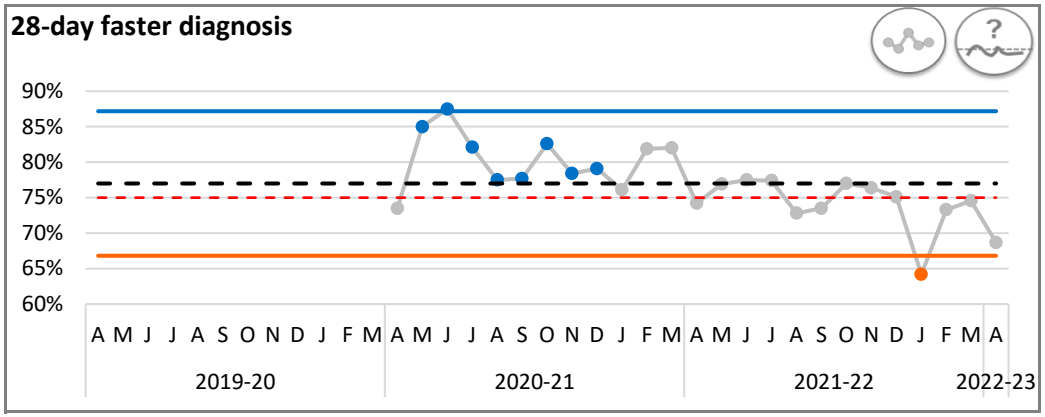


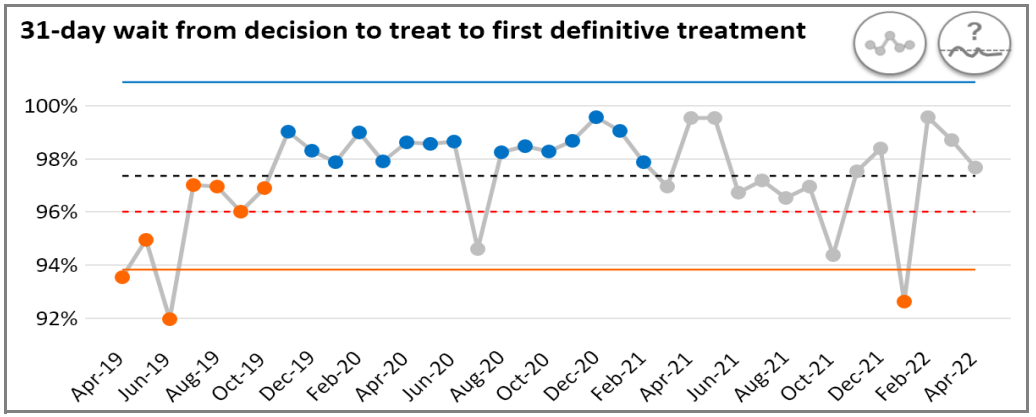
Key Issues and Executive Response

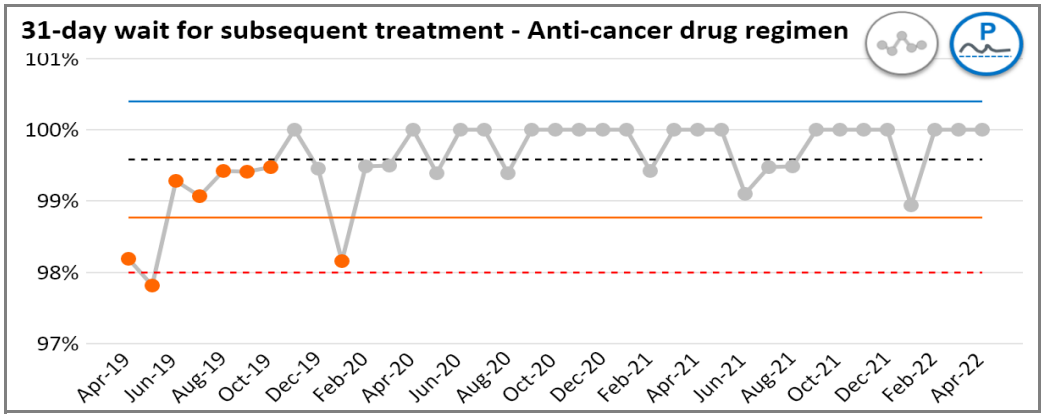
- Continued strong performance: achieved 6 of the 8 national targets in April.
- Robust weekly cancer PTL management in place. Good progress on specialty cancer action plans.
- Deep dives for tumour sites continue. Additional scrutiny and support leading to improved performance.
- The Trust has achieved the following standards in April: 31 Day first treatment, 31 day second or subsequent treatment for chemotherapy, radiotherapy and surgery, 62 day for screening patients and also 62-day urgent referral to treatment for all cancers.
- The Trust has not achieved the 2ww GP referral to first OPA and also 2ww for Breast symptoms for April due to:
  - high number of 2ww referrals has caused capacity issues and also patient choice delays.
- Timed pathways in place for all Tumour sites to improve and sustain 62 day and FDS performance.
- Radiology and histopathology continue to prioritise cancer patients from urgent and routine to avoid delays and also offering WLI work to increase capacity.
- Monthly breach analysis to identify issues and resolve the delays in the pathways.
- Radiology continues to be a major issue with capacity and staffing, which is likely to affect 62 day cancer performance for the next months.

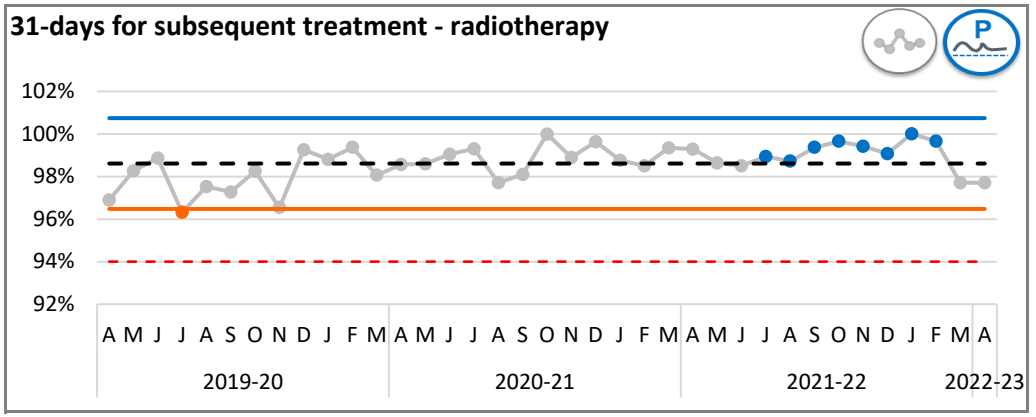

Two week wait to see a specialist for all patients referred with susp
100%
98%
96%
94%
92%
Apr-19 Jun-19 Aug-19 Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22


Two week wait to see a specialist for all patients who exhibited bre
100%
90%
80%
Apr-19 Jun-19 Aug-19 Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22


28-day faster diagnosis
90%
85%
80%
75%
70%
65%
60%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23


31-day wait from decision to treat to first definitive treatment
100%
98%
96%
94%
92%
Apr-19 Jun-19 Aug-19 Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22

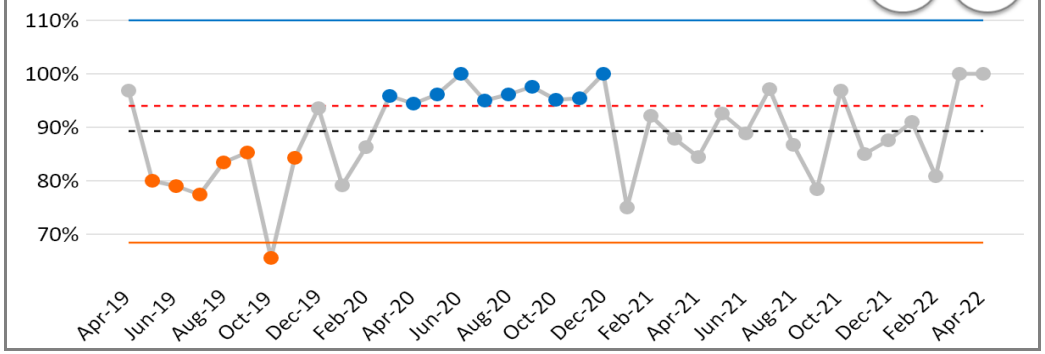

31-day wait for subsequent treatment - Anti-cancer drug regimen
101%
100%
99%
98%
97%
Apr-19 Jun-19 Aug-19 Oct-19 Dec-19 Feb-20 Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22


31-days for subsequent treatment - radiotherapy
102%
100%
98%
96%
94%
92%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23

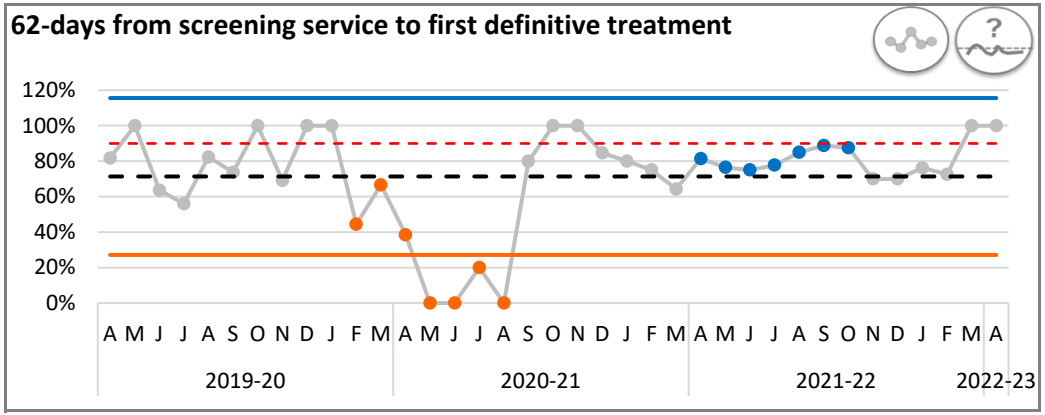
Responsive Services

Cancer Waiting Times

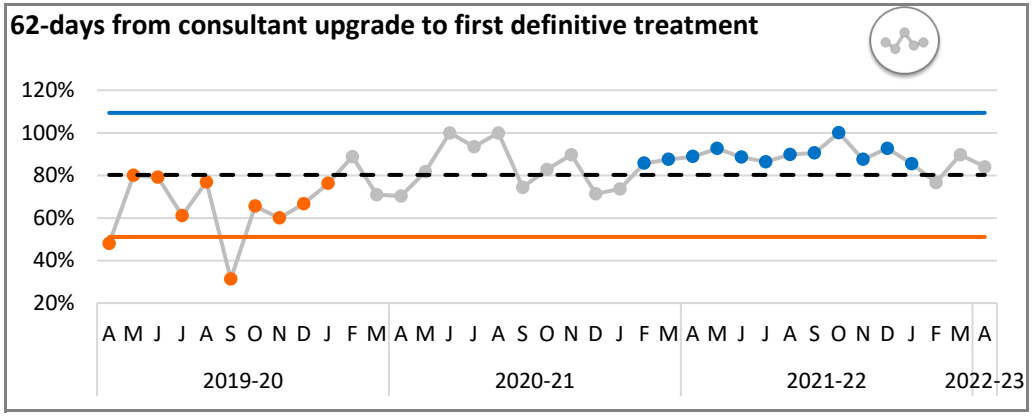
31-day wait for subsequent treatment - Surgery



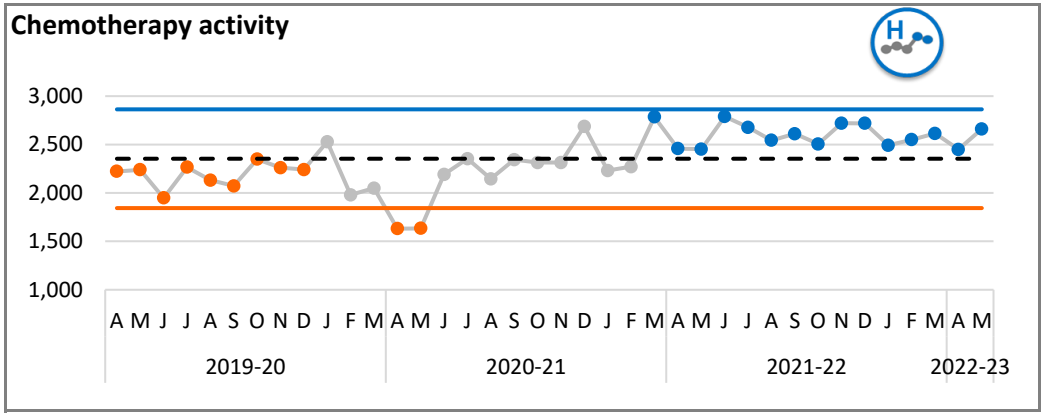
62-days from screening service to first definitive treatment



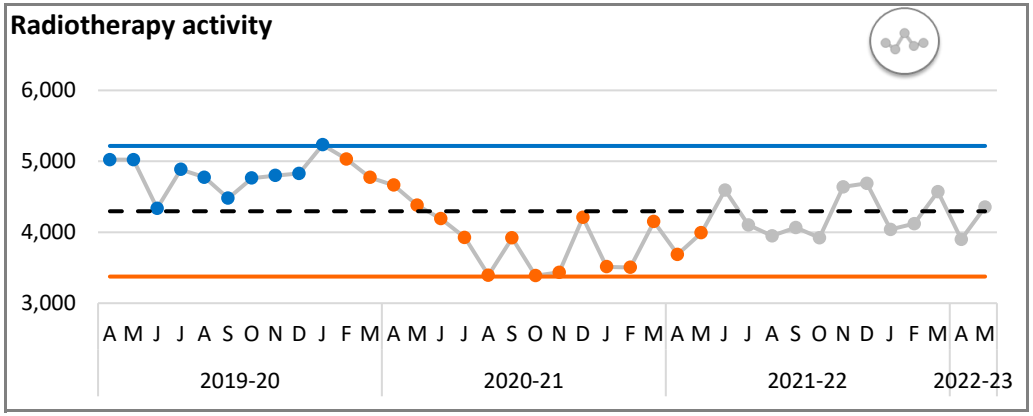
62-days from consultant upgrade to first definitive treatment



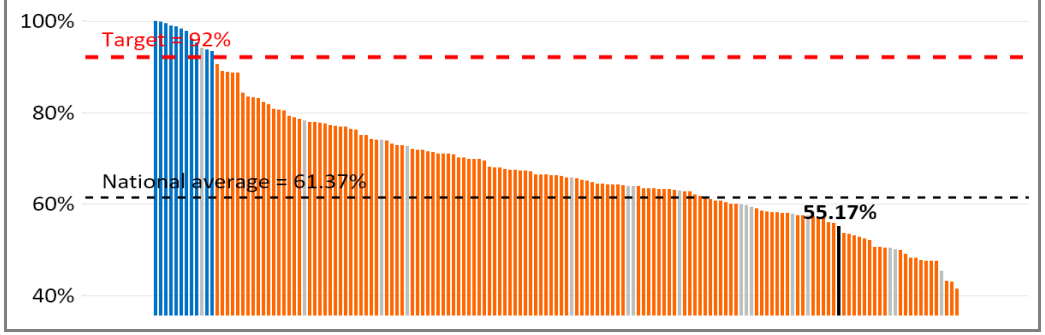
Chemotherapy activity



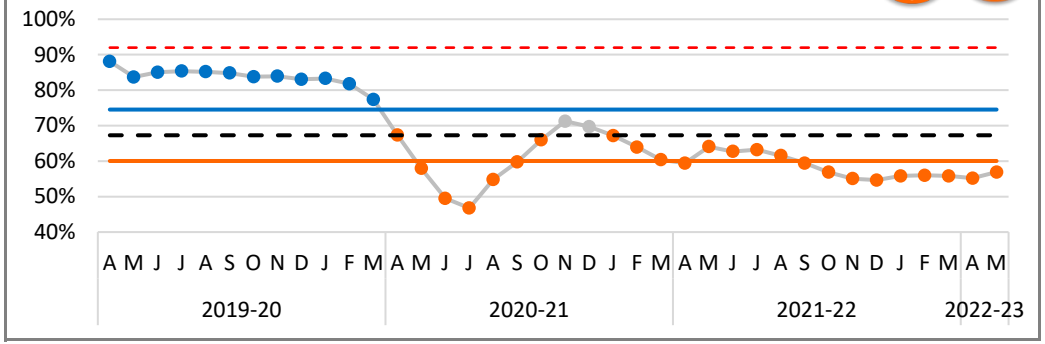
Radiotherapy activity



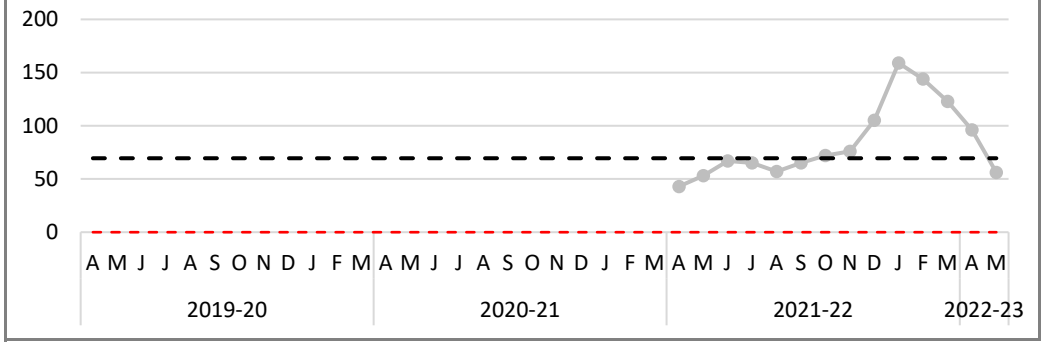
Incomplete pathways peer distribution - Apr-22



Incomplete pathways waiting no more than 18-weeks from referral



Zero tolerance RTT waits over 104 weeks for incomplete pathways



Key Issues and Executive Response

RTT Performance

- Clinically urgent and long waiting patients continue to be treated as priority which is negatively impacting on 18 weeks performance.
- The number of 104+ week waiters has decreased for the fourth month in a row. 104+ week target is on track for fewer than 10 patients at the end of June, where patients are fit enough and have not chosen to delay their treatment.
- Capacity has been agreed for long waiting T&O patients to be dated before the end of June deadline.

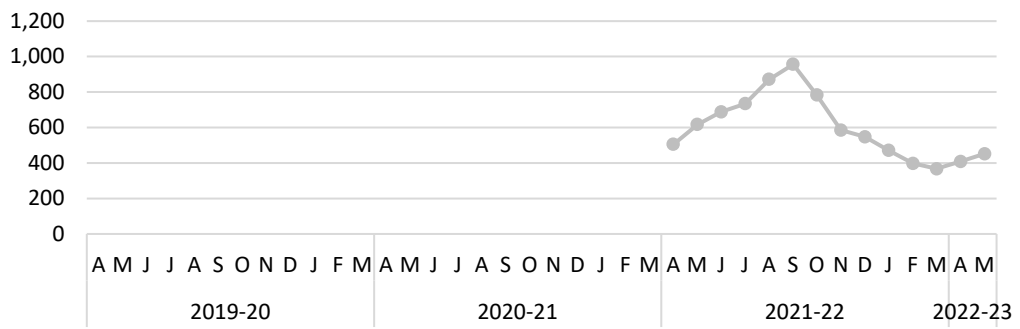
Data Quality

- Processes continue to improve, reducing duplicates and inappropriate clock starts as demonstrated by 8 months below the mean. Clock stops have significantly increased for both non-admitted and admitted pathways.

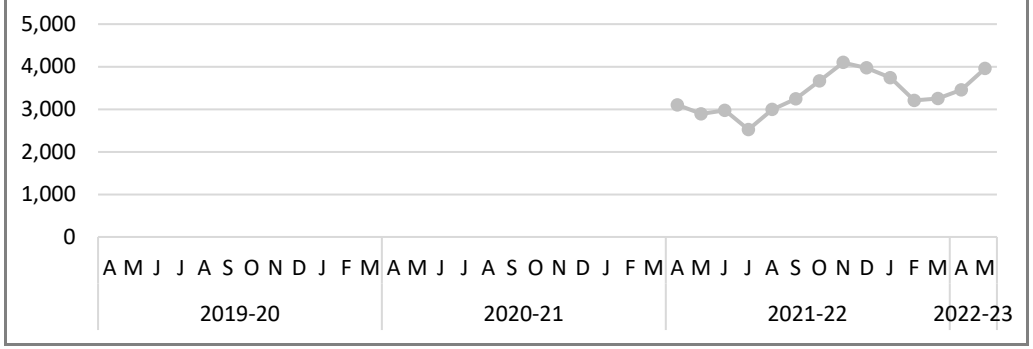
Activity

- Referrals have remained above the mean, with a slight increase this month.
- Outpatient new appointments and follow-ups remain steady around the mean. Services are putting plans in place to increase new capacity and reduce follow-ups.
- Day cases and outpatient procedure activity remain above the mean and have increased slightly in month.
- IP numbers have increased in month, with theatre utilisation improving.
- Advice and Guidance continues to improve above the UCL, dropping slightly in month.
- DNA rate has increased for the third month in a row, as has the New to Follow-Up ratio.

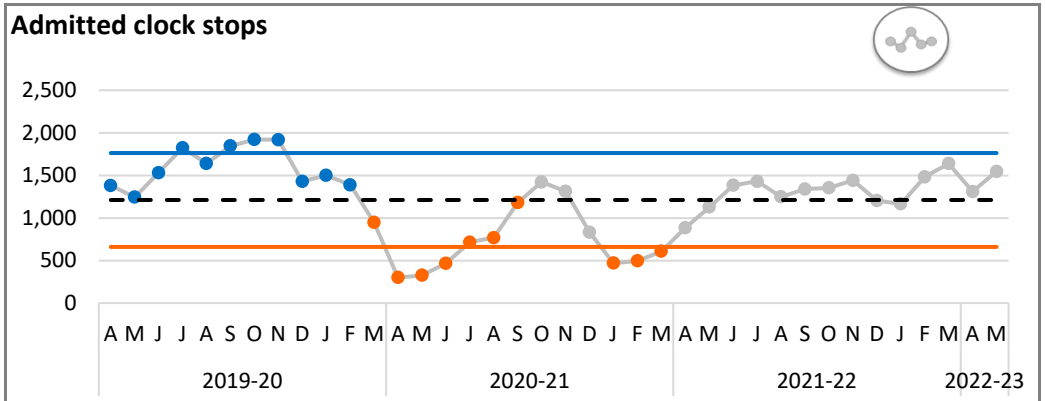
RTT waits over 78 weeks for incomplete pathways



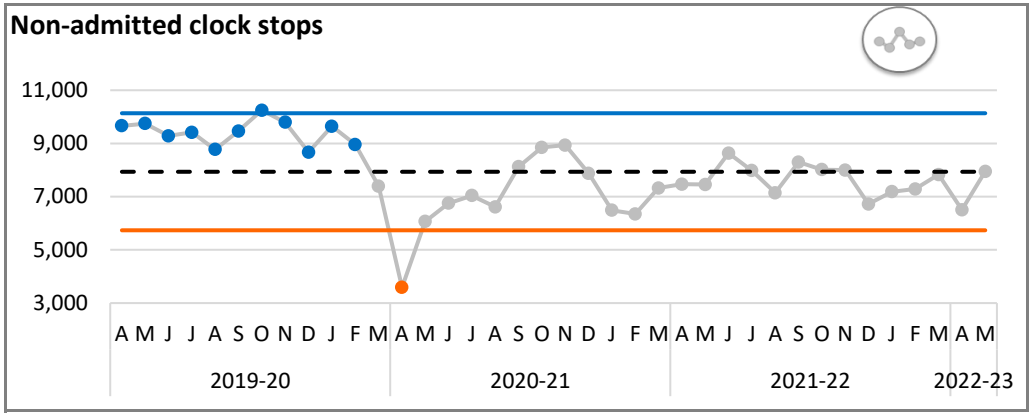
RTT waits over 52 weeks for incomplete pathways



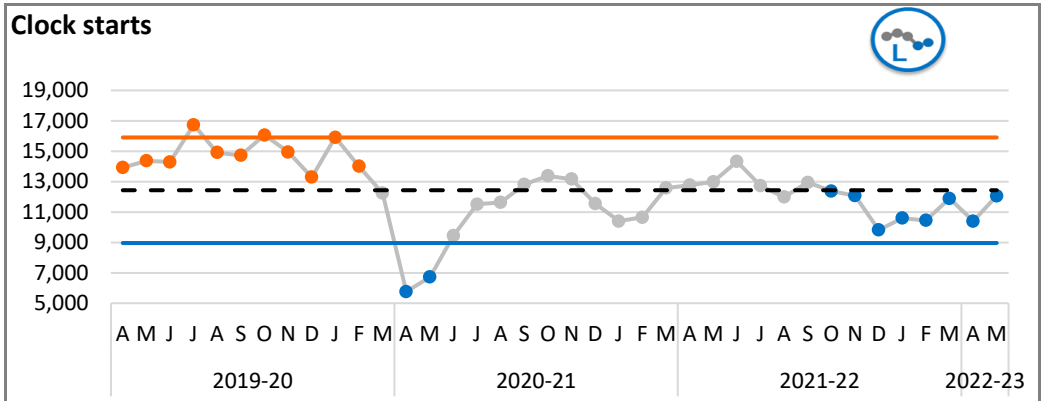
Admitted clock stops



Non-admitted clock stops



Clock starts

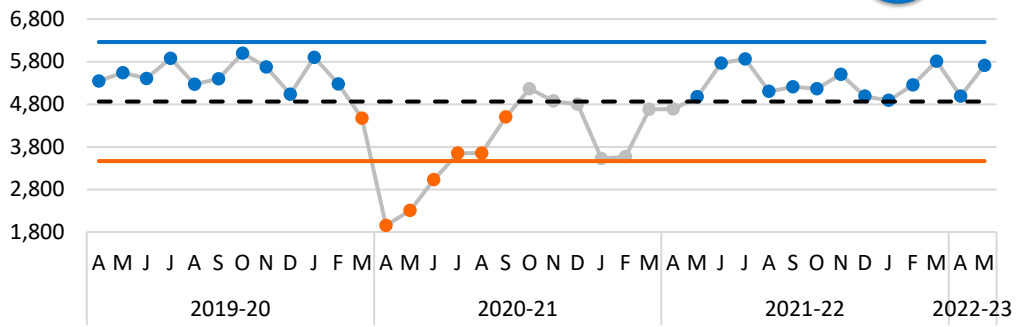


Responsive Services

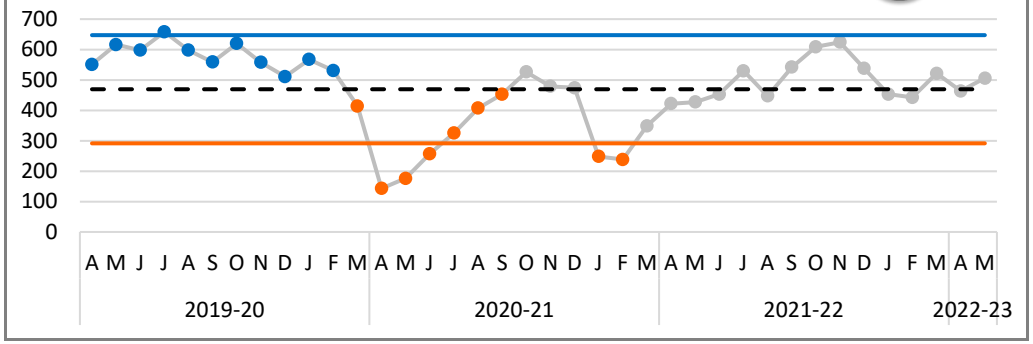
RTT 18 Weeks Supporting Metrics | Elective Recovery Fund

East and North Hertfordshire NHS Trust

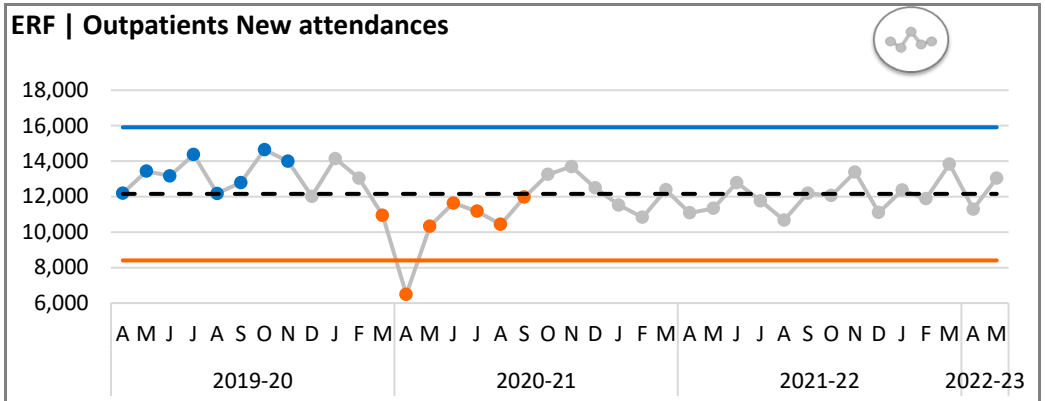
ERF | Day cases



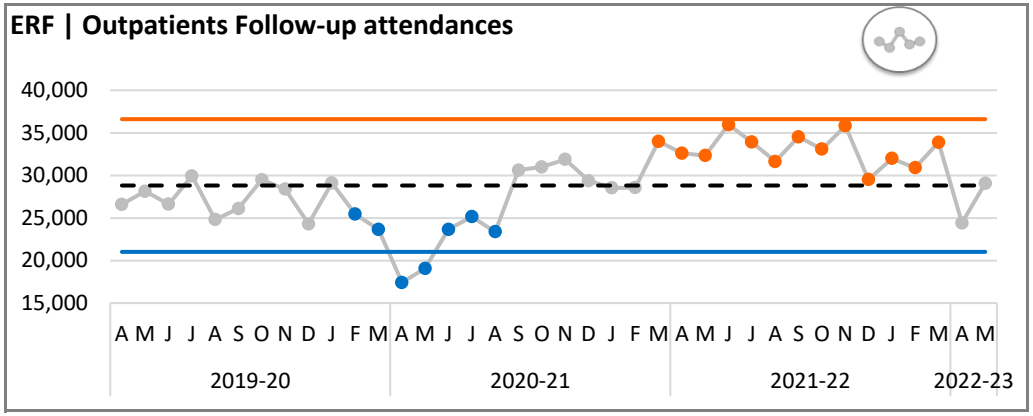
ERF | Elective inpatients



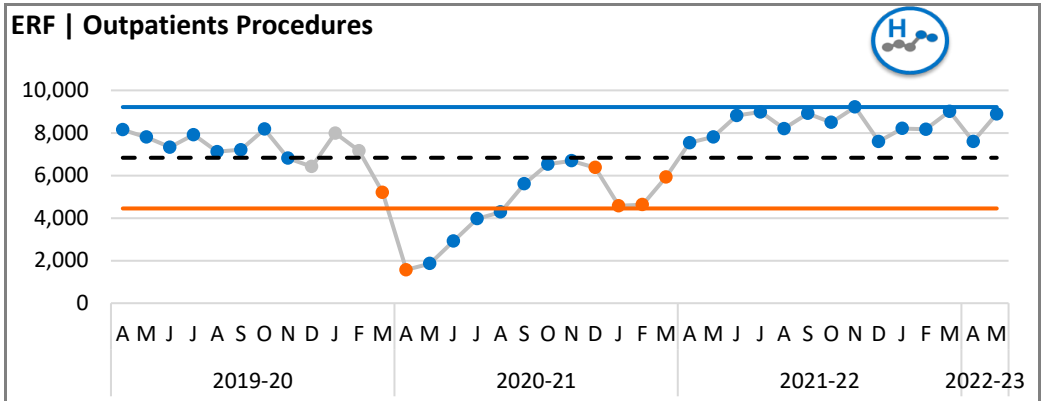
ERF | Outpatients New attendances



ERF | Outpatients Follow-up attendances



ERF | Outpatients Procedures

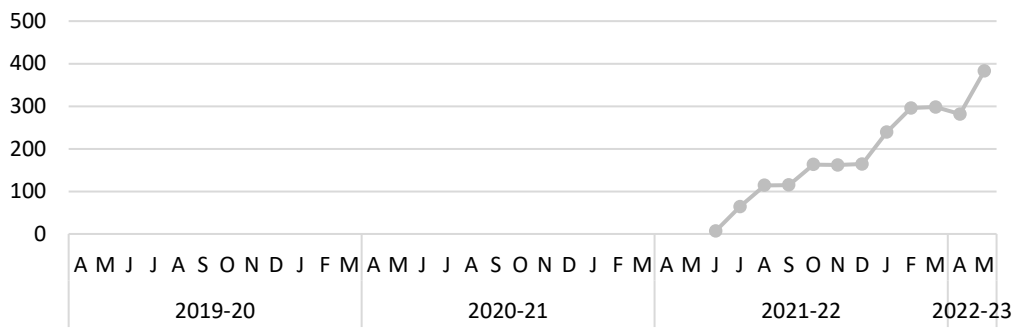


Responsive Services

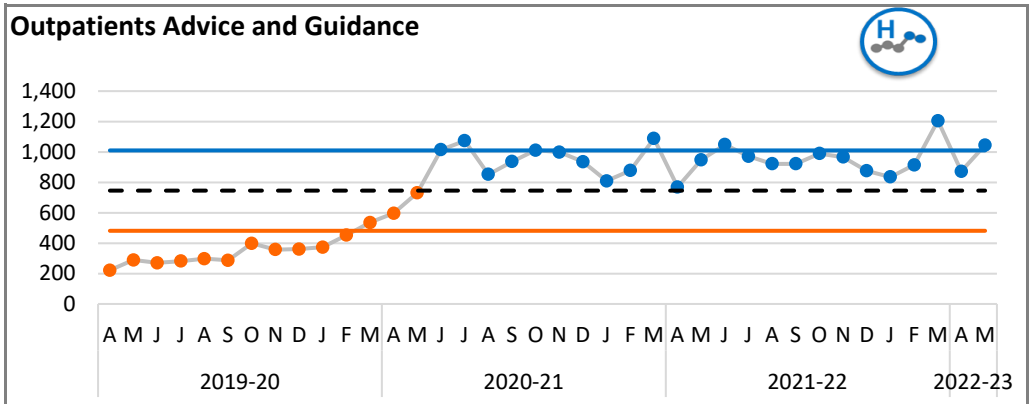
RTT 18 Weeks Supporting Metrics | Outpatients

East and North Hertfordshire NHS Trust

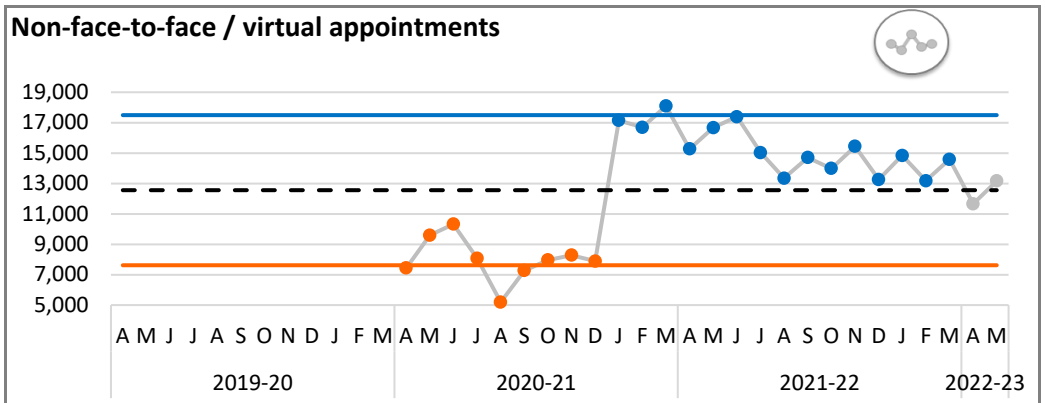
Number of episodes moved to PIFU for the first time



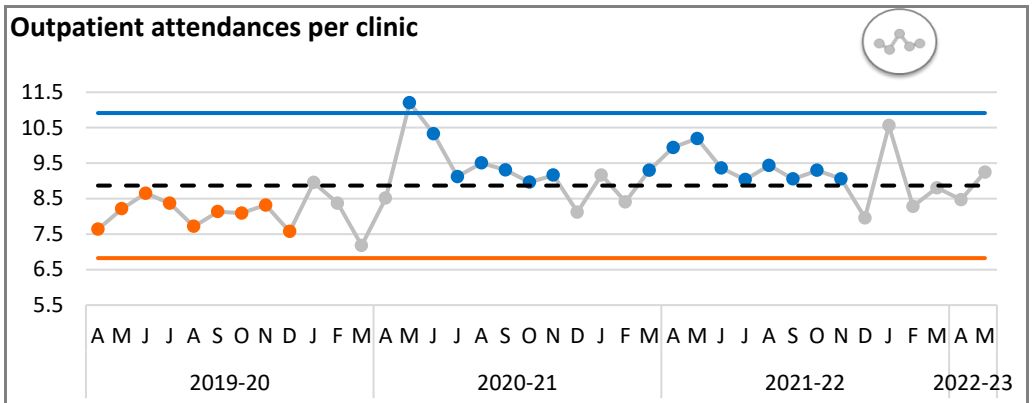
Outpatients Advice and Guidance



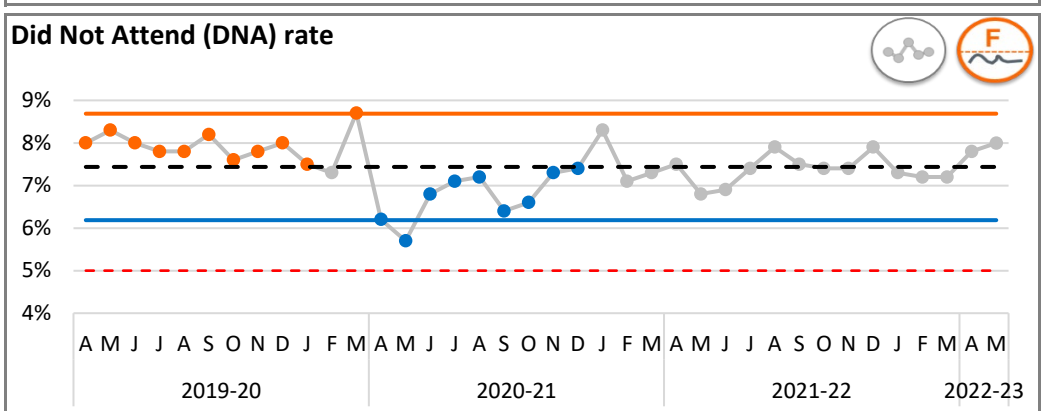
Non-face-to-face / virtual appointments



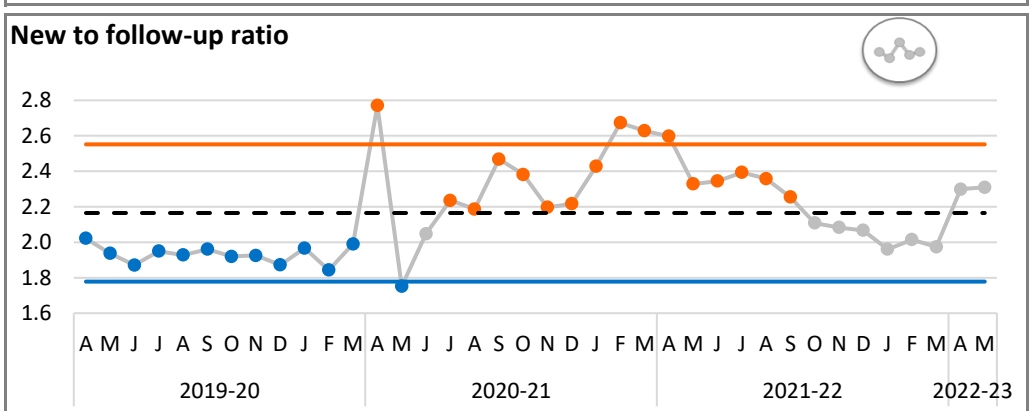
Outpatient attendances per clinic



Did Not Attend (DNA) rate



New to follow-up ratio

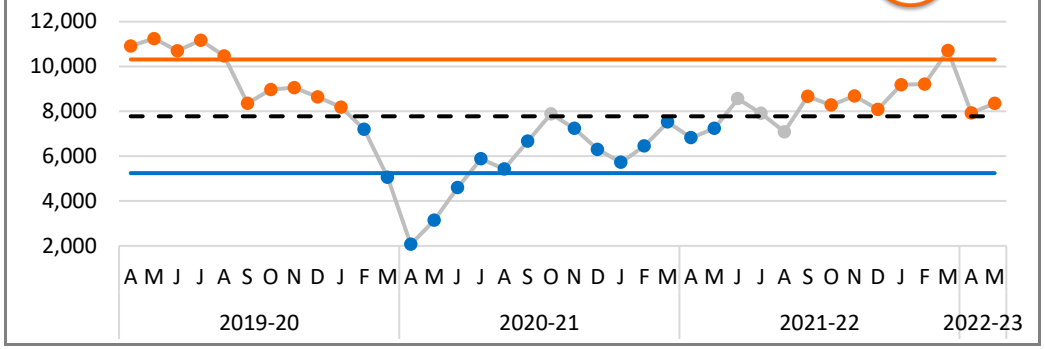


Responsive Services

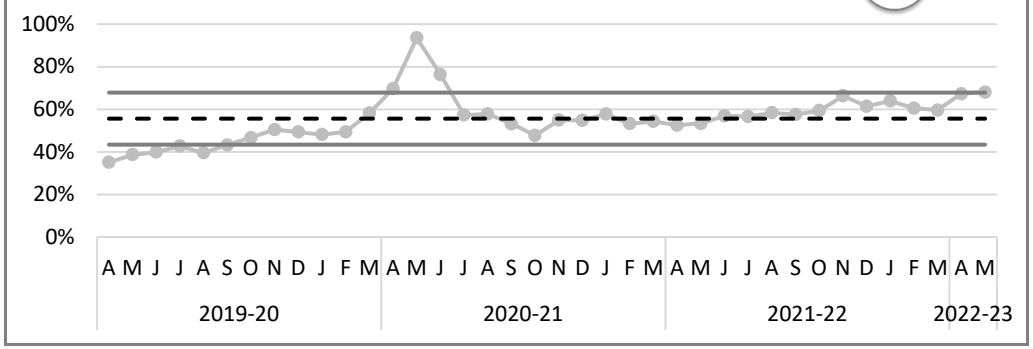
RTT 18 Weeks Supporting Metrics | Outpatients | Inpatients

East and North Hertfordshire NHS Trust

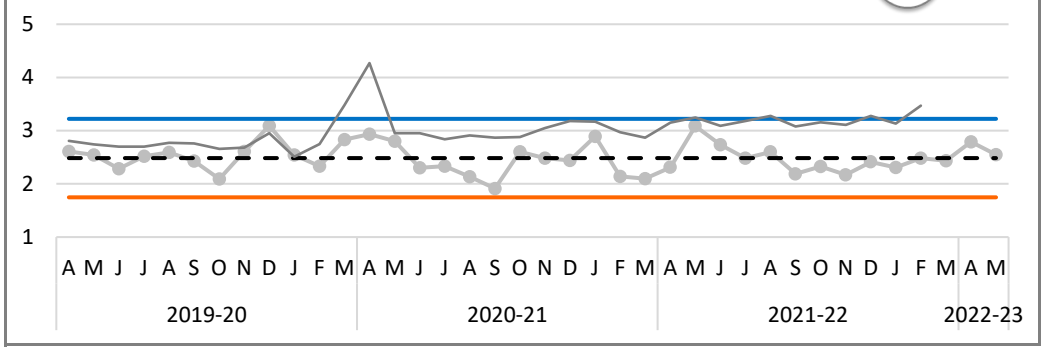
Referrals received



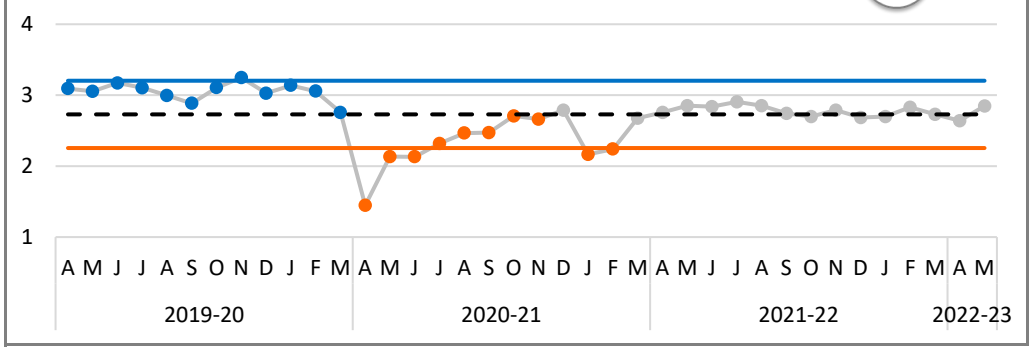
Referral conversion rate



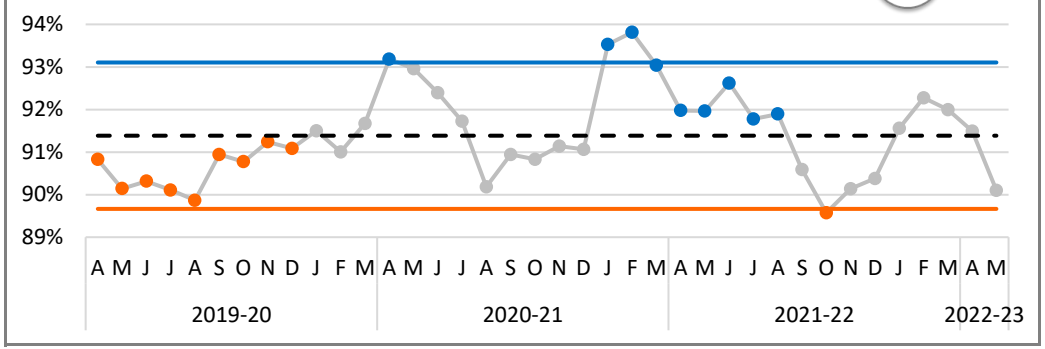
Elective length of stay



Theatre utilisation - cases per list

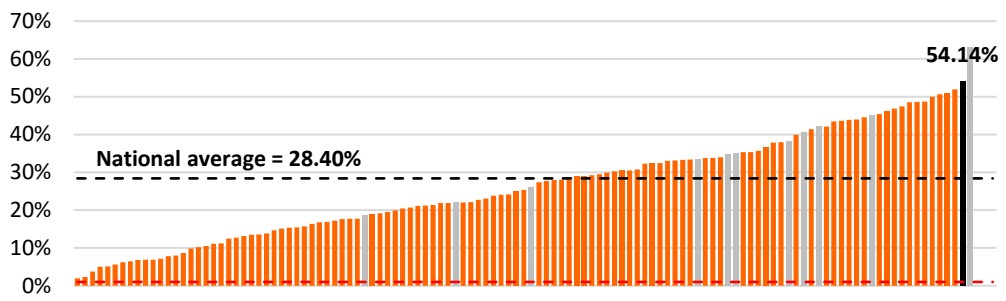


Day case rate

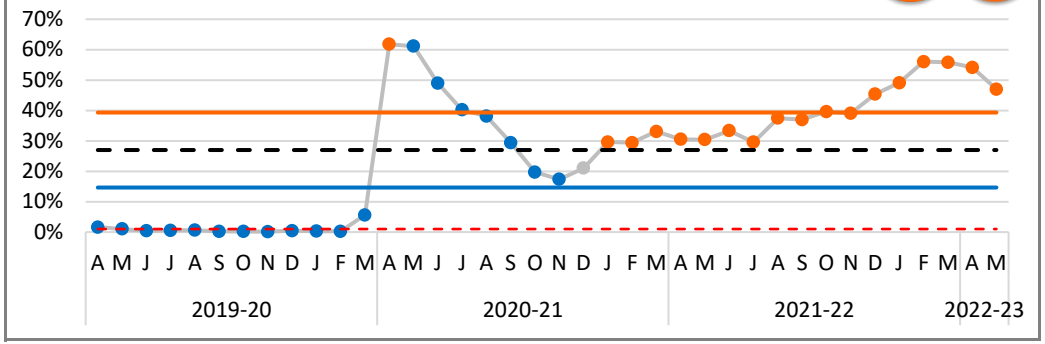


East and North Hertfordshire NHS Trust

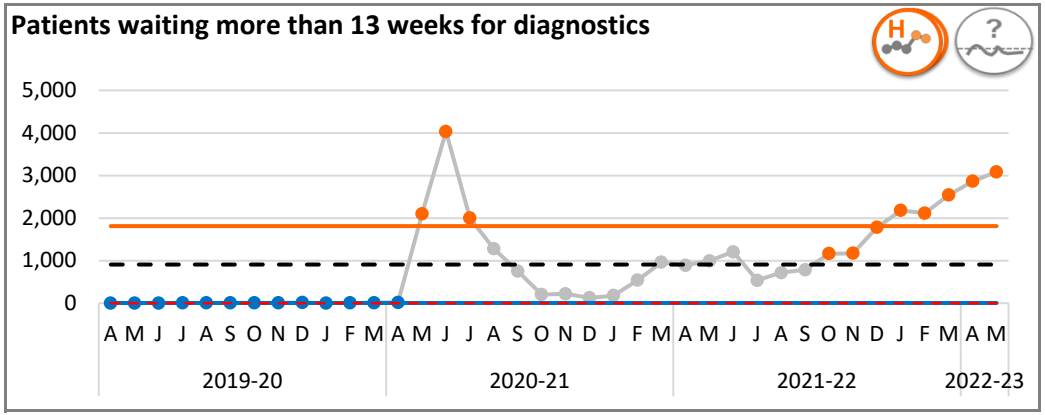
Diagnostics waiting times peer distribution - Apr-22



Patients waiting more than six weeks for diagnostics



Patients waiting more than 13 weeks for diagnostics



Key Issues and Executive Response

Excellence

- Significant reduction in waiting time for CT guided injections and US guided injections (supporting RTT position and long waiters).
- Successful reset week for breast US which notably reduced waiting list by 45% - with an additional reset week scheduled for early July.
- CDH over-delivery for CT and MRI.
- Collaboration between Radiology and Services to reduce 104wk wait position.
- Workforce drives have resulted in a further 2 radiographers starting in May, with 8 in the pipeline and 2 Consultant Radiologists appointed.
- Echo funding approved for 7 days services from October - recruitment underway.

Challenges

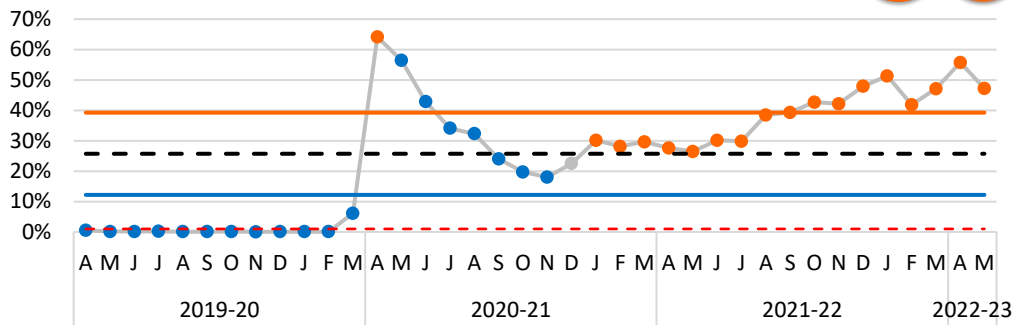
- Continued increase in cancer demand month on month for CT, MRI & US, impacting ability to regain DM01 compliance.
- Overall demand increased in Q1 for ED requests compared to same period in 19/20.
- Workforce shortages (vacancy and sickness) continues to create capacity shortfalls and inability to provide additional capacity.
- National supply issue with CT contrast.
- Risk to echo compliance due to backlog.
- Echo insourcing delay to contract to support clearing backlog - aim to start from mid-August.

Actions

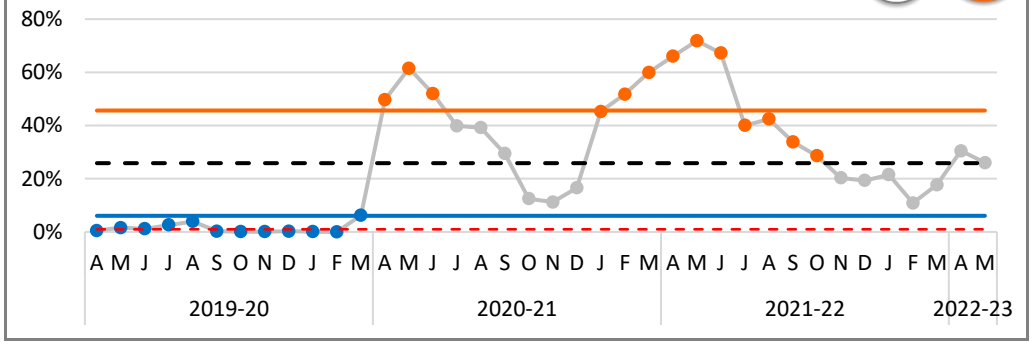
- Continue collaboration with ICS colleagues over mutual aid options.
- Site visit and discussions in place to review additional van days (in particular MRI) to support backlog clearance.
- Workforce steering group in place to review skill mix, recruitment and career progression.
- Clinical Decision System tool meeting being arranged to support demand management.
- Weekly contrast meetings in place to review protocols, PGDs, booking profile and stock.

Diagnostics Waiting Times Supporting Metrics

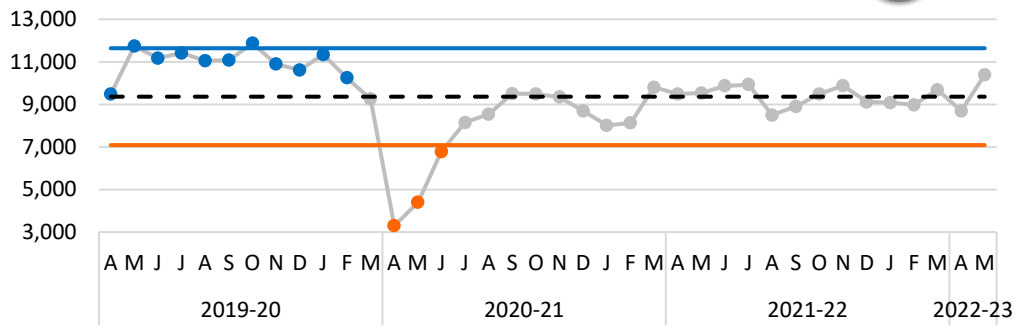
Patients waiting more than six weeks for an Radiology (all modalities)



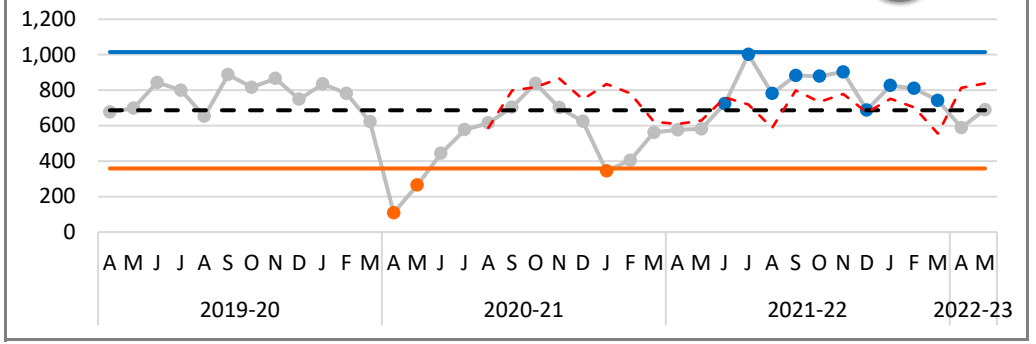
Patients waiting more than six weeks for Endoscopy (all modalities)



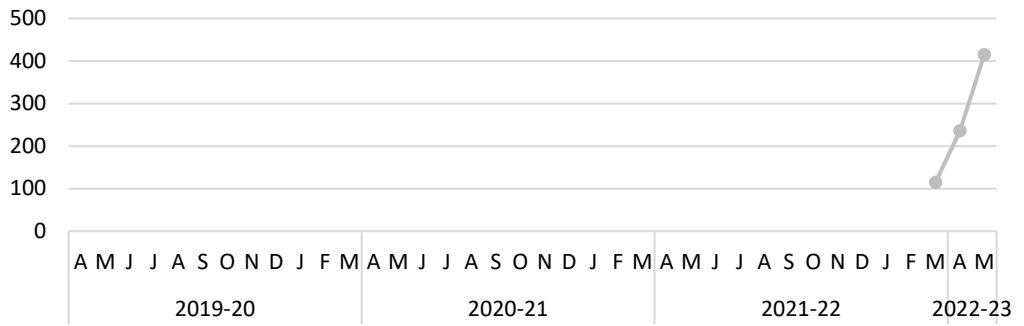
Radiology activity



Endoscopy activity



Community diagnostics centre activity



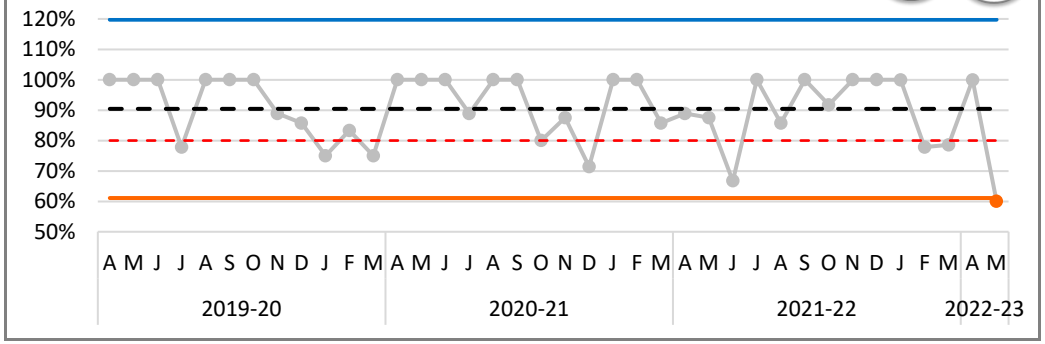
Trust SSNAP grade	Q4 2021-22	D

Breach reasons

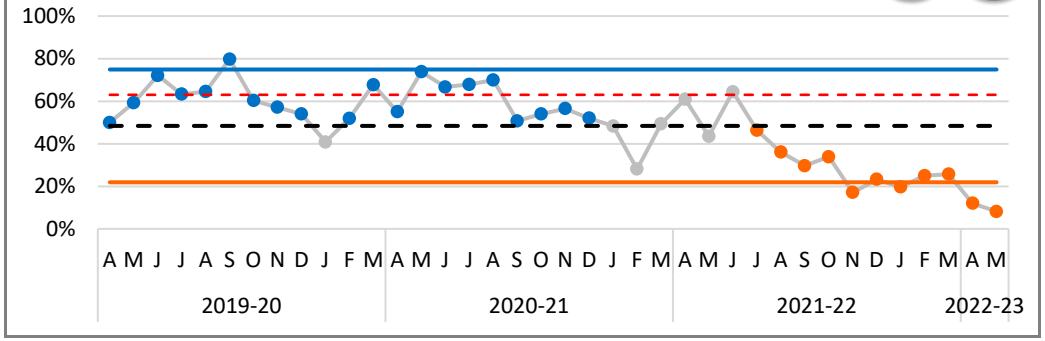
In-hours	27
Challenging Diagnosis/Complex Patient pathway/Clinical Need	9
Late Referral	9
Share Care Transfers	1
Pathway (ED Delays)	6

Out-of-hours	35
Bed Capacity	25
Inpatient Stroke	5
COVID POC	7
Other	0

% of patients with diagnosis of AF and commenced on anticoagulants



4-hours direct to Stroke unit from ED

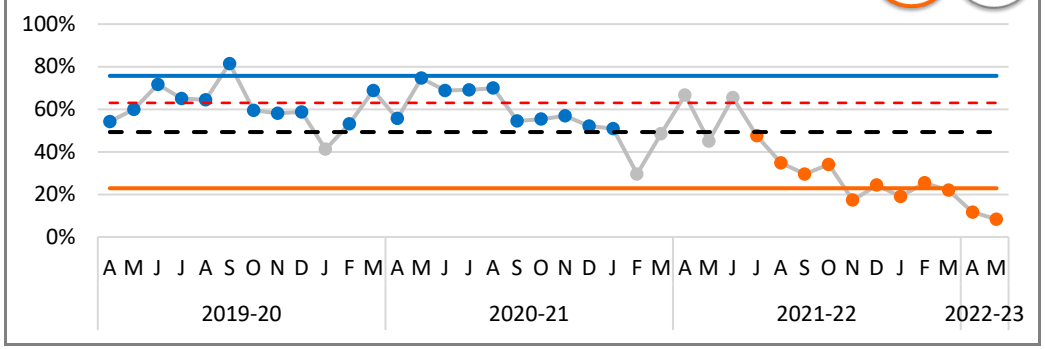


Key Issues and Executive Response

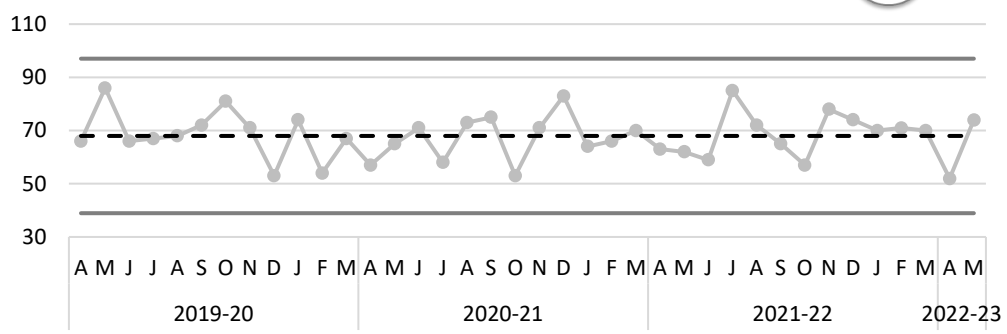
- SSNAP rating for Q4 (Jan - March 2022) declined to D.
- Main factors: decline in performance within SALT services from B to D due to shortfall of staffing due to impact of COVID-related sickness and vacant posts. Assurance provided and mitigation in-place for management vacancies until September.
- Ongoing shortfall of Therapy establishment to achieve the SSNAP domain for care delivered. Occupational Therapy decline from C to D and Physiotherapy decline from B to D.
- Decline across Therapy performance has an overall impact on the domain for Discharge processes, which declined from A to B.
- Concerns with May and upcoming months on performance across the domains due to high levels of vacancies, impact on delivery of domain requirements.
- As per the Statistical Process Control chart, the area of most concern is Direct to Stroke unit within 4 hours - this forms priority for review and development of action plans.
- Other domains have stable systems and processes, but ongoing monthly review for all domains supported with improvements plans.
- 4-hour performance is an issue reported as per the South region Integrated Stroke Delivery Network (ISDN), as area of concerns and review of actions to support improvements.
- High number of breaches due to limited bed capacity and COVID swabbing requirements prior to admission.
- Ringfencing of Stroke bed capacity being reviewed in support of improvement on this domain. Implemented from early June. Daily monitoring of adherence.
- Improvement in-month on scanning.
- Meeting the target for patient receiving Thrombolysis treatment for five consecutive months.

Stroke Services Supporting Metrics

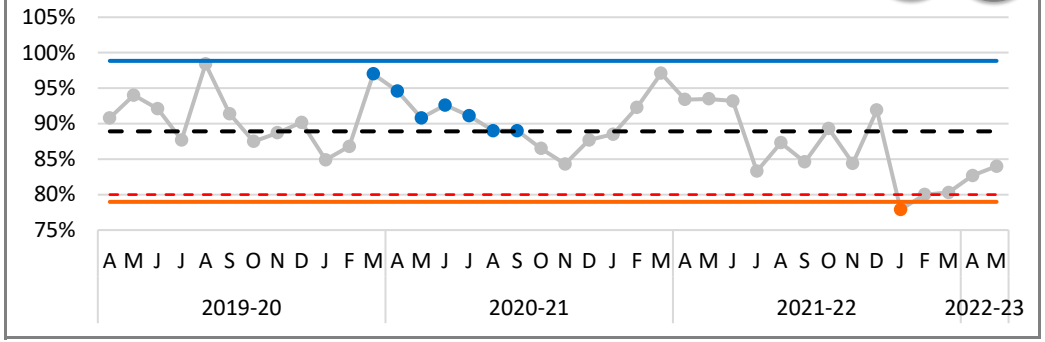
4-hours direct to Stroke unit from ED with exclusions



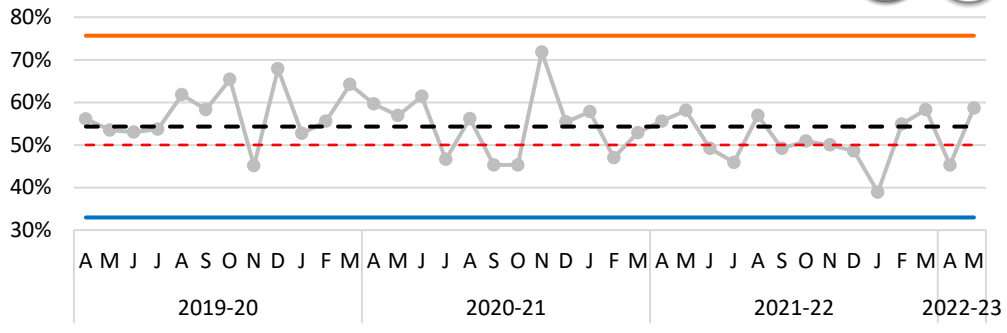
Number of confirmed Strokes in-month on SSNAP



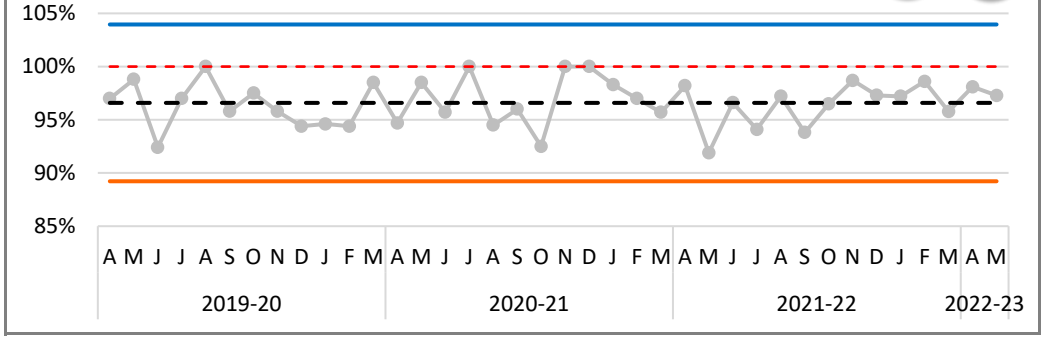
If applicable at least 90% of patients' stay is spent on a stroke unit



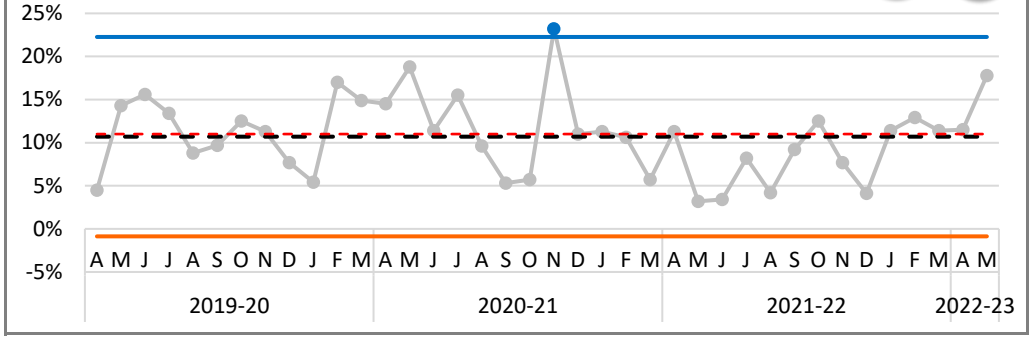
Urgent brain imaging within 60-mins for suspected acute stroke



Scanned within 12-hours - all Strokes

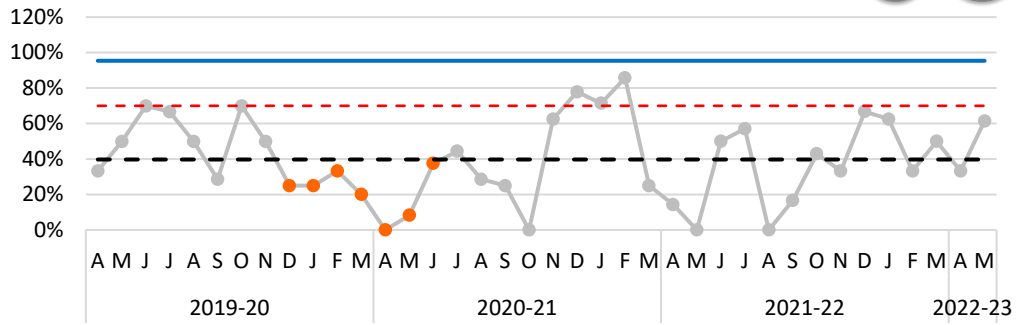


% of all stroke patients who receive thrombolysis

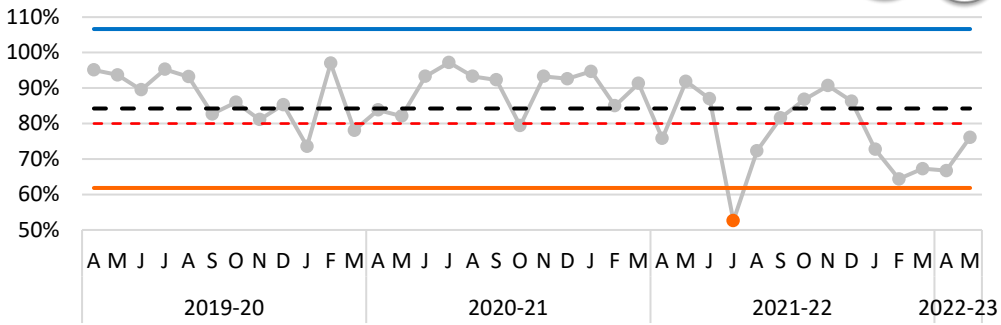


Stroke Services Supporting Metrics

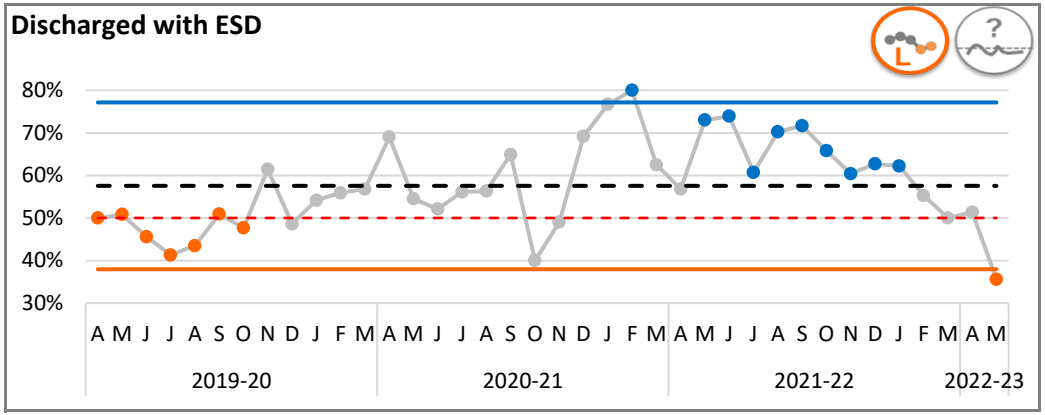
Thrombolysis door to needle time (within 60-minutes)



Discharged with JCP

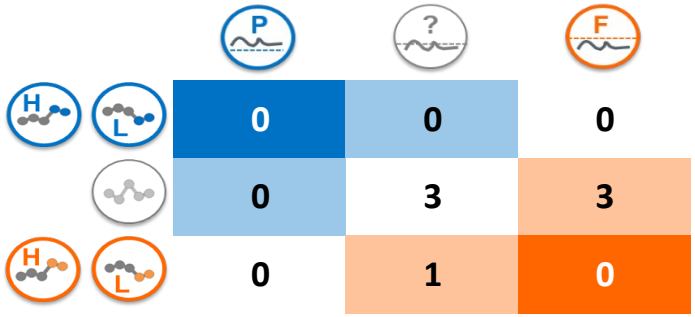


Discharged with ESD



People

Month 02 | 2022-23



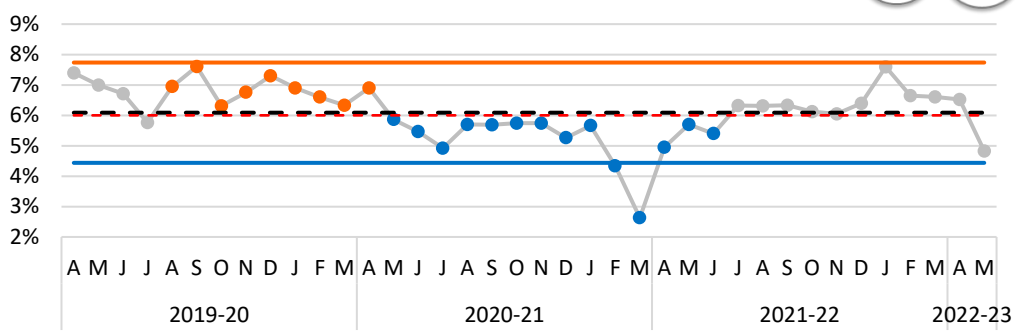
People

Summary

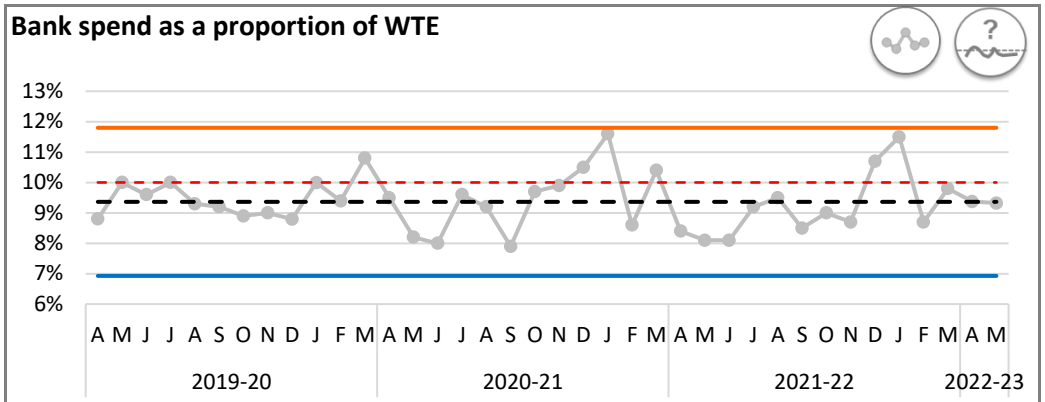
East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	May-22	6%	4.8%			Common cause variation Metric will inconsistently hit & miss the target
	Bank spend as a proportion of WTE	May-22	10%	9.3%			Common cause variation Metric will inconsistently hit & miss the target
	Agency spend as a proportion of WTE	May-22	4%	3.5%			Common cause variation Metric will inconsistently hit & miss the target
Grow	Statutory and mandatory training compliance rate	May-22	90%	86.7%			Common cause variation Metric will consistently fail the target
	Appraisal rate	May-22	90%	68.2%			Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	May-22	12%	10.2%			Common cause variation Metric will consistently fail the target
Care	Sickness rate	May-22	3.8%	5.0%			Nine consecutive points above the mean Metric will inconsistently hit & miss the target

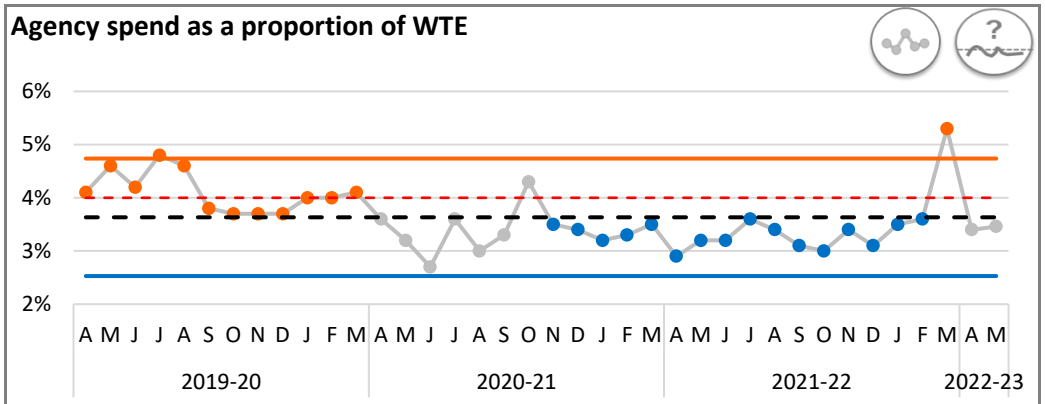
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- International recruitment continues, with 9 midwives due to arrive in summer 2022 as part of a collaborative regional approach.
- There is a 3-month social media campaign for radiographers and sonographers currently, as well as international recruitment of 15 radiographers. A similar campaign for theatres is currently being planned for launch in June 2022.
- There are 260 applicants in the recruitment pipeline including 35 doctors and 94 nurses/midwives.
- Clinical support worker vacancies remain a high priority, with 45 individuals in the pipeline to commence employment in the coming months.
- Agency spend was 141k lower than the monthly ceiling target which is consistent with the reduction in temporary staffing demand (42k fewer hours requested than M12).
- Elective Recovery staffing support plans are underway, 25 Consultant CVs shared with a number of interviews taking place over the coming weeks to support additional requirements.
- People Team Virtual Assistant approved - work has begun with IBM on content with plans for launch around Q2.

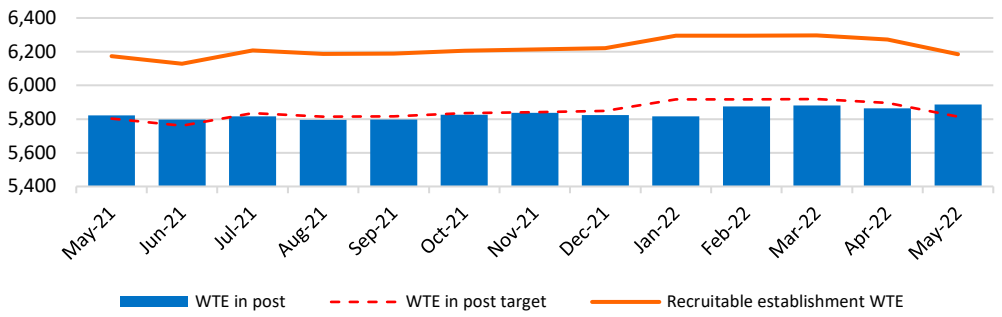
People

Work Together

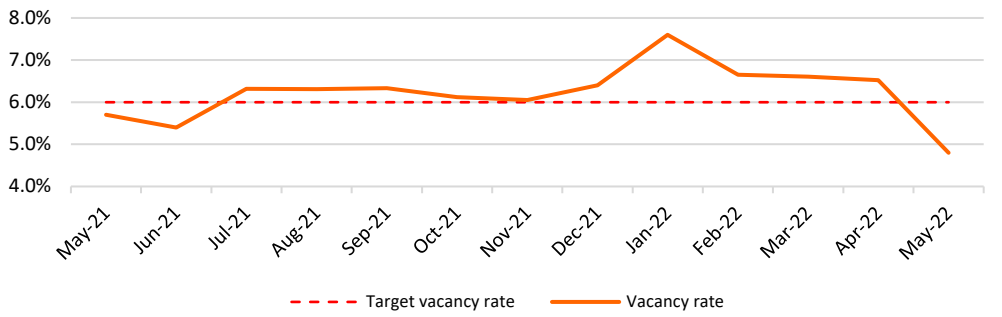
East and North Hertfordshire NHS Trust

Metric	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Trend
Time to hire (weeks)	10	11	10	9	9	9	10	10	10	11	11	11	11	10	
Recruitment experience	4	4.7	4.7	4.7	4.7	4.6	4.5	4.5	4.5	4.7	4.7	4.7	4.4	4.4	
Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	2.00			1.43			1.53			1.58			tbc	
Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	1.20			1.62			3.10			1.23			tbc	
% of Clinical Workforce (AFC) on eRoster	> 90%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	
% of Medical & Dental on eRoster	> 60%						84.0%	83.0%	84.0%	84.0%	84.0%	84.0%	85.0%	85.0%	
% of Rosters Approved more than 6 weeks in advance (NHS E/I recommended)	> 80%						63.5%	58.9%	61.2%	68.5%	68.2%	47.7%	42.2%	65.9%	
% Staff on Annual Leave	13% - 17%	12.0%	12.0%	13.4%	16.7%	15.0%	11.3%	12.7%	12.4%	15.6%	13.8%	17.1%	16.6%	13.8%	
Pulse survey Flexibility	55%	64.3%			56.6%			tbc			tbc			tbc	

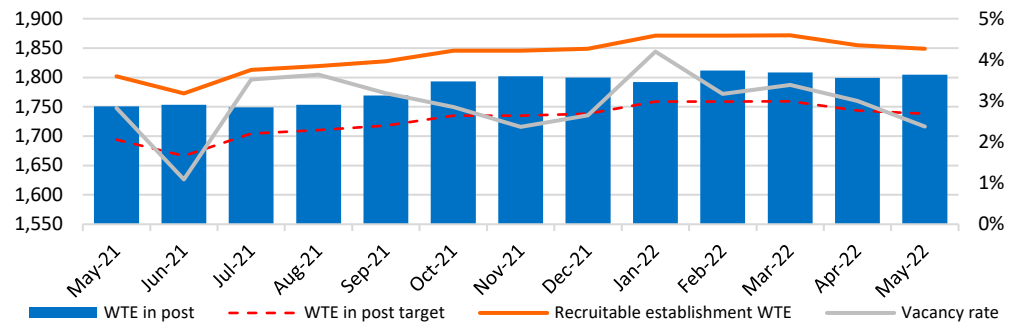
WTE in-post



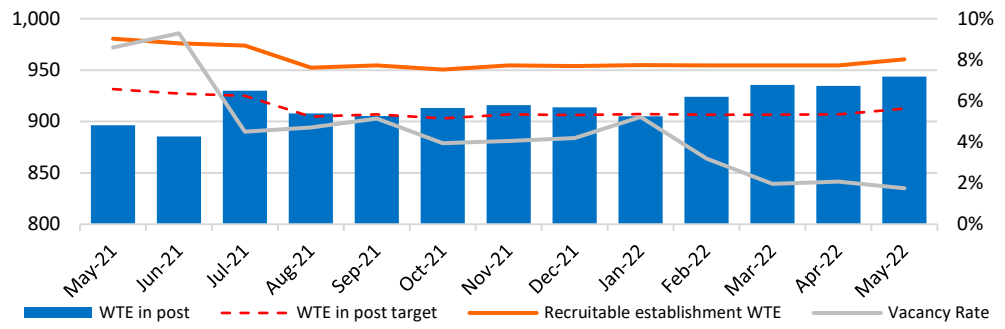
Vacancy rate - all staff groups



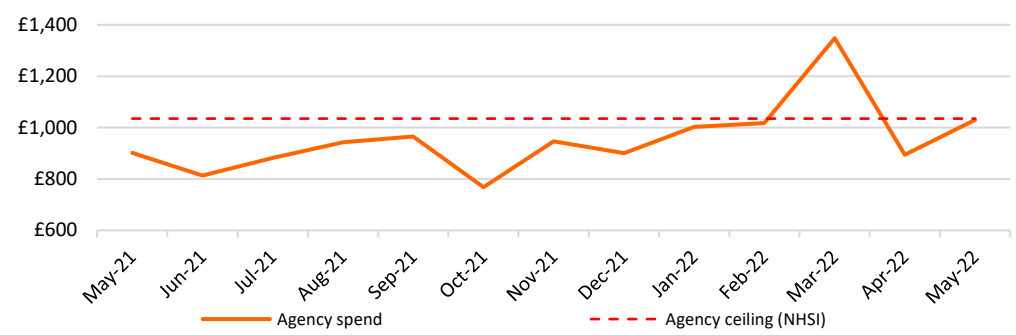
Nursing and Midwifery Qualified - WTE in-post



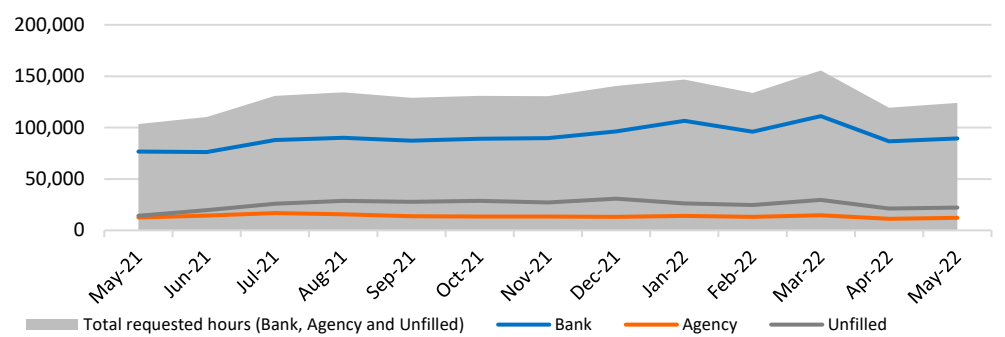
Medical - WTE in-post



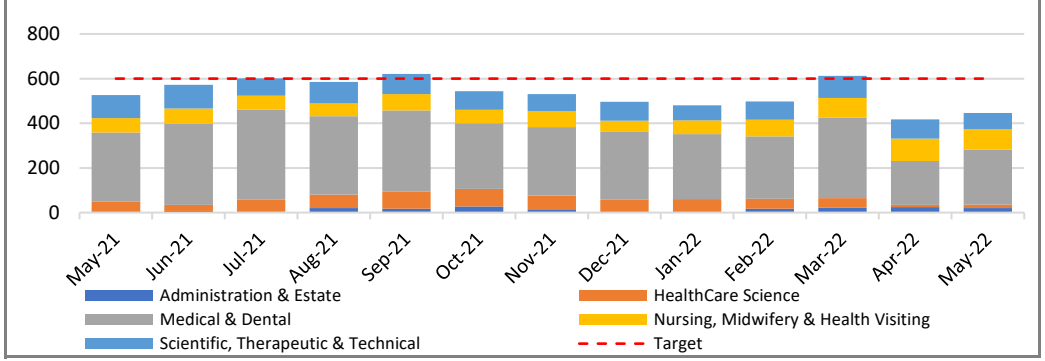
NHSI agency ceiling target



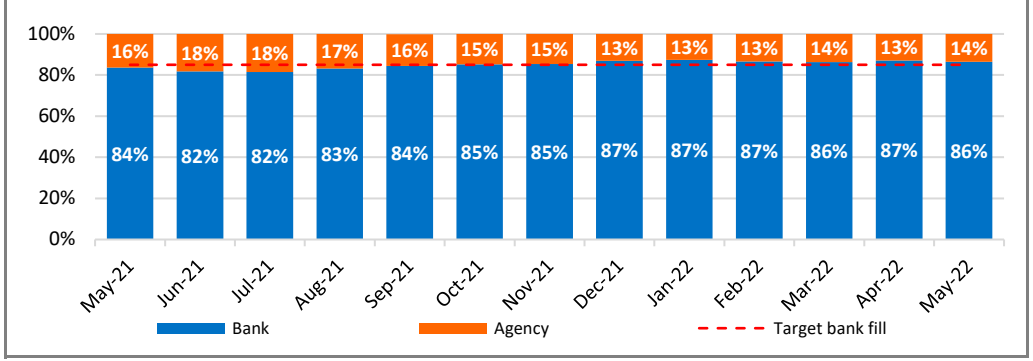
Fill performance (hours filled)



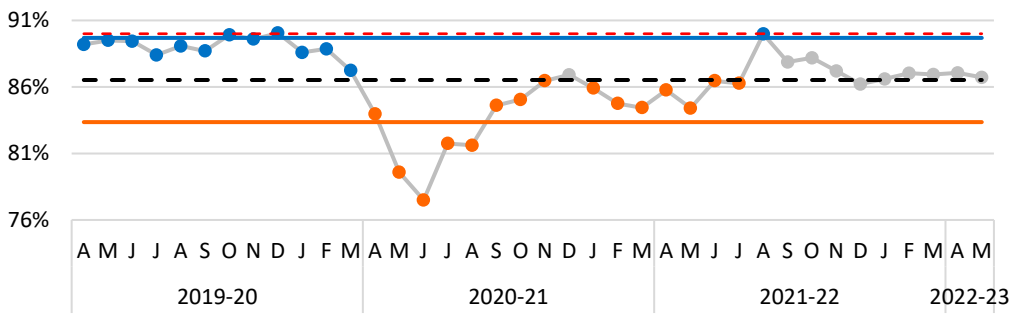
Agency price cap breaches



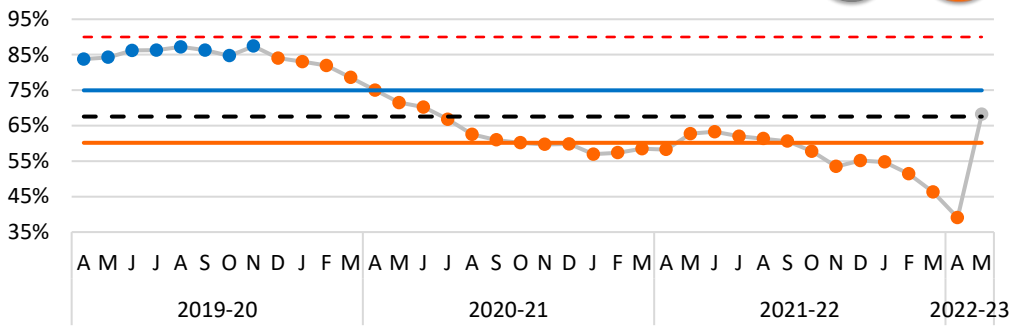
Bank and agency fill performance



Statutory and mandatory training compliance rate



Appraisal rate

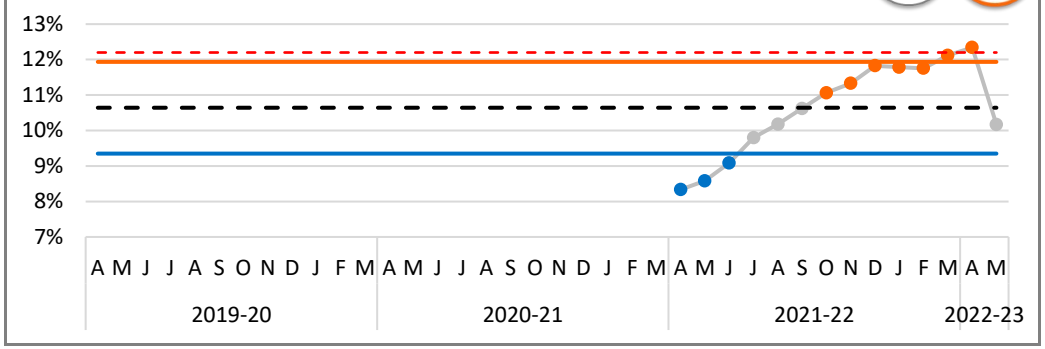


Key Issues and Executive Response

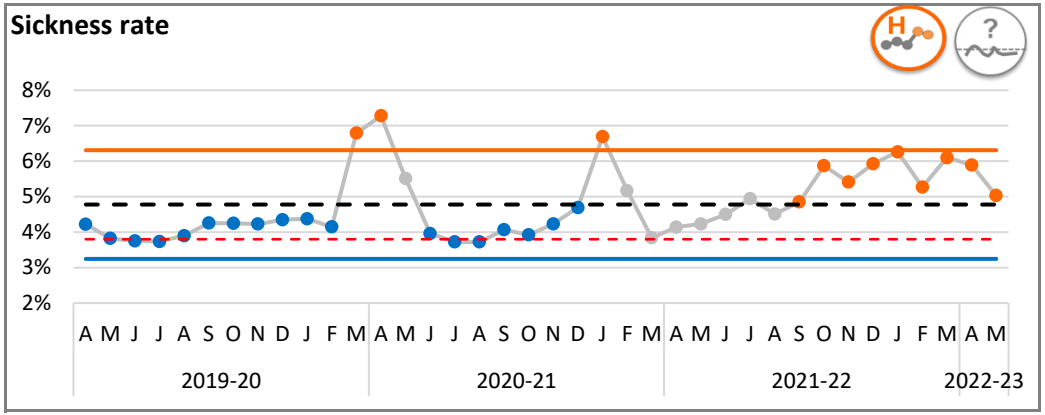
- Grow together reviews are progressing as part of the new April to August cycle. Virtual training sessions and drop in events took place in April and will continue during the appraisal cycle. Staff are continuing to undertake Grow reviews over the next 4 months.
- To improve mandatory training compliance, notifications were sent in April via In-brief (newsletter) to prompt managers to ensure training is up to date prior to the grow together review cycle commencing. Further targeted reminders are planned this month. Key issues affecting compliance relate mainly to Face-to-Face training DNAs. Action plans are being developed to address this.
- The Statutory Mandatory Steering group met in April 2022 and confirmed the addition of MCA/DoLs to the Trust's statutory training matrix as a core mandatory requirement. Future compliance reports will include updates on MCA/DoLs compliance.
- The Continuing Professional Development (CPD) Training needs analysis for 22/23 has concluded, with around £900k worth of training requests put forward across all services, against a potential budget of circa £700k. Training requests are being reviewed and approved requests will be confirmed in June

Metric	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Pulse survey Training and development opportunities	55%	55%		55%			tbc			tbc			tbc	
Pulse survey Talent management	55%	62%		55%			tbc			tbc			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	

Turnover rate



Sickness rate



Key Issues and Executive Response

Thrive Together

- Team talks on staff survey are launched with actions to be agreed and collated to enable measure against local actions agreed throughout 2022.
- The People Pulse Survey has gone live again and so far, responses are looking more positive than the previous quarter.
- Staff turnover metrics have been re-calculated to reflect the way that turn-over rates are captured across the system. A deep dive into turnover will be discussed in the newly formed People Committee.
- The Trust is in the process of resetting its values. This is following organisation-wide engagement for input into the behaviours people want to see and the associated values. A stakeholder group has been convened to review the initial results and will continue to meet throughout May.
- Staff Award nominations have been assessed and a shortlist and winners assessed, invitations have gone out to staff to attend the award evening on July 7th.
- Long service badges are being distributed via Executives throughout May and June.

Care Together

- Sickness absence rates continue to be significantly above target which has been driven by the number of Covid cases in the area.
- The Trust is performing significantly better than the previous year for sickness absence related to mental health and musculoskeletal. The Trust is planning an improvement trajectory for the year which represents a 10% reduction for stress and mental health and a 5% reduction for musculoskeletal compared to the previous year.
- Delivery of all furniture from make a wish schemes now in situ and evaluation will get underway as to the difference this is making for staff morale/engagement.

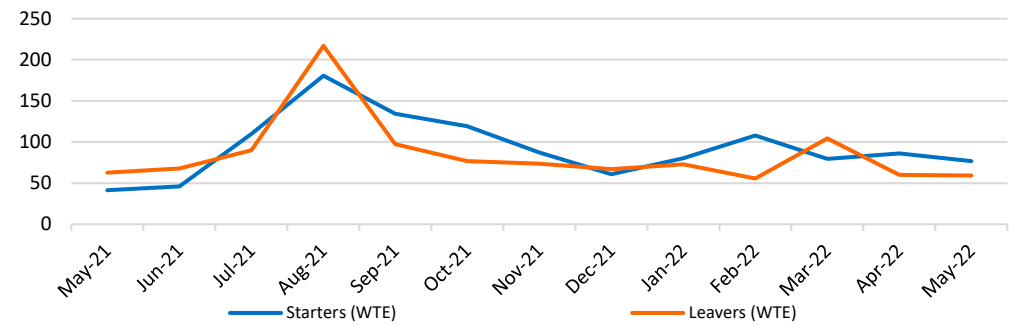
People

Thrive Together | Care Together

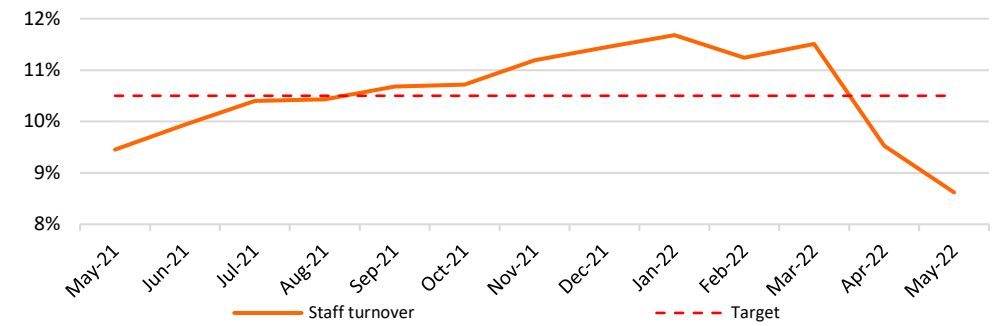
East and North Hertfordshire NHS Trust

Metric	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Trend
Pulse survey My leader	75%	85.5%		79.8%			tbc			tbc			tbc		
Pulse survey Harnessing individuality	60%	61.8%		52.8%			tbc			tbc			tbc		
Pulse Survey Not experiencing discrimination	95%	75.9%		70.8%			tbc			tbc			tbc		
Model employer targets (% achieved)	100%	50%		67%			83%			50%			tbc		
Average length of suspension (days)	20	57.2	76.6	105.0	96.0	142.5	140.0	177.5	86.0	226.5	201.0	137.2	193.0	212.0	
Average length of Disciplinary (excluding suspensions) (days)	60	63.0	47.7	86.0	74.0	71.6	51.0	54.9	43.5	72.5	112.4	86.3	81.7	142.0	
Average length of Grievance (including dignity at work) (days)	60	80.0	86.0	74.0	37.9	23.3	37.0	46.9	45.9	57.7	64.8	94.2	77.3	109.0	
Pulse survey Well-being	70%	78.9%		71.5%			tbc			tbc			tbc		
Pulse survey Reasonable adjustments	50%	88.7%		91.4%			tbc			tbc			tbc		
Staff FFT - Recommend as a place to work	60%	56.6%		41.7%			tbc			tbc			tbc		
Staff FFT - Recommend as a place of care	70%	72.7%		65.9%			tbc			tbc			tbc		
Sickness FTE Days Lost	6,777	7,633	7,818	8,905	8,102	8,437	10,599	9,474	10,735	11,278	8,672	11,124	10,363	9,187	
Mental health related absence (days lost)	1,650	1,702	1,899	1,945	1,583	1,725	2,223	2,021	1,787	1,455	1,434	1,526	1,397	1,752	
MSK related absence (days lost)	1,285	1,170	1,325	1,260	1,196	1,152	1,308	1,204	1,166	1,157	881	886	845	1,236	

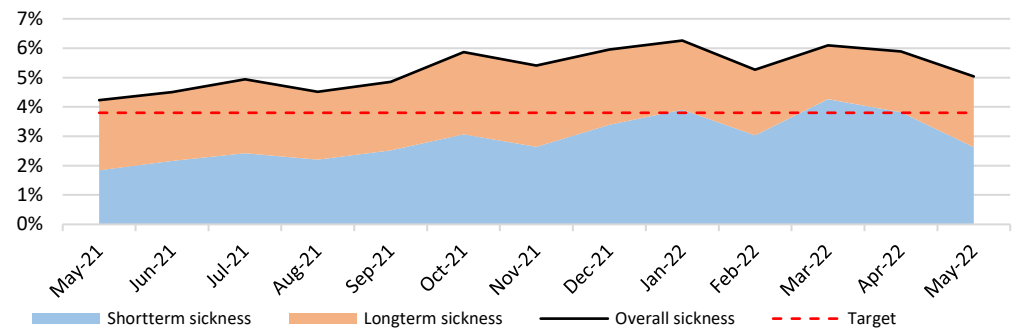
Starters and leavers



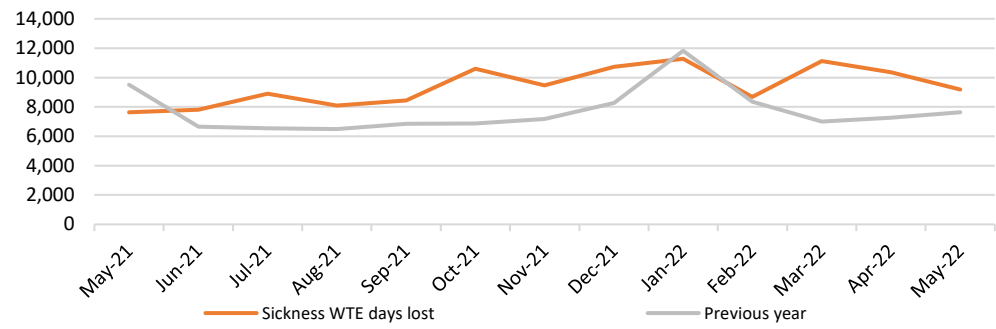
Qualified Nursing and Midwifery staff turnover



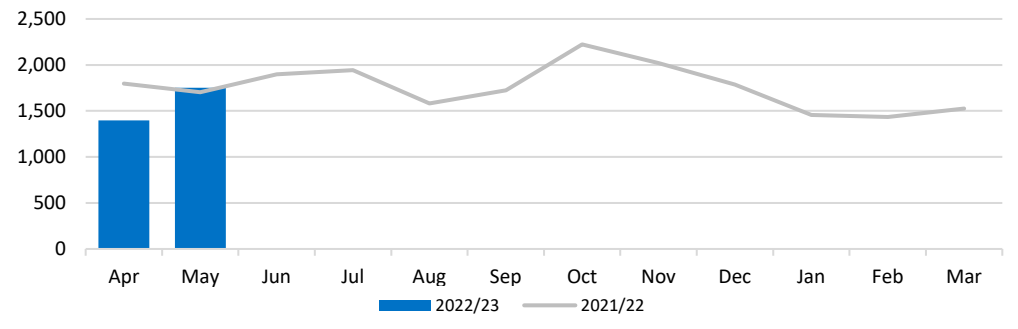
Staff sickness



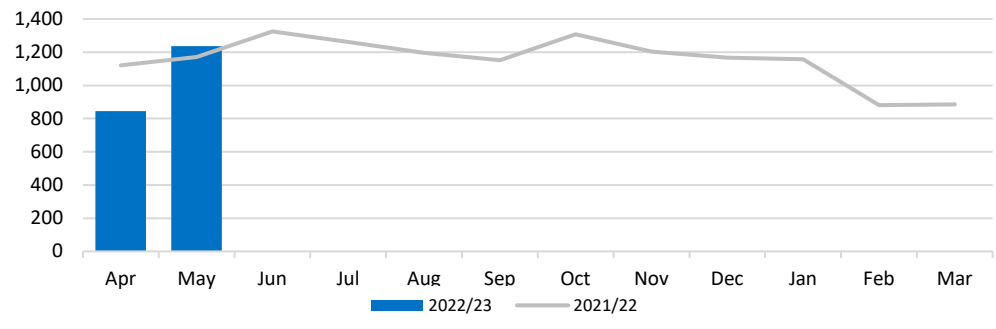
Sickness days lost



Mental Health-related sickness

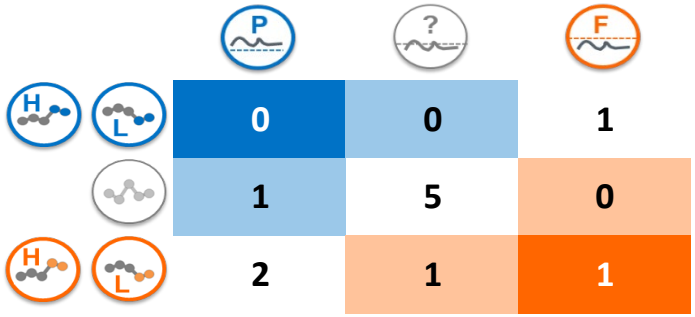


Musculoskeletal-related sickness



Sustainable Services

Month 02 | 2022-23



Sustainable Services

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	May-22	-2.4	-2.1			Common cause variation Metric will inconsistently pass & fail the target
	CIPS achieved	May-22	1,245	707			No data Apr-20 to Sep-21
	Cash balance	May-22	77.9	65.4	H	F	8 points above the upper process limit Metric will consistently fail the target
Key Financial Drivers	Income earned	May-22	45.3	45.9			Common cause variation Metric will inconsistently pass & fail the target
	Pay costs	May-22	29.5	29.4	H		11 points above the mean Metric will inconsistently pass & fail the target
	Non-pay costs (including financing)	May-22	15.5	15.9			Common cause variation Metric will inconsistently pass & fail the target

Sustainable Services

Summary

East and North Hertfordshire NHS Trust

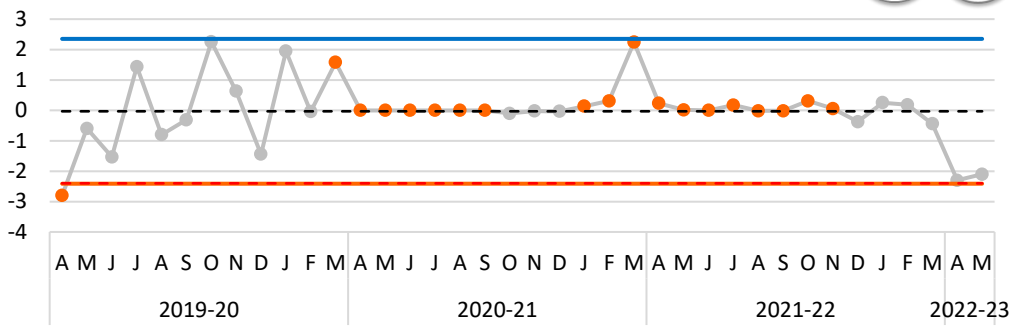
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	May-22	24.9	25.6	H	P	2 points above the upper process limit Metric will consistently pass the target
	Average monthly substantive pay costs (000s)	May-22	0.9	4.5	H	F	9 points above the mean Metric will consistently fail the target
	Agency costs	May-22		0.9			Common cause variation No target
	Unit cost of agency staff	May-22		13.6			Common cause variation No target
	Bank costs	May-22	3.7	2.9		P	Common cause variation Metric will consistently pass the target
	Overtime and WLI costs	May-22	0.5	0.4	H	P	One point above the upper process limit Metric will consistently pass the target
Other Financial Metrics	Elective Recovery Fund income earned	May-22	1.1	2.2			
	Drugs and consumable spend	May-22	2.8	3.3		?	Common cause variation Metric will inconsistently pass & fail the target
	Private patients income earned	May-22	0.4	0.3		?	Common cause variation Metric will inconsistently pass & fail the target

Sustainable Services

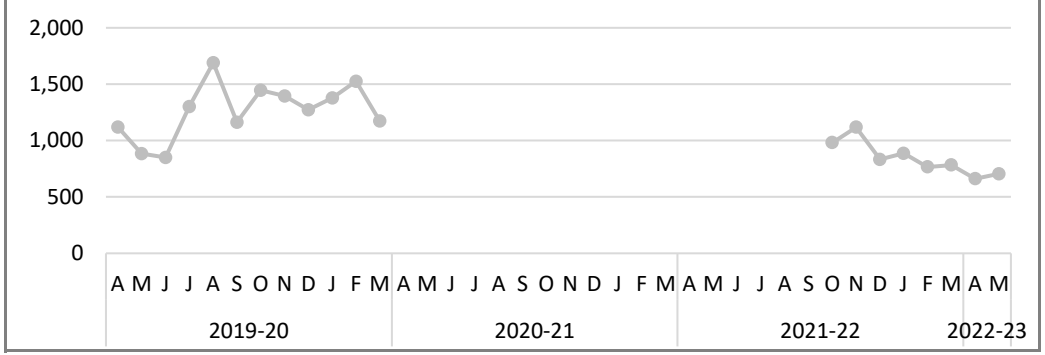
Summary Financial Position

East and North Hertfordshire NHS Trust

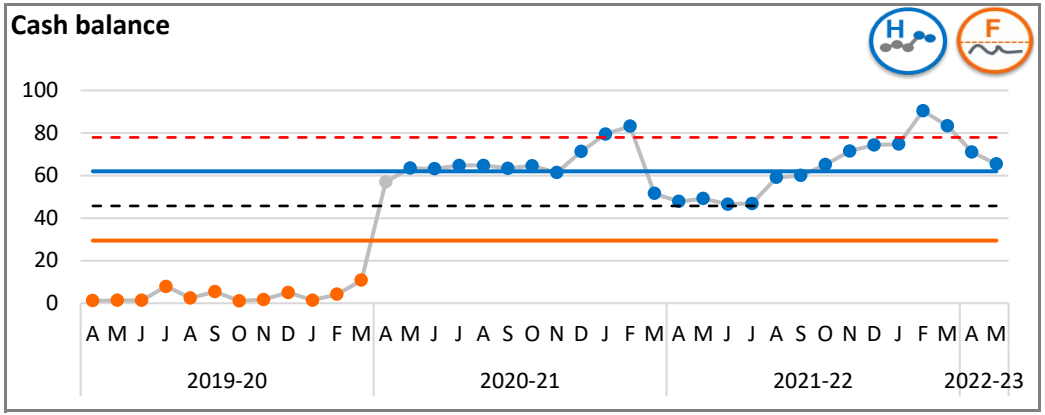
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust reports its M2 financial performance against the £9.9m deficit plan that it submitted in April 22. A revised balanced annual plan that includes the receipt of additional national inflation funding will be implemented in M3.
- The Trust reports a £2.2m deficit in May, this increases the YTD deficit position to £4.5m. This is in line with the deficit plan.
- The Trust's elective activity plan assumes a gradual ramp up of additional capacity during Q1. Progress during April and May has been modest compared with the 19/20 baseline, with a significant step changed anticipated in June. The Trust position has assumed full receipt of ERF funds.
- Delivery against the Trust's CIP target is a concern at this stage, with a cumulative undershoot of £1.3m reported at M2. Divisional recovery plans are an urgent priority.
- Significant overspends against medical staffing budgets are reported at M2. These are predominately concentrated in the Trust's urgent emergency care pathway.

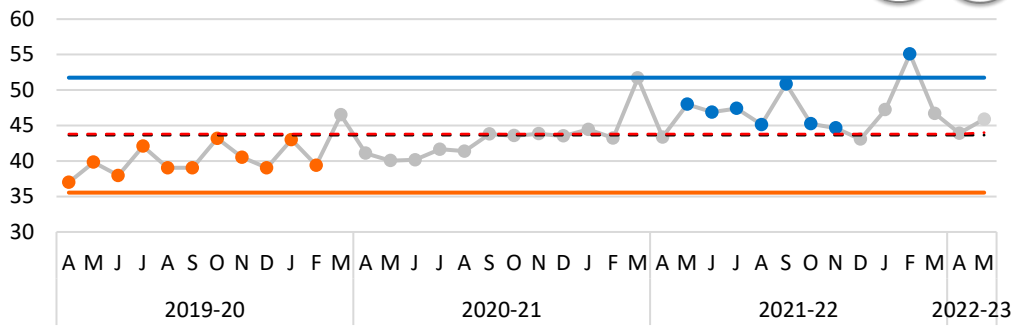
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	526.9	86.8	85.7	-1.2
Pay	-347.6	-58.4	-58.1	0.3
Non Pay	-183.1	-31.8	-30.8	1.0
EBITDA	**-3.8**	**-3.3**	**-3.2**	**0.1**
Financing Costs	-31.1	-5.2	-5.4	-0.1
Retained Deficit exc. PSF	**-34.9**	**-8.6**	**-8.6**	**0.0**
Top-Up Payments	9.8	1.6	1.6	0.0
Systems Funding	15.2	2.5	2.5	-0.0
Adj Financial Performance	-0.2	-0.0	-0.1	-0.1
Deficit (Incl Fin Adj's)	**-10.1**	**-4.4**	**-4.5**	**-0.1**

Sustainable Services

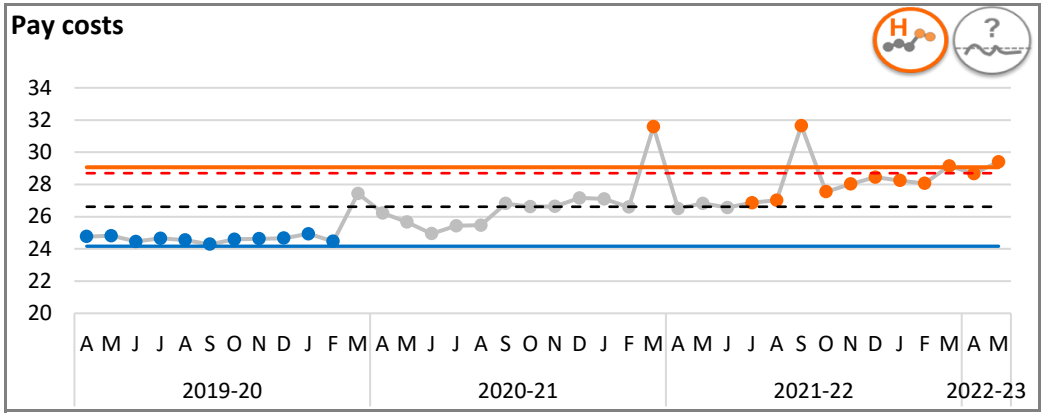
Key Financial Drivers

East and North Hertfordshire NHS Trust

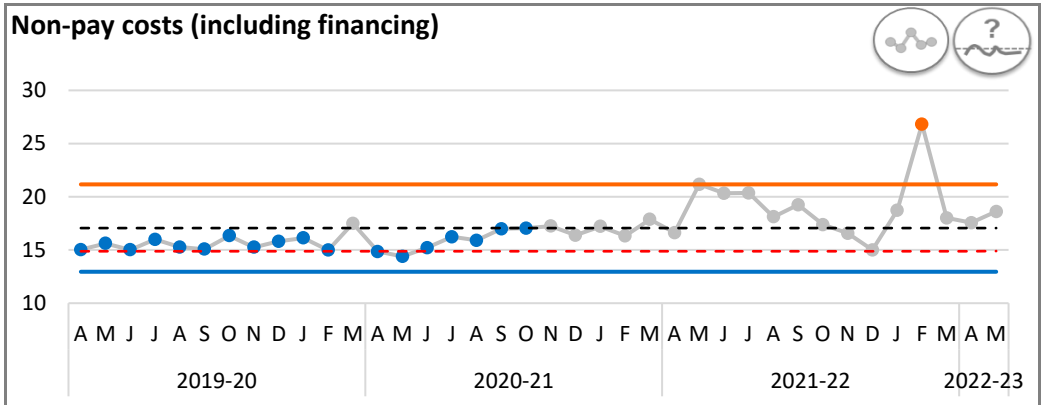
Income earned



Pay costs



Non-pay costs (including financing)



Key Issues and Executive Response

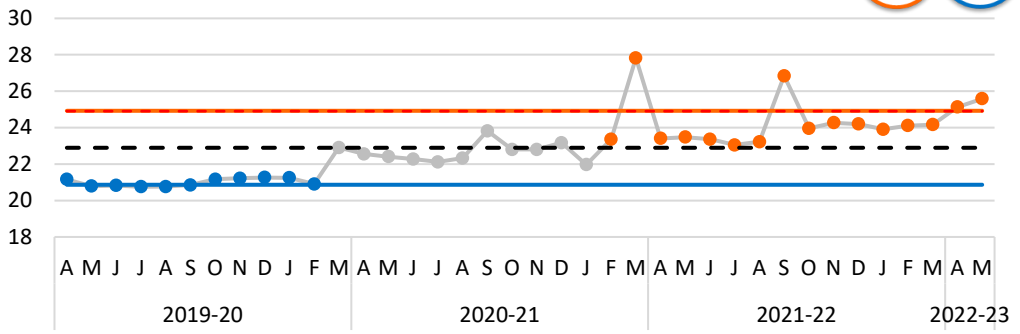
- Month 2 financial performance continues to represent a challenging start to the financial year for the Trust. In May there is a reported deficit of £2.1m (£4.4m YTD). Whilst this in line with the provisional plan, this represents a significant overspend against the Trust's original plan.
- In the year to date the value of ERF activity that the Trust has performed in broadly equivalent to 19/20 but significantly below the 22/23 plan required to deliver national targets. The Trust has assumed full receipt of ERF funding on the basis that additional capacity investments will recover the shortfall in the remainder of the year. The costs of this additional capacity are already presenting in the Trust's YTD position.
- Capacity plans have now been agreed with Divisions which should deliver the 110% elective target against 19/20 levels. Capacity will be expanded by a number of means – additional posts, WLI's, locum and agency and also Theatre and OP transformation plans to drive productivity. Weekly elective throughput monitoring meetings are now in place.
- Slippage against CIP targets (£0.7m in month, £1.2m YTD) represents a major concern at the Month 2 reporting period. Divisional capacity to support effective project and delivery arrangements remains a concern that requires redress.
- Month 2 has again provided some evidence that effective budgetary controls require strengthening in conjunction with budget holders. In response a range of direct training support packages are being deployed by the Finance team.
- The Trust continues to closely monitor the impact of high levels of inflation upon its financial plan.
- A sequence of monthly divisional finance boards are in place chaired by the Director of Finance.

Sustainable Services

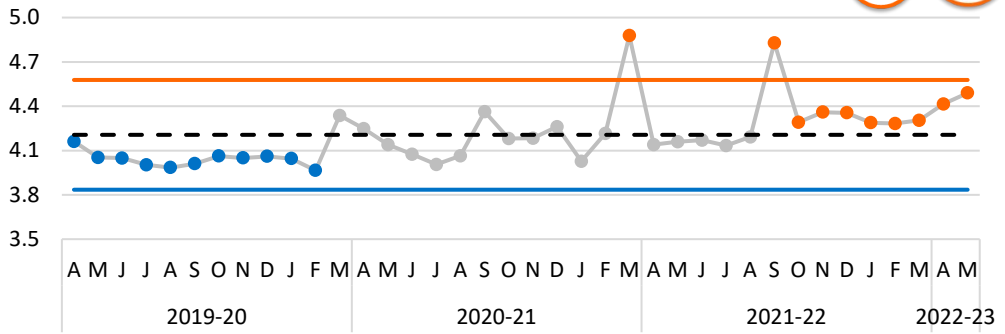
Key Payroll Metrics

East and North Hertfordshire NHS Trust

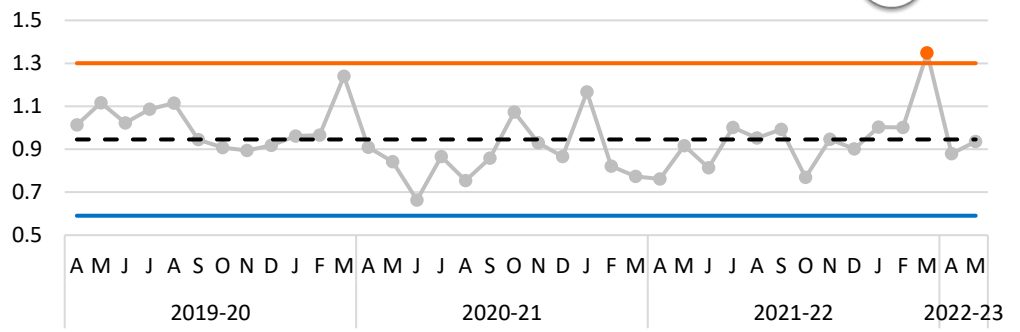
Substantive pay costs



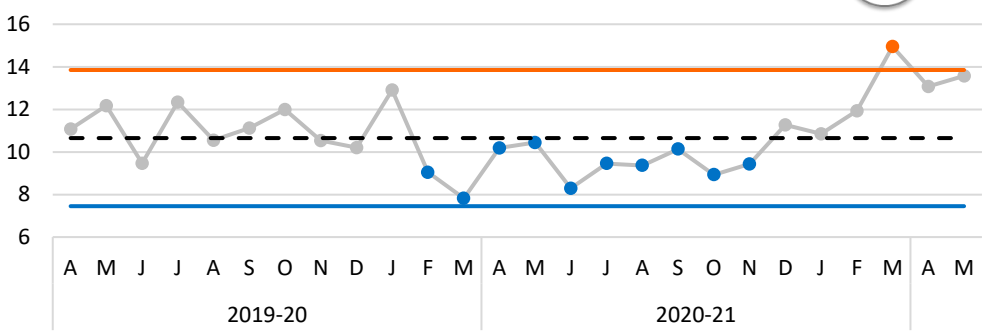
Average monthly substantive pay costs



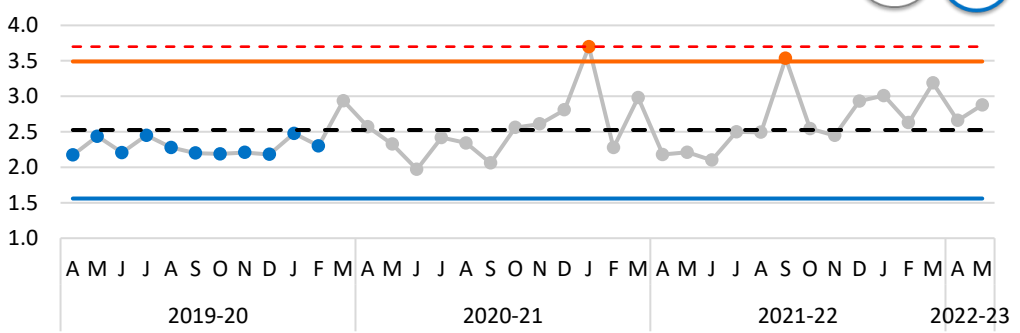
Agency Costs



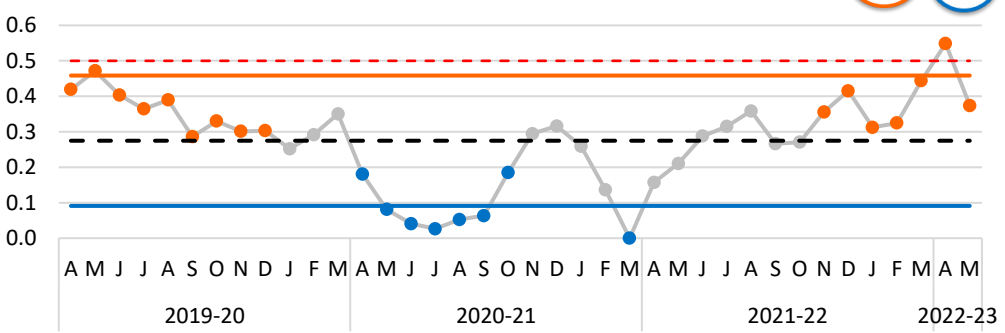
Unit cost of agency staff



Bank costs



Overtime and WLI costs

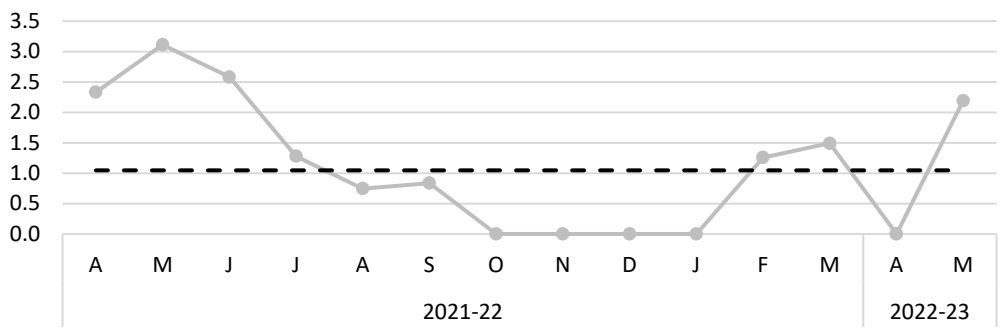


Sustainable Services

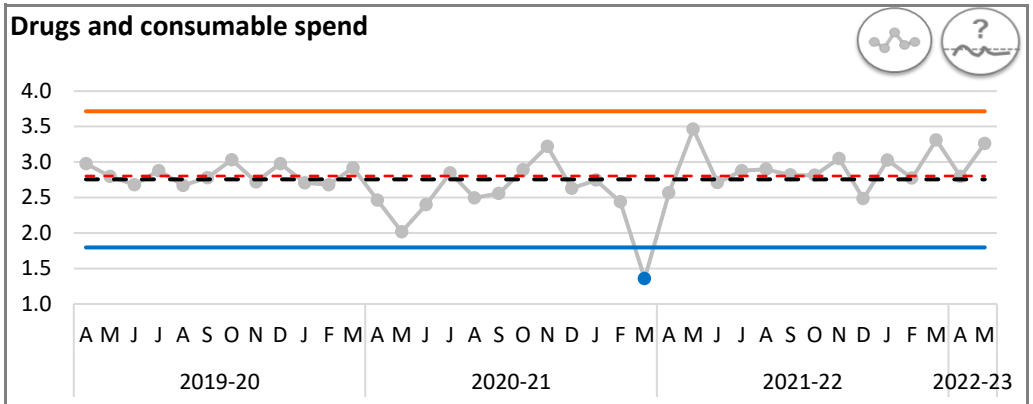
Other Financial Indicators

East and North Hertfordshire NHS Trust

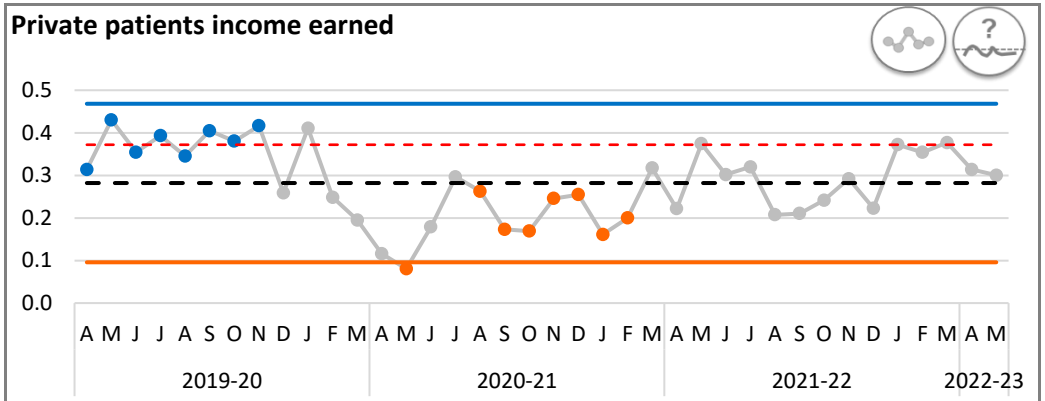
Elective Recovery Fund income earned (In month)



Drugs and consumable spend



Private patients income earned



East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	13
Report title	Strategic Transformation Update			**Meeting Date**	6th July 2022
Presenter	Kevin O' Hart, Director of Improvement				
Author	Kevin O' Hart, Director of Improvement				
Responsible Director	Kevin O'Hart			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

- The inaugural meeting of the Executive Programme Board (EPB) took place on 12th May. This will be the new Trust executive forum for coordinating the development, oversight, and delivery of key internal and external strategic transformational priorities and objectives.
- All strategic initiatives will be managed using a robust, standardised project and programme management model, supported by the transformation team.
- This initial report highlights the baseline portfolio that has been agreed; additional programmes relating to the eight strategic objectives for 22/23 will be reviewed at the July meeting.
- This new model incorporates an executive SRO allocated to each programme who will be accountable for delivery; specific SRO allocations reflect a new, collective executive approach to strategic objective delivery.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

- Failure to deliver these programmes will significantly impact on the successful delivery of both the Trusts strategic objectives, as well as core NHSE planning guidance targets for elective recovery and urgent and emergency care.

Risk: *Please specify any links to the BAF or Risk Register*

- Programmes predominantly relate to BAF risk 001/21 operational delivery of core standards, 003/21 financial delivery and 003/21 ICP/ ICS collaboration.

Report previously considered by & date(s):

- Executive Programme Board 9th June 22/23.

Recommendation	The Board is asked to note the progress to date.

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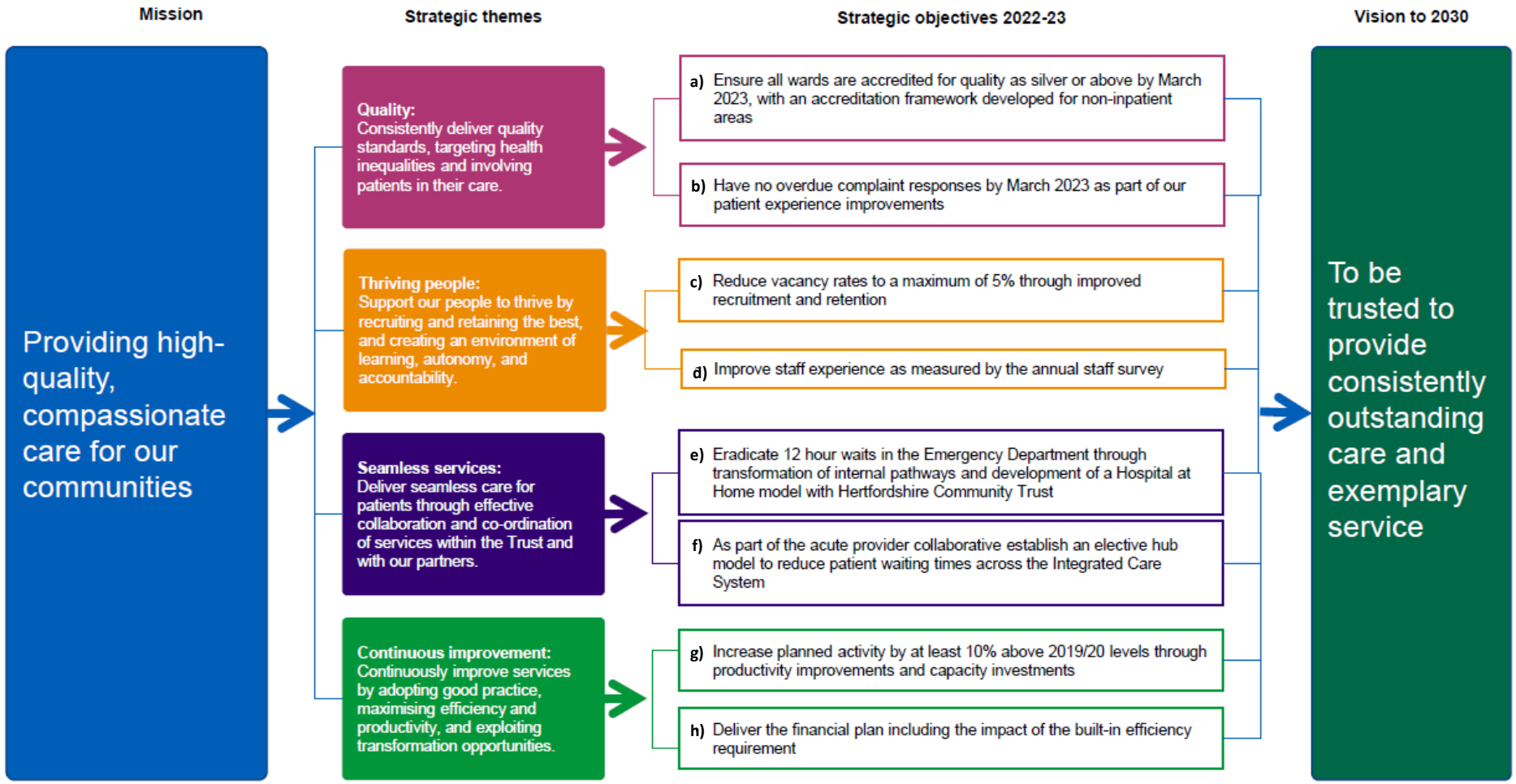
Strategic Objectives 2022 - 23

East and North Hertfordshire NHS Trust



Executive Programme Board Updates
Section 1 – Elective Recovery Portfolio

East and North Hertfordshire NHS Trust

Strategic Objective G - Community Diagnostic Centre	Milestones	KPIs
SRO – Kevin O'Hart, Director of Improvement		

Phase 1 of the CDC Programme has included the expansion of opening hours evenings and weekends at QE11 for existing modalities including x-ray, ultrasound, CT, MRI and DEXA; this increased capacity supports the elective recovery programme. In addition two new pathways for one-stop ECHO and Fibroscan services have also been commissioned. Current performance significantly exceeds agreed trajectories across three modalities, with a further two modalities (X-ray, U/S) behind schedule and one-stop ECHO delayed in mobilisation due to recruitment challenges. A range of workforce actions already underway including a completed radiology staff consultation exercise will increase workforce capacity over the next three months. Decisions not to redeploy staff from over-exceeding modalities is based on waiting times and risk stratification issues. U/S remains the only modality unlikely to recover position; this is due to both a national staff shortage of sonographers and issues with qualification and skills recognition from overseas candidates.
Phase 2 of the CDC Programme involves several additional new pathways across respiratory, cardiology and ophthalmology offering a range of direct access and one-stop models for patients based on current unmet need; a funding decision from NHSE is expected towards the end of June with mobilisation later in 22/23.

Strategic Objective G - Outpatient Transformation	Milestones	KPIs
SRO – Mark Stanton, Chief Information Officer		

Initial work has focussed on developing the patient initiated follow-up (PIFU) model and establishing 10 specialities onto live pathways to support self-management and reduce follow-up activity where clinically safe to do so, this is also now mandated by NHSE planning guidance . Current PIFU activity is 0.7% of all OPD attendances and the national target is to reach 5% of all OPD activity by March 2023. Progress and pace has been influenced by the need to obtain clinical engagement and buy-in with the model which is fundamentally a change programme.
New PIFU pathways for more complex needs, and inpatients on discharge have been developed and will enter test phase with gastroenterology in July.
It was agreed at EPB in June that there was a requirement to pause and consider the future vision and model for OPD as part of the refresh work. Workshops are planned for July with the aim to define a new vision and strategy and present the A3 scope via the EPB in September. The subsequent multi-year programme will focus on the end to end process , designed with strong clinical leadership, operational, transformation and digital collaboration.

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

Strategic Objective H - Surgical Pathways	Milestones	KPIs
SRO – Martin Armstrong, Director of Finance & Deputy CEO		
There are a range of enabling projects underway that contribute towards improving efficiency and productivity of surgical pathways and achievement of pre-pandemic activity levels. Within POA services process mapping and clinical reconfiguration work has been completed with agreement to launch a new electronic TCI card now confirmed and resourced. These actions will support the team in managing increased booking requirements to support elective recovery which currently is a manual, paper-based system. Pathway mapping, functionality requirements and configuration is underway for the new Bluespier theatre system; launch is scheduled for November and when fully operational will allow teams to better monitor, manage and improve their utilisation and theatre efficiency. A new AI theatre scheduling tool (STAT) has commenced this month; software analyses historical surgeon performance data and suggests theatre lists based on an individuals procedure timings. An external consultancy has also supported a full review for a new theatre workforce and skill mix model that aims to improve leadership and capability across the theatre complexes. This this will require a staff consultation prior to commencement and a recruitment campaign is been worked up in the background. Finally a new theatre timetable has been designed which takes into account for when the new procedure rooms come online; this will create additional theatre capacity to support elective recovery and allow lower risk procedures to safely move out of the main theatres complex. All surgical specialities have received a deep dive efficiency pack that includes Model Hospital benchmarking as well as BADS and GIRFT opportunities. Efficiency opportunity meetings have been held with all surgical specialities and speciality-level workplans developed to support stretch targets for average cases per list, all of which is being monitored via weekly 6-4-2 meetings.		

Section 2 – Patient Flow Transformation

Strategic Objective E - Discharge Improvement Programme	Milestones	KPIs
SRO – Rachael Corser , Chief Nursing Officer		
Current practice for board and ward rounds has been benchmarked as part of a baseline exercise; due to various changes during the pandemic there is now significant variation between ward areas. Revised SOPs have been co-designed based on best practice and are due to be signed off by the consultant body in early July. Those wards who are very close to best practice will be supported to achieve this, and will be asked to provide peer support and act as exemplar wards. Those wards who are furthest away from best practice will be		

prioritised for ECIST and transformation support to identify the key barriers in place and work together to resolve these. The medical staffing team are already engaged so any subsequent job planning requirements can be considered as early as possible. The communications team are supporting with a comprehensive plan which will support with the wider roll-out.
Criteria-led discharge pilots (one surgical, one medical) are currently under development with the aim of informing a new Trust model. Following learning from the last MADE week a new site dashboard has gone live and work to simplify the multitude of entry fields on Nerve Centre relating to discharge to encourage improved and accurate recording is nearing completion. The dashboard is monitored daily for data quality validation and accuracy is improving week on week. A quick reference guide for recording patient pathway status and criteria to reside has been approved and launched across ward areas. Training and awareness is been targeted via quality huddles.
NHSE confirmation that additional hospital discharge funding during Covid was to cease in 22/23 has led to a system response involving all stakeholders in the co-design for a new model for discharge. Demand and capacity modelling has been undertaken and HCC anticipate a system-wide business case that seeks to address the financial shortfall is submitted in early July. As part of this wider work a pilot to test a trusted-assessor IDT model is already underway on Ashwell . The aim is to reduce the reliance on the IDT team where clinically safe to do so in more simple discharge planning ; thereby focusing limited IDT resource on the more complex patients. Initial learning has identified a cohort of patients returning to care homes where ongoing needs remain largely unchanged. Initial data highlighted discharge was facilitated much quicker when the a new process involving direct ward / care home planning was tested.

Strategic Objective E - Hospital at Home	Milestones	KPIs
SRO – Michael Chilvers , Medical Director		

Initial bed modelling and activity forecasts have been submitted via the ICS to access the national £200m funding pot for 22/23 with a full HCP business case scheduled for submission in July. Recent work has focused on medical staff feedback involving interoperability , this has also included a new simplified electronic referral process and shared access between Nerve Centre and SystemOne to allow GP's involved in patient care a shared view of patients documentation. Consultant-led MDT in-reach sessions are already live within the frail elderly pathway and work is now concentrating on the use of a frail unwell assessment model to support admissions avoidance in this area. Progression of this work will involve analytics highlighting patients who frequently attend ED or are regularly admitted to hospital.
A new HCT triage model behind the new referral process is now able to sign-post to a wider range of commissioned services outside of the H@H model; this broadens the offer and builds on the stakeholder engagement feedback we received from CDs .
A POA pilot for T&O is starting 11th July, the team have identified suitable patients (total hip / knee replacements) with remote monitoring and interventions planned in advance to ensure patients are fit for their operation, reducing the risk of cancellations on the day.
Based on the current trajectory , the ICS activity target of 107 beds is likely to be achieved by December 2022; the largest proportion of this activity is being met by primary care referrals into the service, though ENHT ESD referrals are now slowly increasing .

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	14
Report title	System Collaboration Update		**Meeting Date**	6 July 2022
Presenter	Martin Armstrong – Deputy CEO			
Author	Martin Armstrong – Deputy CEO			
Responsible Director	Martin Armstrong – Deputy CEO		**Approval Date**	17-06-22
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

The report provides an overview of recent system and place based collaborative activity that the Trust has engaged in with partner organisations

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Specific emphasis is placed on activities support the Trust's ability to deliver achieve strategic objectives through joint working with partner organisations.

Risk: *Please specify any links to the BAF or Risk Register*

The report links through to specific BAF risks associated with collaborative working – 006/21

Report previously considered by & date(s):

N/A

Recommendation	The Board/Committee is asked to discuss the activities contained within the report.

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Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

East & North Herts NHS Trust

System Collaboration Activity Report

This report provides updates to Committee members in respect of key strands of significant collaborative system activity that the Trust is actively participating in.

HCP Engagement Events

On the 10th June the HCP held its third senior leaders' engagement event. All HCP stakeholders were represented. The session focused upon the current financial challenges that faced the NHS and their implications for system and place-based working. The event considered the structure and parameters of a place based financial framework and how this might be mobilised. This was supported by illustrative examples in respect of both Hospital @ Home and Frequent Flyers projects. Some further consideration was also given to both HCP priorities across 22/23 and the governance structure that would support their delivery. A further event is scheduled to take place in September.

Pathology Tendering Process

The Trust remains an active partner in the process to tender ICS pathology services. The timeline for the project has slipped as a product of a number of issues and presently the earliest award of any contract is expected during Q3 of the new financial year.

In May 2022 final and best offer bids were received by the ICS from potential providers a process of review, clarification and review is presently underway.

A full business case will be produced by the project team for consideration and approval by participant organisations prior to any contract award. The FPPC will act as the key body to review and scrutinise the business case with onward recommendation to the Trust Board given the duration and financial value of the contract that will be proposed. A separate more detailed report in respect of tendering progress has been provided to the Strategy Committee.

Community Diagnostic Centres

The expansion of diagnostic services placed within more varied and diverse community settings is a core feature of the government's strategy to improve access to services and address the post pandemic waiting list challenge. The place-based community has responded to this challenge by designing a model for expansion and deployment. This has been achieved through diverse stakeholder design events including acute, community and commissioning colleagues.

The Trust was successful with a Year 1 bid during 21/22 and mobilisation of services associated with the bid are progressing. This activity is tracked and monitored through the new Executive Programme Board. Planning for Y2 and beyond expansion continues and is co-ordinated at an ICS level. Significant pressure has emerged in present of delivering

additional diagnostic capacity within the three place footprints within the revenue and capacity envelope that is available, and negotiations continue in respect of distribution. All three local acute providers have engaged in preliminary scoping work with private sector diagnostic providers to discuss options to supplement NHS funding availability. In respect of ENHT this opportunity will be guided by Diagnostic Imaging demand and capacity modelling across all main Radiology modalities. The Strategy Committee will receive further update as and when this work develops further.

Elective Surge Hub

In January 2022 NHS providers were encouraged to develop bids for the development of additional elective surge capacity to support the reduction of elective waiting lists and the improvement of waiting times in line with NHS planning guidance targets. It was expected that successful capital proposals would focus upon facilities that could operate in isolation from emergency pressures, could deliver high volumes of low acuity activity and would be accessible to providers and requirements across an entire system.

The initial preferred option developed for HWE ICS was based around an expansion of the Lister Treatment Centre (LTC). However, the position was subsequently complicated by the emergence of a potential option to purchase the One Hatfield private hospital. A full option appraisal of the two schemes was requested to reach a final determination of the preferred way forward by the system. However, in the meantime national timetables required a regional response to access available funding, and as a result a notional allocation has been identified to progress any finally determined prefence. This fixed allocation methodology may subsequently prove a significant risk.

During the course of May and June 2022 it has become increasingly clear that the commercial barriers in respect of One Hatfield are unlikely to be overcome and that a transaction to purchase the facility by the NHS would be extremely problematic. As such the ICS has asked that work to finalise configuration options at the LTC are prioritised and finalised. The development of a short form business case that can support this option will be progressed by the Trust.

In addition to the capital application process the Trust recognises the importance of developing and operating the new facility as a system resource and ensuring open access to surgeons from other providers. As such a collaborative approach to the operating model must be developed. It is anticipated that the Elective Surge Hub programme will be monitored through the Executive Programme Board forum.

Provider Collaboration

NHSE expects that provider collaboratives will be key components of system working going forward, being mechanisms through which providers will work together at scale to plan, deliver and transform services. As a result, all Trusts are expected to be part of our or more provider collaborative during 22/23.

In addition to the E&N place-based partnership that the Trust is presently participating in, acute providers across the ICS have also met in January and February to evaluate options to formally collaborate in respect of acute service delivery and transformation. Executive Directors from ENHT, WHHT and PAH participated in a workshop session that explored a range of collaborative considerations.

- The benefits of acute collaborative activity
- The Case for Change
- Criteria and Scope for collaborative working
- Opportunities for Transformation
- Potential Governance & Resourcing Arrangements

Broad agreement was reached across all participants in respect of the advantages and common benefits that would be derived through the formalisation of an acute collaborative across the ICS footprint. A work programme of further activities and workshops to develop and agree the collaborative arrangements was agreed.

Hospital at Home Expansion / Hospital Discharge Programme implications

One of the key priorities for 22/23 as outlined in national planning guidance is the necessity of systems and organisations developing plans to further rollout the capacity of virtual ward arrangements that can act as credible alternatives to inpatient admission. Significant additional funding will be made available to support this objective. This has been confirmed and specified with system SDF allocations for 22/23

Whilst the current virtual ward arrangements that are in place across the E&N place represent an encouraging but modest start to this service model during 21/22, it is clear to the Trust that the true potential of this method of care remains relatively untapped.

The Trust and place-based partners have come together to agree an effective model to implement expanded hospital at home arrangements. This process is presently co-ordinated by the HCP Development Director with support from stakeholders. It is expected that this will culminate in the development of business case that will set out both the clinical / operational model and also associated funding and financial aspects.

In addition to this activity the Trust has also engaged in a series of HCC workshops across May and June to understand the impact of the end of funding for the National Hospital Discharge Programme from 1st July onwards. This activity has focused upon understanding the impact and effectiveness of this scheme over the last two years and the impact of its withdrawal. This is likely to translate into a business case seeking support and funding from NHS system stakeholders to support the maintenance of some elements of this capacity going forward. However, given the extremely financial challenged nature of ICS finances it is difficult to determine where this funding would come from.

East of England Imaging Network
The EoE region has established 2 imaging networks. These are designed to enable clinical images from care settings close to the patient to be rapidly transferred to specialist clinicians across diverse geographical settings. ENHT is acting as the governance and leadership hub for one of these networks. During 2021/22 the networks were successful in developing bids and securing funds that support the expansion of home reporting, iRefer CDS and Imaging sharing capability and infrastructure for providers across the region.

The development of infrastructure bids for 22/23 are currently in development. The Trust CIO is leading this process for the Network.

MVCC Transfer Programme
The Trust continues to work alongside both NHSE and UCLH in support of the transfer of MVCC services. Confirmation of funding in relation to the preferred relocation option remains pending from the National Hospital Programme. The Trust continues to work alongside other stakeholders in the work up of relocation options.

Martin Armstrong
Deputy Chief Executive
June 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Public		**Agenda Item**	15
Report title	Digital Update		**Meeting Date**	6/7/22
Presenter	Mark Stanton CIO			
Author	Mark Stanton CIO			
Responsible Director	Mark Stanton CIO		**Approval Date**	6/7/22
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

1. **Activity in Delivery/planned**

The report provides a brief update for the 3 Digital streams funded under 22/23 Capital

Keeping our Patients safe (KOPS) – Digitisation of our Inpatient process for both Doctor and Nurse activity utilising our current Nervecentre licencing

Supporting our Specialties – Some specialties (eg maternity) have requirements that fall outside of the scope of an EPR, this stream delivers against requirements with both Trust and National capital

Evolving our technology – This stream is future proofing our local infrastructure which includes End user devices (EUD) and accessibility.

Programmes around Outpatient Transformation are still forming and as yet not included in this update.

All our programmes have Project boards in the main chaired by a Consultant Doctor with an overarching digital design authority (DDA) ensuring design is consistent with our clinical strategy.

2. **EPR Strategy**

Since the Strategy Outline case (SOC) was approved at the May Trust Board, it has been reviewed by the National teams and new funding guidelines have been published.

Subject to approval the Trust is being awarded £10M of funds which need to be match funded. This level of investment will support the recommendations of the SOC and Match funding falls within the Trusts affordability levels.

The funds are awarded on the basis that the Trust meets the Minimal Digital Foundation (MDF) by 2025 (HIMMS level 5). Whilst convergence across the HWE needs to be a consideration the focus needs to be meeting the MDF.

Impact: where significant implication(s) need highlighting *Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal* *Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability* *CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources*	
Risk: *Please specify any links to the BAF or Risk Register*	
Report previously considered by & date(s):	
Recommendation	The Board/Committee is asked to note the Digital progress

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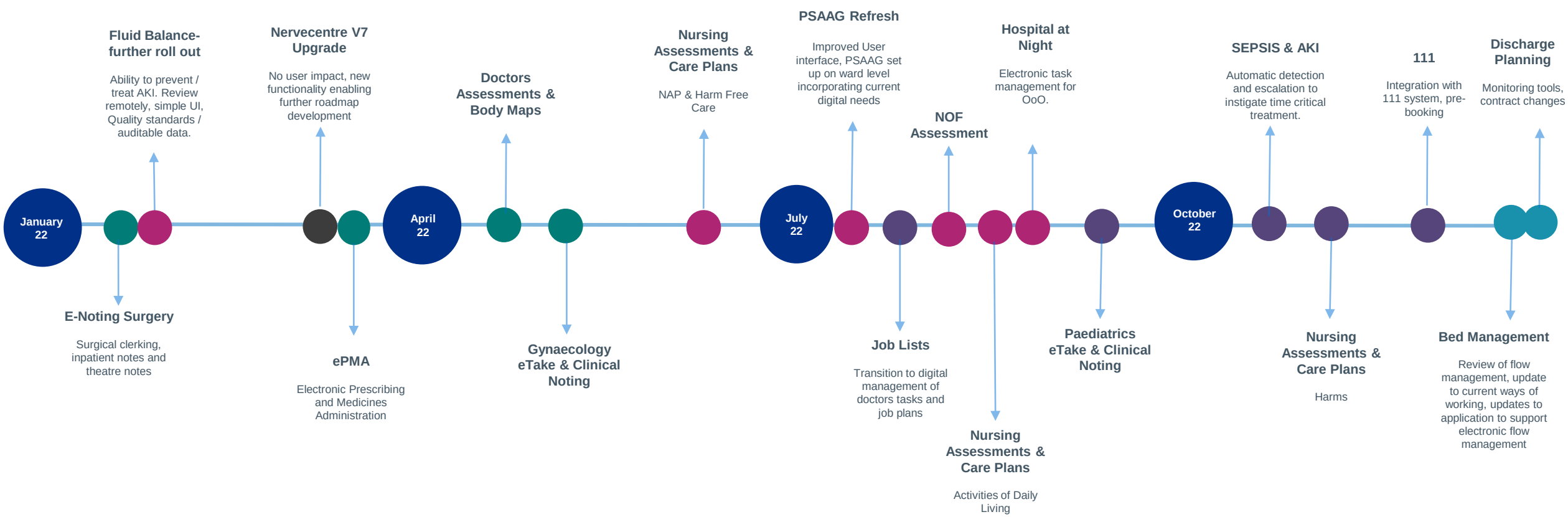
Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

Digital Update

Mark Stanton – CIO
Trust Board July 2022

Keeping Our Patients Safe – 2022 Roadmap

East and North Hertfordshire NHS Trust



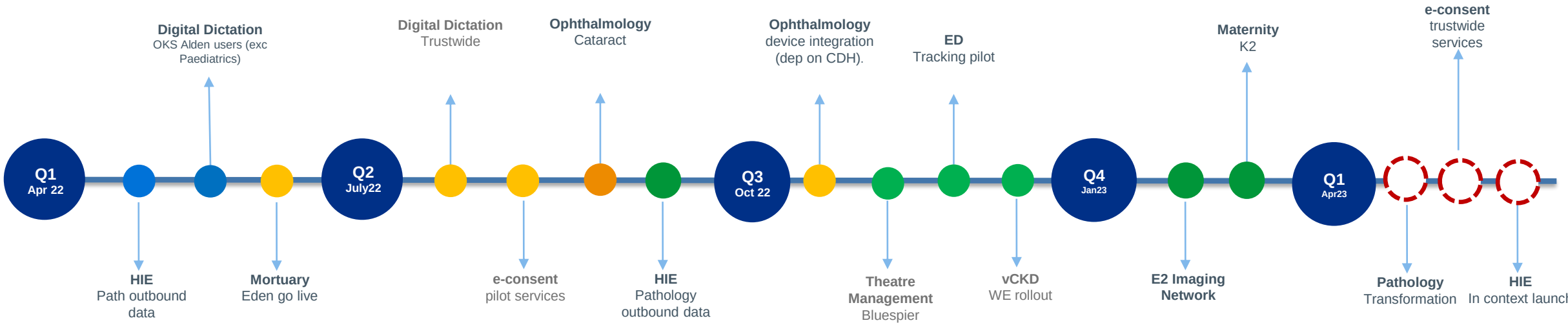
#enh digital

Delivering digital services for the Trust

Quality | People | Pathways | Ease of use | Sustainability

Supporting our Specialties – 2022 Roadmap

NHS
East and North Hertfordshire
NHS Trust



Key

- Awaiting kick-off and plan
- Funding required
- Critical risk, little or no chance of delivery
- On-track, no immediate issues or risk
- Some risk or issue impacting delivery
- Complete

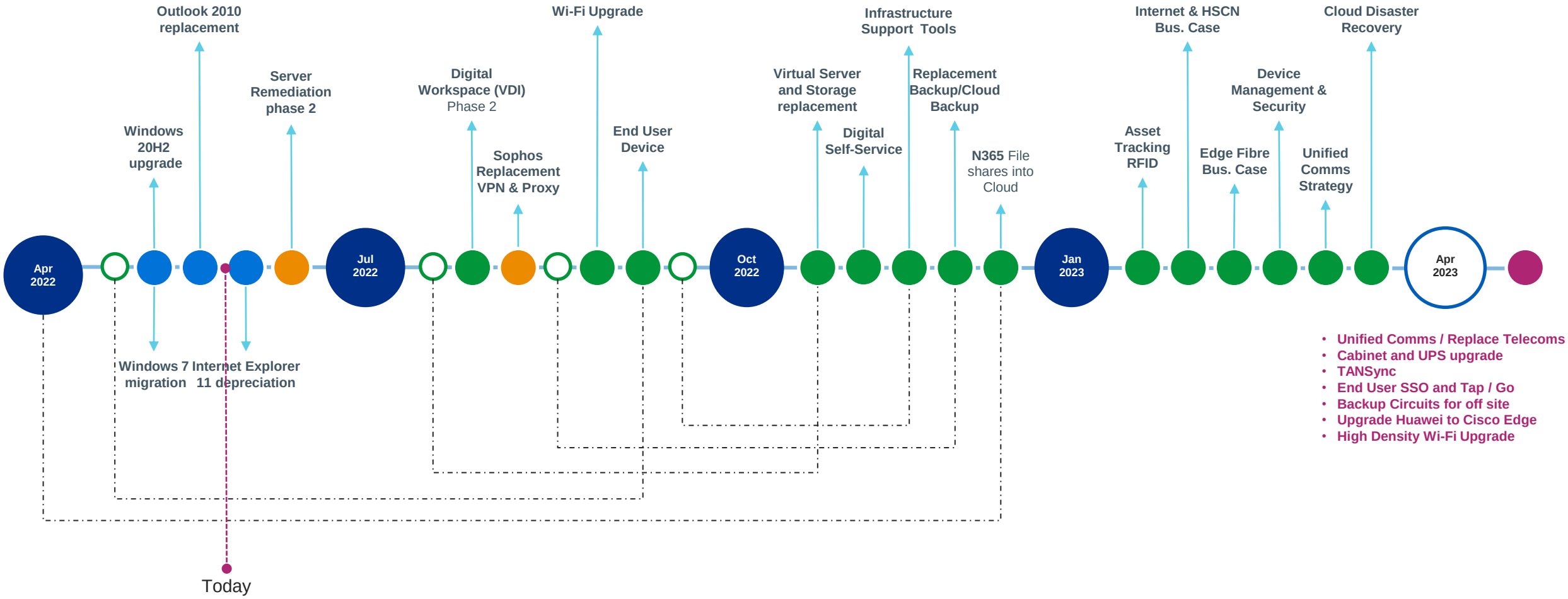
Quality | People | Pathways | Ease of use | Sustainability

#enh digital

Delivering digital services for the Trust

Evolving our Technology – 2022 Roadmap

NHS East and North Hertfordshire NHS Trust



#enh digital

Delivering digital services for the Trust

Quality | People | Pathways | Ease of use | Sustainability

Leveling up - EPR

East and North Hertfordshire NHS Trust

- ENH categorised as a level 2 maturity Trust (0-low, 3- High) – EPR in place but investment required to get to a Minimal Digital Foundation (MDF similar to HIMMS level 5)
- Potential for £10M Capital investment + £2M revenue to be allocated over the next 3 Years. Requires fund matching over the next 5 years
- Supports Strategy outline Case (SOC) of leveraging value from the current EPR's (Lorenzo, Nervecentre) in use within the Trust.
- Final ICS led Submission required by 18th July 2022

Meeting	Trust Board		**Agenda Item**	17
Report title	Annual Safeguarding Report		**Meeting Date**	6 July 2022
Presenter	Cheryl Lewis, Head of Safeguarding			
Authors	Cheryl Lewis, Head of Safeguarding Enda Gallagher, Lead Nurse for Adult Safeguarding Sarah Corrigan, Lead Nurse for Children's Safeguarding Andrea Holton, Named Safeguarding Midwife Vinod Tyagi, Named Dr for Adults and Children's Safeguarding Carolle-Anne Colford, Clinical Director Community Paediatrics and temporary Looked after Children Doctor			
Responsible Director	Chief Nurse		**Approval Date**	
Purpose (*tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

The Safeguarding Annual Report 2021/2022 outlines the work undertaken by the Trust during the past year. Safeguarding is the term used for protecting children and adults from abuse or neglect.

The production and publication of this Annual Report provides assurance and demonstrates the robust procedures and arrangements that are in place within the Trust to ensure that children and adults are safeguarded appropriately. The key indicators show that the Trust continues to meet and maintain all statutory functions in relation to the safeguarding of unborn babies, children, young people, and adults.

During this reporting period, East and North Herts CCG completed its annual assurance visit and findings were good and positively moving towards outstanding.

The Trust safeguarding team remains committed to responding to national emerging issues within safeguarding such as the National Child Safeguarding Practices review panel's report into the Myth of Invisible Men, response to the Domestic Bill, and the Amendment to the Mental Capacity Act (MCA) /Liberty Protection Safeguards (LPS).

Safeguarding is a whole systems approach, and the Trust is a partner agency of the Hertfordshire Children's Safeguarding Partnership (HCSP) and the Hertfordshire Safeguarding Adult Board (HSAB). The safeguarding team has worked with the partnership in response to local identified need, including work to reduce sudden unexpected death in infancy, transitional safeguarding, multi-agency supervision pilot, and working with fathers and partners.

Disappointingly, compliance with safeguarding training and safeguarding supervision, has not achieved its key performance indicator set at 90%, despite an extensive multi-agency training program and supported by e-learning packages, provided by the Trust safeguarding team and wider safeguarding partnership, and regular supervision sessions provided to key staff. A priority focus for the year ahead must be that all Trust staff are given the opportunity to engage with their learning and development, to be equipped with the necessary skills and knowledge to recognise and respond appropriately to safeguarding concerns. However, despite this, referrals and information sharing forms continue to increase, and a high number of applications for Deprivation of liberty Safeguards applied for.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Key highlights of 2021/2022 include:-

- White Ribbon Campaign and 16 days of Action
  - progress towards accreditation continues
  - 16 days of promotion for domestic abuse including staff awareness stalls, promoting the practice of recognition and response to domestic abuse for both staff and patients across Trust sites
  - launch of the joint REFUGE and NHS Domestic abuse training package
- Modern Slavery Day held on 18 October 2021- an opportunity to raise awareness of the Trust strategy and a focus on homelessness and sexual exploitation
- Transitional Safeguarding - hospital youth worker project and voice of the young people
- Mental Health
  - Communication passports to support frequent attenders and transition
  - Care Education and Treatment Reviews to support collaborative working
  - Frequent attenders work and frequent attenders' plans includes safeguarding risks
  - Hospital youth worker project
    - funding extended
    - Development of QR codes to support signposting onto additional services
  - Mental health first aid training
  - Trauma informed care commissioned for unscheduled care settings
  - Tablet devices to support apps and surveys, access to youth programmes, referrals to Beacon for Trauma support
- Multi Agency Risk Assessment Conference (MARAC) - new process implemented to include community services in the MARAC
- Multi Agency Child Exploitation – sharing information for multi-agency risk assessment and safety plans
- Safer Sleep campaign – risk assessment tool, and review of resources available to reduce sudden unexpected death in infancy.
- The Myth of Invisible Fathers – in response to national panel report. Research project into the role of fathers/partners in children's lives
- Medical Neglect – in response to local learning the policy was re-launched with particular focus on 'Was not Brought'; i.e., children or vulnerable adults who are not brought to hospital appointments as opposed to 'Did Not Attend' (DNA)
- Liberty Protection Safeguards – working group resumed in preparation for launch of national standards
- Independent Sexual Violence Advisor (ISVA) – successful bid and recruitment for a hospital based ISVA. New model developed and introduced successfully.
- Patient Initiated Follow Up (PIFU) - for Ear Nose Throat (ENT) introduced, with those vulnerable identified with clear pathways of care.
- Multi Agency Supervision pilot with Children's social services
- Midwifery and Health Visitor information sharing pathway

Other team projects and highlights include:-

- Safeguarding Champions relaunch – with a focus on visibility
- Frequent attenders – safeguarding representation
- Qlikview data for paediatric liaison service
- Daily learning visits – key areas Children's Emergency Department and Children's Assessment Unit
- Weekly adult Emergency Department training – for doctors and nurses

Activity

- Supported 675 adults who experienced abuse in the community
- Included in the above number were 184 victims of domestic abuse with the majority of concerns raised to contacts with our Emergency Department.
- Processed and held accountability for 493 Deprivation of Liberty (DoLS) applications made on behalf of inpatients.
- 330 Child protection medical examinations undertaken (18% increase on previous reporting year)
- 677 known children referred to children's social care and 149 unborn babies were referred.

Risk: *Please specify any links to the BAF or Risk Register*

There is an emerging risk that the current capacity within the safeguarding team will be unable to continue to meet the increasing demands of the service following a year-on-year increase in activity across the board, plus with the introduction of the new Liberty Protection Safeguards.

Report previously considered by & date(s):

[See note 12]

Recommendation	The Board/Committee is asked to receive the report for information and assurance that the Trust is compliant with its duties under the Children Act (2004), Mental Capacity Act (2005) and Care Act (2014)

Introduction

Welcome to the third combined East and North Herts NHS Trust (ENHT) safeguarding annual report 2021-2022. ENHT continues to be committed to safeguarding all patients, their families and our staff and safeguarding is a fundamental component of our Trust values. Safeguarding is everyone's responsibility, and we all have a duty to protect our patients from abuse and harm.

This annual report reflects the arrangements to safeguard and promote the welfare of children, young people, and adults at risk within East and North Hertfordshire NHS Trust. In doing so, the Trust discharges part of its responsibility for Board-level assurance, scrutiny, and challenge of safeguarding practice within the Trust, as outlined in the statutory requirements of section 11 of the Children's Act (2004), Working Together to Safeguard Children (2018), the Mental Capacity Act (2015) and the Care Act (2014).

In addition to the above requirements, the Trust as a registered provider with the Care Quality Commission (CQC), must have regard for the Regulations as established under the Health and Social Care Act (2008), including but not limited to, Regulation 13 and Regulation 17, relating to protecting service users from abuse and good governance.

The Trust regularly reports to East and North Herts Clinical Commissioning Group, Hertfordshire Safeguarding Children's Partnership and Hertfordshire Safeguarding Adults Board.

National Context and overview of ENHT progress

Amendment to the Mental Capacity Act (MCA) /Liberty Protection Safeguards (LPS)

In March 2022, the draft Code of Practice and draft regulations that support the LPS have been published for a 16-week period of consultation. The draft Code of Practice includes both an update to the original Mental Capacity Act code and all the detail of the new LPS – giving examples to flesh out the definition of a deprivation of liberty to trigger the safeguards.

There are six sets of regulations, including important details on the assessments and authorisations, monitoring and reporting, the training and approval of the new AMCP role,

and IMCAs, as well as details of a draft workforce and training strategy, and an updated impact assessment. No date has been set for when the new legislation will come into force.

Progress within ENHT

The safeguarding team continue to attend and contribute to the Hertfordshire wide partnership steering group – considering the impact of the changes across the multi-agency partnership. A draft business case has been produced based on current activity and the workforce required based on the predictions. The draft Code of Practice supports the preferred proposal set out in the business case.

The Trust LPS working group continued to meet bi-monthly, with the frequency of meetings stepping up to monthly since the publication of the draft Code.

Domestic Abuse Bill (2021)

Developing a workforce who can recognise and respond to domestic abuse effectively has been a priority at ENHT throughout 2021. With the welcomed Domestic Abuse bill, highlighting a commitment to prevention, effective care, and support for survivors of domestic abuse, ENHT safeguarding team have been an active partner in the involvement in the Hertfordshire Domestic Abuse Partnership strategy 2022 – 2025: responding to the Domestic Abuse Bill (2021) and ensuring that effective partnership working is in place for survivors of domestic abuse.

The Myth of Invisible Men (2021)

The Child Safeguarding Practice Review Panel's report 'The Myth of Invisible Men: Safeguarding Children from Non-Accidental Injury' examined safeguarding of children under the age of one year from non-accidental injury caused by male carers. In summary, the data showed that men are more likely to be perpetrators of physical abuse and harm to babies than women. It indicates that birth fathers are much more likely to be the perpetrator than other male figures. Importantly, whilst just over 50 per cent of families were involved with local authority children's services (either through early help services or children's social care), this means nearly 50 per cent of the cases considered as part of the review were only ever known to universal services.

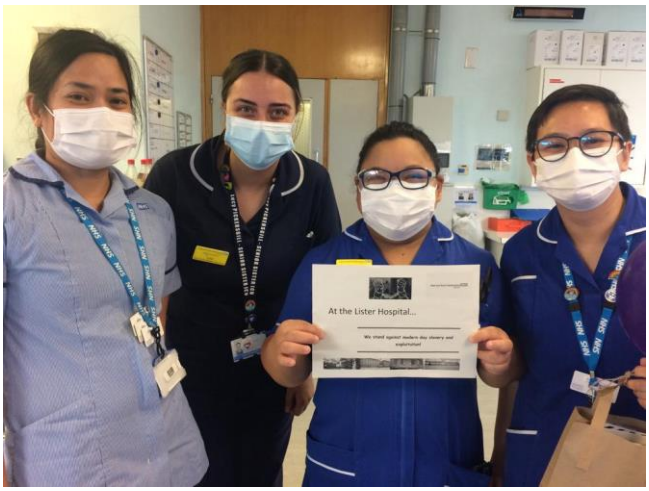
Some of the report's recommendations were, that ante and post-natal health provision be developed to fully include fathers and to include extra support to those who need it and increase practitioner's ability to identify risk factors at an early stage.

Progress within ENHT

ENHT are participating in research on engagement with fathers and partners and exploring ways to further improve engagement, including funding for midwives to be based in multi-disciplinary teams with the local authority.

Modern Slavery

Modern Slavery Day was held across all 4 main sites of the Trust in October 2021- it was an opportunity to raise awareness of the Trust strategy and a focus on homelessness and sexual exploitation. Over 150 Trust staff engaged with the day. Pledges were made in support of eradicating this abhorrent crime.



The event culminated with the Nursing Times 'nurse of the year' presenting her work with women suspected of being trafficked for sex work.

Transitional Safeguarding

Adolescence and the transition to adulthood involve a whole host of changes within young people's lives, making this a particularly challenging and vulnerable time. The Trust hospital youth worker, with support from the Trust safeguarding team, is undertaking a project with a focus to create a voice of the young people that can feed into different services – helping to support a more fluid and smooth transition. The Trust safeguarding team are an integrated team with children and adult safeguarding nurses working together and co located. This allows for good communication and a 'think family' approach.

Work has focussed so far on; identifying frequent attenders, exploring how those who are care experienced can be identified, to support trauma informed care identification, and redesigning paediatric assessment documentation with HEADSS assessment to support staff when treating young people.

Local partnership working

ENHT has a responsibility to cooperate with the operation of the Hertfordshire Safeguarding Children's Partnership and Hertfordshire Adults Safeguarding Board as a statutory partner. We share responsibility for the effective discharge of its functions in safeguarding and promoting the welfare of children and adults by ensuring representation at Board meetings and subgroups.

The safeguarding team continue to work closely and collaboratively with the Independent Domestic Violence Advisors (Refuge), Local Authority Safeguarding teams, CCG safeguarding teams and other Health safeguarding teams in Hertfordshire, and Police Specialist and safeguarding teams.

Currently, the Trust is a key partner agency for safeguarding and is involved in the following groups:

- HSCP/HSAB Board Meetings
- Practice Policies and Procedures – subgroups for adults and children's

- Active contribution to Safeguarding Adult Reviews, Rapid Reviews, care leavers reviews and local learning reviews
- Active contribution to Hertfordshire's Improving health care outcomes groups for individuals with an LD
- Active members of the Trust's frequent attenders' panel
- Active Members of HSAB's policy and procedures subgroup.
- Active contribution to Safeguarding Adult Reviews, Rapid Reviews, and Care Leaver Reviews
- Active contribution to Domestic Homicide Reviews (DHR'S)
- Active members of the HSAB domestic homicide review sub-group.
- Active participation at complex safeguarding meetings
- Attendance and sharing information at the Multi-Agency Risk Assessment Conference (MARAC)
- Sharing information for section 17 and 47 requests, strategy meetings, Multi-Agency Safeguarding Hub (Bedfordshire and Hertfordshire), and Multi Agency Child Exploitation (MACE)

The Trust safeguarding team have also been involved in the following areas of partnership work:

- Task and Finish group – Sudden Unexpected Death in Infancy
- Task and Finish Group – The Myth of Invisible Men
- Task and finish group – Transitional Safeguarding
- Safeguarding supervision pilot with children social care
- Consent for Surgery – Children Looked After procedure
- Multi Agency Bruising audit
- Multi Agency Audit of Physical abuse Pathways
- Multi-Agency Audit Working with fathers and Partners

Key Achievement – High level of commitment to partnership working and participation in specific work streams driving forward improvements in practices policies and procedures and ultimately better outcomes for families across the communities served

Safeguarding Governance and Structure

The Trust is statutorily required to maintain certain posts and roles within the organisation in relation to safeguarding. These have been fulfilled throughout this annual reporting period.

There were some vacancies within the safeguarding team and some periods of long-term sickness and redeployment, which had a direct impact on the team's ability to progress with service developments whilst delivering Business as Usual. There was an increased demand on the team in several areas including: responding to higher levels of safeguarding activity, supporting/delivering more training (key performance indicator), supporting staff at the point of care (increasing acuity and presentations of safeguarding), safeguarding supervision requirements (key performance indicator), multi-agency and partnership working.

The head of safeguarding has submitted a business case to increase the establishment in the safeguarding team, which was benchmarked against other similar acute NHS trusts. Unlike the majority of acute safeguarding teams, ENHT is commissioned to provide safeguarding services to community paediatrics – which involves an on-call child protection rota – 5 days a week, and safeguarding supervision to caseload holders. This requires

additional training and case oversight from the safeguarding team. More staff would enable the team to meet the current increasing demand whilst ensuring the team are able to respond to the increasing safeguarding agenda in the future.

The Chief Nurse for ENHT is the Executive lead for safeguarding and represents the Trust at both Hertfordshire adults safeguarding board and children's partnership. When required, the Head of Safeguarding deputises. The Deputy Chief Nurse supports the Chief Nurse in the Executive role. This responsibility aligns to governance, systems and maintaining organisational focus on safeguarding.

The Head of Safeguarding in collaboration with the Chief Nurse, is responsible for setting the strategic direction for the safeguarding team and has overall oversight of the safeguarding activity within the Trust.

The leads for safeguarding (adult, children and named midwife), are responsible for providing the Trust with the operational advice, support, guidance, and input.

The safeguarding professionals are committed to supporting all Trust staff in understanding their safeguarding duties, roles, and responsibilities, embedding this into 'everyday business' and improving outcomes for all vulnerable people.

Within the clinical and non-clinical divisions, the Divisional Director, Divisional Chairs, Heads of Nursing and/or Senior Managers continue to be responsible for the implementation of and compliance with Trust policies and procedures and maintaining standards of practice and quality of care provision with clinical and non-clinical teams.

The Joint Safeguarding Committee (JSC) continues to meet bimonthly. These meetings are chaired by the Chief Nurse. The committee oversees all safeguarding work across the Trust. The meetings are attended by the head and leads for safeguarding (including the named midwife). There is representation from all the Trust clinical divisions, and they provide divisional reports. ENHCCG adults and children's safeguarding leads and learning disability nurses from Hertfordshire County Council are in attendance/ are represented along with a Trust board non-executive director. The committee reports safeguarding activity and provides assurance to the Quality and Safety Committee within the Trust.

A safeguarding operational meeting was introduced on a bimonthly basis to support the work of the committee, by managing operational issues. This report into the Joint Safeguarding Committee.

The Learning Disability Working Group is a sub-group of the JSC and continues to meet bi-monthly.

During the reporting period, a Trust wide Mental Health Steering Group was established which reports into the JSC. The safeguarding team have driven some key activity including the development of robust reporting around sectioning and in particular Section 5:2 – to ensure there is a clear pathway for reporting and monitoring of the number of patients.

The safeguarding team monitor performance through the use of a comprehensive dashboard. The information is used to review the work plan and is shared with the relevant boards and committees for monitoring purposes.

Key Achievement – Development of 8a Named Midwife Post (previously band 7), bringing the position in line with leads for children's and adult safeguarding – with additional roles and responsibilities, skills and expertise to further develop the maternity safeguarding service.

Trust safeguarding policies and procedures

The safeguarding policies and procedures are regularly updated to reflect any changes in practice, learning from case reviews and national guidance and recommendations. Any updates or new policies continue to be approved by the JSC.

During the reporting year, the following Trust policies, and standard operating procedures (SOP) have been updated and or introduced:-

- Chaperoning – addition to policy
- Care of Adults with a Learning Disability and Autism Policy
- Neonatal Unit SOP – new SOP

In addition, the safeguarding team have been involved in the update of the following Hertfordshire wide Policies and Procedures (HSCP/HSAB)

- HSCP Medical Neglect
- HSCP Rapid Response Protocol

Pathways updated and developed:

- Safeguarding Adults Supervision – new pathway
- Patient Initiated Follow Up (PIFU) (ENT) – new pathway

In addition, the safeguarding team have contributed to the following Trust policies and SOPS:-

- Restrictive Physical Interventions and the Clinical Holding of Children and Young People up to 18 years of age
- Perinatal Mental Health SOP

Assurance Visits

Arrangements to Safeguard Children under Section 11 of the Children Act 2004 and Adult Safeguarding Assurance Visit.

A combined Adult Safeguarding Assurance visit, and Section 11 audit visit was carried out in July 2021 by East and North Hertfordshire CCG to ensure compliance with our responsibilities under the Children's Act to safeguard children. Notable practice and recommendations were discussed during the visit. The score is overall 'good', moving positively towards achieving 'outstanding'. The audit established the Trust was able to demonstrate it was meeting the statutory requirements. A detailed action plan was developed and is monitored through the divisional board and JSC. It is on track for completion.

CQC Provider Collaborative Review (PCR)

In June 2021, CQC undertook a PCR fieldwork visit across the Herts and West Essex (HWE) Integrated Care System (ICS) focusing on the experiences of children and young people with existing and emerging mental health needs who had been in contact with mental health services during the pandemic period and how providers/services came together to support. There was a particular focus on the experiences of Children and Young People from BAME backgrounds.

The review identified many areas of practice that are working well and why and suggested/ recommended areas of future focus. ENHT Mental Health Steering Group is overseeing the implementation of learning from the findings of the review.

Key Achievement – Findings from assurance visit of 'good' moving positively towards 'outstanding'.

Quality Schedule

The Trust confirmed key performance indicators with the CCG to ensure compliance with statutory safeguarding requirements. A quarterly safeguarding adults and children's dashboard continues to be submitted to the CCG to demonstrate progress. Matters are escalated via the Trust JSC who have responsibility for monitoring the implementation of any action plans.

Metrics for attendance at strategy discussions shows a continued improvement resulting in an end of year position 100% attendance.

We are now able to collect and collate data which identifies the number of children affected by domestic abuse (through referrals to children's social care and cases heard at Multi Agency Risk Assessment Conference)

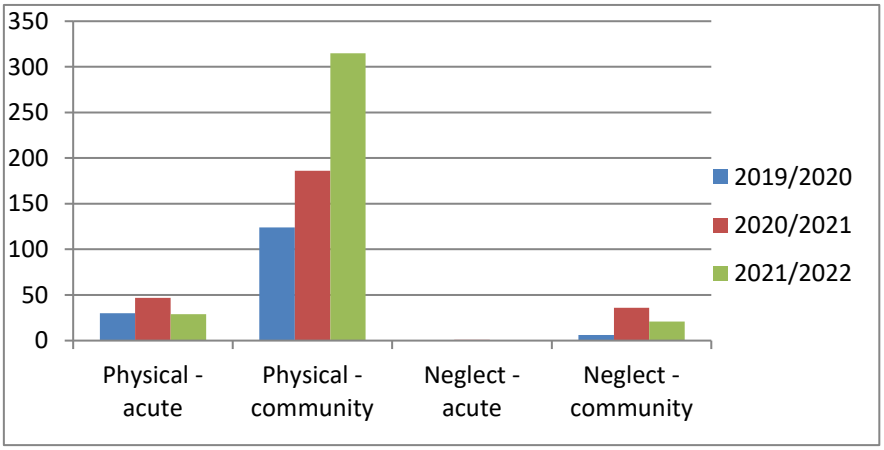
Knife crime data is now shared for adult attendances to the organisation.

Safeguarding training metrics continue to not be met (target compliance of 95% has been set). Nursing and midwifery staffing groups are achieving compliance. Medical and dental staff groups have not met their safeguarding statutory training requirements. To monitor and drive-up training compliance, Trust executives plan further challenge at divisional Accountability Review Meetings (ARMs) to ensure improvement plans are in place and on track for achievement.

Safeguarding children's supervision targets continue to not be met. This is partly due to several factors including staff availability to attend the planned sessions due to acuity of work, staff shortages and sickness within teams. The safeguarding team continue to provide the basic number of sessions to meet the requirements, however, they do not have the capacity to provide additional sessions to support the teams working at the point of care.

Safeguarding Activity

Child Protection Medicals



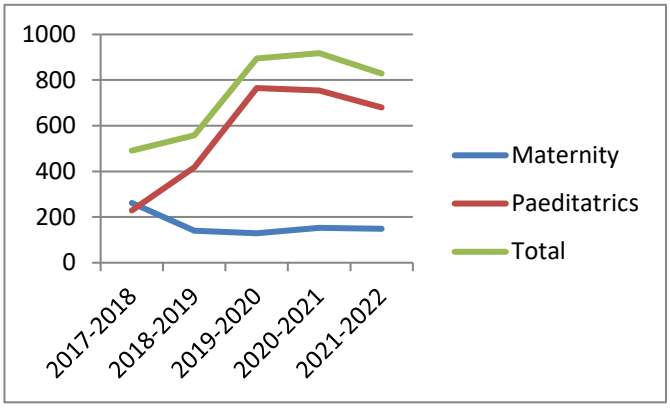
Child Protection (CP) medicals are undertaken as per the guidance of Royal College of Paediatrics and Child Health. All child protection medicals are done by a consultant or a senior trainee under consultant supervision. The Child Protection medical proforma is in line with the revised RCPCH guidance (2020).

The chart above depicts the Child Protection medical activity over the past three years. It is evident that there has been a 69% increase in the activity for community child protection medicals in 2021/22 with the main referral reason and concern as physical abuse.

There remains an increase in neglect medicals being requested (since 2019) – This could be attributed to the ongoing work from both the partnership and Children's safeguarding team in

raising the profile of neglect and increasing recognition of the direct health implications for a child and ensuring there is an effective and child focused assessment of this.

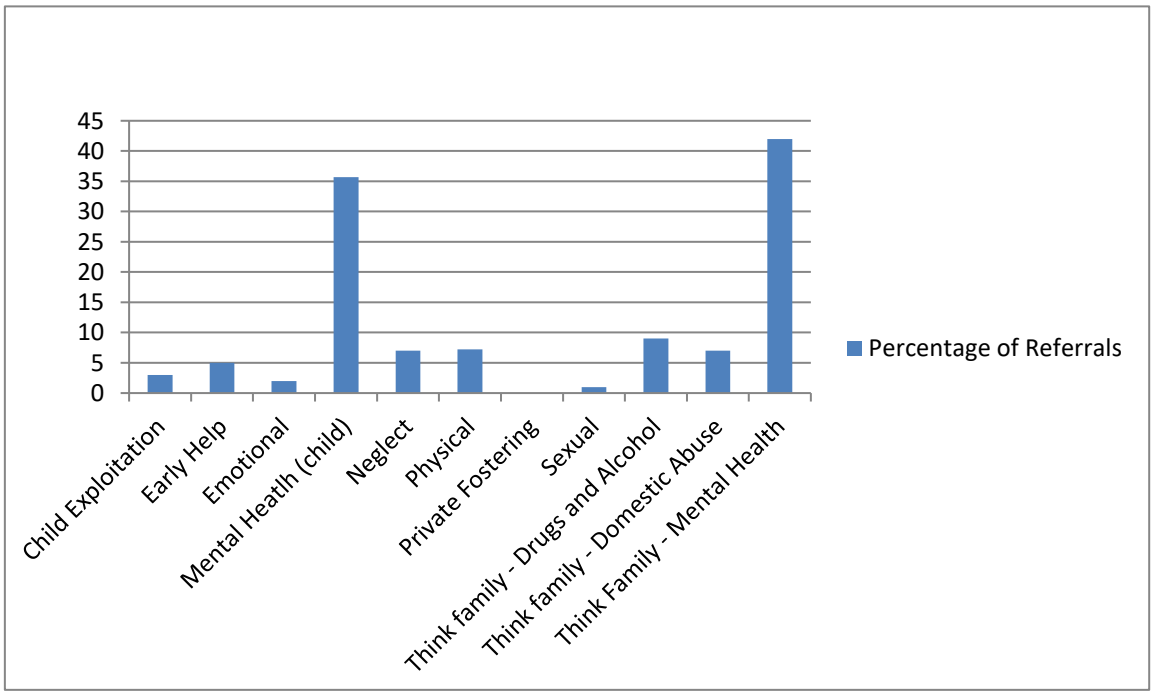
Referrals to Social Care



Recognising and referring vulnerable children and families is a key role and responsibility of all staff working for ENHT. Referrals are made to children's Services when a professional considers a child or unborn baby to be at risk of significant harm – these include children attending with possible non-accidental injury, and concerns involving neglect. Referrals are also made when adults present for care and issues are identified around domestic abuse, mental health, and drug and alcohol issues (Think Family agenda).

The chart/graph above reflects a year-on-year increase in Children's Service referrals from 2017 -2021. In 2021, we saw a small decrease in the number of referrals. All attendances to ENHT for children and young people up to the age of 18 yrs. continue to be screened by the Trust safeguarding team. An increase has been seen in an early help response to concerns, which could explain the slight reduction in referrals. Cases continue to be discussed at the weekly multi-agency psychosocial meeting, offering further assurance on appropriate thresholds being applied in relation to early help, or referrals to children's social care. With the significant increase from 2017 in the identification and recognition of safeguarding concerns for children and young people, there is acknowledgement that this figure remains at a reassuring high level, indicating a workforce who are identifying and recognising safeguarding children concerns consistently over the last 3 years.

Nature of concerns referred to Children's Social Care – 2021/2022:



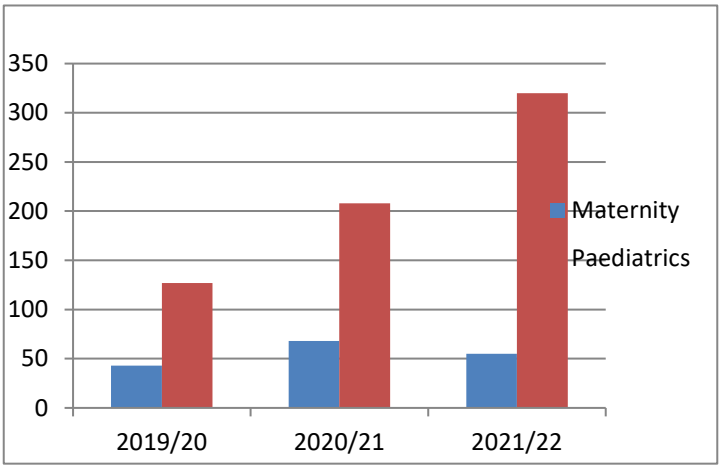
This chart/graph provides a breakdown of the types of concern referred to children's social care. There was a consistently high level of referrals for presentations of adults attending the

Emergency Department – In line with the 'Think Family Agenda'; with parental mental health being the most significant theme of referral for 2021.

A 10% increase in referrals relating to children attending with mental health crisis was noted from 2020; It is not routine for all children presenting to ENHT to be referred to Children's Services and this increase reflects an increase in social complexity which accompanies child mental health presentations.

It is important to note that there has been an increase in the recognition of families and children requiring early help & identification of neglect for children during 202- 2022. This could be attributed to a focus and drive across the safeguarding partnership of the Neglect Strategy.

Strategy Discussions



A key assurance surrounding the efficacy of safeguarding children is partnership and multiagency working; ensuring there is good engagement, timely information sharing and collective multiagency plans in place to safeguard children. Strategy meetings are pivotal in determining the child's welfare and planning rapid action to safeguarding the child/ young person. This involves ensuring the child's health is an integral aspect of this plan.

At ENHT, we have been committed to working with our partner agencies to improve our attendance and participation at strategy meetings. There has been a clear year-on-year increase in the amount of strategy meetings which are attended by both the safeguarding team and paediatric team, enabling the development of effective rapid action plans with an effective health focus. In 2021/2022, the safeguarding team attended 337 strategy meetings which are in keeping with the increased referral and recognition across the partnership for children requiring child protection medical assessments for concerns of physical abuse and neglect.

Maternity Risk Assessment

The total number of births in the period 1 April 2021 to 31 March 2022 was 5293 (previous reporting period saw 4564 births) -increase in 14% of births on the previous reporting year.

Risk assessment is undertaken through assessing Information Sharing Forms (ISFs) completed by midwives and other professionals. These continue to be triaged by the maternity safeguarding team and discussed at monthly maternity meetings with social care where further information sharing is undertaken as appropriate, and plans are made on the level of intervention required – for example, universal service provision, or further intervention to address vulnerability and need.

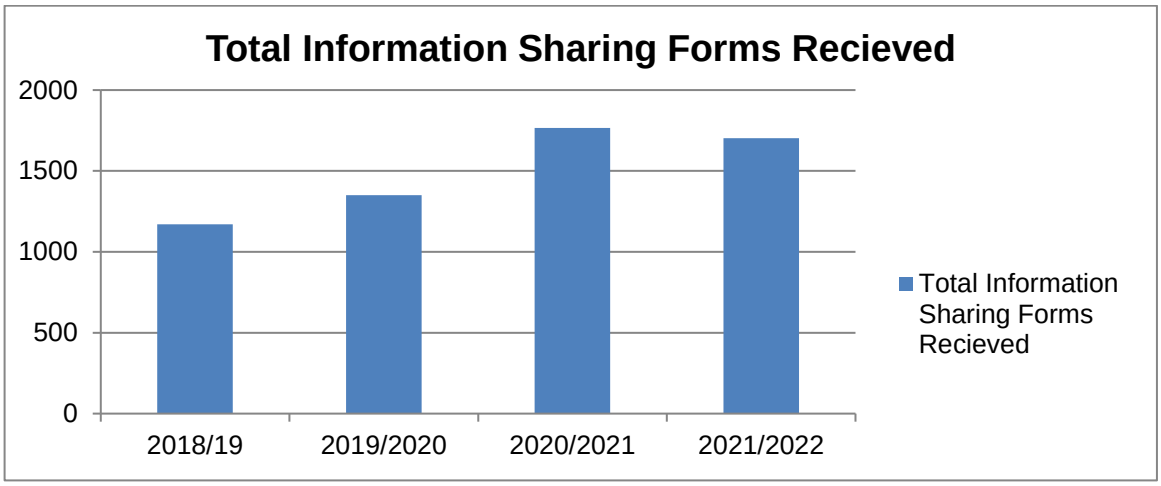
Following feedback from all stakeholders the newly appointed maternity safeguarding team are currently reviewing these meetings with the wider teams.

All teams will meet with an overarching aim to look at the importance of timely referrals, follow up outcomes of referrals made whilst ensuring adequate time is available to provide a trauma informed family approach for all cases. There are plans in place to meet with Children's social care to offer an increase on enhanced collaborated working.

The intention is to further improve the quality of both risk assessment and the detailed content of referrals. It is possible that we may agree to utilise a model on how the team see risk alongside increasing confidence in both professional curiosity and action taken. This model aims to offer a natural flow into the established model already used by Children's services. The consistency of this is intended to offer wider thinking, set standards, and support expectations of our families within both health and Children's services even before a referral is made.

The following chart/graph outlines the number of Information Sharing Forms (ISFs). This reporting period saw a decrease in information sharing forms (3%) on the previous reporting period. All ISFs are screened and forwarded to the Public Health nurses (Health Visiting services, GP, and Community Midwifery team).

Total number of information sharing forms received (Maternity safeguarding).



New cases continue to be risk assessed at the maternity information sharing meetings and actions are recorded. Cases are tracked at this meeting and information is shared regarding outcomes of assessments, child in needs plans, child protection plans and thresholds for legal planning.

There were 40 Initial Child Protection Case Conferences which is a decrease of 35% on the previous reporting period (61 conferences for 2020/2021). 100% of the child protection conferences were attended.

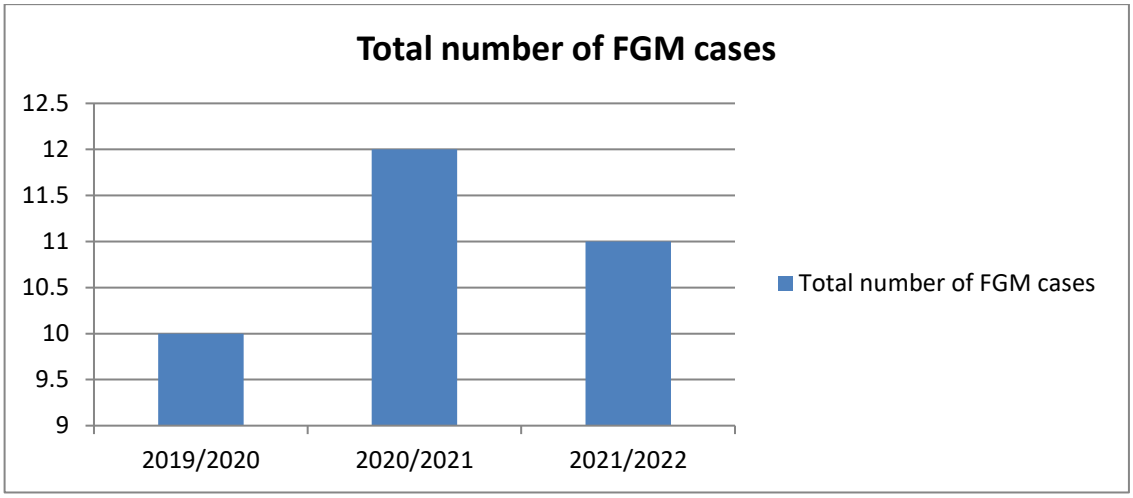
Female Genital Mutilation (FGM)

There are low numbers of women booked for maternity care within ENHT who have undergone FGM. The chart/graph below demonstrates the numbers of women booked for the last 3 reporting years. In all cases, risk assessment is undertaken, and referrals are made to children's social care, in line with Hertfordshire Safeguarding Children's Partnership policy, and the General Practitioner and Health Visitor are notified for all cases.

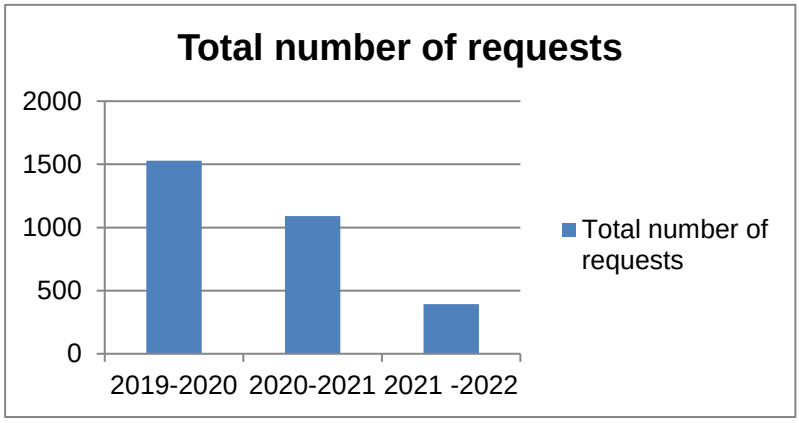
The safeguarding midwives continue to add an alert to the national spine entry for every female child born to a mother who has sustained FGM. This information is then available for frontline unscheduled care workers within ENHT for further risk assessment if attending.

The statistics are nationally reported quarterly, and the Trust guideline is currently under review and sits in line with the local partnership board enabling consistency through the internal and wider team approach. The work around FGM is a team approach, with the specialist consultant and championship midwife enhancing team training. This gives an opportunity to approach with expertise and empowerment for the family to fully understand the implications and legality around the impact FGM has on young children and women.

Total number of FGM cases managed by ENHT maternity services.



Requests for Information – S17, 47 and Multi-Agency Safeguarding Hub (MASH)



Where requested to do so by local authority children's social care, practitioners have a duty to co-operate under section 27 of the Children Act 1989 by assisting the local authority in carrying out its children's social care functions – including information sharing.

In previous years, it was identified that all S17/47 and MASH requests were directly being requested to ENHT safeguarding team – in instances where children were not known, and no information was held by ENHT about the child or family. There has been effective partnership working over the last 2 years looking at streamlining requests for information for children who are known to our service, therefore, supporting an appropriate and proportionate information sharing process which is tailored to the child and their family.

Looked After Children (LAC)

Looked After Children (LAC) Health Assessments ENHT 2021-2022

LAC (children) continue to be seen for Health Assessments - Initial Health Assessments (IHAs) within 28 days of a child coming into care, then every 6 months (under 5's) or annually (5+) (Review Health Assessments - RHAs). Paediatricians carry out all LAC IHAs for under 10's and RHAs for all children where adoption is in their care plan. HAs are requested by the child's social worker and arranged through the LAC team.

In 2021/22 the timescale for completing and returning IHAs to the LAC team was within 10 working days of the request. In 2021-22 the agreement was that RHAs were completed and returned within 5 weeks.

It was agreed with the LAC health team and commissioners that children in special schools would have their LAC health reviews in school at the same time as their annual health review even if this was out of timescales as it is in the child's best interest.

Breaches are investigated and where appropriate, covered through exception reporting – for example last minute 'was not brought', carers refusing to bring the child etc.

The target for both IHAs and RHAs completion within timescale is 90%. The figures are reported to the JSC. The figures are also supplied to the Health of Looked after Children Leadership group which meets quarterly.

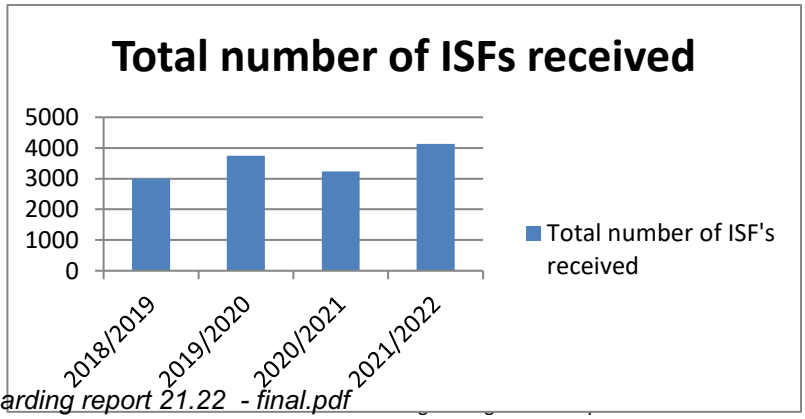
The courts continue to favour placements within the extended family and adoption is considered very much a last resort. This has led to a reduction in the number of children becoming 'Looked After' and a reduction in the number of adoptive placements.

In 2021/22, 98 LAC medicals, 62 IHAs and 36 RHAs were undertaken. These figures also include the medicals for adoption panels. In three of the months, medicals returned within timescales were below 75%.

In April 2021, the Medial Advisor (MA) for adoption and fostering for ENHT retired. The Trust had not been able to recruit a new MA at that time and the role was covered by another community paediatric consultant and a senior paediatric registrar (ST8). The issues with covering the role within existing job plans meant that capacity to accommodate IHAs and RHAs was at times challenging. Since March 2022, only one consultant is covering the role with 2 PAs in a 4 PA role. IHA clinics have been prioritised as have Adoption and ADM panels. The MA role is due to go out to advert shortly.

Although COVID-19 continues to have an impact, all IHAs and RHAs have been conducted face to face with appropriate PPE and infection control practices in place.

Paediatric Liaison



The paediatric liaison service has seen changes over the past year in relation to activity levels and continues to be a pressured area.

The bulk upload system continues to run alongside the existing

paediatric liaison service. In addition, the information sharing criteria remains in place for those children attending the organisation with additional concerns that benefit from having their information shared with their health visitor, school nurse and any other partner agency involved in their care and wellbeing as relevant.

The information continues to be shared via the paediatric liaison service, and contains detailed information on the attendance, findings, actions and outcomes, and any further additional support that maybe required. Risk analysis is more meaningful based on a full picture of the presentation. Taking action to support a child, young person, or their family early, or as soon as it emerges, prevents escalation of presentations requiring more specialist interventions.

There has been a year-on-year increase in the recognition and information sharing from ENHT to partner agencies from the point of care staff; recognising children & young people attending the Trust who will require further ongoing support, follow up contact from outside agencies and community health services, such as Health Visitors and School Nursing Services. The safety netting process of screening of all discharge summaries for children and young people under the age of 18 remains in place. This has been a fundamental aspect of ensuring all attendances which meet the information sharing criteria are reviewed by the paediatric liaison team.

Where missed opportunities are identified, this process provides a system which enables and supports the safeguarding children & paediatric liaison teaching activity throughout ED and Paediatrics. This has been a fundamental aspect to improving practice and recognising vulnerability for children and young people. The team contribute to Emergency Department, doctor and nursing supervision on a monthly basis, lead on the paediatric and neonatal psychosocial meetings, and provide daily teaching and learning sessions for staff in the Child Assessment Unit and Children's Emergency Department.

The Paediatric Liaison Service continues to prioritise and strengthen partnership relationships; through chairing and leading on Paediatric Liaison meetings with Hertfordshire Community NHS Trust; strengthening the regular and consistent multiagency attendance in the the weekly paediatric psychosocial meeting (including IDVA/ISVA/Children's Services/CGL/Hospital Youth working Services). This has been the foundation of supporting staff at the point of care being part of and engaged with how agencies work together to safeguarding children and promote their health and wellbeing.

It is important to note that with the increase in activity across all aspects of the children's safeguarding team activity, permanent nursing staffing hours have not increased.

Child Deaths

The lead for child death within ENHT sits with the Deputy Divisional Director of Nursing & Quality for Children's Services and is supported by the clinical director for paediatrics. In addition, the paediatric liaison/safeguarding children's team, along with the divisional quality manager also supports and continues to be the link between professionals for CDOP, Hertfordshire Community NHS Trust (HCT) and ENHT. The link professionals represent the Trust at rapid response meetings quarterly and share agency summary reports.

During the reporting period, ENHT sadly reported the deaths of 14 children, 6 of which were unexpected and 8 of which were expected.

All child deaths continue to be reported on the Trust risk management and incident reporting system (Datix) and are reviewed by the Serious Incident Review Panel who support the decision-making process if further investigation is required. In all cases a Rapid Incident

Review/Child Death Review is completed and taken to panel for further decision making on any further investigation required.

ENHT continue to be an active member of the rapid Response to Child Death steering group.

Safeguarding Adults activity

During 2021/22, there was an increase of 13% in the number of vulnerable adult safeguarding concerns raised in the organisation when compared to the previous year. The total number of concerns raised was 719; this represented the highest number of concerns per calendar year on Trust records. 94% (676) of Safeguarding of vulnerable adults' concerns were raised by Trust staff and related to suspected abuse which occurred in a community setting. 6% (43) were raised against an ENHT service.

Out of the 43 concerns raised against a Trust service, 66% were either not substantiated by a section 42 enquiry process or upon initial investigation by the Trust in conjunction with the local authority, were deemed not to meet the threshold for a S42 enquiry. 34% of concerns raised against a Trust service during 2021/22 are currently pending a decision on whether a S42 process is warranted.

During the year 12% of concerns raised against a Trust service were substantiated and largely centred on omissions in the discharge process, tissue viability incidents or failure to inform care providers on post discharge care plans in terms of ongoing wound care. The future preventative actions for these concerns are overseen by the Harm Free Care steering group and the Trust's discharge steering group.

The following table shows the number of concerns raised by staff relating to suspected abuse having occurred in the community.

Type/ incident abuse	Cases 2020/21	Cases 2021/22	Percentage case mix change
Domestic abuse	**151**	**185**	**↑18.2%**
Financial abuse	**22**	**16**	**↓ 27.2%**
Concern exacerbated by drug use	**4**	**7**	**↑ 42.8%**
Concern exacerbated by poor mental health	**72**	**93**	**↑ 22.5%**
Suspected modern slavery	**1**	**2**	**Numbers statistically low.**
Neglect/act of omission	**148**	**178**	**↑ 16.8%**
Organisational abuse	**5**	**0**	**Numbers statistically low**
Physical and psychological abuse	**41**	**5**	**↓ 87.8%**
Self-Neglect	**116**	**132**	**↑ 12.1%**
Sexual assault	**9**	**18**	**↑ 50%**

During 2021/22 staff raised 185 domestic abuse concerns which was an increase of 18.2% when compared to the previous years – a similar pattern seen nationally in direct correlation to the impact of COVID-19 and lock down restrictions. All individuals reporting abuse were referred to domestic abuse services (Trust co-located Independent Domestic Violence Advisor). Where the victim had needs for care and support, safeguarding referrals where

also sent to the local authority, with consent or when indicated the victim was supported to report the abuse to the police.

Incidents relating to suspected acts of neglect or acts of omission occurring in the community most frequently related to the development of pressure ulcers which were noted in the Emergency Department amongst individuals who had care packages in place or individuals who lived in a commissioned care environment which provided carers. Reports of patients with care and support needs arriving in the Emergency Department displaying signs of self-neglect increased for the second consecutive year.

There has been a significant drop in the number of reported cases involving physical and psychological abuse – this is attributed to a revised coding and categorising psychological abuse within a domestic abuse context.

Prevent – referrals to Channel Panel

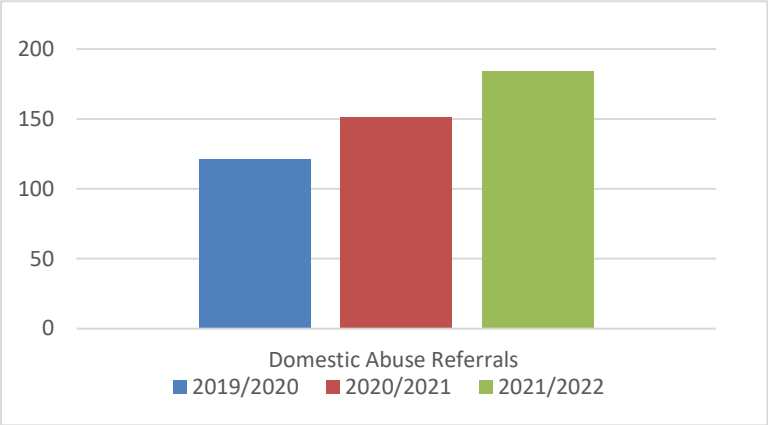
No referrals met the threshold for referral to the local authority channel panel. All Trust staff are required to complete the home office WRAP prevent level 3 training and the use of the basic awareness module was phased out in 2020. Currently 83% of Trust staff have completed Level 3 training and the aim is to reach 85% Trust wide staff compliance during Q1 of 2022/23.

Domestic abuse

During 2021, ENHT commenced a Domestic Abuse Quality Improvement (QI) project, aimed at developing trust wide training and education on domestic abuse. This is both virtual and face to face training offer, which is co-produced & delivered by our onsite IDVA team. The QI project has been focusing on the improvements of recognition and response to DA in high-risk areas, such as the Emergency Department, Gynaecology, Orthopaedics, plastics, and Maternity Services.

Alongside this, the first Trust Wide Domestic Abuse Steering Group was created and chaired by the Equality & Diversity Team & safeguarding team. There have been significant developments in the collaborative working between departments on embedding effective domestic abuse support Trust wide. This has resulted in the enrolment of 10 White Ribbon Ambassadors and champions Trust wide. This includes members of our Executive team who have been championing the Quality Improvement and White Ribbon application for accreditation.

The Trust is committed to supporting awareness raising events around domestic abuse through 16 days of action and White Ribbon Day. It was a huge achievement to reach over 200 staff members through domestic abuse training sessions & awareness stall activity. The focus of this was to raise awareness of the DA Trust Pathway & our onsite IDVA services.



The chart/graph opposite refers to the number of referrals which have been made from the point of care staff following recognising domestic abuse for their patients. We have seen an increase of 21% of referrals made from last year and a 52% increase on referrals compared to pre COVID-19attendances. This is a significant increase in the recognition and effective response to domestic abuse Trust wide. It provides further assurance in the efficacy and improvements in accessing DA training and creating a workforce who can identify and respond to more subtle and nuanced attendances which could be suggestive of DA & enhancing clinicians' skills of asking the DA question in a safe and compassionate manner.

Independent Sexual Violence Advisor (ISVA)

In August 2021, the Trust was successful in a bid for funding until March 2023 to recruit a hospital based Independent Sexual Violence Advisor (ISVA). Following successful recruitment, the ISVA commenced in post in November 2021. The role is to offer impartial advice, information, and crucially support to victims following disclosure of sexual violence or assault. They support victims with reporting to police, accessing sexual assault referral centres (SARCS), and other specialist support such as pre-trial therapy, counselling, health and social care, housing, and benefits.

In the short period of time that the ISVA has been in post, 30 referrals have been made to the service, with approximately a third of the cases for children and young people under the age of 18.

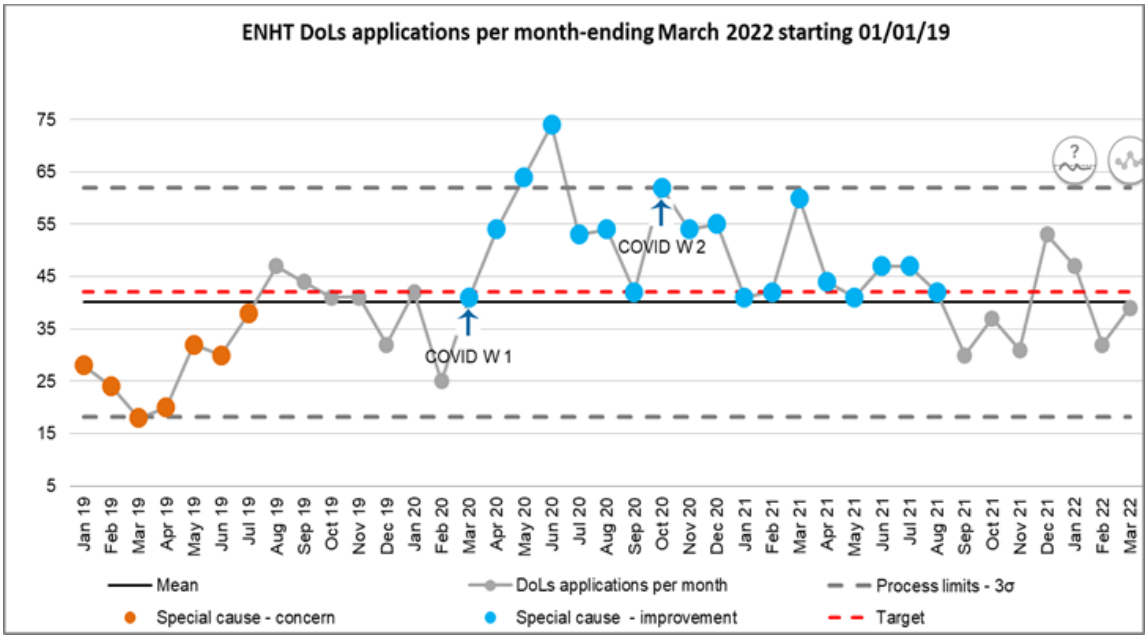
The ISVA service is available to staff and patients. At the end of the reporting period, all referrals were for patients. Further work is planned to continue to raise the profile of the ISVA and the range of services provided.

Key Achievement. Successful bid for and recruitment to ISVA role – meaning victims of this abhorrent crime can receive timely access to advice, support, and information**.** Supporting our Trust vision of reducing violence against women and girls' strategy.

Deprivation of Liberty Safeguards (DoLS) and new Liberty Protection Safeguards (LPS)

DoLS provide legal protection for those people aged 18 years and over who lack the mental capacity to consent to the arrangements for their care or treatment in a hospital, or care home, and in whom, within the meaning of Article 5 of the European Convention of Human Rights (ECHR), are deprived of their liberty, in their best interests, to protect them from harm.

During 2018/19, 296 urgent DoLS applications were made by the Trust. This increased to 375 in 2019/20 and in 2020/21 increased to 655. In 2021/22, 493 DoLS applications where made which remains an increase when compared to pre pandemic rates. The increase noted in 2020/21 was largely related to an increase in the number of patients being admitted with COVID pneumonia associated delirium. There was an increase in inpatient admissions of individuals who were frail and elderly who had an underlying disturbance in the functioning of the mind or brain which includes a diagnosis of dementia.



It is anticipated that from October 2023, the DoLS process will change as outlined in the Mental Capacity Amendment Act of 2019 and will become known as Liberty Protection Safeguards (LPS). The Department of Health and Social Care have released a consultation on a code of practice for the amended act and the Trust is preparing an organisational response to this consultation

In anticipation for the launch of LPS the safeguarding team have set up a local LPS working group. More will be known about the level of additional resource required to enable the Trust to become a fully compliant responsible body throughout the course of 2022/23.

Rapid Reviews (RRs) Safeguarding Adults Reviews (SAR), Partnership Case reviews (PCR) Domestic Homicide Reviews (DHRs)

The Trust reported 1 case to the Hertfordshire Rapid Review panel where a decision was made for no notification to national panel. It was locally decided to have a round table Rapid Review which doubled up as a learning review and an action plan was produced which is monitored in the HSCP subgroup. This case involved a child with neglect that had been known to ENHT services. An action plan is in place and work around medical neglect has been launched.

The Trust received requests for information for a further 5 cases for the rapid review panel, all of whom were not known to ENHT services.

Four serious incidents (SIs) were declared during the reporting period:

- Safeguarding maternity (1). The SI report is still being written and initial learning has already been implemented into practice, including updates to the Perinatal Mental Health SOP
- Safeguarding children (1) – 1 action remains open in relation to the alcohol intoxication pathway
- Adult safeguarding (2) – learning has been implemented including amendments to the patient discharge passport, and learning has been shared at weekly matrons and ward leaders' meetings.

The Trust was involved in one new DHR review and continues with work on action plans for the review of a historical domestic homicide case from previous reporting year.

Mental Health

The Trust is working with internal and external partners on developing a Mental Health Strategy. The Trust's vision for our Mental Health Strategy is to deliver high-quality, compassionate care for patients of all ages through an integrated approach to physical and mental health, in an appropriate and safe environment, from staff who are the most clinically appropriate to deliver it.

The Trust's Mental Health Strategy objectives are as follows:

- Improve the quality of care for those dealing with serious mental health illnesses and ensure they are cared for in a safe environment
- Work collaboratively with mental health services and patients, to support a system-wide approach to delivering patient pathways
- Support patients with physical health conditions in managing their mental health needs
- Ensure we have an appropriately skilled workforce to deliver compassionate care to patients with mental health illnesses
- Ensure carers have access to the services they need to support their mental health
- A focus on staff mental health and wellbeing, with support to identify and manage their mental health needs

The Trust has a Mental Health Steering Group, which is working on the development and implementation of the Mental Health Strategy. The Trust is also re-launching the Learning Disabilities Group, led by the Deputy Chief Nurse.

The Trust has introduced Mental Health First Aiders to provide additional support. Mental Health First Aiders are a point of contact to support anyone experiencing a mental health issue or emotional distress. They are not therapists or psychiatrists, but they can give initial support and signposting to appropriate help if required. A list of Mental Health First Aiders is available to all staff on the Trust Intranet, and courses are available throughout the year for any staff members who wish to become Mental Health First Aiders.

The Trust wide Mental Health Steering Group continues to report directly to the JSC.

The Trust continues to see a significant increase in the number and complexity of patients attending with mental health issues. All attendances for under 18yrs are screened by the paediatric liaison team and further safety netting is provided for the more complex cases requiring referrals to children's social care.

Work completed by the safeguarding team this year includes:-

- Communication passports to support frequent attenders and transition
- Care Education and Treatment Reviews to support collaborative working
- Frequent attenders work and frequent attenders' plans including safeguarding risks
- Hospital youth worker project funding extended
- Development of QR codes to support signposting onto additional services
- Mental health first aid training
- Trauma informed care commissioned for unscheduled care settings
- Tablet devices to support apps and surveys, access to youth programmes, referrals to Beacon for Trauma support

Safeguarding and Audit Activity

During the reporting period, a comprehensive audit programme was undertaken, and action plans were developed to address the recommendations. The table highlights the audits undertaken, and learning identified.

Audit activity

Safeguarding Audit or Quality Assurance Activity undertaken by Topic/Title	Methodology i.e., Employee Survey, dip sample, case file audit, Customer Survey etc.	Outcome (Summary of key findings / learning)	Has the learning and actions been implemented?
Staff's Awareness of Safeguarding For 16 and 17 year olds attended ENHT	Case File Audit	The audit demonstrates areas of good practice in consideration of safeguarding issues, for this age group, however the documentation used needs to be updated in relation to risk assessment tools available for staff and some basic questions around demographics to be mandatory to help identify risk further.	Learning has been shared; some actions remain outstanding due to priorities around COVID-19. Actions back on track for completion.
HSCP Multi-Agency Bruising Audit	Staff Survey	The audit demonstrated an improvement in staff awareness of the policy, increasing confidence in using the policy, increase in staff accessing training	Bruising lite bite training is a permanent feature now on the Safeguarding Trust training programme and covered in all generic levels of safeguarding training.
HSCP Multi-Agency Audit of Physical Abuse Pathways	Case file audit	Primarily practice was in line with the policy, the quality off referrals was good	All learning implemented – no outstanding actions
Domestic Abuse Training Scoping Exercise	Views and evaluation of trust current DA training offer.	Review of current DA training offer. Identification of requirement for standalone session required for training and upskilling of staff.	Actions from evaluation now embedded in new DA provision of training.
Paediatric Liaison Audit	Audit of Psychosocial records	Improvements noted to the number of cases where additional concerns were being identified by the paed liaison service which reflects a heightened awareness of vulnerability for children at the point of care. Increase in paediatric liaison activity.	Action plan in place.
WNBI Audit	Retrospective audit of case files	Initial findings demonstrated improvements to compliance to the WNBI across paediatric service. Further work and support required for enhancing WNBI practice for children & YP across the trust – and support for when further escalation is required.	Action plan in place
Ward accreditation scheme audit	Case file and staff awareness	The purpose of a ward accreditation scheme to continually drive safer patient care with the aim of motivating staff and sharing best practice between ward areas to gain organisational clinical consistency and drive high standards of care. (For additional information	Areas of good practice identified with processes in place for peer learning and for the analysis of what works well and what doesn't work well shared. Aim is to promote 'working well practice' and extrapolate learning or identify amendments to

		please see Trust policy 'Clinical excellence accreditation framework, CGSG 194) The ward accreditation scheme audit process continued throughout 2021/22. The matrons and ward sisters monthly audit will now include measurements of MCA and DoLS compliance	practice improving the effectiveness of the 'doesn't work well' aspects of clinical care delivery.
MCA DOLS audit x 3	Case file Audit	Direction given to clinical areas on the application of DoLS refresher training given to ward teams. (Initial findings not all patients who lacked mental capacity to maintain a safe environment independently who were specialled or under continuous supervision for significant time periods had a DoLS in place. Results and recommendations of MCA/DoLS audit conducted in March and April 2022 will be disseminated to clinical areas in May 2022 analysis of findings is currently been undertaken	Improvements noted in the clinical application of DOLS seen between audit 1 results and audit 3 results. Audit conducted in Q4 2021/22 currently being analysed with learning to be disseminated during Q1 of 2022/23
Annual National LD Standards benchmarking audit.	Gap analysis undertaken on established Trust practices in comparison to NHS I/E LD standards. Staff survey on Trust LD infrastructure and practice awareness undertaken. Audit undertaken on the hospital experience of individuals with an LD who received care during 2020/21.	Awaiting NHSEI publication of result due in June 2022. The results for the previous year were discussed at LD working group with a focus on improving patient experience with the introduction of 'Ask, Listen, See and Do'.	The Trust is meeting the majority of standards the greatest improvement of note is that more than 85% of Trust staff has undertaken learning disability awareness Training via an eLearning module developed by health education England. The Trust LD working group is responsible for overseeing the attainment of LD standards for acute NHS Trusts. Area for focus in 2022/23 will be improving staff awareness of making reasonable adjustments and outlining of process required to insure the safe hospital discharge of individuals with and LD

Safeguarding Training

In order to protect children and adults from harm, all healthcare staff must be competent to recognise safeguarding concerns across the life span and be able to effectively action as appropriate within their role. Safeguarding training is a fundamental part of the Trust's duty to safeguard our most vulnerable people.

All Trust safeguarding training packages are based on the intercollegiate documents for both adults and children's safeguarding competencies for health care staff (2018 and 2019 respectively). The safeguarding learning and development and training needs analysis is commensurate with this guidance.

The safeguarding training packages are continuously reviewed and delivered predominately through eLearning modules., Additional safeguarding adults and children's safeguarding training is offered in a classroom-based format for Level 3 compliance purposes.

MCA/DoLS training was previously delivered alongside adult safeguarding L2 however due to the move to eLearning, staff are now required to complete MCA/DoLS as a separate module uploaded to the staff academy.35% of Trust staff have completed this module and the aim of the safeguarding team is to focus on improving compliance to 80% by the end of August 2022.

A WRAP prevent level 3 module for health care developed by the home office was also uploaded to ESR for all staff to complete. Currently 83% of Trust staff have completed this eLearning module.

The Trust target is for 90% of Trust staff to complete the training outlined in the table below. Staff are required to complete eLearning modules via the Staff Academy which was introduced in April 2021.

Module	Average Compliance Rate	Target
Adult safeguarding L1 (All Trust staff)	90%	90%
Adult safeguarding L2 (safeguarding training strategy for staff inclusion criteria)	86%	90%
WRAP prevent L3 (All Trust staff)	83%	85%
MCA/DoLS	35%*	90%
Learning disability Awareness	89%*	85%
Child Safeguarding L1 (all Trust Staff)	90%	90%
Child Safeguarding L2 (safeguarding training strategy for staff inclusion criteria)	88%	90%
Child Safeguarding L3 (safeguarding training strategy for staff inclusion criteria)	82%	90%

*End of year position highlights challenges with data collection due to change from Electronic Staffing Records to Academy system.

Compliance is monitored by the divisions (QLIKVIEW data) and reported bi-monthly to the JSC along with actions to address non-compliance. For continued assurance and oversight, the safeguarding team will request a percentage of passports from staff groups to ensure they are being utilised to capture training. It can be said with confidence, that the ongoing pressures at the point of care have impacted staffs' ability to engage with training.

Staffing groups that continue to have low compliance with training are medical and dental staff – this has been escalated to the Trust Medical Director and actions to increase compliance are under development.

Staff are encouraged to attend external training events provided by Hertfordshire Safeguarding Children's Partnership and Hertfordshire adult safeguarding board.

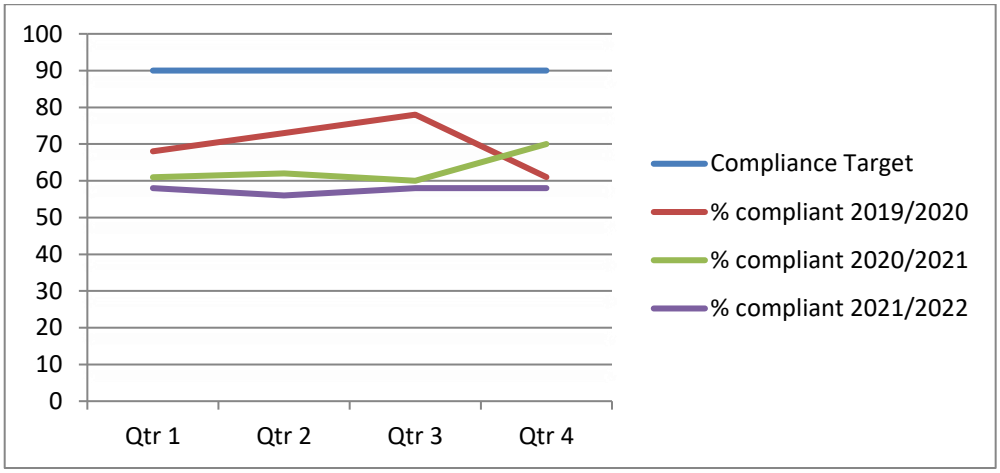
Supervision and Peer Review

Supervision – Children's safeguarding

The safeguarding team continue to provide formal and informal safeguarding supervision to all frontline clinical staff working in paediatrics. The Trust target for compliance as set by the Clinical Commissioning Group (CCG) is 90% for Band 6 and 7 staff and caseload holders working within community setting.

Supervision continues to be provided to the safeguarding team by the CCG, and by the Head nurse and lead nurses for safeguarding within the Trust. In addition, peer support continues for the safeguarding nurses with West Herts NHS Trust safeguarding nurses.

The following chart demonstrates compliance with supervision for the reporting period, and previous reporting periods for comparison. It is worth noting that these figures do not always reflect the ad-hoc supervision provided to staff – which is the safety net for when concerns present and support and advice is required by the safeguarding team.



Safeguarding supervision remained a key activity for the safeguarding team. The weekly psychosocial meetings and twice monthly neonatal psychosocial meetings continued to remain multi-agency in nature. It is worth noting during the timescales of measurement of these figures - staff shortages and clinical pressures meant staff availability to attend the sessions provided was impacted significantly. Staffing pressures within the safeguarding team also impacted the accurate recording of staff attendance and did not reflect staff off sick or on leave. These staff were then counted as a 'did not attend' a session rather than exceptional reporting. Moving forward, a more robust process is in place to ensure accurate recording of attendance at sessions.

The safeguarding team prioritised areas of supervision to ED, Paediatrics and community services. In addition, the team have provided weekly supervision time for ED nursing staff, monthly supervision to medical staff working in the ED, alongside the usual safeguarding supervision offer to paediatrics and the Trust as a whole. This has supported safeguarding practice during the height of Trust operational pressures, and offered a space for staff to reflect on some of the complex safeguarding cases which have frequently presented to our high risk areas. We have seen good engagement in these sessions, but this data is not reflected or captured to acurately reflect the supervision activity and offer from the safeguarding team within this report.

Supervision – Maternity Safeguarding

There has been a drop in compliance with safeguarding supervision for maternity services over the reporting year (average 53%) due to the challenges of acuity and staffing presures faced within maternity services. The safeguarding team have continued to offer safeguarding sessions for all identified staff, plus via extra sessions for ward based staff and leaders. A

plan is in place to not only increase the number of midwives who access safeguaring supervision but the way we showcase the value. The initial action has been to set a recurring 3 monthly date for team safeguarding supervision which has been agreed by both the maternity safeguading team and the community team leaders. This will put a safety net in planning in advance and a commitment to engagement.

All specialist midwives will be offered safeguarding supervision to not only support them in experiencial learning but to offer guidance to the team when requiring advice and support . All leadership team will have the opportunity to engage with an aim to support the smooth running of active cases that require acute and pre planning of cases.

The focus of the monthly safeguarding meeting with matrons will be to discuss pending cases for that month with an aim to assure the team that planning is in place and to offer scope around how the team can meet the family approach.

There will be monthly drop in sessions for all midwives to access on a rolling week day to accommodate working patterns. The focus of this is to initially invite all staff to explore their complex cases then to widen the scope to focus on generalised supervision around current safeguarding local and national agenda.

The local directive is that all community midwives are offered safeguarding supervision due to the nature of managing high risk cases and the work carried out with the wider teams. The recommended uptake is set at 90% engagement every 3 months and with careful planning and commitment from the maternity safeguarding team we aim to meet this expectation. The maternity safeguading team have a robust plan to make safeguarding supervision not only statutory but appealing and with an aim for this to enhance their practice. It has been reported that some staff find this an invasive and misunderstood concept so the focus is to remove this fear and offer this as an exciting opportunity for professional growth.

Supervision – Adult Safeguarding

The safeguarding team have developed an adult supervision pathway which was presented at the Trust JSC in May 2021.

The Trust's adult safeguarding team provide education to staff on national and local safeguarding process and raise awareness on the recognition of abuse and its causes. The safeguarding team routinely provides direct supervision, advice and support to frontline staff that are actively managing and reporting concerns on a case-by-case basis. The supervision pathway offers line managers an opportunity to supervise staff on safeguarding matters outside of situations where direct case supervision is offered by adult safeguarding practitioners. This function also serves as an opportunity for staff to meet L3 adult safeguarding compliance

Peer Review

Peer review is a form of reflective practice and helps to decrease professional isolation and improve sharing of best practice.

The goal of peer review is to provide uniform practice through a proactive culture of shared learning, supervision, education and training and improvement of service and multiagency processes. The table below demonstrates attendance at peer review during the reporting period.

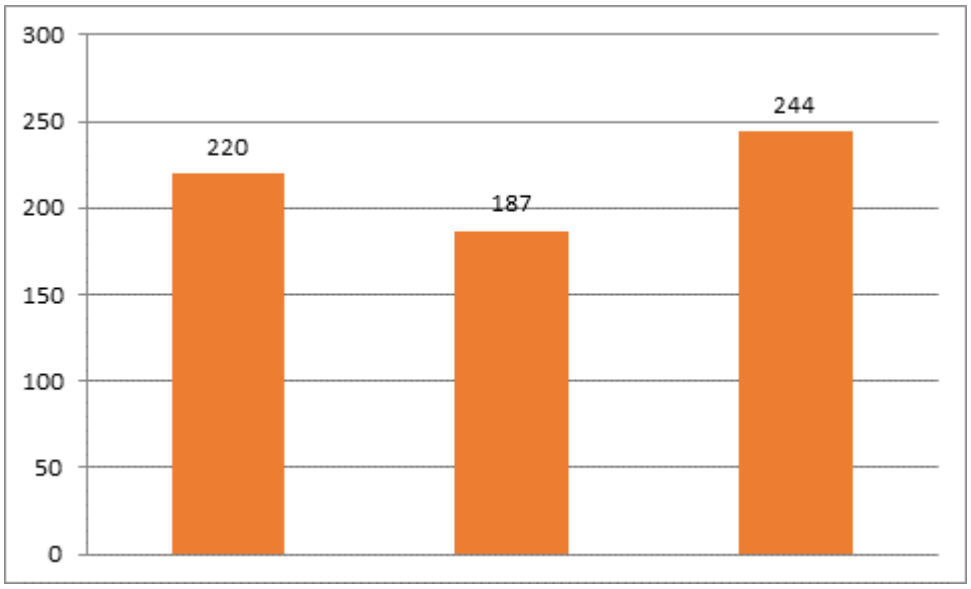
2021/22	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Acute and neonatal Consultants	6	12	5	8	5	9	9	6	*	8	6	10	84
Community Consultants	10	17	18	9	5	18	16	13	10	19	15	18	160
Total	16	29	23	17	10	17	25	19	10	27	21	28	244

*No peer review

The attendance is monitored with minimum expected attendance of individual consultants at peer review at least once every 12-week cycle. We encourage all consultants and junior doctors to attend the peer reviews and feedback is given to consultants and associate specialists who are not able to attend peer review meetings for more than three months.

Peer review is used as a training format using case discussions and is well attended by acute and community paediatrician and the junior medical teams. We also discuss any learning from recent national SCR and any local SI/learning.

Peer review attendance is recorded on electronic staff record (ESR). Peer review attendance for last 3 years is shown below:



Safeguarding Champions

During 2021 we have successfully relaunched the Safeguarding Champions' network and have reviewed the roles and responsibilities of the champions which includes providing enhanced safeguarding knowledge within their departments, contributing to local audits and practice development and improvements. With the relaunch of the champions, work is currently underway to improve visibility of the champions in their departments and increase staff knowledge around their role and the support they can offer at the point of care. More recently, we have recruited over 20 safeguarding champions from adult areas, who have joined the most recent champion event; creating a integrated safeguarding approach across the life span.

Care of Adults with a Learning Disability

Health Liaison Team

The Acute Liaison Learning Disability Nurses (Hertfordshire Health and Community Services) continue to support patients with Learning Disabilities (LD) and their carers when using hospital services. They will assist Trust staff in making reasonable adjustments for patients, advising staff about what reasonable adjustments might be required, using appropriate communication tools for people with LD, enabling appropriate discharge packages of care, end of life care and will provide training for staff around the needs of patients with a learning disability.

The Trust uses an LD alert on the electronic patient records – alerts are available to use on Nervecentre and Lorenzo. As of March 2022, there were 3132 individuals listed on our electronic records who had an LD alert flag on their records the majority of these individuals are Hertfordshire residents this is an increase of 8% when compared to the previous year.

The alerts on the Nervecentre continue to produce a daily report which is emailed to the LD nurses and matrons so that they are aware of the patients who are in hospital. At the daily site safety huddle on the acute site (Lister Hospital) all the patients with LD are discussed to ensure that if there are any concerns about care or any delays which need to be resolved, these can be acted on by the right people in a timely manner. The LD nurses participate in these meetings and are supported by the adult safeguarding team.

Activity reported on the 2021 National Learning Disability Audit:-

Measurement (Individuals with an LD)	Number
Number of individuals with an LD flag on Lorenzo:	**3132**
Number of outpatient interactions with a Trust service	**1635**
Total number of occupied bed days	**2005**
Average number of inpatients per day. (Occupying an inpatient bed)	**5.5**
Average number of outpatient interactions per day.	**4.5**

Learning disability working group and improvement action plan

During 2021/22 there has been focused work on improving care for patients with learning disability. There were two SIs declared during the year relating to the care of individuals with a learning disability. Learning from one SI was shared by the patient safety pharmacist at a matrons and ward leaders meeting. The incident was used to amend the current patient discharge passport to mitigate against a risk of a reoccurrence. The second SI identified learning about the management of pressure area care on a medical ward, with the tissue viability team leading on the completion of a preventative action plan related to this incident which will be incorporated into tissue viability teaching.

The Trust participated in the National Learning Disability Audit in January 2022 to benchmark Trust performance against NHSE/I standards for the care of individuals with a learning disability. Areas where deficits are noted are incorporated into the Trust's LD working group's action plan.

The Learning Disability Working group is scheduled to meet bi-monthly and is chaired by the Deputy Chief Nurse. The membership includes commissioners, representatives from the clinical divisions, health liaisons team members, safeguarding practitioners and the Trust's equality and diversity lead. The working group's meeting pattern was disrupted between November 2021 – April 2022 due to the COVID-19 pandemic. Currently the working group is reviewing the terms and reference along with its membership and action

plan for 2021/22. The group's focus for 2022/23 is to improve patient experience and increase the application of reasonable adjustments in clinical practice.

The Trust remained members of HSAB's Improving Healthcare Outcomes Group (IHOG). The Trust's management of individuals with learning disability and autism policy was updated to include learning identified through membership of the group and through LeDeR reviews.

The Trust continues to work in partnership with external agencies, carers, and families of individuals with an LD to improve patient care on an ongoing basis.

The Trust's standard operational procedure for LeDeR referrals was updated in February 2022 to include the nationally revised reporting mechanisms, including the extension of the LeDeR program to review the deaths of individuals with autism.

The Trust introduced learning disability mandatory training for all staff in 2021; currently 89% of staff have completed the module.

Risk Register

There are currently 7 open Adult & Children safeguarding risks on the risk register. All safeguarding risks are up to date.

Risk	Title	Current score	Outstanding Actions
7431	Reduced oversight of maternity safeguarding due to staffing challenges	15	Bank support to cover staff shortages
6893	Adult Safeguarding Training Compliance	15	To achieve above 90% compliance for all levels of safeguarding training. (all divisional leads)
5412	Risk of missed safeguarding children concerns - Adults who present with risk factors and the Think family agenda	12	ED staff to record if adults who attend have any children or dependants and identify if there are any safeguarding concerns Think family - staff to be aware of the think family agenda, routine enquiry, and application of the safeguarding children's policy.
4381	Children at risk if compliance with safeguarding children's training less than 90%	12	To achieve above 90% compliance with level 3 safeguarding training within the medicine division To achieve above 90% compliance with level 3 safeguarding training within Women's and Children's division
5187	Risk that the Supervising Authority for Deprivation of Liberty Safeguards	9	Supervising Authority are automatically extending 7-day urgent applications to 14 days.

	(DoLS) cannot authorise standard applications in time		Matrons for clinical areas are tasked with monitoring DoLS applications and notifying the Adult Safeguarding lead when urgent is due to expire and whether Supervising Authority have undertaken Best Interests and Mental Health assessment. Adult Safeguarding lead nurse and CQC compliance officer maintain database and request regular updates on progress from Matrons and DoLS team Clinical staff need to use the least restrictive options in providing care and treatment to patients if clinically appropriate and patient safety can be maintained
7129	Clinical effectuation of LPS under the Mental Capacity Amendment Act 2019	6	Trust response to consultation LPS working group and work plan

The following table outlines the risks that have reached their target score and become as accepted risks but remain on the risk register. Controls are reviewed periodically to ensure the risk score does not change.

Opened	Speciality	Risk title	Initial Score	Current Score	Target Score	Date Accepted
24/07/2019	Safeguarding children	Children's social care referrals – Hertfordshire	6	6	6	11/03/2020

Priorities for 2022/2023

In considering the progress made against the priorities of the previous year, along with the current national priorities and agenda for safeguarding, the priorities below will continue to underpin the Trust safeguarding strategy and forward plan for the safeguarding team:

- Embed level 3 safeguarding adult level 3 training Trust wide – working towards achieving expected compliance
- Achieve and maintain training compliance at above 90% for all levels of safeguarding training
- Achieve and maintain safeguarding supervision compliance at 90% for identified staff
- Develop programme of level 3 safeguarding specialist topics – Exploitation, Neglect, Action Learning sets, etc
- Targeted work to ensure MCA/DoLS training compliance is available on Qlikview and compliance achieves and maintains above 90%

- Drive the business case for Liberty Protection Safeguards (LPS) and work plan to ensure Trust is ready for implementation
- Digital transformation and safeguarding documentation – including screening and assessment tools, safeguarding alerts and record keeping
- Continue to develop adult safeguarding champions role
- Continue to drive key HSCP/HSAB strategies – Neglect, domestic Abuse, Modern Slavery – including tools and integrated working
- Demonstrate how we are sharing learning from SIs, rapid reviews, and local learning reviews and how we measure changes to practice as a result
- Develop process for transition from children's to adult's services for care experienced children.
- Devise and implement a Chaperone audit rolling programme
- Drive the business case forward for increase in safeguarding team in direct response to increase in activity
- Continue to develop understanding and response to working with fathers and partners in response to national report on The Myth of Invisible Men

East and North Hertfordshire NHS Trust

Meeting	**TRUST BOARD - PUBLIC SESSION**		**Agenda Item**	18
Report title	**Learning from Deaths Report**		**Meeting Date**	6 July 2022
Presenter	Medical Director			
Author	Mortality Improvement Lead			
Responsible Director	Medical Director		**Approval Date**	08 June 2022
Purpose *(tick one box only)*	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

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.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

1. **Trust Strategic Objectives:**
   a. **Quality:** To deliver high quality, compassionate services, consistently across all our sites,
   b. **Pathways:** To develop pathways across care boundaries, where this delivers best patient care
2. **Compliance with Learning from Deaths NQB Guidance**
3. **Potential impact in all five CQC domains**

Risk: *Please specify any links to the BAF or Risk Register*

Please refer to page 6 of the report

Report previously considered by & date(s):

Mortality Surveillance Committee – 08 June 2022

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

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

This report provides a summary of the information contained in the detailed Learning from Deaths report which has been considered both by the Mortality Surveillance Committee and the Quality and Safety Committee. This summary is provided to the public Board meeting in line with NQB Learning from Deaths national reporting requirements.

1. Key mortality metrics

Table 1 below provides headline information on the Trust's current mortality performance.

Table 1: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 1.19% for the 12-month period to April 2022 compared to 1.27% for the latest 3 years.
HSMR: (data period Mar21 – Feb22)	HSMR for the 12-month period is **89.67, 'First quartile'.**
SHMI: (data period Jan21 – Dec21)	Headline SHMI for the 12-month period is **88.26 'lower than expected' band 3.**
HSMR – Peer comparison	ENHT ranked 1st (of 8) within the Model Hospital list* of peers.

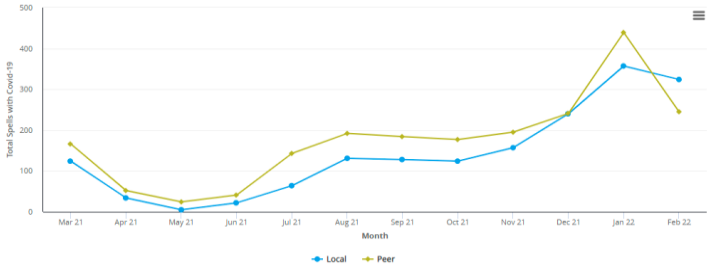
* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital (updated in 2021), rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

2. COVID-19

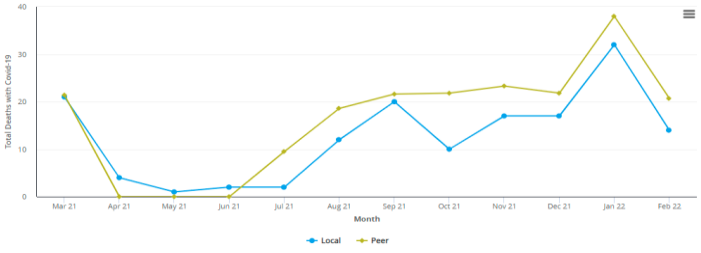
The following charts provided by CHKS show the Trust's alignment with national peers for both spells and deaths reported with COVID-19.

Fig 1: Covid-19 Peer Comparison: Mar21 to Feb22

Spells with COVID-19 (Peer: National)



Deaths with COVID-19 (Peer: National)



3. Mortality alerts

3.1 CUSUM alerts

The latest release from CHKS showed one HSMR CUSUM red alert for the rolling year to February 2022. The Head of Coding has confirmed that the coding of the deaths underpinning the alert for coronary atherosclerosis was correct. At May Mortality Surveillance Committee, it was agreed that coding of this diagnosis group would continue to be monitored by Cardiology/Head of Coding on a monthly basis, with an update to the Committee in 6 months.

Table 2: HSMR CUSUM Alerts March 2021 to February 2022

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
101 - Coronary atherosclerosis and other heart disease	375.40	10	3	7

Source: CHKS (CUSUM alerts coloured)

The CHKS report also indicated two SHMI outlier alerts for the period to November 2021 (amber alert: lower confidence limit above national average; red alert: lower confidence limit in upper quartile). These were for the diagnosis groups of ill-defined heart disease and skin disorders. These were discussed at May Mortality Surveillance Committee, where it was agreed that the Head of Coding will review the coding of the deaths underpinning the alerts to assess what further action may be necessary.

Table 3: SHMI Outlier Alerts December 2020 to November 2021

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
61 - 104: Other and ill-defined heart disease	952.00	3	0	3
108 - 198, 199, 200: Skin disorders	271.97	26	10	16

3.2 External alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)

The National Hip Fracture Database is still only showing 30-day mortality to December 2020. In December 2020 30-day mortality stood at 12.0%, significantly above the national average. An internal review is underway to provide a more up-to-date picture. More recent local crude mortality provides some indication that 30-day mortality has reduced. As remedial work continues, delays to theatre access remain a key barrier to improvement. This issue has been escalated to the Quality & Safety Committee.

Outputs from the CCG's audit of deaths in the community within 30 days of discharge has now been received and considered by the #NOF service team. In response to this the service has commenced the following additional review work:

- Audit comparing mortality in the dementia care home group to others
- Audit to check that the discharge passport/physio/nursing input is being communicated to the patient's discharge destination. (Falls assessment, bone protection, nutritional assessment are part of the Trust's process and a requirement for NHFD but were queried in the CCG audit).

4. Focus areas for improvement

5.

Table 4: Focus Areas for Improvement

Diagnosis group	Summary update
Acute Myocardial Infarct	Following an initial six-month joint Cardiology-Coding initiative to review MI, it was agreed at May Mortality Surveillance Committee that the collaboration should continue with a further update in six months' time.
Sepsis	HSMR performance relative to national peer remains well placed. There has been some improvement regarding achievement of sepsis targets including compliance with the Sepsis 6 care bundle. Expressions of interest have been requested for the post of Sepsis Lead following the resignation of Yvonne Barlow.
Stroke	SSNAP rating has improved to C. Stroke HSMR remains above the national peer average, but not to a statistically significant extent. SHMI has reduced to below the national peer. The most recently reported SSNAP risk adjusted mortality, considered a better mortality indicator, has improved – but is currently only available for the year 2019-20. More recent HSMR/SHMI rates have improved.

Diagnosis group	Summary update
Emergency Laparotomy	Focussed improvement work remains on-going. Positive news includes the recruitment of a NELA data coordinator, restart of the geriatric service for NELA patients and engagement with the consultant palliative lead in EoL discussions. Continuing delays to the re-establishment of the Surgical Assessment Unit/Surgical SDEC and the lack of a dedicated emergency theatre for general surgery continue to present challenges to improvement.

5. Learning from deaths data

5.1 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 for Q4 2021-22.

Table 5: Q4 2021-22: Learning from deaths data

	Jan-22	Feb-22	Mar-22
Total in-patient deaths	125	106	113
Mortality reviews completed	80	72	60
Total new ACONs raised	2	8	18
Concluded ACONs (2021-22 deaths): probably ≥50% due to problem in care	0	0	0
Learning disability deaths	0	1	1
Mental illness deaths	4	1	2
Stillbirths	1	2	0
Child deaths (including neonats/CED)	1	2	1
Maternity deaths	0	0	0
SIs declared regarding deceased patient	2	4*	1
SIs approved regarding deceased patient	8	0	0
Complaints regarding deceased patient	3	1	3
Requests for a Report to the Coroner	12	4	3
Regulation 28 (Prevention of Future Deaths)	1	0	0

** including 3 HSIB*

5.2 Learning from deaths dashboard and outcomes summary

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 2021-22 deaths which can appear to skew the data.

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).

Table 6: 2021-22 concluded ACONs ratings

Apr-Mar 2021-22: Concluded ACONs discussed by Mortality Surveillance Committee		
Avoidability of Death Rating	**Definition**	**SI/RCA detail**
1	**Definitely avoidable**	**-**
2	**Strong evidence of avoidability**	**-**
3	**Probably avoidable, more than 50-50**	**2**
4	Possibly avoidable, but not very likely, less than 50-50	5
5	Slight evidence of avoidablity	14
6	Definitely not avoidable	24

Quality of Care Rating	**Definition**	**SI/RCA detail**
A	Excellent	1
B	Good	6
C	Adequate	9
D	**Poor**	**18**
E	Very poor	11

Note: the above data relates to ACONs concluded during 2021-22, irrespective of when the death occurred.

6. Learning and themes from concluded mortality reviews highlighted for concerns and learning opportunities (ACONs)

Cases raised as Areas of Concern (ACONs) as a consequence of mortality case record reviews, are central to the topics covered at clinical governance Rolling Half Days and other forums such as Mortality and Morbidity meetings. These meetings provided a forum for discussion, learning and the creation of appropriate Specialty-specific action plans and represent a key element of the Trust's learning from deaths framework.

Throughout the year emerging themes are collated and shared across the Trust via governance and performance sessions and specialist working groups. The information is also used to inform broad quality improvement initiatives.

7. Current risks

Table 7 below summarises key risks identified:

Table 7: Current risks

Risks	Red/amber rating
COVID-19	
Fractured Neck of Femur mortality	
Medical Examiner Integration & Community expansion	
Mortality review reform: Process, review format & IT platform	

3.0 Options/recommendations

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

Appendix 1: ENHT Learning from deaths dashboard March 2022

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: March 2022

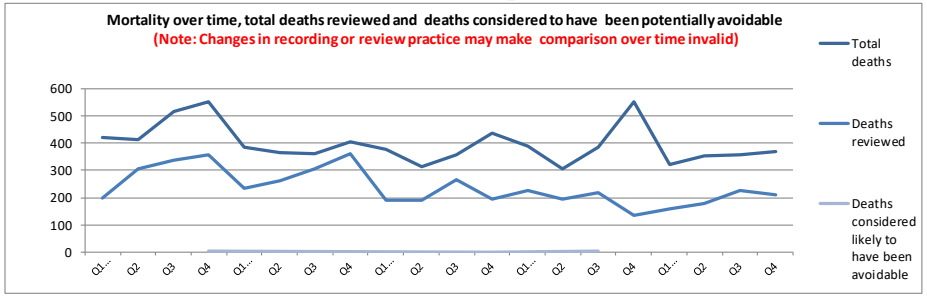
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose 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	111	60	72	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
370	358	212	225	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1405	1634	772	774	0	2

Time Series: Start date 2017-18 Q1 End date 2021-22 Q4



Total Deaths Reviewed by RCP Methodology Score

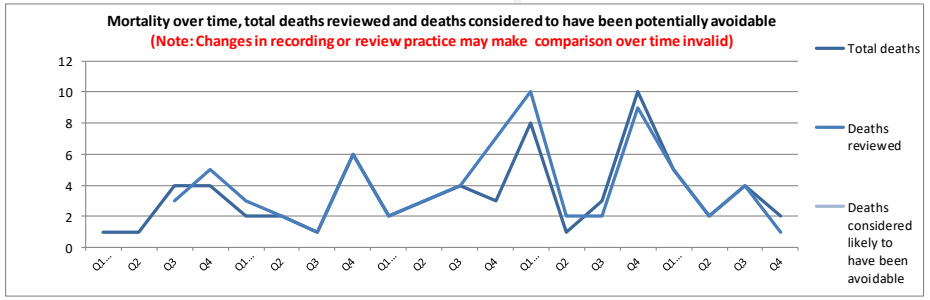
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	56	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	0.5%	This Quarter (QTD)	1	0.5%	This Quarter (QTD	200	99.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	5	0.7%	This Year (YTD)	5	0.7%	This Year (YTD)	757	98.7%

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
1	1	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	4	1	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
13	22	12	23	0	0

Time Series: Start date 2017-18 Q1 End date 2021-22 Q4



East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	19
Report title	Nursing and Midwifery Establishment Review		**Meeting Date**	6 July 2022
Presenter	Rachael Corser			
Author	Emily Watts Lead Nurse for Workforce			
Responsible Director	Chief Nurse		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

The nursing establishment review was undertaken in April 2022. 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 frameworks, professional judgement, quality and safety indicators, benchmarking with other Trusts using NHSI Model Health system [Appendix 1] and national guidance for safe staffing.

Non ward based areas were also reviewed looking at activity, service model, using national guidance, benchmarking, and professional judgement. Whilst shift plans have been revised according to patient acuity and current activity, there is further work needed to agree funding for the revised shift plans which will be updated in a separate paper for September.

The RCN (2019) Workforce standards, highlights that a lack of nursing leadership and relevant support structures within organisations impacts on safety, quality of care and patient mortality as well as the mental health and general wellbeing of the nursing workforce. It is well documented that having good leadership and enough skilled trained staff will be key to the safe and effective restoration of healthcare services and will support staff wellbeing and recruitment and retention within the organisation. The recommendations in this review will support current workforce challenges heading into Winter.

key recommendation

- To agree the skill mix changes in 11A.
- Continue to progress future Nursing and midwifery workforce reviews to meet the service demands

Impact:

Quality and patient Safety risks, Staff wellbeing, recruitment and retention, competent well-trained staff, leadership development.

Risk: *Please specify any links to the BAF or Risk Register*

People

Quality Safety	
Report previously considered by & date(s):	
Nursing, Midwifery and AHP Board Clinical operational workforce steering group	
Recommendation	The Board/Committee is asked to approve the recommendations

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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.

Developing workforce safeguards (NHS England, 2019) states that effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high quality care to patients and service users. Establishment setting must be done annually, with a mid-year review, and should take account of:

- Patient acuity and dependency using an evidence-based tool (as designed and where available)
- Activity levels
- Seasonal variation in demand
- Service developments
- contract commissioning
- Service changes
- Staff supply and experience issues
- Where temporary staff has been required above the set planned establishment
- Patient and staff outcome measures.

The guidance also states the importance that all stakeholders, including commissioners, are sighted on all recommendations to maintain or change establishments. Stakeholders should understand the rationale behind such recommendations and their anticipated impact.

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 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.
The RCN (2022) latest report recognises Nursing staff in the UK are being asked to keep going in the face of intolerable pressure. The results showed that In all NHS care settings,

84% of respondents reported that staffing levels were not sufficient compared to 69% working in independent sectors.

For nursing and midwifery, the budgeted establishment and required ward/department roster template must be aligned. They must be determined by factoring in headroom and outputs from the recommended six-monthly safe staffing establishment reviews. These reviews should use the National Quality Board's (2018) evidence-based guidance.

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, with nurses leaving the profession or leaving to work in a less challenging environments and difficulties in recruiting support workers)due to the increasing pressures they face.
- 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 result of funding and successful international recruitment has enabled the Trust to improve vacancies for registered nurses; however is still reliant on temporary staffing with no resilience in flex to meet surge plans, winter pressures and support well-being initiatives
- International recruits and grow our own initiatives have increased our requirements for study leave impacting on overall unavailability but not reflective through vacancy rates
- National shortage of clinical support workers
- Implementing the Enhanced Recovery programme
- NHSEI requirement to increase beds by 7.5% which will require a 30 bedded Winter Ward to open in January 2023
- NHSP bank staff are mainly trust staff; the split of multi-post holder and bank only is 75/25, putting more pressure on our nursing teams to pick up bank shifts when they are already tired
- 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:

- 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 Ward Managers, Matrons, Divisional Nursing and Quality Directors / Deputies, the people team and financial colleagues, ensuring robust clinical discussions and context were captured. Table 1 demonstrates methodology tools for each service that were utilised.

Table 1

Area	Methodology
Wards - AMU, Paediatrics, A+E	Safer Nursing Care Tool (SNCT) Professional Judgement Benchmarking + Model Hospital Review of quality indicators
The following areas were also included in the establishment review and any existing amendments to shift plans agreed using winter initiative funding. These areas will be brought back in January as part of annual budget setting / planning cycle.	
Outpatient Departments	Professional judgement as no current validated tool
Neonatal Unit	British association of perinatal medicine (BAPM) Guidelines and professional judgment
Critical Care	ICS guidelines and professional Judgement
Maternity	Birth Rate + and professional judgement
Endoscopy	Joint advisory group (JAG) guidance and professional judgement
Theatres	External review
Renal	British Renal Standards, professional judgement
Cancer Service's	SNCT for ward 10 + Professional judgement

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 2.

Table 2

Planned Registered Nurse to Patient ratio per division

Division		Available Shifts (RN + Unreg)						RN to Bed Ratio		
		Early Reg	Early Unreg	Late Reg	Late Unreg	Night Reg	Night Unreg	Early	Late	Night
Unplanned		4	4	4	4	4	3	1/5	1/5	1/6
Planned (Excluding Critical Care)		4	3	4	3	4	2	1/6	1/7	1/7
Cancer		4	3	4	3	3	2	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.

CHPPD is used prospectively to identify the likely care time required for expected patient type for a service. This is then compared to the required CHPPD for actual patients using the service, and then comparing the actual CHPPD provided by staff on the ward to assess if wards were appropriately staffed for actual patients.

Table 3 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 3.

Table 3

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	7.04	7.18	7.20
Planned (Excluding Critical Care)	5.66	5.89	6.14
Cancer	6.15	5.47	9.86

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. SNCT is NICE approved as an effective evidence-based staffing tool.

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.

Table 4 below shows the occupancy information for each division for the sample period, with 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 4

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 Oct 2021	SNCT recommended WTE (22% Headroom)	Variance of Total Funded Est. based on occupancy to SNCT recommended
Unplanned	96%	34.50	36.32	34.22	32.21	2.28
Planned (Excluding Critical Care)	88%	33.04	37.78	35.69	33.53	-0.49
Cancer	71%	22.87	32.05	30.49	20.82	2.05

- Clinical speciality
- Ward size and layout (evidence suggests the tool does not work well in small wards)
- Side rooms
- Staff capacity, skill mix, competence and leadership
- Organisational support and support roles
- Ward manager supervisory time

The combined data demonstrating CHPPD Benchmark Recommended WTE compared to the SNCT Recommended WTE can be found in Appendix 4.

2.4 Professional Judgement

All Ward Managers, Matrons, Divisional Nursing and Quality Director / Deputies, Finance, workforce leads and the E-roster team met with the Deputy Chief Nurse to review all the above data and triangulate associated quality indicators, Datix incidents and themes, and red flag events. 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 Directors were engaged and took ownership of their clinical areas.

2.5 National Benchmarks

The latest available March 2022 data was taken as a benchmark which compares local peers with the NHSI Model health system. ENHT was rated in the lowest quartile for CHPPD for total nursing. See Appendix 1 for the data.

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 September 2021 – 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 trained and competent in the SNCT, 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. It should be noted that further training is required with SNCT scoring in areas below 90% accuracy (prior to validation and correction). 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 health system [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.

3.0 Inpatient Wards

Following the SNCT review and meetings with the senior nursing team reviewed all areas.
All ward managers felt that their staffing levels were safe when fully recruited to. Some areas were an outlier when compared with the SNCT results. Robust discussions and professional judgement were part of the considerations when reviewing the data.
11A has requested a change in skill mix due to the complex respiratory patients they continue to care for. It is proposed that a band 2 post is removed and a band 2 post is changed to a band 4 post to support with the complex care required on 11A. This will be cost neutral.

7.0 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.
Further work continues with divisions for non-ward based areas and will be summarised in a paper recommending investments needed due to service demands to go to board in September.

8.0 Recommendations for Board

- Approve the change to 11A shift plan as reviewed and recommended by the senior nurse teams
- Support recruitment into the 22% headroom to ensure a resilient workforce going into winter
- Continue work to align budgets to shift plans
- Governance Process to be agreed for non-ward based establishment reviews
- Paper to go to board in September for the recommendations for non-ward based areas and proposed investment required

Appendix 1

Benchmarking data comparing local peers From the NHSI Model health system – latest data available March 2022

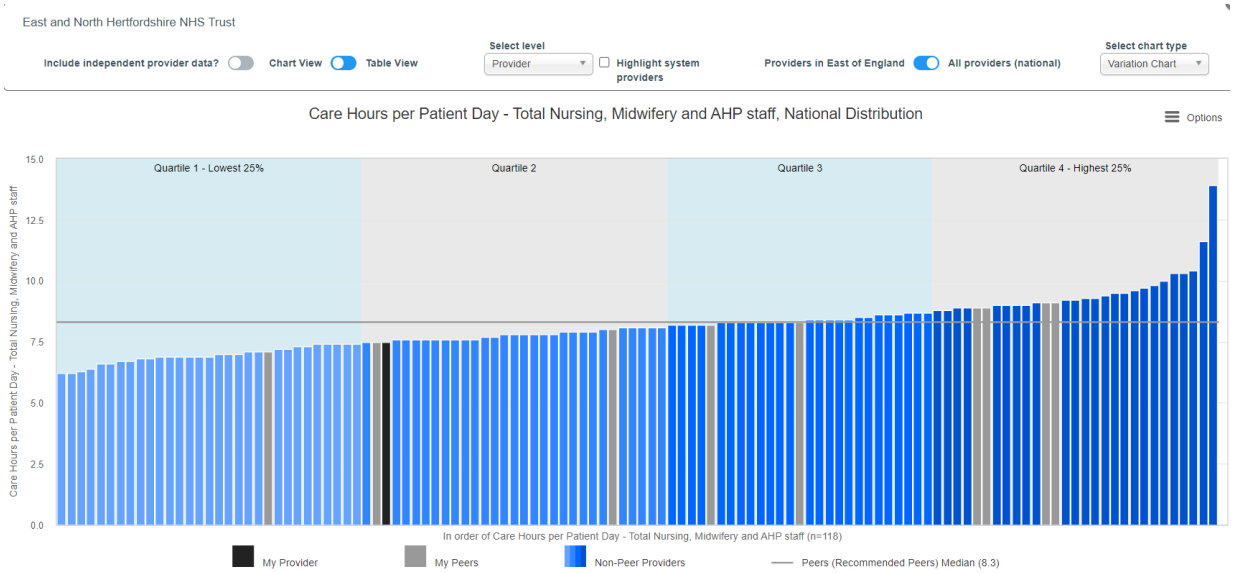

Table 1

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**	47%	53%	51%	49%
		11B RSU	75%	25%	69%	31%
	Oncology	**10A**	57%	43%	60%	40%
	General	**10B**	52%	48%	52%	48%
	Renal	**6A**	58%	42%	60%	40%
	General / Renal	**6B**	67%	33%	68%	32%
	Gastro	**8A**	58%	42%	61%	39%
	Care of the Elderly	**9A**	50%	50%	49%	51%
		9B	50%	50%	49%	51%
	Cardiology	**ACU**	57%	43%	57%	43%
	Acute	**AMU1**	56%	44%	47%	53%
		AMU2	66%	34%	56%	44%
		SSU	63%	38%	62%	38%
	Frailty	**Ashwell**	52%	48%	48%	52%
	Stroke	**Barley**	52%	48%	53%	47%
		Pirton	66%	34%	65%	35%
	Paediatrics	**Bluebell**	73%	27%	74%	26%
Planned	General Surgery & Vascular	**7A**	59%	41%	62%	38%
	Urology & Colorectal	**7B**	59%	41%	59%	41%
	Plastics & ENT, Female Surgery	**5A**	59%	41%	61%	39%
	T&O & NoF	**5B**	58%	42%	60%	40%
	Elective Surgery	**Swift**	57%	43%	60%	40%
	ATCC	**Critical Care**	82%	18%	98%	2%
Cancer	Oncology	**Ward 10**	57%	43%	63%	37%

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	Number of Beds	Available Shifts (RN + Unreg)						RN to Bed Ratio			Actual RN to patient ratio per day
				Early Reg	Early Unreg	Late Reg	Late Unreg	Night Reg	Night Unreg	Early	Late	Night	
Unplanned	Respiratory	**11A**	29	4	5	4	5	4	3	1/7	1/7	1/7	1:7.22
		11B RSU	12	3	1	3	1	3	1	1/4	1/4	1/4	1:3.93
	Oncology	**10A**	10	2	2	2	2	2	1	1/5	1/5	1/5	1:6.36
	General	**10B**	30	5	5	4	5	4	3	1/6	1/7	1/7	1:7.43
	Renal	**6A**	30	5	4	4	4	4	2	1/6	1/7	1/7	1:7.14
	General / Renal	**6B**	24	5	4	5	3	4	1	1/5	1/5	1/6	1:5.29
	Gastro	**8A**	30	5	4	4	4	4	2	1/6	1/7	1/7	1:6.85
	Care of the Elderly	**9A**	30	4	5	4	5	4	3	1/7	1/7	1/7	1:7.68
		9B	30	4	5	4	5	4	3	1/7	1/7	1/7	1:7.43
	Cardiology	**ACU**	22	4	3	4	3	4	3	1/5	1/5	1/5	1:5.02
	Acute	**AMU1**	33	8	8	8	8	8	8	1/4	1/4	1/4	1:4.30
		AMU2	16	4	2	4	2	4	2	1/4	1/4	1/4	1:4.67
		SSU	15	3	2	3	2	2	1	1/5	1/5	1/7	1:6.97
	Frailty	**Ashwell**	24	4	4	4	3	3	3	1/6	1/6	1/8	1:7.34
	Stroke	**Barley**	24	4	4	4	3	3	3	1/6	1/6	1/8	1:6.57
		Pirton	22	5	2	5	2	3	2	2/9	2/9	1/7	1:5.54
	Paediatrics	**Bluebell**	16	4	2	4	2	4	1	1/4	1/4	1/4	1:3.67
Planned	General Surgery & Vascular	**7A**	29	4	4	4	3	4	2	1/7	1/7	1/7	1:6.76
	Urology & Colorectal	**7B**	30	5	4	4	4	4	2	1/6	1/7	1/7	1:6.81
	Plastics & ENT, Female Surgery	**5A**	30	5	4	5	4	4	2	1/6	1/6	1/7	1:5.94
	T&O & NoF	**5B**	30	5	4	4	4	4	2	1/6	1/7	1/7	1:6.96
	Elective Surgery	**Swift**	26	4	3	4	3	4	3	1/6	1/6	1/6	1:5.88
	ATCC	**Critical Care**	18							0	0	0	1:1.24
Cancer	Oncology	**Ward 10**	22	4	3	4	3	3	2	1/5	1/5	1/7	1:3.92

Appendix 3

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**	6.24	7.73	6.52
		11B RSU	7.54	7.63	8.88
	Oncology	**10A**	7.91	6.36	6.27
	General	**10B**	6.22	6.53	6.21
	Renal	**6A**	5.47	6.30	5.60
	General / Renal	**6B**	6.43	6.41	6.57
	Gastro	**8A**	5.61	5.79	5.66
	Care of the Elderly	**9A**	6.03	7.63	6.25
		9B	6.01	7.49	6.55
	Cardiology	**ACU**	7.18	5.25	8.88
	Acute	**AMU1**	10.91	9.14	11.73
		AMU2	11.30	9.90	9.30
		SSU	6.00	5.81	5.51
	Frailty	**Ashwell**	6.37	7.94	6.62
	Stroke	**Barley**	6.29	6.57	6.62
		Pirton	6.19	6.91	6.38
	Paediatrics	**Bluebell**	7.91	8.73	8.92
Planned	General Surgery & Vascular	**7A**	5.10	5.54	5.70
	Urology & Colorectal	**7B**	5.46	5.24	5.92
	Plastics & ENT, Female Surgery	**5A**	5.74	5.59	6.49
	T&O & NoF	**5B**	5.51	7.13	5.70
	Elective Surgery	**Swift**	6.48	5.95	6.87
	ATCC	**Critical Care**	21.72	20.46	19.81
Cance	Oncology	**Ward 10**	6.15	5.47	9.86

Appendix 4

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 (Reg & Unreg)	Recruitable Establishment (Reg & Unreg) Apr 22	SNCT recommended WTE (22% Headroom)	Variance of Total Funded Est. based on occupancy to SNCT recommended
Unplanned	Respiratory	11A	95.34%	39.87	41.82	39.48	41.84	-1.97
		11B RSU	89.58%	19.76	22.06	20.98	17.77	2.00
	Oncology	10A	123.50%	23.29	18.86	17.92	17.17	6.12
	General	10B	93.17%	40.29	43.24	40.95	39.83	0.46
	Renal	6A	92.00%	35.25	38.31	36.40	38.62	-3.38
	General / Renal	6B	91.88%	32.94	35.85	34.21	30.90	2.04
	Gastro	8A	91.50%	34.56	37.77	35.88	34.95	-0.39
	Care of the Elderly	9A	97.50%	40.87	41.92	39.86	43.20	-2.33
		9B	94.83%	39.66	41.82	39.58	41.48	-1.82
	Cardiology	ACU	83.41%	33.16	39.75	35.32	21.20	11.96
	Acute	AMU1	93.48%	70.54	75.46	71.84	52.25	18.30
		AMU2	131.67%	34.96	26.55	25.29	24.63	10.32
		SSU	93.00%	18.91	20.33	17.98	18.05	0.86
	Frailty	Ashwell	98.13%	34.88	35.55	33.58	36.65	-1.77
	Stroke	Barley	91.88%	32.26	35.11	33.15	31.48	0.78
		Pirton	95.68%	30.63	32.01	30.36	31.90	-1.28
	Paediatrics	Bluebell	79.38%	24.61	31.00	29.01	25.72	-1.11
Planned	General Surgery & Vascular	7A	88.10%	31.32	35.55	33.61	32.21	-0.89
	Urology & Colorectal	7B	90.00%	34.22	38.02	35.95	32.35	1.87
	Plastics & ENT, Female Surgery	5A	81.33%	32.48	39.94	37.97	29.46	3.03
	T&O & NoF	5B	93.67%	35.98	38.41	36.15	44.96	-8.98
	Elective Surgery	Swift	84.42%	31.21	36.97	34.77	28.68	2.53
	ATCC	Critical Care	77.78%	82.18	105.66			82.18
Cancer	Oncology	Ward 10	71.36%	22.87	32.05	30.49	20.82	2.05

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East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	20
Report title	Patient Experience Annual Report		**Meeting Date**	6 July 2022
Presenter	Chief Nurse			
Author	Complaints, PALS and Patient and Carer Experience Lead			
Responsible Director	Chief Nurse		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

This report provides assurance that all aspects of patient experience are managed effectively in line with the Trust objectives. The report details outputs of the Patient Experience Team in 2021/22, with particular focus on trends and themes arising from complaints, pals and survey feedback. Also highlighting the amazing work from our volunteer's department and Trust wide Admiral Nurse.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

CQC Domains - Patient experience departments within the Trust have challenges in delivering on the current departments within excluding carers. By restructuring, this will the resource to strengthen and define workstreams.

Trust strategic objective - Carer's lead – further support is needed to cover the carers lead role with a new strategy needed to be written and implemented. Lack of capacity is providing a large barrier for this not being managed appropriately.

Risk: *Please specify any links to the BAF or Risk Register*

The lack of capacity within the complaints and PALS has been logged on the risk register due to the significant delays and responsiveness.

Report previously considered by & date(s):

Patient and Carer Experience Group – 27TH June 2022

Recommendation	The Board is asked to discuss the report.

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

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

Patient Experience Annual Report

Introduction and Background

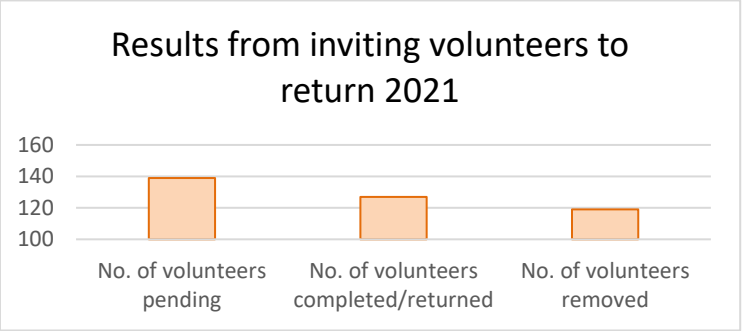
This annual report provides high level assurance that service users and their families are effectively listened to and staff are supported to respond to feedback in a timely, effective manner. 2021-2022 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to respond to feedback, and engage and involve people who access our all services provided by the Trust.

2021 – 2022 has also seen a significant amount of challenge to all staff across the organisation whilst responding to the COVID-19 pandemic which impacted on the trust from March of 2020. The patient experience team responded to this pandemic promptly and effectively by developing a comprehensive plan to continue to seek new ways of engaging with service users.

1. Volunteers supporting improvements in patient and carer experience

Over the last year, Voluntary Services' focus was returning the Trust's volunteers, who were previously 'paused' over much of the pandemic period. As well as welcoming back volunteers to their original roles, the team identified new roles for volunteers who either wanted a change or whose previous roles were no longer available due to changes in their department.

The team contacted 385 'paused' volunteers to query whether they were prepared to return to volunteering at that time. From the contacted cohort, 127 were processed and returned. Some volunteers (139) asked to be added to a 'pending' list and to be contacted once more in Spring 2022. The remaining volunteers (119) decided to stop volunteering.

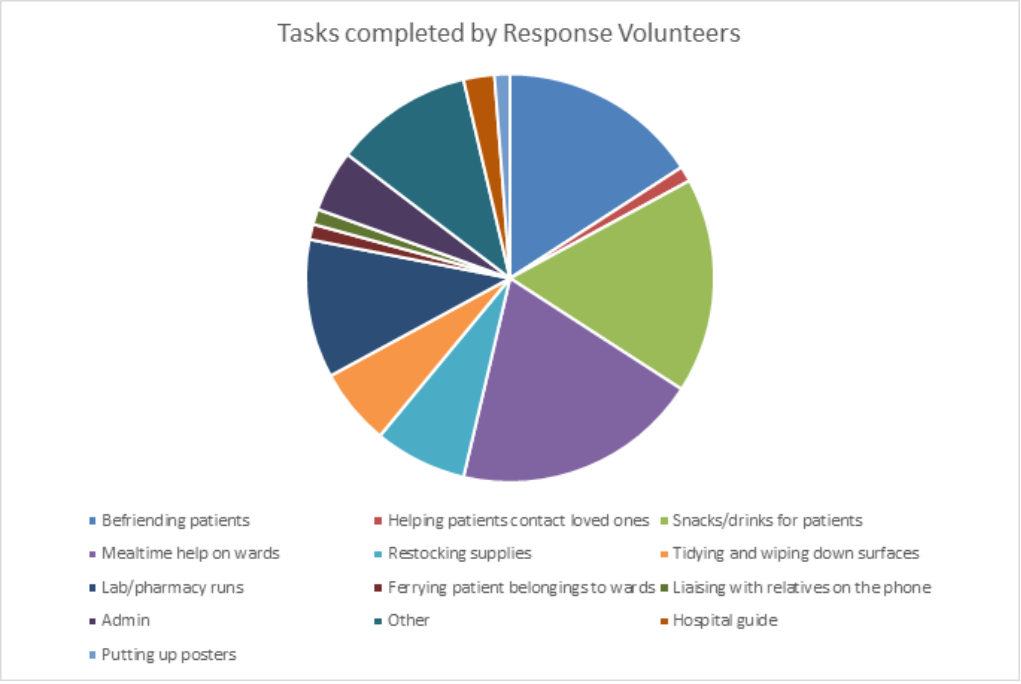


The returning process for the volunteers was thorough and extensive – the team took the opportunity to ensure all volunteers were consistent and compliant with the Trust's required checks and clearances as well as any updated changes introduced following COVID-19; (i.e. DBS checks completed as most of them had expired), re-processing them through Health at Work (to ensure any changes in their health would be highlighted in order for us to provide any reasonable adjustments as necessary), completing their mandatory training updates, completing an additional e-learning module on infection control and completing an individual risk assessment.

By the end of March 2022, the Trust had nearly 300 active volunteers registered across their sites.

The Response Volunteer programme continued to run alongside the returning volunteer roles, with over 100 individuals registered within this role. Response Volunteers provide a flexible service whereby they undertake different tasks; supporting whatever the need is across the hospital that day. Patients and family/loved ones can also make direct requests of the Response Volunteers.

Voluntary Services introduced 'activity trollies' into three areas of Lister Hospital (the tower block, Strathmore Wing and the Treatment Centre). Response Volunteers visit wards across the hospital with the trolley and approach each patient offering them a variety of activities (e.g. colouring, crosswords, Sudoku or word searches, making a greetings card from one of the specially-made kits, or doing one of the other craft activities on the trolley). Sometimes patients simply benefit from enjoying some company and conversation from the Response Volunteers. The activity trollies aim to improve patient experience by providing patients with some form of entertainment or a chat with a friendly face.

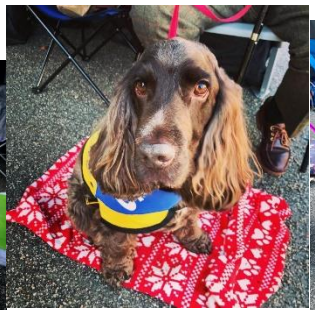


Voluntary Services often work with other departments to develop new volunteering roles. The team worked with the Trust's Admiral Nurse to develop a Dementia Support Volunteer role. These specially trained volunteers spend time with people with dementia, helping them do activities and exercises which will help to stimulate, calm and divert them, and make them feel more comfortable and cared for in their unfamiliar surroundings.

The team also worked with the Trust's physiotherapy team to develop the Supportive Exercise Volunteer role. The physiotherapy team give patients a simple exercise plan to use whilst in hospital; often patients need help and extra motivation to complete their exercises as regularly as they should. These volunteers are supervised by a physiotherapist, learning how to support patients in doing their exercises. Once they and the physiotherapy team are confident in their abilities, they begin volunteering on their own, helping patients to undertake their prescribed exercises, and playing a vital role in maintaining essential mobility.

Voluntary Services also strive to improve staff wellbeing and morale; in turn supporting them to provide the best patient care and experience possible. Although the therapy dogs were not yet permitted back in patient areas, the team hosted staff events outdoors; providing staff with the opportunity to rest, relax and spend time with our furry friends.





2. Butterfly service

Butterflies are a team of volunteers who support people at the very end of life. The team managed to maintain a service 7 days a week during the pandemic despite their numbers being reduced to 6 people. The reduced numbers were due to many volunteers falling into vulnerable categories and also due to lock down periods. At Christmas time the Butterfly Service held a recruitment campaign and had 250 applications, so going into 2021 they had a larger team, increasing from 34 to 64 volunteers, representing a more diverse section of the community

In June 2020 the team were recognised for their outstanding work and received an MBE for Volunteer Groups, The Queen's Award for Voluntary Service; this is the highest award a voluntary group can receive in the UK. Due to the pandemic, the presentation was deferred to 2021 when it was presented by HRH The Princess Royal at a special ceremony at the Lister Hospital.

In July 2020, the Butterfly Volunteers were awarded 'The Heroes of Hertfordshire' from the HM Lord Lieutenant of Hertfordshire, Robert Voss CBE and the High Sherriff of Hertfordshire, Henry Holland-Hibbert, in recognition of their continued service. From April 2020 to March 2021, the Butterfly Service

received 399 end of life patient referrals, they made 805 visits of which 525 of those visits, the patient was alone and they covered over 330 hours of volunteering.

3. Admiral Nurse Service

Admiral Nurses are registered nurses who have specialist knowledge of dementia care. An admission to hospital is particularly challenging for people with dementia and the Admiral Nurse provides vital support to family members during this time. In addition, the role provides education, leadership, development and support to other colleagues and service providers. ENHT have employed an Admiral Nurse since 2018. Following a gap between post holders, the service was relaunched in September 2021.

Key achievements to date include:

Production of a 3-year dementia strategy, establishing a working group to support delivery and a steering group to ensure oversight and governance

335 families of people with dementia supported

Support to staff who are also caring for a loved one with dementia

Mandatory dementia awareness training for all staff and Tier 2 delivered as interactive face to face sessions to 50 staff directly caring for people with dementia

Employing and training a team of dementia volunteers whose role is to provide social interaction and interactive activities for people with dementia during their hospital stay. The role includes finding out more about the person through conversations with their family to enable ward staff to deliver person centred care. The volunteers have helped to improve the experience of over 60 people with dementia. Families have fed back, “When Kerry called to find out about Dad it was such a relief to know that someone cared enough to find out about Dad as a person, and his life experiences. It brought me comfort to know that Kerry was spending time with Dad and providing mental stimulation in an otherwise long and boring day in hospital”. “Sonia spent time talking to my Mum about her family and her life experiences and even gave her a massage”

Even more achievements to date include:

Securing ENHT charity funding to provide dementia activity boxes including radio and CD players for all areas.

Provision of dementia information resource folders to all areas

Promotion of national dementia awareness events

Introduction of dementia best practice award of the month

Caring conversations education programme implemented to support partnership in care and involvement of carers during an inpatient stay

Left: Kerry with the Omi Vista interactive activity. Right: Sonia with a twiddle blanket provided by local sewing group

Cecile, ward manager on 9B with resource folder

4. Complaints and PALS Annual Report 2021-22

This report provides a summary of formal complaints received in 2021-22 in accordance with the NHS Complaints Regulations (2009).

The Trust is committed to improving the experience of our patients and complaints and concerns provide valuable information to ensure that learning is identified, and changes made to ensure that our patients, carers and relatives have a positive experience.

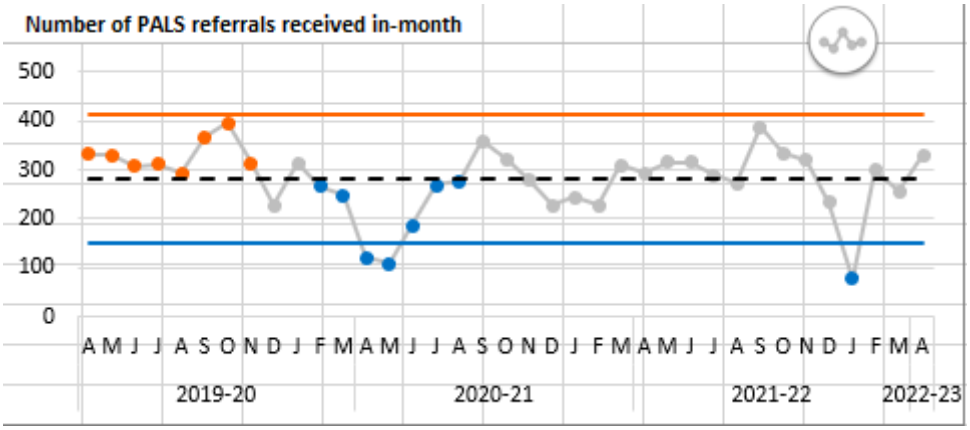
Users of the services are encouraged to discuss their concerns with staff at the point an issue is identified. However, during 2021/22 with the COVID-19 pandemic and restricted visiting in place, the Trust recognised that it was not possible to have these discussions in person. The keeping in touch service (KIT) continued to offer virtual video visits and/or clinical update calls to patients and their families. Families booked via a virtual call centre which was set up with redeployed and shielding staff. Clinical information from the ward teams was collated on a proforma and relayed to the family.

The Patient Advice and Liaison Service (PALS) provide 'on the spot advice and support' with the aim of timely resolution. In the event that this has not been achieved, PALS discuss with patients and relatives how their concerns can be appropriately resolved and where appropriate, provide advice to them on the formal complaints process.

The Trust recognises the value that learning from complaints and concerns brings. It is vital to make the process simple and easily accessible, and leaflets and posters are displayed throughout the hospital to help facilitate patient and carer feedback. During this year the clinical teams have been actively encouraged to share any relevant learning with the complaints team. This is to ensure that it is reflected in the final response so that the patient and/or relative can see the positive actions that have been taken. It also demonstrates first hand our commitment to learning from patient feedback and improving patient experience moving forward.

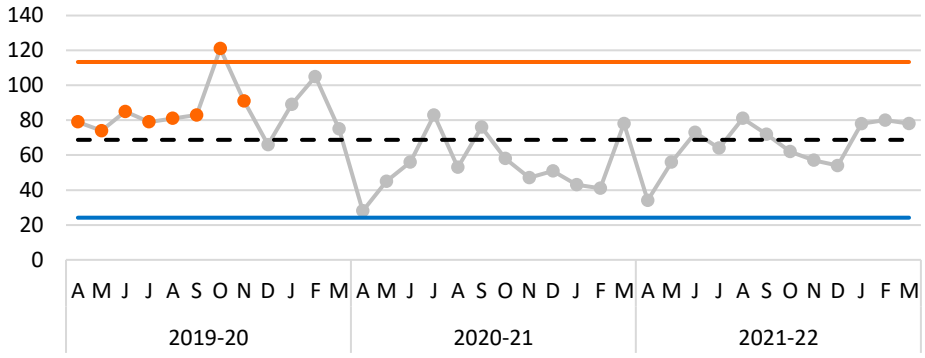
5. PALS Enquiries – Concerns

The numbers of concerns have risen this year to 3614 in comparison to 2935 last year. The themes for these concerns relate to waiting times and appointments in which all non-emergency ones were postponed during the Covid 19 pandemic. Due to the volume of waiting appointments waiting times have grown within the departments, to help with communicating the times to patients and families, the NHS launched My Planned Care in April 2022. My Planned care allows for anyone to find out the waiting times for the department they are wishing to see in all Trusts throughout the UK. Appointment waiting times are also being communicated on letters out to patients after a referral so not to set the wrong expectation of wait.

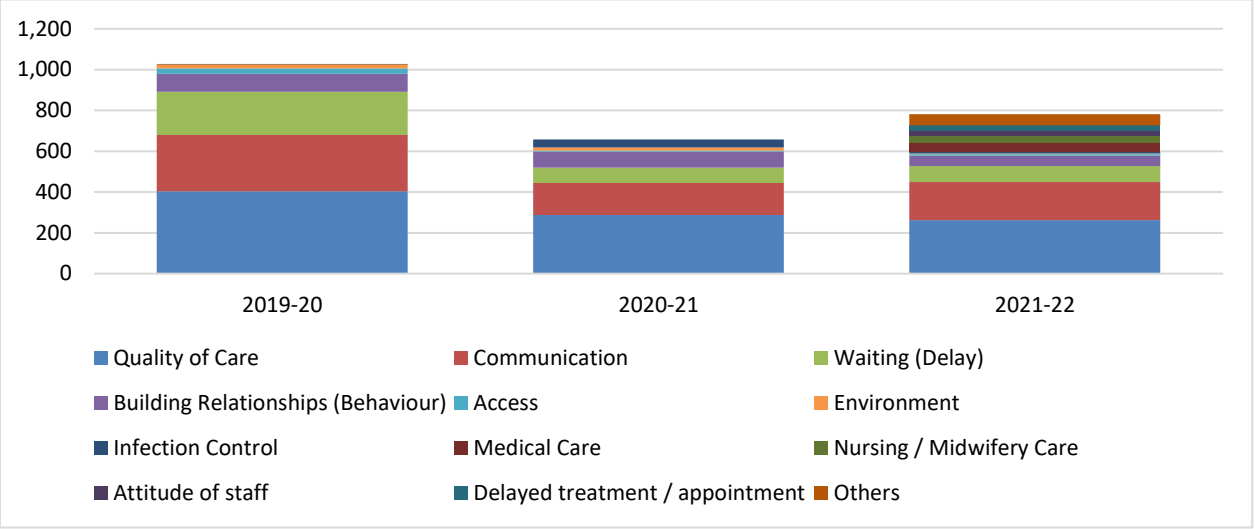


6. Formal complaints activity

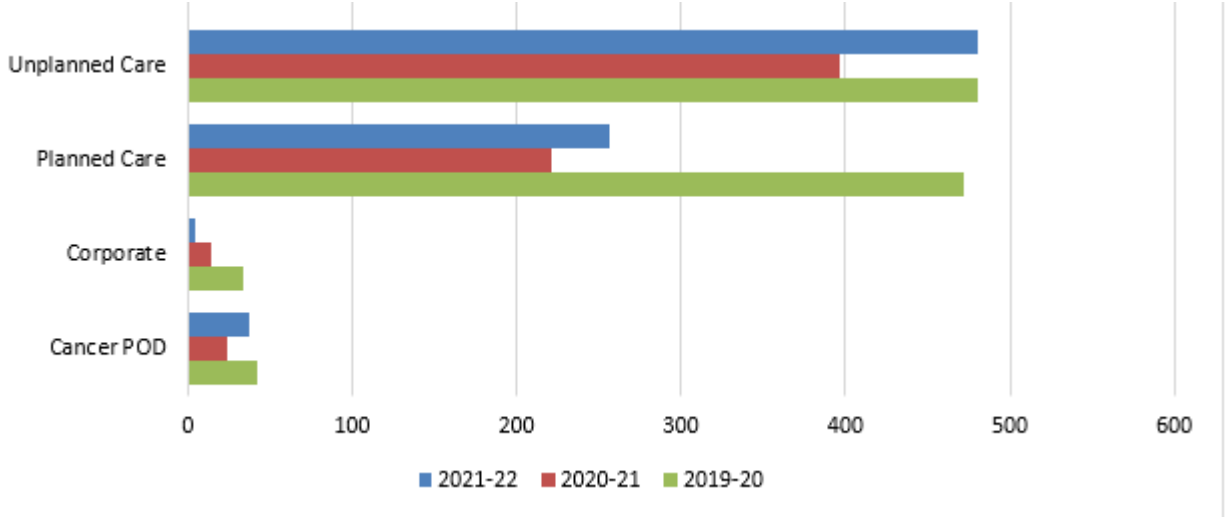
During 2021/22, as a result of the reduction in services, the number of formal complaints opened has increased. The following chart demonstrates the number of new formal complaints opened over the previous 3 financial years. As shown below, 2021/22 saw an increase in the number of new complaints received at the Trust, an increase of 18%. In 2021/22 777 formal complaints were received across all services (from 656 in 2020/21) We believe that due to the COVID-19 pandemic the impact to appointments and waiting times has led to this dramatic rise.



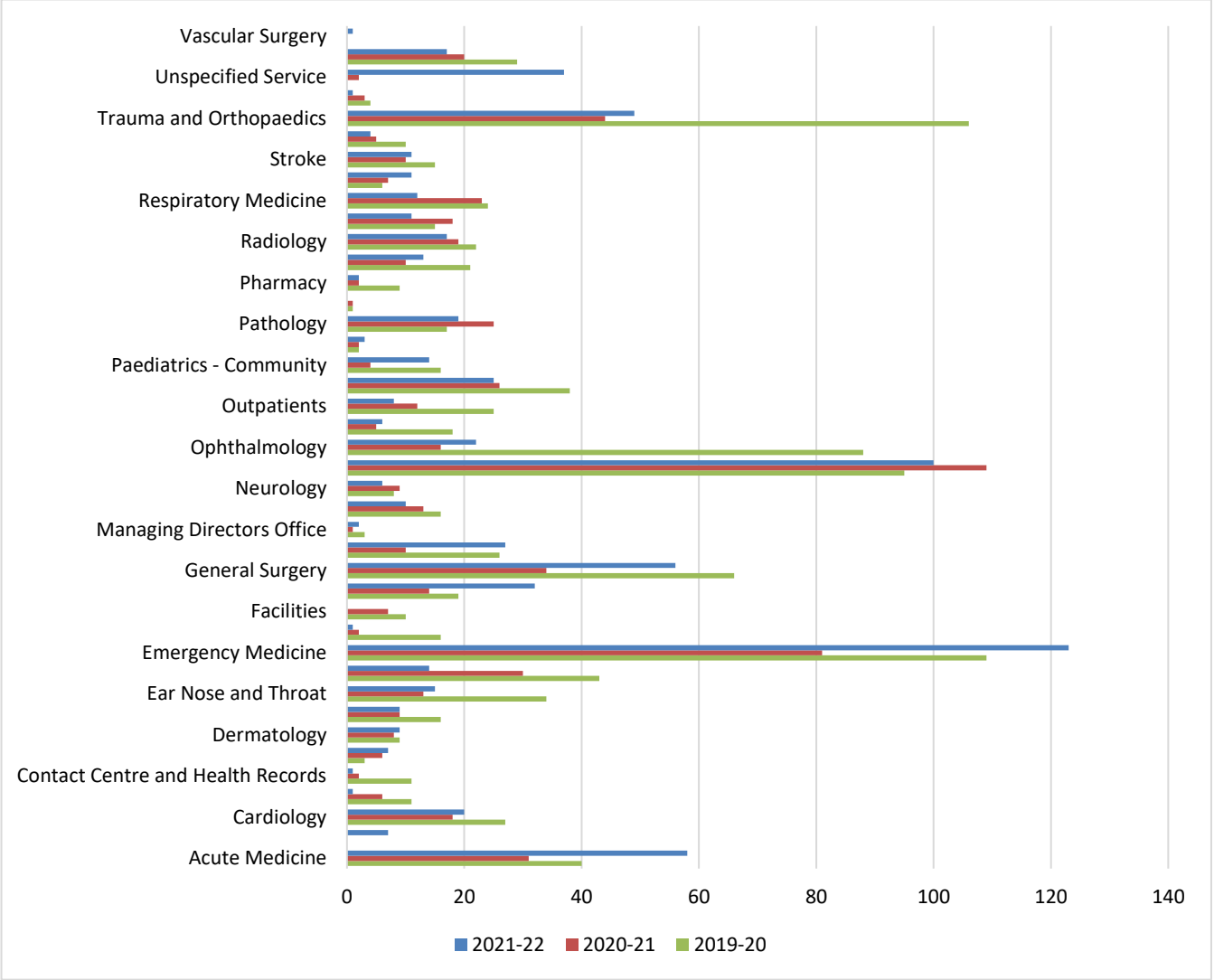
The graph below shows the categories raised within complaints over the last 3 financial years. It is noted that due to the new reporting system on Datix that new categories were added in 2021 such as attitude of staff and medical care in which enables us to pin point the data more appropriately. Communication and quality of care remain the highest categories to receive the complaints within over the last 3 years. Communication this year potions to the communication around care, appointments and waiting times in which people are waiting to be seen.



As you can see from the table below, Unplanned care remains the division with the largest amount of complaints being raised.



The below chart demonstrates the rise in complaints in 2021/22 in the Emergency Department within the Trust, followed closely by Ophthalmology. There are continuous improvement works within the Emergency Department such as redeveloping the departments environment and also reviewing shift patterns for staff to cover the higher amounts of people within the waiting area.



7. Acknowledgement of formal complaints

There is a mandatory requirement to acknowledge all formal complaints within three working days of receipt. In 2021/22, 90.4% of all complaints received were acknowledged within this timeframe. This has dropped slightly compared to 2020/21 due to the rise in complaints and vacancy within the complaints team.

8. Outcomes of formal complaints

During 2021/22, 389 formal complaints were closed. Of those closed, 21% were upheld, 43% partially upheld and 46% were not upheld.

9. Learning from complaints and concerns

Women Services received a complaint surrounding consent to examinations. A Consultant Lead is now in place to triage patients to support and review the roles of junior doctors to ensure they have appropriate skills to improve patient experience.

Emergency Department complaint upheld due to lack of documentation. All staff are reminded to update patient notes in a timely fashion as the impact of no communication or poorly written notes impacts on patient experience. Lead for ED advised that this message would be shared with the ED staff.

A referral to Community Paediatrics for An Autism Spectrum Disorder (ASD) assessment was under review as the parent has requested the GP escalate the appointment. The member of staff reviewing the referral then took unscheduled leave and the referral was not processed. As a result of this complaint the process for referral is under review and the appointment wait times are also being monitored.

Emergency Department - Patients have raised concerns regarding the crowded waiting rooms and delays in being seen. The Emergency Department Transformation is taking place in response to the demands placed upon the service. This is a national problem but will support an improved patient experience regarding triaging and waiting times.

Patients with minor injuries have been triaged and advised to attend the QE11 where staff were redeployed to support and treat in a timely manner and reduce the pressure on ED at Lister Hospital which allowed staff to triage and treat patients presenting with life threatening conditions.

Paediatric Emergency Department was relocated and a sensory room was implemented to support children and young adults to provide a safe and quiet space when they attend hospital.

10. Parliamentary and Health Service Ombudsman

From April 2021 – March 2022 the PHSO reviewed fifteen cases. They confirmed they would not be investigating ten of these, but they would be further looking into five. Of those five, three investigations are still ongoing, one complete with no further action being taken and one upheld on closure.

The one case which was upheld on closure from further investigation by the PHSO, with the following actions required:

Case 1 – The Trust was required to pay £950 for the lack of communication to the family whilst on an assessment waiting list.

11. Facts and Figures 2021-22

National CQC Adult Inpatient Survey 2021

Results currently embargoed.

National Cancer Survey 2020 (published March 2021)

This year's survey was voluntary, and we were one of only 55 trusts in the country to participate. This means that scores have not been compared nationally this year and that we are unable to split the results between trust sites.

Overall statistically the results are static, Patient's average overall rating of care was good 8.6 which shows that despite the pandemic cancer patients continued to receive care and treatment.

Statistically significant improvements since 2020 have been seen in questions asking about communication; only 12 % of patients felt hospital staff spoke as if they weren't there, which is reduced from 22% the year before. Reflecting the significant work on safer staffing the trust has undertaken, 79% of

patients felt there were enough staff on duty to care for them, an increase of 21% from 2019; there was also an increase in the numbers of patients who felt waiting times in clinic were appropriate. This is likely related to the increased use of virtual consultations and changes to patient pathways due to the pandemic.

The only statistical reductions related to clinical trials not discussed with patients - the majority of trials were stopped during the time period of this survey and that patients didn't feel as supported by their GP down to 35% from 41% the year before.

The key areas the trust will be focusing on going forward is the information and support provided to cancer patients along all stages of their cancer journey. We will continue to work with the numerous teams who care for these patients as well as involving patients themselves so we can improve services.

National Maternity Survey 2021 (published January 2021)

The 2021 Maternity Survey was the first mixed-mode maternity survey in the NHS Survey Programme, where women were encouraged to respond online (but were also given the option of postal completion). As a result of this, the response rate increased substantially, from 36% in 2019 to 52% in 2021, with 89% of women taking part online. Responses were received from more than 23,000 women nationally. 210 people responded to the ENHT survey, a response rate of 60% which was above the average response rate for similar trusts of 54%. A total of **87** questions were asked, of these **52** can be positively scored.

This year's survey shows results have declined in many areas nationally, likely reflecting the impact that the COVID-19 pandemic had on services and staff. Results show that areas particularly affected were involvement of partners, choice, information provision and staff availability. Despite the pressures of the pandemic, the majority of women continued to report positive experiences of maternity care, particularly during their labour and birth.

Areas for improvement have been identified nationally around postnatal care – results continued to show poorer experiences of care for many women postnatally compared with other aspects of the maternity pathway. This aspect of care in particular has worsened during the pandemic, with the results for several questions showing statistically significant declines.

34% of women said they would have liked to have seen a midwife 'more often' during their postnatal care compared with 25% in 2019; and 55% of women who needed it said that in the six weeks after the birth of their baby, they 'definitely' received help and advice from a midwife or health visitor about feeding their baby, down from 62% in 2019.

12. Local Surveys

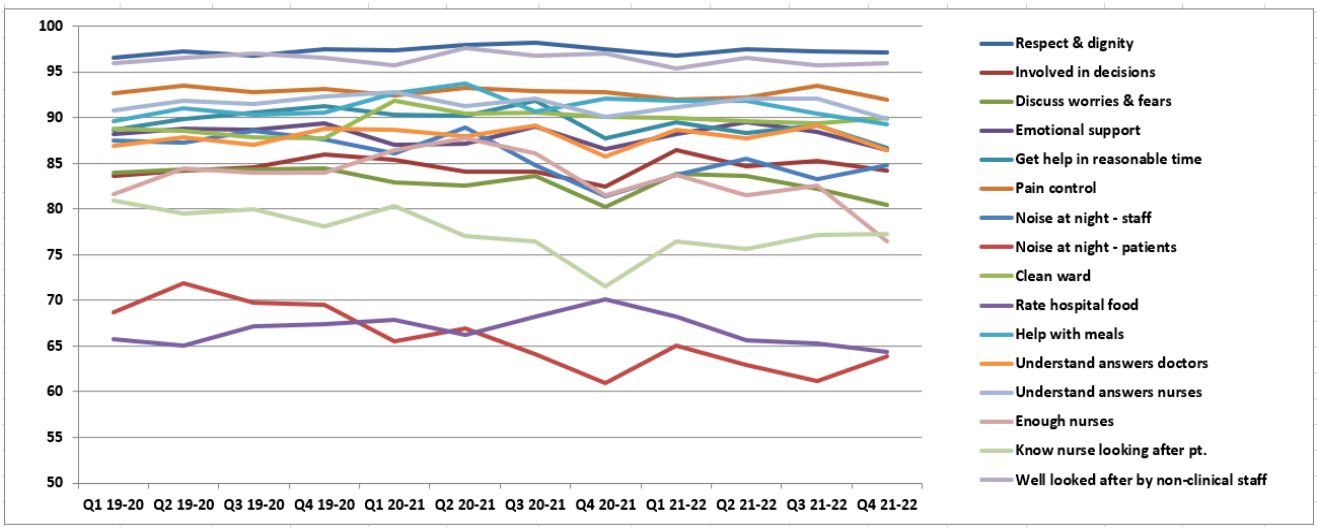
The Trust continually monitors feedback from patients and uses this feedback to make changes and improvements to the services it provides. An electronic patient survey system is in place called 'IQVIA' which enables patients to provide feedback by completing a survey on a simple electronic device (I-Pad) whilst they are in the hospital, or on a paper survey if preferred. Due to ward pressures and visiting restrictions during 2021/22 patients completed 12,533 surveys, which is an increase to the previous year's 6937. (This excludes the single question Friends and Family Test survey)

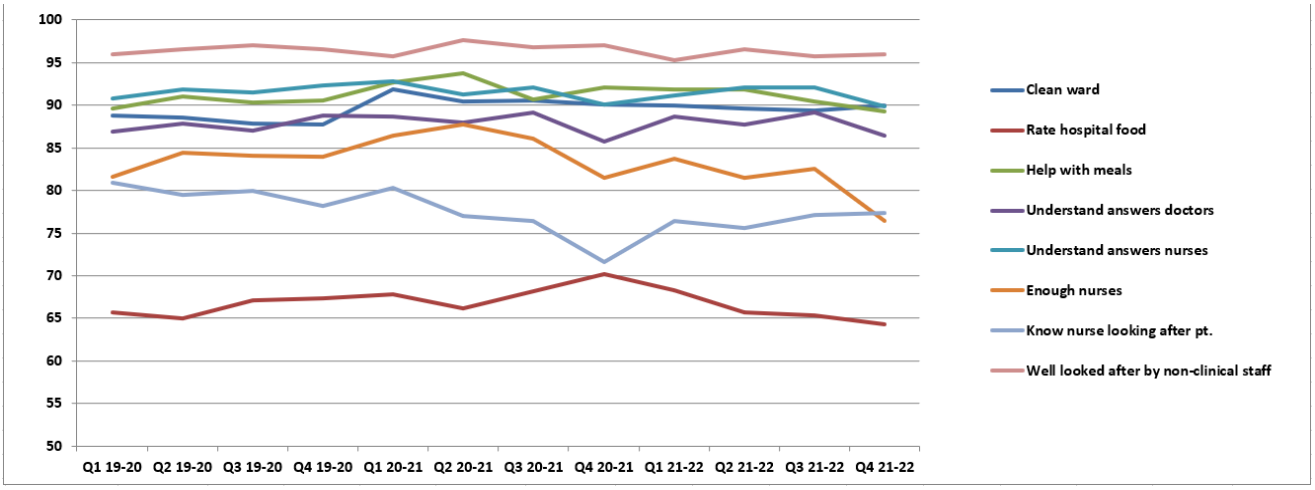
IQVIA Local Patient Experience Surveys	No of responses 2017-18	No of responses 2018-19	No of responses 2019-20	No of responses 2020-21	No of responses 2021-22
Day Case	2091	760	706	210	610
Critical Care	107	200	245	63	28
Emergency Department / UCC	321	279	157	49	514
Discharge	583	677	731	112	3
Renal Dialysis	1101	1453	1352	1134	937
Outpatient Department	5447	5969	5814	757	2139
Neonatal	139	154	182	81	154
Maternity	2625	1820	1341	829	1307
Inpatient	12239	12311	11587	3597	4928
Assessment	832	652	697	3	1
Community Respiratory	221	275	214	3	104
Experience of EoL Care	16	52	50	15	30
Bramble safeguarding	3	1	0	0	0
Renal Tele-clinic	41	25	10	0	1
Keeping in Touch	x	x	X	52	128
What matters to you	x	x	X	32	1649
Total	**25766**	**24628**	**23086**	**6937**	**12533**

The data collected from this survey enables the Trust to monitor feedback month by month and address any areas of concern. The questions asked within the inpatient survey cover a wide range of topics such as:

- Respect and Dignity
- Medication
- Environment
- Support
- Staffing

The following chart shows a comparison of the inpatient survey results between April 2019 - March 2022





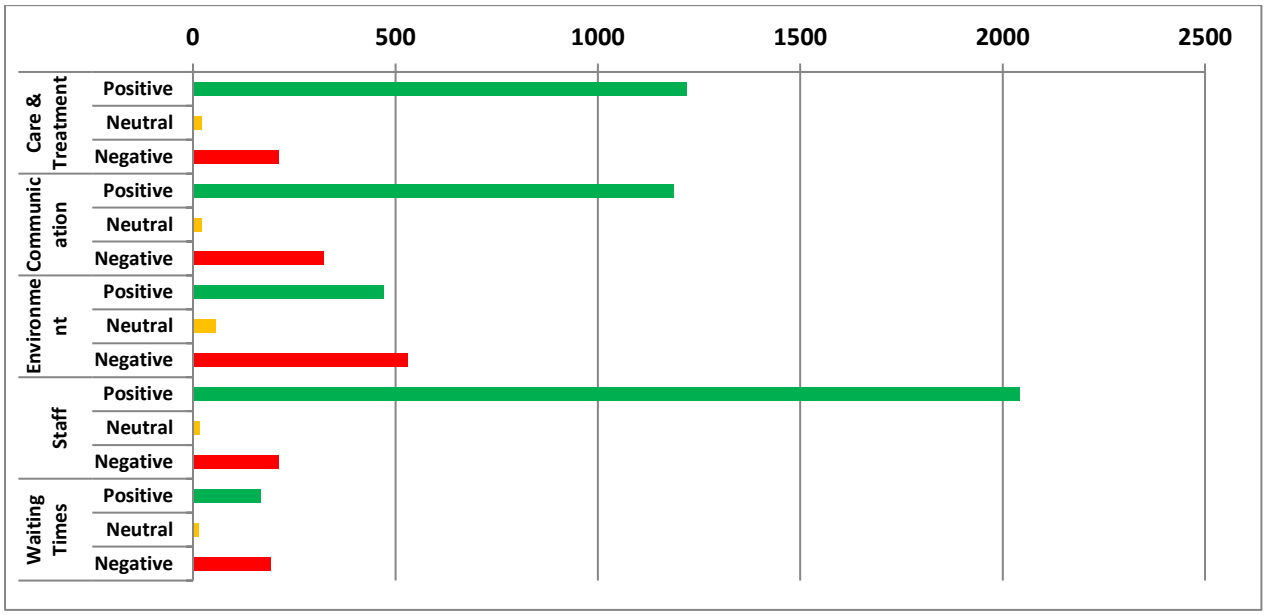
Comment sentiment trends

The IQVIA patient experience survey system automatically allocates a positive, neutral or negative rating to patient comments, theming them against the following five

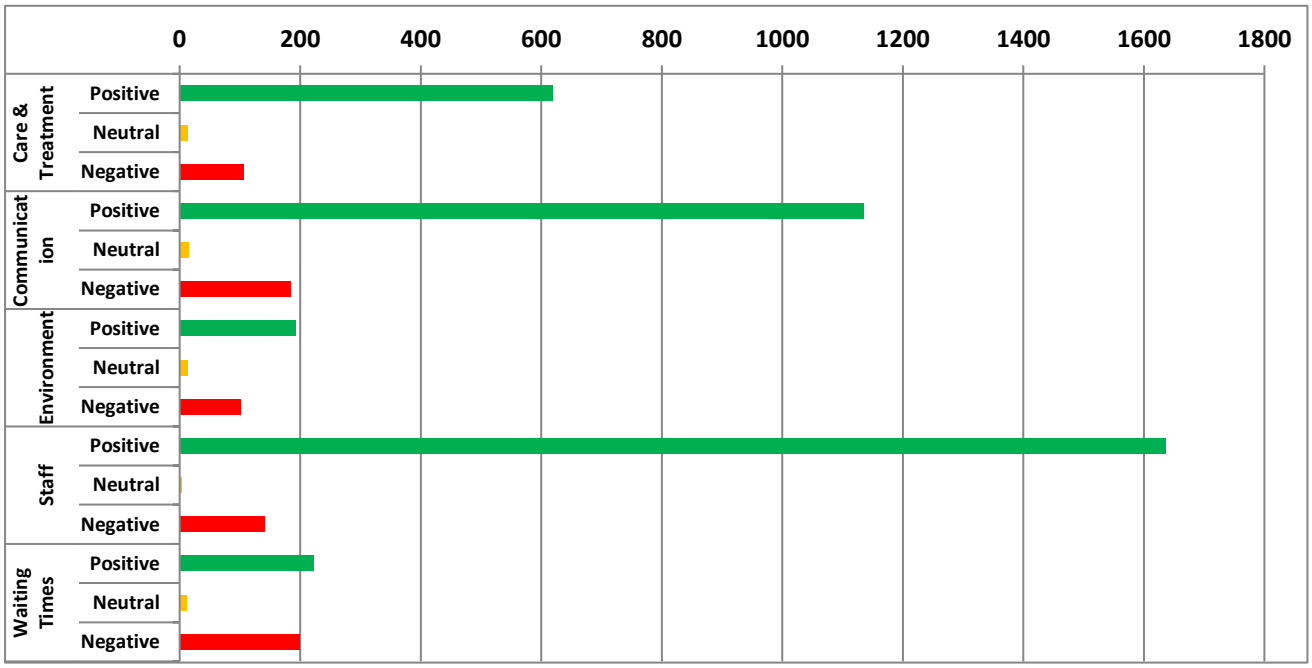
categories: Care and treatment, Communication, Environment, Staff, Waiting. This system has been set up using a 'word bank' against each of these categories.

The graphs below summarise the number of positive, negative and neutral comments against each category for 2021-22 for the Inpatient surveys and Outpatient surveys:

Inpatient Survey



Outpatient Survey



13. Friends and Family Test

The Friends and Family Test (FFT) asks **'Overall, how was your experience of our service?'** There are six response options ranging from 'very good' to 'very poor'.

We have continued to collect feedback from patients during the Covid-19 pandemic although the response numbers are increasing they are still reduced in comparison to the pre-Covid period. Access to the Trust's surveys continues to be promoted to patients via the Trust website and the quick link www.tellusmore.or.uk – posters with this link and a QR code are widely displayed throughout the Trust. We also carry out post-discharge telephone calls to patients to ask for feedback regarding their experience of their most recent visit to hospital.

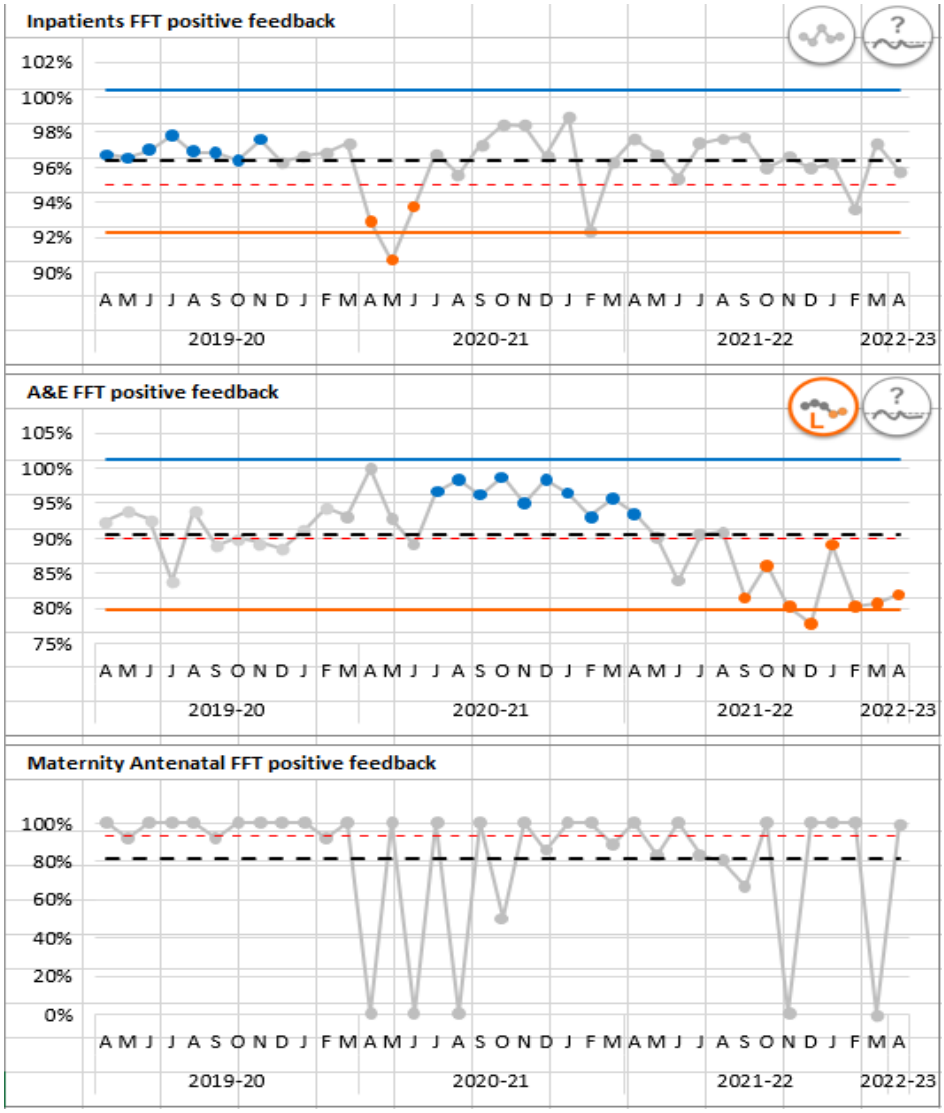
An easy read version of the FFT survey is offered to people (with appropriate support if needed) who have dementia, learning disability, are profoundly deaf, deafblind, blind/vision loss, have little or no English or low levels of literacy. Guidance is available for staff offering the FFT survey to patients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

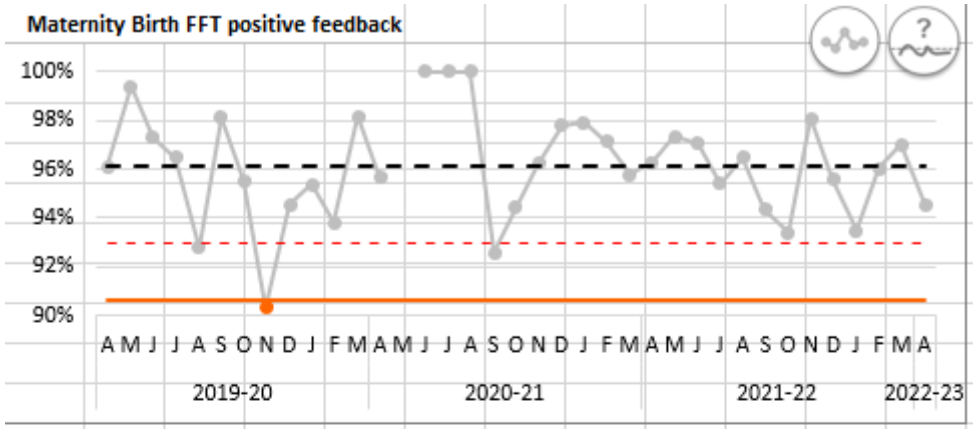
Summary of Trust FFT results and response rates (2021-22):

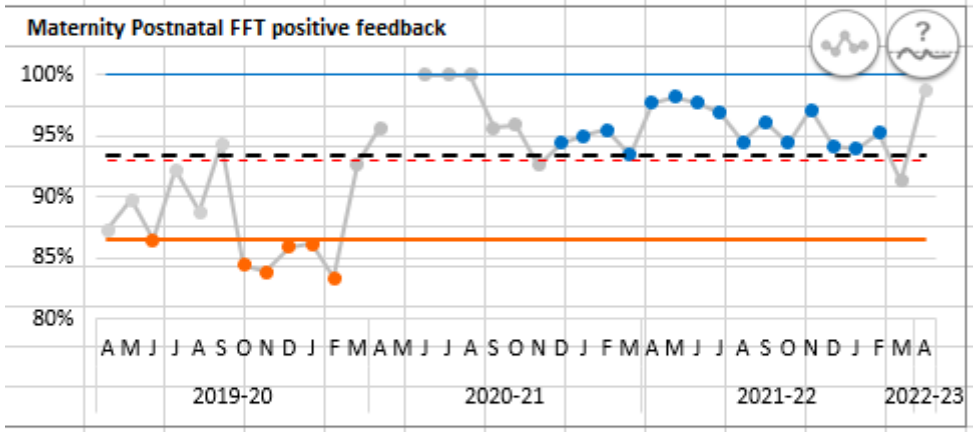
In 2021-2220,842 patients responded to the Friends and Family Test question (compared to14,533).

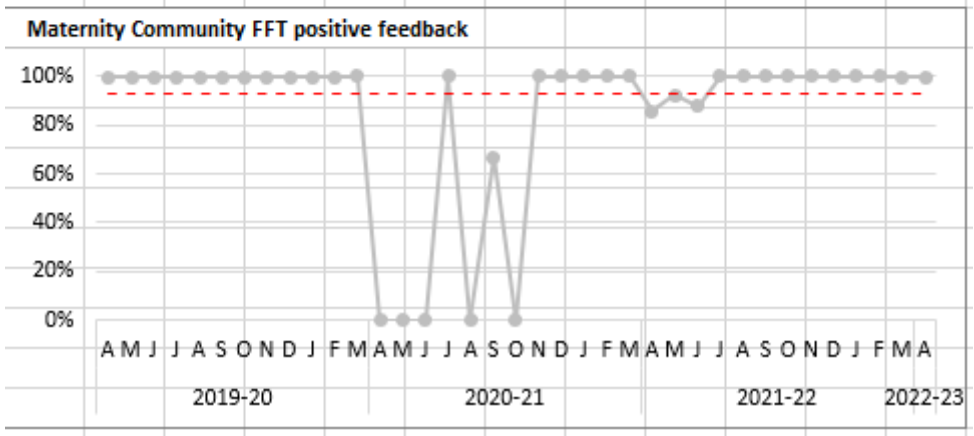
The following charts show the number of positive responses, total responses and benchmarking data.

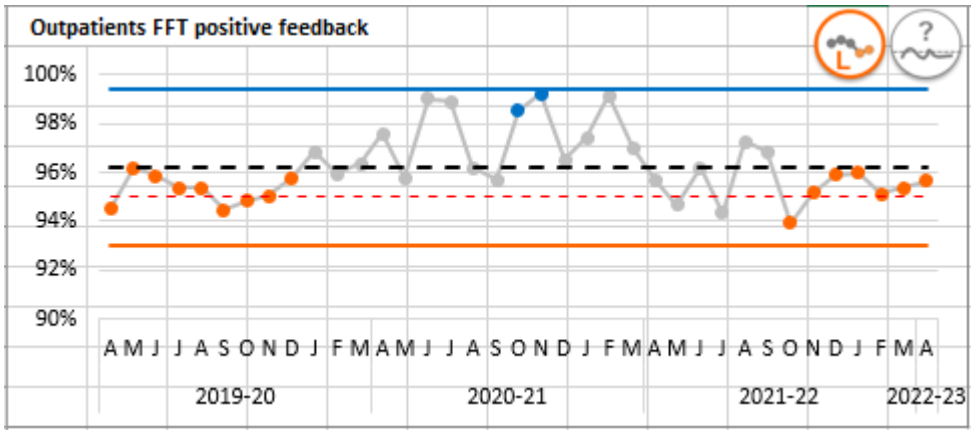
	Inpatients/ Day Case	ED-UCC	Outpatients	Maternity				TOTAL
				Antenatal	Birth	Postnatal	Community	
Q1 2021-22	2953	497	1489	11	382	367	36	5735
Q2 2021-22	2593	670	1692	13	350	341	25	5684
Q3 2021-22	2064	432	1784	9	285	278	14	4866
Q4 2021-22	1750	386	1705	8	350	342	16	4557
Total	9360	1985	6670	41	1367	1328	91	20842


Inpatients FFT positive feedback
102%
100%
98%
96%
94%
92%
90%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23
A&E FFT positive feedback
105%
100%
95%
90%
85%
80%
75%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23
Maternity Antenatal FFT positive feedback
100%
80%
60%
40%
20%
0%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23


Maternity Birth FFT positive feedback
100%
98%
96%
94%
92%
90%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23


Maternity Postnatal FFT positive feedback
100%
95%
90%
85%
80%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23


Maternity Community FFT positive feedback
100%
80%
60%
40%
20%
0%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23


Outpatients FFT positive feedback
100%
98%
96%
94%
92%
90%
A M J J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A
2019-20
2020-21
2021-22
2022-23

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	21
Report title	Quality Account		**Meeting Date**	6 July 2022
Presenter	Rachael Corser, Chief Nurse			
Author	Margaret Devaney, Associate Director of Patient Safety			
Responsible Director	Rachael Corser, Chief Nurse		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To present the Quality Account for 2021/22.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

This section helps the reader understand if the paper relates to updating on or mitigating a significant known risk(s) or identifies any new significant risks [See note 11]

Report previously considered by & date(s):

NA

Recommendation	The Committee is asked to note the Clinical Harm Review Update

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

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

June
2022

NHS
East and North Hertfordshire
NHS Trust

Quality Account 2021/22

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)

The Trust's vision is "Proud to deliver high-quality, compassionate care to our community".

The Trust has 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**.

Trust strategy and values refresh

During 2021/22, the Trust has been undertaken an extensive refresh of its strategy, including a bottom-up review of service ambitions and a strategic review of the Trust's vision, mission and strategic objectives. This work will be concluded during 2022/23. The Trust is also in the process of refreshing its values, which will be reported in next year's Quality Account.

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.

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

Key objectives of the Quality Strategy include:

 To understand where variation exists and uses data to proactively drive improvement by reducing the 'unwarranted variation'. Aiming to enable staff to develop 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 People strategy was launched in January 2020 setting out its compelling vision for the people in the organisation. The strategy detailed plans under the four pillars of: work, grow, thrive and care. The people strategy is just beyond two years since implementation. It has been strongly tested with exceptional challenges on the workforce due to Covid, which was unforeseen at the time, and directions given from the national team within the People Plan. The People and Organisation Strategy is set out below.

An integrated business and workforce plan has been developed to 2030 over the past year and this clearly signals what, where and how we need to focus to enable change to delivery models, workforce composition and the types of roles needed in the future to meet the demands of the community we serve.

Organisational Structure

The Trust has two operational Divisions: Planned Care, and Unplanned Care. Each division has a Divisional Medical Director, who is a senior clinician, a Divisional Nursing and Quality Director, and an Operations Director. This triumvirate structure is replicated at specialty level.

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

1.2 Statement from the Chief Executive

As we emerge from the pandemic and begin to live with Covid, it's important that we stop and reflect upon the achievements of our colleagues after what has been an unprecedented two years. This 2021/2022 Quality Account outlines our achievements, identifies where improvements could be made and sets out our future continuous quality improvement plans.

I am proud of the work colleagues across the Trust have done in response to the pandemic throughout the last 12 months. Not least the achievements of our research and development team, whose efforts have directly led to innovative treatment for our patients. The pandemic has also highlighted the unique role of NHS staff in identifying those patients who are the most vulnerable – I am pleased that the work delivered by our safeguarding team has helped support our staff with identifying and providing advice to those patients who may be at risk, including through initiatives such as the White Ribbon Campaign and the 16 days of action.

Despite the challenges of the pandemic, I am delighted that we've been able to continue with the Pathway to Excellence® programme and the implementation of our Clinical Excellence Accreditation Framework which saw 16 wards achieve gold or silver accreditation; demonstrating the excellent quality of care provided. We have also been able to celebrate our nursing and midwifery colleagues who go above and beyond through the Cavell Star Awards with more than 20 staff recognised.

The commitment that all our staff continue to show is also demonstrated through the results of the Friends and Family Test, where more than 90% of patients in almost all departments would recommend the service to their family and friends. Despite the ongoing challenges which we have seen across the country in terms of longer than average waiting times in emergency departments, I'm pleased that our patients reported our staff continued to provide caring and supportive care, with good communication and clear explanations regarding their treatment.

Despite the successes of the last year, it's important to recognise the impact that the pandemic has had on quality performance – including on elements of patient safety, inpatient falls and the number of serious incidents reported – full details of which are set out within the report. We know there are other areas where further improvements are needed, including reducing the delays in Lister Hospital's emergency department and improving the efficiency of discharge and patient flow. As an organisation we are committed to making these improvements, working closely with our system partners and service users to do this.

I'd like to thank all our staff who have continued to deliver compassionate high-quality care to our patients – the work they continue to do is outstanding. To the best of my knowledge the information in this document is accurate.

Adam Sewell-Jones, Chief Executive

PART 2

2.1 Priorities for improvement

Priority One: Build ENHT Quality Improvement Capability and Capacity

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

Monitoring: Quality and Safety Committee

Reporting: Scheduled update to Education Committee

Responsible Directors: Chief Nurse / Director of Improvement

Theme	Measure	20/21	21/22	22/23
1.1 Clinical and non-clinical staff are offered opportunities to gain knowledge on Quality Improvement theory.	Quality Improvement for all Theory and Practitioner level	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 sessions for new FY1 doctors and new consultants. Induction sessions for all not achieved. 'What matters to you?' is a part of all QI projects supported by the QI team.	• Induction training for all • Improvement apprenticeship - 15 starters • Continue with bite-size training for 200 people
	Quality Improvement for Leaders	Align continuous quality improvement leadership through: • Patient safety • Patient experience • Clinical Leadership Programme priorities	**Patient safety:** • Harm free care collaborative set up • QI projects on 5 wards instigated and supported discharge leads in their improvement strategy • Deteriorating patient subject matters experts have set up projects in clinical areas **Patient and carer experience:** **Clinical leadership programme:**	• Increased numbers of clinical areas involved in safety improvement • Formalise structure for deteriorating patient collaborative • Formalise structure for Patient and carer experience collaborative • Improvement leads for patient and carer

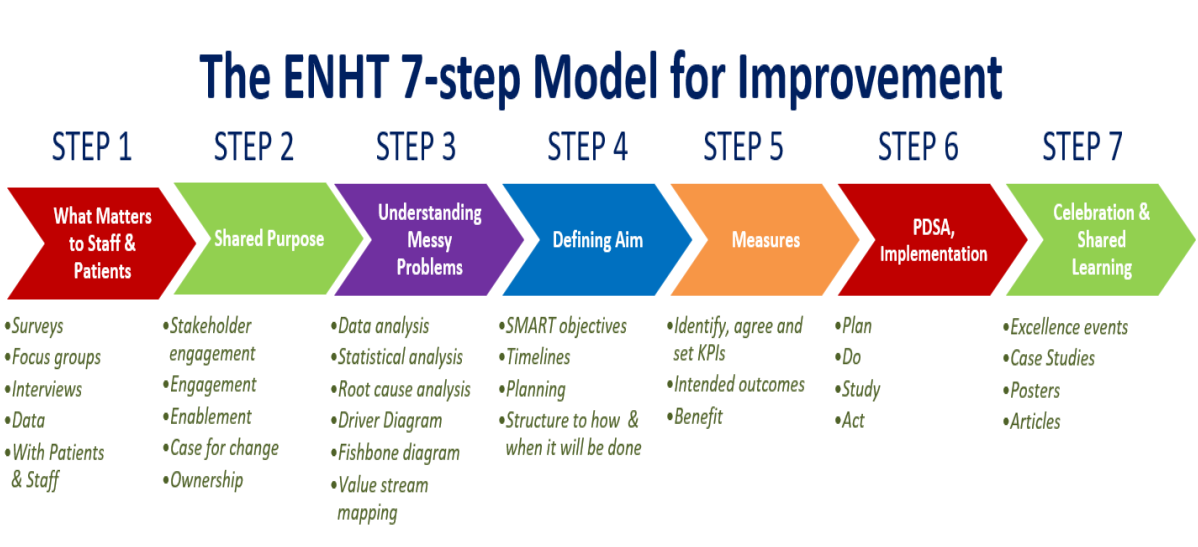
Theme	Measure	20/21	21/22	22/23
			• 22 leaders started in Cohort 2 and are currently completing a quality improvement project.	experience identified and increased number of experience related projects and learning from excellence.
	Organisational wide quality learning events	Deploy 'virtual' summer celebration with assistance of Organisation Development (OD) and communications teams	• Presentations at the quality huddle every 2 weeks celebrating and sharing the learning from QI projects. • Celebration of excellence in nursing and midwifery awards every quarter.	• Annual RCN celebration event- awards and recognition of learning event. • National Patient Safety day celebrations and recognition awards. • Pathways to Excellence recognition of QI contributions • Divisional Board updates
	Measurement masterclass sessions	Offer 1 virtual masterclass (inclusive of corporate and divisional leadership teams).	Measurement for improvement sessions run by QI team and plot the dots session for board.	Continue quarterly measurement masterclasses.
1.2 Staff are supported to practically apply Quality Improvement knowledge through QI coaching.	Establish 'quality clinics' that will empower all staff to discuss quality, scope new ideas and think how they could work differently.	Offer a virtual clinic every week with a QI coach to explore a QI idea.	Two virtual coaching clinics are offered weekly and coaches will also drop into clinical areas to run clinics locally for teams.	Offer coaching or learning coordination in clinical areas.
	Agree and deliver curriculum for Quality. Improvement coaches	Offer training to all band senior leaders (band 7s and 8s) from the corporate and divisional leadership teams	Engaged education and divisional colleagues to agree to set up an apprenticeship in QI with an accredited provider at level 3, 4, 5 and 6 to grow our	Deploy cohort 1 of apprenticeship for QI (level 5 and 6) across 2022/23.

Theme	Measure	20/21	21/22	22/23
		to this level exploring the use of virtual training and coaching them while they lead improvement projects.	coaching capability.	
1.3 Deliver organisational wide structured Quality Improvement continuous learning programme	Adopt 'Patient Safety Breakthrough Series Collaborative'	Look at lessons learned from the trust wide simulation team teaching and COVID response and offer a virtual breakthrough series.	• Developed e-learning for all new starters. • Continued to offer bite-size training virtually. • Improvement in action teaching and coaching on the clinical leadership programme.	Design a collaborative structure that supports a shared learning approach to improvement of patient and carer experience
1.4 Clinical Excellence Framework	Design and imbed ENHT Exemplar ward programme	Scale and spread quality improvement plans to drive continuous improvement across accreditation pathway pillars.	Supporting all teams that are not achieving their fundamentals of care with improvement plans	Scale and spread reliable compliance of agreed quality fundamentals through supporting all inpatient clinical areas to achieve silver accreditation status and also to start scoping non inpatient areas for the accreditation framework
1.5 Adopt a framework that reflects and values patient co-design	Patient co-design faculty shall be established	Following a 'what matters to you' model ENH QI and Engagement team shall continue to build new ways of working that promote meaningful patient involvement though continuous quality improvement plans.	All improvement programmes have patient representatives and we are encouraging all projects to involve patients with an aim of co-production of all QI projects by 2024.	• Continue monthly shared decision-making council. • Recruit patient and carer partners to ensure diverse and inclusive representation. • Increased numbers of patient and carer partners in projects and programmes

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

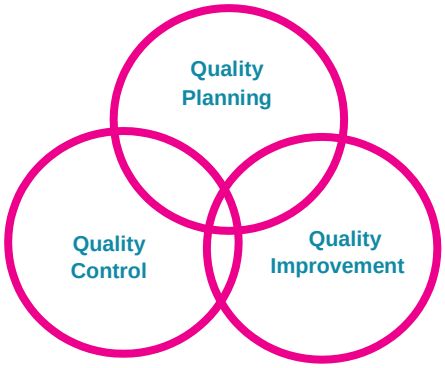
The quality improvement team was set up in September 2019 and restructured in 2020. The team have worked alongside our transformation, education, organisational development and digital teams to develop the East and North Hertfordshire model for a cohesive '7 steps for improvement', known as the 'Here to improve' model (figure 1).

Figure 1.



The Trust is committed to develop skills and knowledge across all workforce groups. By reaching a 'tipping point' over time, through training and coaching people to adopt improvement techniques, this will contribute to the Trust's approach to managing different dimensions of quality (figure 2)

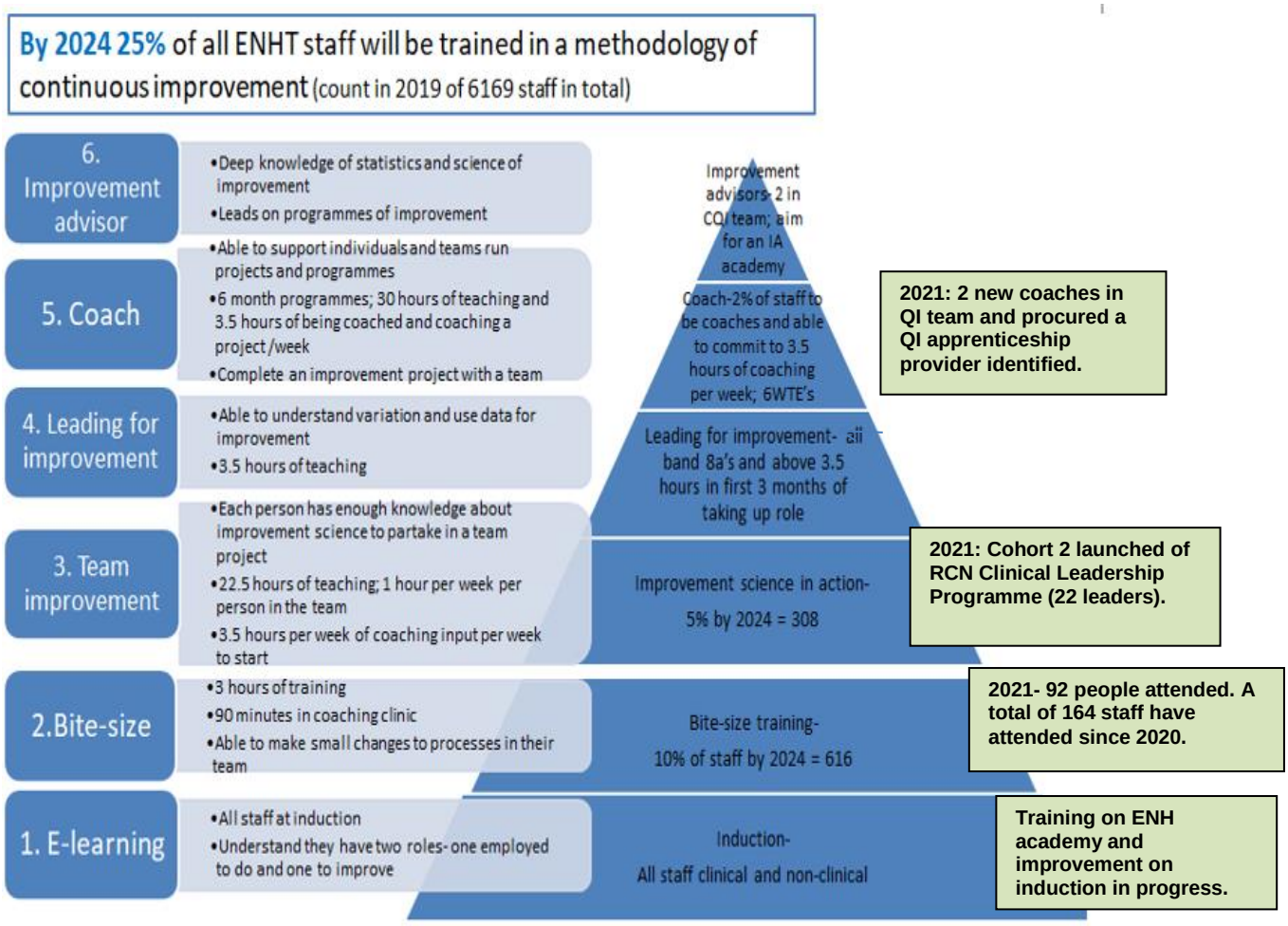
Figure 2



At this 'tipping point' or 'saturation point' the organisation will have a shared language and understanding of how to apply improvement tools and drive change through continuous learning.

Reaching our organisaitonal satuaration 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 3 below.

Figure 3

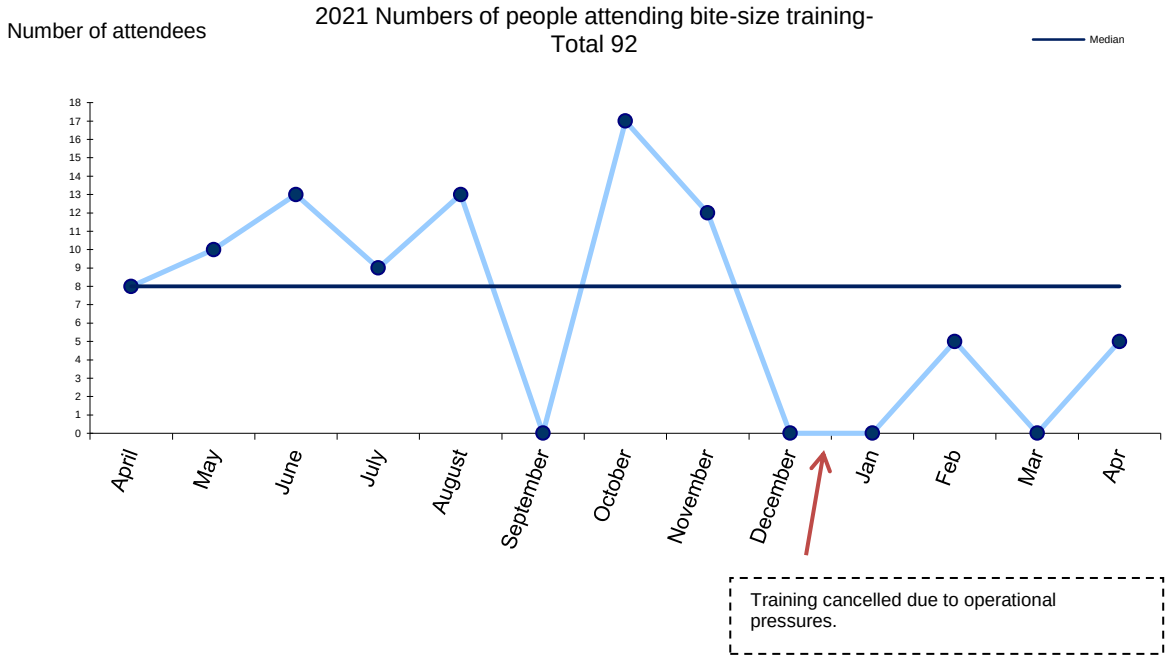


Training shall be designed for different levels to support wider adoption.

- **Level 1** shall target all staff in the Trust to have a basic understanding of key principles to improvement. 'Here to improve' e-learning has been launched on the East and North Hertfordshire Academy and is available to all staff. The quality improvement lead and capability lead are working in partnership to operationalise this. Sessions for new consultants and junior doctors have been initiated.

- **Level 2** has been targeted to staff that have some basic quality improvement knowledge and would like to learn more about specific topics in a little more depth. These sessions have successfully been delivered through the design of virtual teaching sessions. This involves 3 hours of training in the 7 steps for improvement for example how to design an improvement aim, how to analyse data for improvement, how to innovate and test new ideas. In total we have delivered this session to 164 people with 92 in the year April 2021 to March 2022 (figure 4).

Figure 4 Level 2 bite-size training



- **Level 3** has been targeted at 'team' leadership and wider commitment to adoption of quality improvement.
- **Level 4** 2 new coaches in QI team. 2 previous coaches promoted internally within the organisation. One to programme lead and one to the admiral nurse.
- **Level 5** The quality improvement team worked with the education and capability teams to procure level 3, 4, 5 and 6 apprenticeships which are due to start in 2022.

All of our projects are recorded onto LifeQI, a quality improvement project platform, recommended by our regional Academic Health Science Network and NHSE/I. This enables project, programme and portfolio management for the Trust.

Capability and capacity building next steps:

- Apprenticeships will be offered to anyone clinical or non-clinical with a passion for improvement. 15-20 places are available for a year to 18 months that will grow our capability and capacity for improvement in action as well as coaching others to do improvement (level 3 and 5).
- The Trust has committed to a third cohort partnership with the RCN Clinical Leadership programme. A further 20 clinical leaders are enrolled and ready to undertake the programme, due to start June 2022 (level 3).
- Quality improvement will be embedded into inductions so that all people joining the organisation know that they have equal responsibilities within their jobs to commit to continuous improvement efforts.

- The Trust is moving onto a new platform called 'ENHance' to enable oversight of all aspects of the quality management system and improve visibility of parts of the system where increased assurance or overall improvement is required.

Learning through QI programmes:

- All staff attending the deteriorating patient and harm free care programmes are subject matter experts (SME) and have been immersed in carrying out improvement work in clinical areas alongside a coach and a clinical team. Through teaching and coaching these people have learned about delivering improvement and many more aspects of managing change. They are expected to drive an improvement project over a period of time.

- **Discharge quality improvement**: a series of wards were all going through an evaluation of the current state of their use of national discharge policies and procedures to understand the variation in practice following safety incidents related to discharge. The clinical teams on 5 wards participated in projects and were offered workshops in conjunction with the national emergency care improvement support team (ECIST).

- **Patient and carer experience improvement**: the leadership post for the quality assurance side of patient and carer experience was vacant for most of 2021. Assurance and improvement sat under the Head of Quality Improvement until December 2021. This focus on assurance left limited capacity to initiate a series of improvement projects. However the 'what matters to you?' team contributed significantly to patient and carer experience and will be described in the patient and carer experience section of this report.

- **Royal College of Nursing (RCN) leadership programme**: This programme is delivered by the organisational development team and the QI team in partnership with the Royal College of Nursing. 22 leaders from nursing and our allied health professions have been through a year-long leadership development programme including teaching and coaching in QI in order to deliver an improvement project. The celebration event is in June 2022 when the third cohort will begin.

Examples of QI projects are included in Annex 1.

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

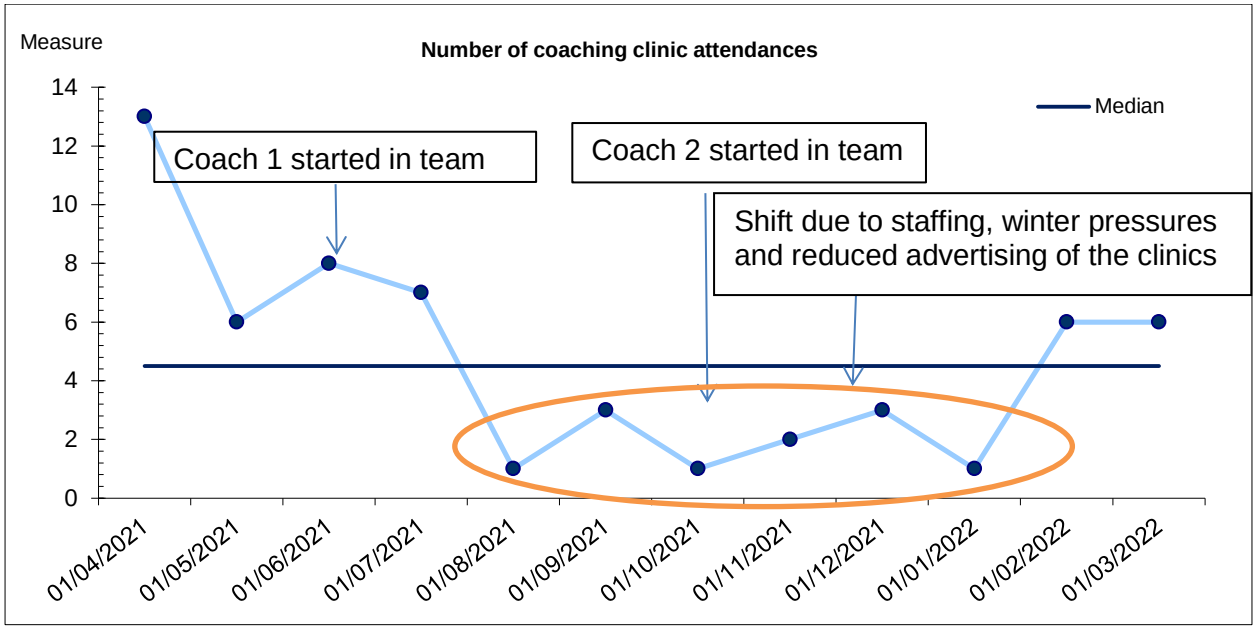
Coaching support for staff is provided from qualified improvement coaches, and the Trust has two full time coaches. Both coaches were recruited from within ENHT. The coaches are supported by the Head of Continuous Quality Improvement and Associate Director for Quality & Safety. Coaching has been provided in clinics and for the projects that feed into the programmes described in section 1.3 and in Annex 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 utilise coaching to take the next step in their QI project. Each project is scored and further coaching support is

allocated based on a score. The more aspects that have been considered from the 7 step model the higher the score and the more support the project receives.

Coaching clinic attendance has supported 57 staff in total during the year, compared with 90 the previous year. The reduction is due to a combination of new starters in the team and the operational pressures within the organisation pointing to challenges with capacity for teams to focus on improvement together.

Figure 5

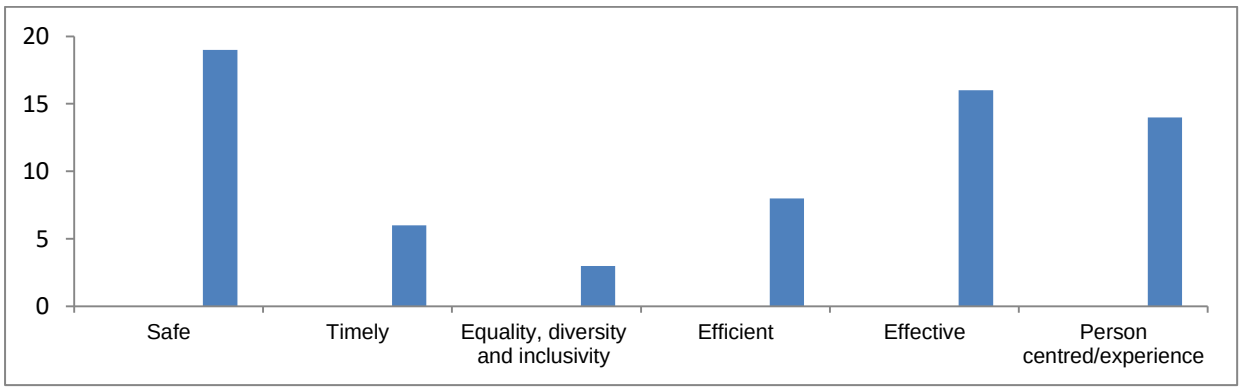


The coaches have supported staff to adopt the recording of their quality improvement projects and programmes on sharing platform LifeQI. There are currently 38 active and 17 completed projects. Each project contributes to a quality priority from the quality strategy and in some cases more than one quality pillar is covered by a project. Safety, efficacy and the experience of our teams and patients appear to be the biggest drivers for change.

Active projects 38; completed projects 17; projects discontinued 13

- Project numbers by division:
- Unplanned care 21
- Planned care 8
- Corporate 5
- Projects not assigned to a division 4

Figure 6 Quality pillars being addressed in projects



1.3 Deliver organisational wide structured Quality Improvement continuous learning programmes

1.3.1 Harm Free Care (HFC) programme

Background: HFC programme is aligned with our Quality Priorities 'Valuing the basics' with an aim to reduce avoidable patient harm from falls, Venous thromboembolism (VTE), Catheter Acquired Urinary Tract Infection (CAUTI), pressure ulcers, nutrition & hydration and medication errors. This is measured through a reduction in overall outcomes for each harm.

How: The HFC work is underpinned by quality improvement methodology that builds an evidence base using our 'Here to Improve Continuous Model for Improvement'. **S**pecific Quality Improvement projects were led by our HFC leads in areas where our quality & safety data highlighted areas of concerns over the last year.

HFC programme driver diagram:

Examples of HFC projects are included in Annex 1.

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, the Trust 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® programme is made up of three components which come together to demonstrate different ways to support nurses and midwives to influence and effect change:

1. **The six pathway standards** of shared decision making, leadership, safety, quality, wellbeing and professional development which support the development of a positive practice environment. They focus on transformational leadership and research and innovation, which ultimately influence situations, outcomes and experiences for patients and staff.

2. **Clinical excellence accreditation framework** provides clinical assurance on how our wards and departments are doing. It supports the Trust in maintaining high standards of practice in care through a journey of continuous improvement and giving reward and recognition where positive practices and innovative local initiatives are demonstrated.

3. **Shared decision making** encourages the sharing of best practice and learning from each other. Through the establishment of shared decision making councils, our healthcare professionals are given the platform to work together on local quality improvement initiatives and be part of one professional voice.

Nursing and midwifery excellence – six pathway standards

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

1. **Shared decision making** creates opportunities for direct care nurses to network, collaborate, share ideas, and be involved in decision-making.
2. **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.
3. **Safety** prioritizes both patient and nurse safety, and fosters a respectful workplace culture free of incivility, bullying, and violence.
4. **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.
5. **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.
6. **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.

Recognising nursing and midwifery excellence:

Recognising and thanking our nursing and midwifery colleagues who go above and beyond is an essential element within a culture of excellence. During the year we have been part of the 'Working with' programme with Cavell Nurses' Trust which gives us access to the Cavell Star Awards. Any nursing or midwifery professional can nominate a colleague who has

shown exceptional care to their colleagues, patients or their patient's families for a Cavell Star Award. Nominations are considered by the trust's Reward and Recognition Shared Decision Making Council. Successful nominees receive a Cavell Star Award medal pack and pin badge along with a framed copy of their nomination and flowers.

To date the following nominations have been awarded; each of these has been celebrated with the person making the nomination and the Chief Nurse either at local events or at the nursing and midwifery quality huddle:

Award Winners	Role	Date
Susan Passfield	Ward Manager 5B	18/02/2021
Eileen Fowler	Nurse Team Lead Children's	18/02/2021
Sarah Collins	Ward Manager Children's Day Services	18/02/2021
Kim Skelton	Lead Pain Management CNS	18/02/2021
Sally Steptoe	Sister, Bluebell Ward	18/02/2021
Alison Baker	Gynaecology CNS	19/02/2021
Catherine Beadle	Clinical Facilitator - Children's	11/03/2021
Lorraine Williams	Lead Infection Prevention and Control Nurse	18/05/2021
Sharon Dudley	Ward Manager	21/05/2021
Vanessa Grinstead	Ward Manager - 11A Respiratory	29/06/2021
June Johnson	Clinical Support Worker phlebotomists	06/07/2021
Nayna Borda	Clinical Support Worker phlebotomists	06/07/2021
Cristina Vinluan	Nurse Team Leader ACU	11/07/2021
Caroline Kirby	Matron AMU	14/07/2021
Clarissa Adupina	Outpatients Team Manager	21/08/2021
Janette Atkins	Team Facilitator & Children's Nurse	01/09/2021
Jericho Almontero	Staff Nurse, Vascular Surgery	06/09/2021
Deloris Brown	Neonatal Services Manager	24/09/2021
Francesca Hogan	Trainee Nursing Associate Swift Ward	03/11/2021
Megan Murthwaite	Clinical Support Worker	18/11/2021
Mandy Simms	Ward Manager 5A	24/11/2021
Sheena Lim	Research Nurse	23/12/2021
Jackie Angello-Gizzi	Clinical Nurse Specialist – Paediatric Diabetes	03/03/2022

Some of our Cavell Star Award winners:

Sue Passfield

Catherine Beadle

Mandy Simms

Lorraine Williams

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 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- departments must achieve a minimum of bronze level in all 18 fundamental standards to become or remain an accredited department.
- **Outcome of assessment** shared in a letter from the chief nurse, which provides details of all key areas of achievement and key areas for improvement- departments can begin working on their continuous journey of improvement.

CEAF award levels achieved to March 2022:

Gold	Silver	Ongoing assessment	To be assessed
Neonatal Unit Bluebell Ward Swift Ward AMU-2 Ward 11A/RSU	Ward 5B Ward 6A Ward 6B Ward 7A Ward 9A Ward 9B Ward 10A Ward 10B Pirton Ward Barley Ward Ashwell Ward	MVCC 10/11	Ward 5A Acute Cardiac Unit Critical Care Unit Ward 7B Ward 8A AMU1/SSU

An annual reassessment is undertaken on all wards with a full comprehensive assessment being undertaken every 3 years. 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. The Chief Nurse presents the wards with their award at the nursing and midwifery quality huddle.

6A, 9A and AMU 2 receiving their awards:

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 3 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 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.

Current shared decision making councils:

Ward Councils	Themed Councils	Specialist Councils
▪ Neonatal unit	▪ Wellbeing ▪ Reward and Recognition ▪ New Starters	▪ Research ▪ Pharmacy ▪ Leadership

	▪ Communications ▪ Co-production	▪ Dementia – Admiral Nurse

Each shared decision making council nominates 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.

Some of the projects our SDMC have been working on include:

- **Fluid balance monitoring**: purchased scales, magnets and posters for ward areas.
- **Referral pathway for plastics patients**: streamlining the process for patients to be seen in a plastics dressing clinic.
- **Criteria led discharge for patients having elective joint replacement**: patients can be discharged by a nurse if they meet the criteria.
- **Acupuncture service proposal for staff**: to be delivered by the pain team, Health at Work providing logistical support, trial period due to commence to enable an evaluation period.

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 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.

Progress with Pathway to Excellence application:

We completed Phase 2, the document submission, for Pathway to Excellence in January 2022. This includes the detailed evidence, known as Elements of Performance, for each of the six pathway standards. Once the outcome of the document submission is shared with the Trust we will move to Phase 3.

Plans for 2022-23:

Nursing and Midwifery Excellence:	
Nursing and midwifery excellence celebration event Launch DAISY Foundation recognition scheme for nurses and midwives	1 April 2022
Survey preparation: sharing communications relating to nursing and midwifery excellence throughout the organisation	April/May 2022
Phase 3: The survey phase where all registered and associate nurses and midwives will be asked to complete the 'pathway survey' to indicate whether the pathway standards have been embedded within the Trust.	May 2022 (estimated)
Phase 4: We receive the results of our PTE submission and survey and, hopefully, PTE recognition.	June/July 2022 (estimated)

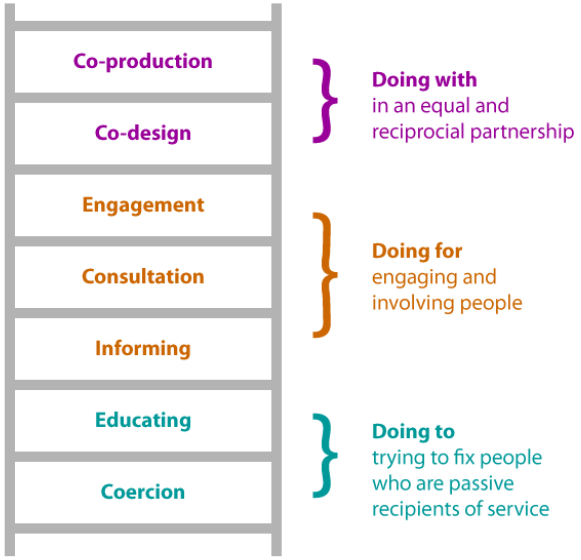
Clinical excellence accreditation: Cohort 7 – 5A, Acute Cardiac Unit, Critical Care Unit Cohort 8 - 7B, 8A, AMU1/SSU (Wards in Cohort 8 have previously received an independent assessment for clinical assurance- self assessments postponed due to clinical demand) Annual reassessments of all wards to continue Develop metrics for Neonatal Unit and Maternity	 March/April 2022 May 2022 Ongoing Ongoing
Shared decision making: Support for existing and development of new shared decision making councils. Council representation at nursing executive committees Development of e-learning training for shared decision making.	 Ongoing Developments

1.5 Service user partnership for co-production

All programmes have patients and carers in the improvement teams. A small percentage of projects have service users in the programmes. We delivered training on the value of co-production in our programmes alongside patient partners.

We have been following the ladder of participation adapted from the Think Local Act Personal website (adapted from Arnstein's model) with an aim of all improvement work being co-designed and co-produced with service users by 2024.

Figure 6



Reference https://www.thinklocalactpersonal.org.uk/co-production-in-commissioning-tool/co-production/In-more-detail/what-makes-co-production-different/

The quality improvement team, excellence teams and patient and carer experience teams are supporting the set up and delivery of a shared decision making council for co-production to ensure the engagement, recruitment and remuneration of service user partners in meaningful improvement design and co-production.

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	20/21	21/22	22/23
2.1	Medication management	Omissions of critical medications	<4%	<4%	<4%
		Antimicrobial stewardship	>90%	>90%	>90%
		Electronic prescribing / administration	Launch	Launch	Generate digital reports
2.2	Sepsis pathway compliance	Screening for sepsis in ED	>95%	>95%	>95%
		Neutropenic sepsis door to needle time	>95%	>95%	>95%
		Antibiotics in ED within an hour	>95%	>95%	>95%
		Antibiotics on the ward within an hour	>95%	>95%	>95%
2.3	Safer Invasive Procedure Standards	Phased approach to developing and imbedding Local Standards for Invasive Procedures	LocSSIPS for 80% of invasive procedures	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	Variable	Variable	>90% reliability
		Launch escalation module and develop a means of monitoring the escalations	Launch	Launch	Measure reliable escalation following launch
2.5	Safeguarding adults and children	Ensuring reduction of harm of patients with known learning disability	Triangulate incidents, complaints and mortality data	Triangulate incidents, complaints and mortality data	25% reduction in number of incidents of harm to individuals with a LD
2.6	VTE risk assessment	Improved compliance with VTE risk assessment part 1 and part 2	>95%	>95%	>95%

2.1 Medication management

Medicines Management

The past year has required flexibility to safely and effectively manage medicines and new services, including;

- The Covid-19 vaccination programme, where we have administered over 32,000 Covid-19 vaccines to both members of the public and staff since the beginning of December 2020.
- The development of the Covid Medicines Delivery Unit (CMDU). This service was designed to identify and protect the most vulnerable members of our society from admission to hospital with Covid-19. Between December 2021 and March 2022, over 2000 patients were referred into the service. We established a virtual clinic run by pharmacy with wider multi-disciplinary team support to prescribe novel medicines such as sotrovimab and paxlovid®.

Over the last year the pharmacy team has had staffing shortages due to Covid-19 sickness and isolation which created operational challenges. Despite these challenges, the team successfully rolled out electronic Prescribing and Medicines Administration (ePMA), a new electronic prescribing system.

	Target 2021/2022	**Achieved 2021/2022**
Electronic prescribing	Launch	Launched across medical and surgical adult in-patient wards
Omissions and delays to critical medicines	4%	3.6%
Antimicrobial stewardship	>90%	82%
The Trust's Medicines Optimisation Strategy	167	140

Electronic prescribing

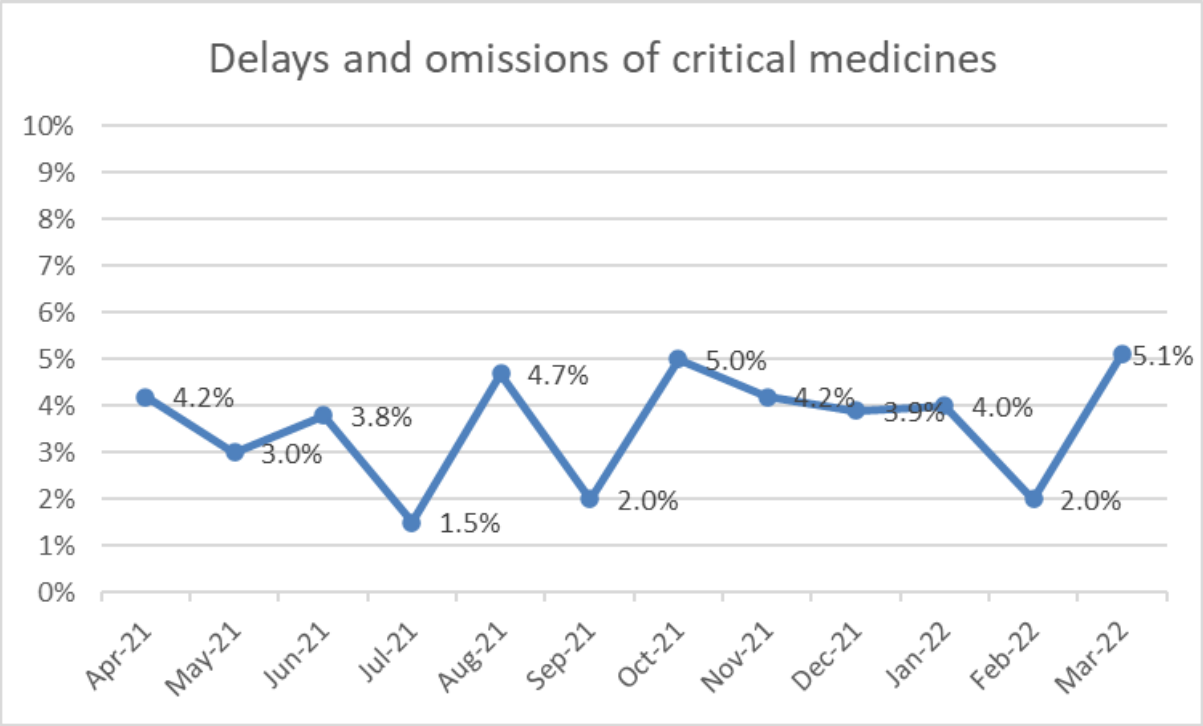
At the beginning of March 2022 Lorenzo® electronic Prescribing and Medicines Administration (ePMA) system was launched across all medical and surgical adult in-patient wards. Roll out was successful and implementation has brought many benefits including improved documentation. The ePMA team are now focusing on embedding the processes into clinical practice; these will be monitored in the ePMA operational group meeting. Over the coming months the focus will move towards benefits realisation of digital prescribing including improvements in patient safety and medicines optimisation.

Critical medicines

The critical medicines audit is conducted across the Trust on a monthly basis. The 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.

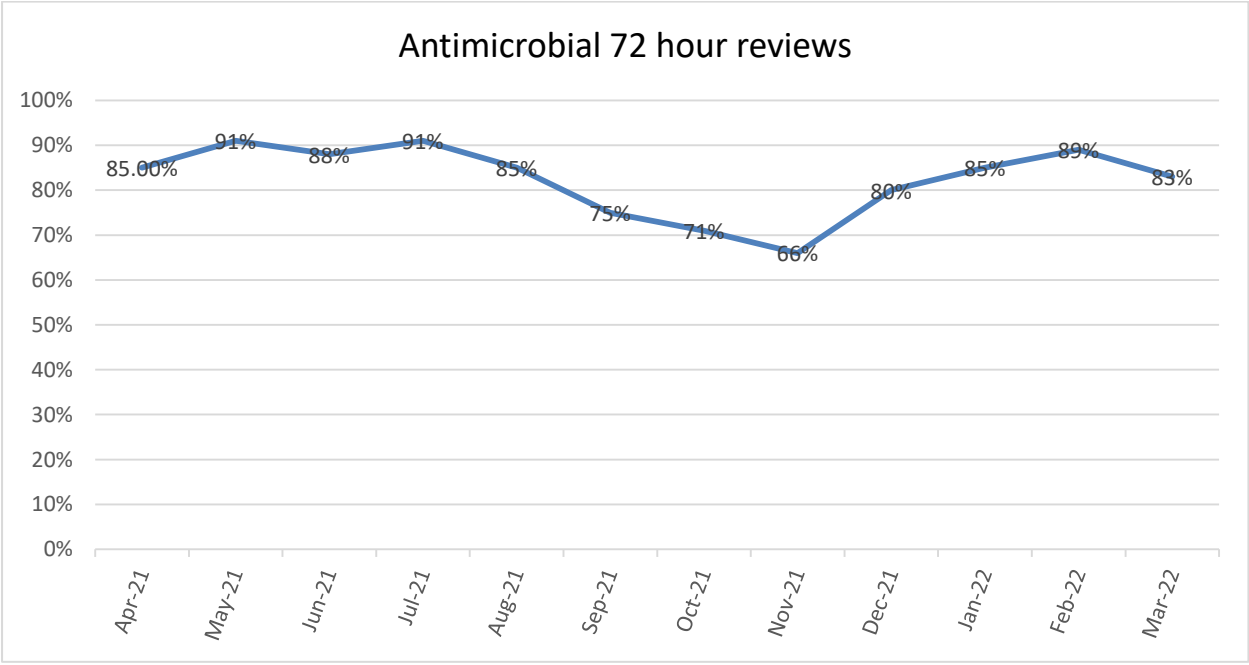
The aim for the Trust is to achieve <4% omissions of critical medications that should not be missed or given late. During 2021/2022 the Trust achieved an average of 3.6%. Between April 2021 and February 2022, the average was 3.4%, this increased in March 2022. This increase could be due to operational pressures, the implementation of ePMA or improved

documentation. The impact of ePMA will be monitored through medication forum and also the ePMA operations group.



Antimicrobial stewardship

Antimicrobial stewardship (AMS) is a coordinated programme to promote the appropriate use of antimicrobials to improve patient outcomes and reduce resistance in the long term. Reviewing the duration of antibiotic usage helps to ensure they are used optimally – long enough to be effective; yet not too long to develop resistance and reduce collateral effects. The aim is to achieve >90% compliance with good governance of antibiotic stewardship.



The graph demonstrates the results of a monthly audit that assesses the antimicrobial reviews for inpatients admitted to the Trust. The 90% target was met between April – July, following which a fall in performance was observed between August –November. Education and training was targeted toward AMS, following this an improvement in compliance was observed between December 2021 - March 2022. The team will focus on education and training and embedding ePMA into AMS.

The Trust's Medicines Optimisation Strategy

The Trust's Medicines Optimisation Strategy 2019-2022 was developed using the NHS Improvement, Hospital Pharmacy and Medicines Optimisation Assessment Framework. The strategy was reviewed and updated in April 2022.

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 Resolution, 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. The aim was to improve our score over the three years of the strategy to be comparable with the highest achieving Trusts. The score has improved from 123 in November 2019 to 140 in April 2022. The main driver for the improvement over the last year has been the implementation of ePMA.

Other areas of progress have included:

- 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 regular basis.
- 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 Chief Nurse receive a biweekly report and action plan on Medication Safety and Security from the Pharmacy and Senior Nurse Executive Walk Around.
- Therapeutics Policy Committee and New Drugs and Formulary Group biannual report was presented to the Clinical Effectiveness Committee in January 2022.
- A new Trust-wide formulary was introduced in May 2021. The impact of implementation with regards improvements in compliance against Hertfordshire Medicines Management Committee (HMMC) recommendations, will be audited in 2022/23 following digitalisation of the patient admitted therapy form.

Areas of focus for 2022/23

- Rewrite the Trust's Medicines Optimisation strategy and plan to launch the new strategy in summer 2022.
- Review the Pharmacy and Medicines Management KPI dashboard in terms of reporting, targets and presentation
- Embed all ePMA processes into clinical practice and move towards benefits realisation
- Aim to reduce the number of omitted and delayed doses of critical medicines to achieve a Trust wide average of <3.5%. Critical medicines will be a harm free care priority in 2022/23.
- The antimicrobial stewardship team will focus on achieving the >90% compliance from the 24-72 hour review audit, to achieve this they will focus on education and training and embedding ePMA into AMS.

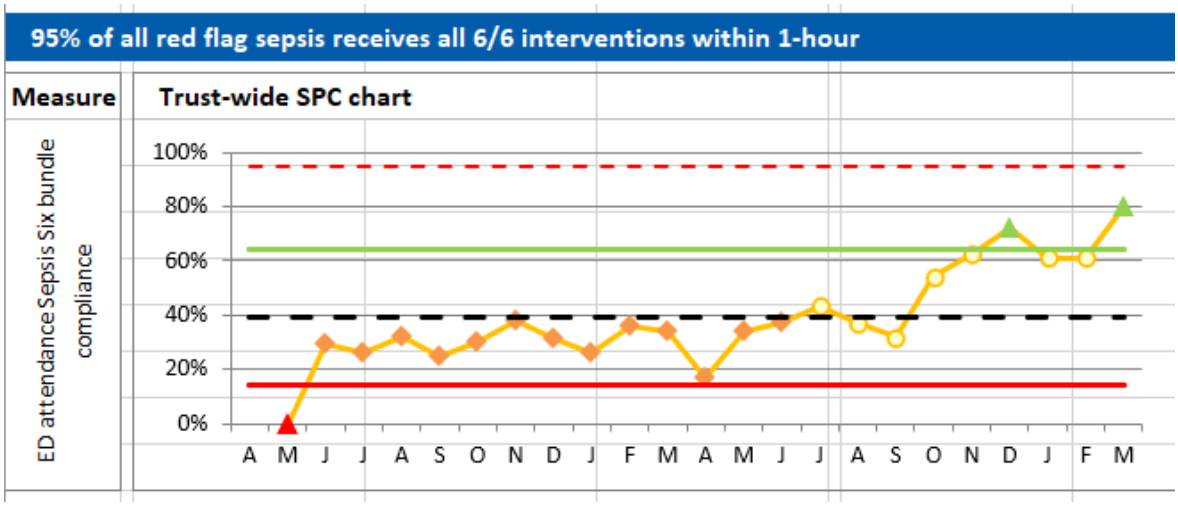
2.2 Sepsis pathway compliance

The Trust continues to prioritise the recognition and management of severe sepsis. Timely administration of intravenous antibiotics remains a key aspect to the whole sepsis 6 treatment bundle. The tracking of improvement compliance is recorded monthly on the quality and safety reporting framework.

	Aim	Achieved
Antibiotics in ED within an hour	> 95%	80%
Antibiotics on the inpatient ward within an hour	> 95%	80%
Neutropenic sepsis door to needle time	> 95%	96%
ED Sepsis six bundle	>95%	49%
IP Sepsis six bundle	>95%	48%

Emergency Department Sepsis Care

While the average compliance remains at 49% for reliability of delivering the sepsis 6 bundle in the emergency department, there has been a sustained improvement trend since October 2021, reaching a compliance of 80% reliability in March 2022.



The sepsis team has been supporting the Emergency Department (ED) by being more clinically visible and available to review the septic patients coming in the department, either via the front door or via ambulance. The team provides support by assessing patients in the back of the ambulance, initiating sepsis treatments when there is a delay in ambulance offload. By doing this, the team ensures that all elements of the Sepsis 6 bundle of care have been carried out within the hour.

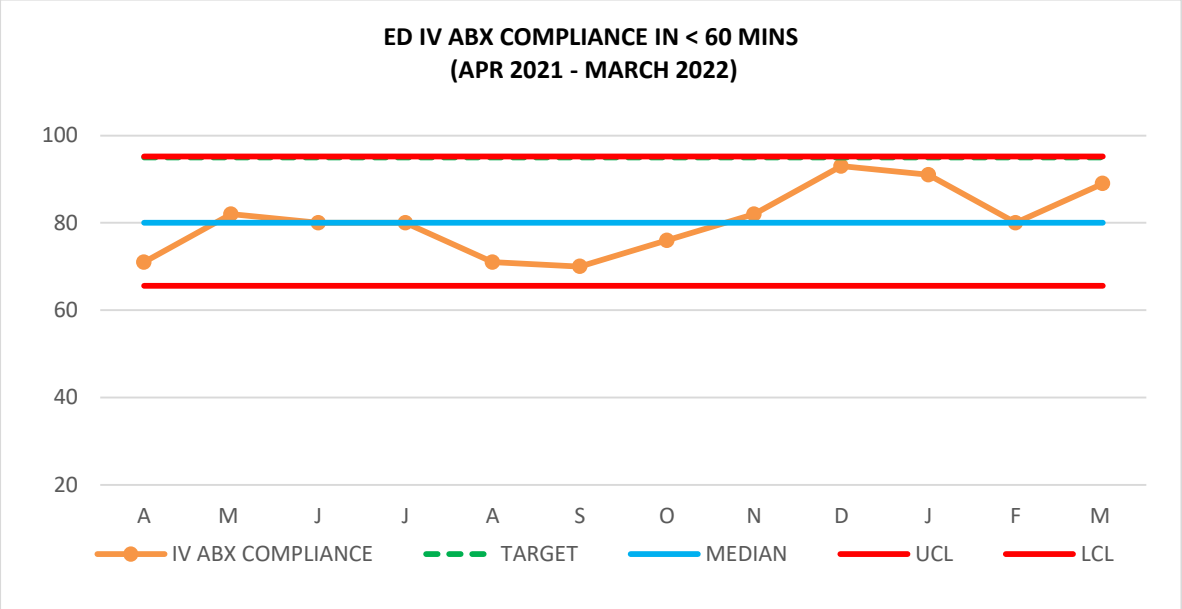
The team has also been very involved in providing virtual sepsis teaching sessions for ED staff, as face-to-face teaching continues to be challenging due to social distancing. The sepsis teaching sessions for ED staff started in September 2021, where the training compliance was 43.1% (72 staff members were trained and 95 staff members required training). The training was provided every week for three months which resulted in an improved compliance rate of 68% (115 staff were trained and only 54 staff require training now).

Emergency Department and In-patient compliance with IV antibiotic administration

Compliance figures have been variable throughout the year. IV antibiotics have been given in the ED within an average of 44 minutes which meets the target of within 60 minutes from trigger. Hence, this has improved their IV antibiotic compliance to 80% compared to 70% from last year.

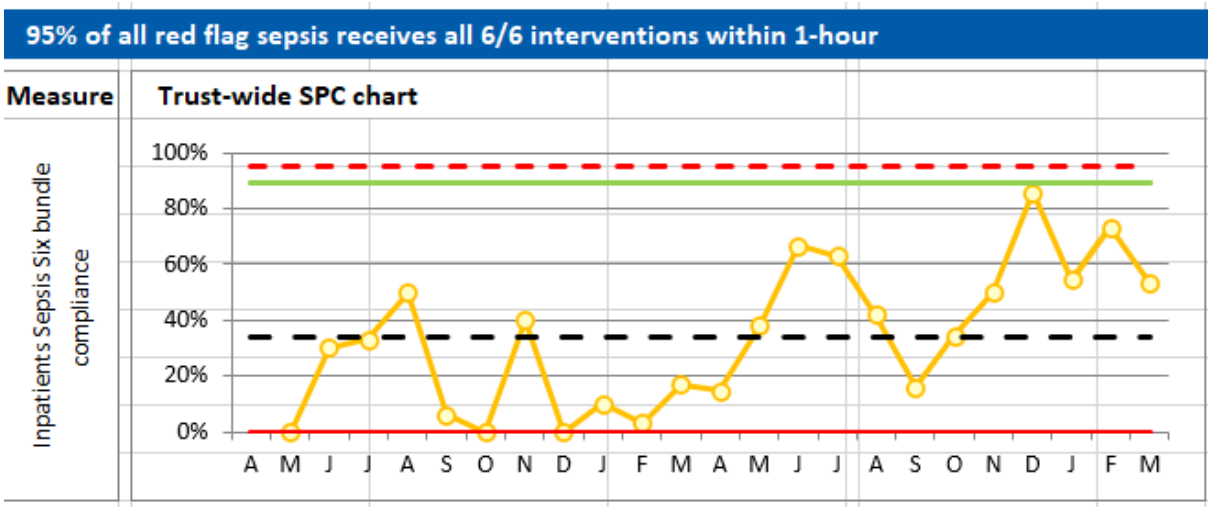
Please refer to Figures 7 and 8 for ED and IP compliance to IV antibiotic administration within 60 minutes. The average time to IV antibiotic can be seen in Figure 7.

Figure 7 (Aim 95%)



Inpatient sepsis care

Administration of IV antibiotics within the 60 minutes time frame in the inpatient area has significantly improved to 80%, compared to 38% from the previous year. The average time to intervention is 33 minutes and the overall trend is improving.



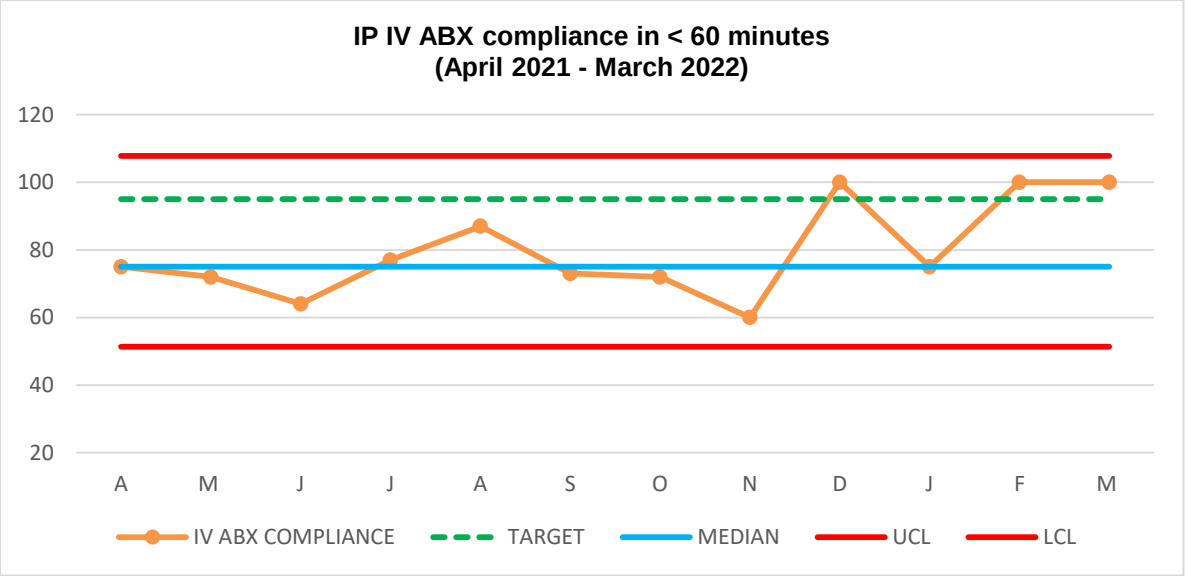
The average time of administration of IV antibiotics within the 60 minute timeframe in the Emergency Department was 82 minutes in April 2021; this is improved to 27 minutes in March 22

Learning themes identified include:

- Adherence to monitoring and recording of urine output in septic patients
- Accurate monitoring and documentation of fluid input and output
- Delay in IV antibiotic and IV fluid administration

- Failure to collect blood cultures
- Failure to collect and measure lactate levels

Figure 8 (Aim 95%)

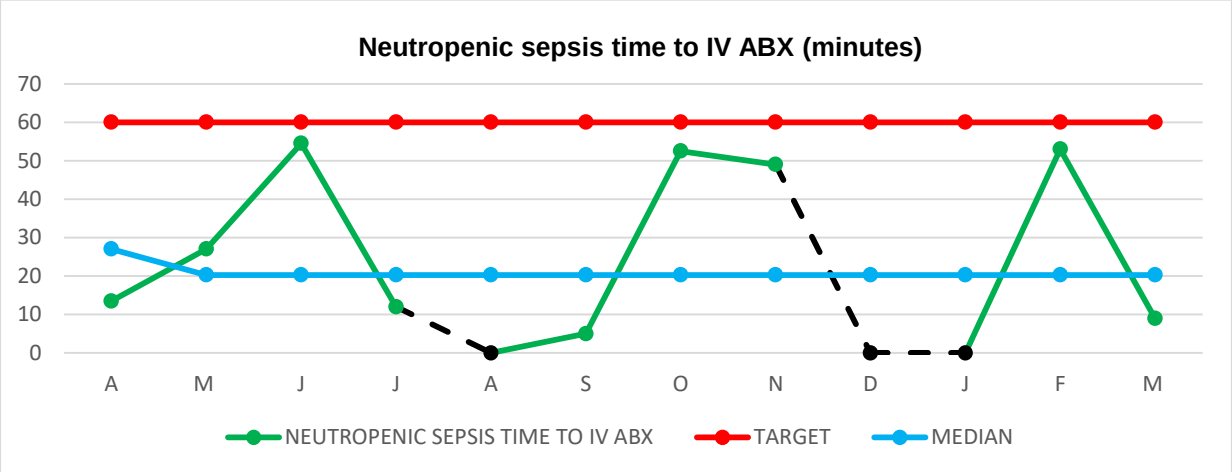


Neutropenic sepsis

A total of 23 patients were audited for neutropenic sepsis between the period of April 2021 to March 2022* across the Emergency Department and Inpatient areas. 91.3% of them received the antibiotics within 60 minutes following sepsis red flag triggers, compared to 83% from the previous year.

The average time to IV antibiotic administration is 30 minutes, which is a significant improvement from 43 minutes of the last year. Please refer to figure 9.

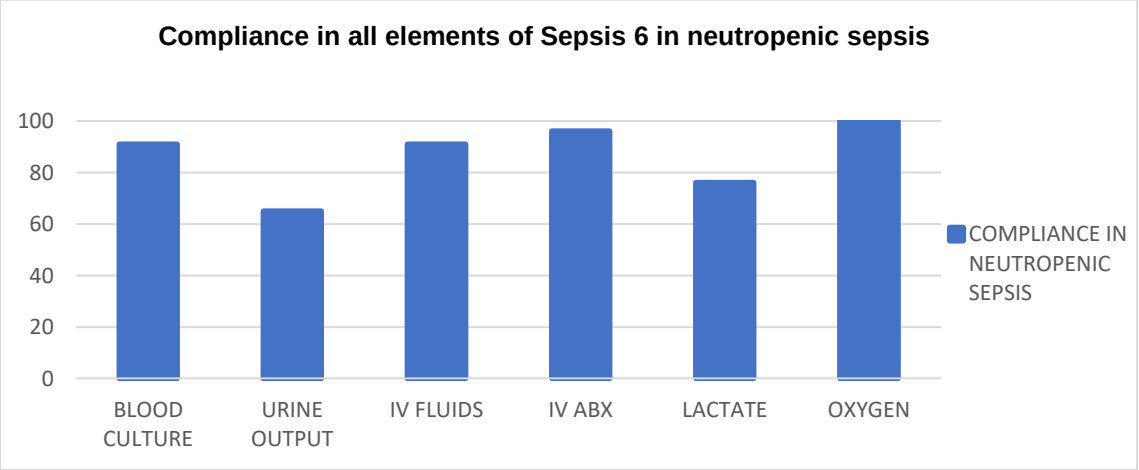
Figure 9



*In August, December and January there were no neutropenic sepsis patients identified for the audit

The compliance for all elements of the Sepsis 6 care bundle to be completed within an hour from trigger is currently 61% (aim was >95%). Please refer to figure 10 to compare the results. All patients who needed oxygen therapy were administered oxygen within an hour from trigger. Reasons for non-compliance are: failure to record and monitor urine output within an hour from trigger (35%), failure to collect and check lactate levels within an hour (24%), neglecting to collect blood cultures within 1 hour from trigger (9%), delay to commence IV fluids within 60 minutes (9%), delay to administer IV antibiotics within 60 mins (4%). Recording and monitoring urine output along with checking lactate levels remain priorities for improvement.

Figure 10



Sepsis 6 bundle

In 2021/2022, the Trust continued to monitor the compliance in initiating and completing all elements of the Sepsis 6 bundle within 60 minutes from triggers, namely:

- Administration of IV antibiotics
- Serum lactate measurement
- Urine output monitoring
- Sample for blood culture
- Administration of IV fluid challenge
- Administration of Oxygen therapy

Over the period of April 2021 to March 2022, the Sepsis 6 compliance has been varying with the lowest recorded compliance of 16% for both ED and IP area. The highest compliance recorded was 80% for ED and 86% for IP. The median for the combined ED and IP compliance is 51.5% which is an improvement on 31% last year. Please refer to figures 11 and 12.

Figure 11 ED attendance Sepsis Six bundle compliance

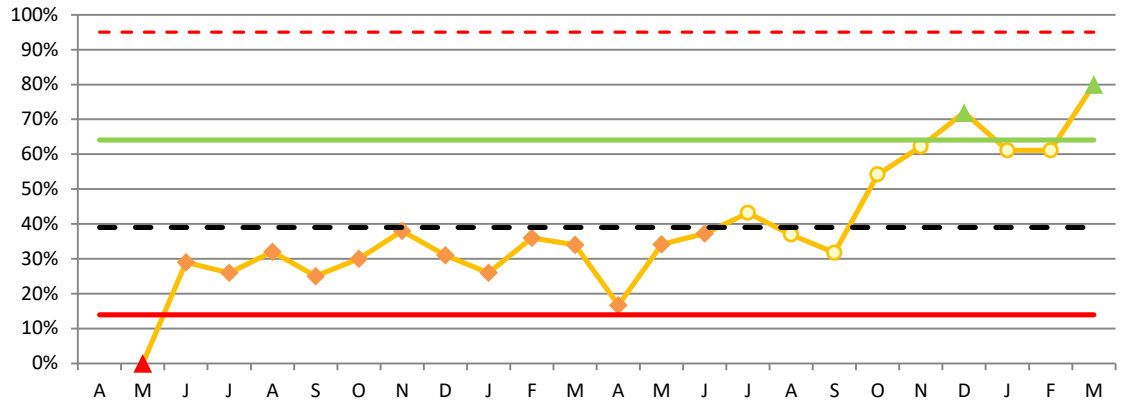
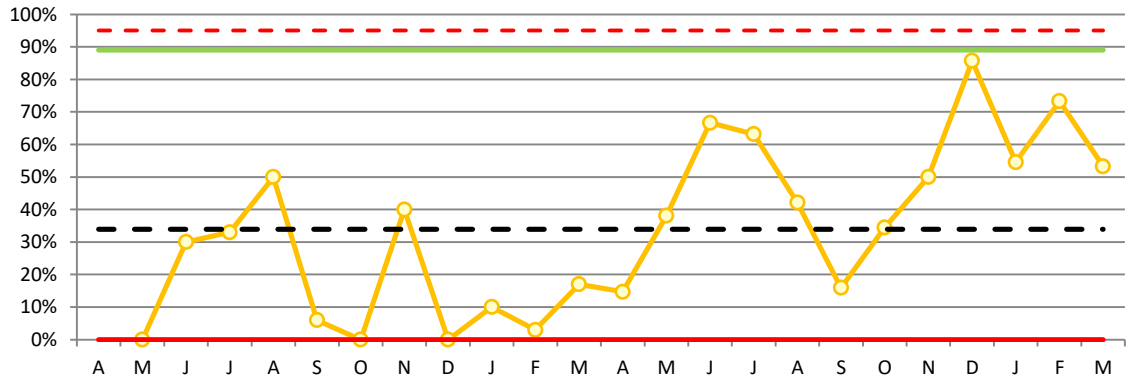


Figure 12 Inpatients Sepsis Six bundle compliance



Managing sepsis remains a quality improvement priority for the Trust-wide Deteriorating Patient Collaborative. Targeted work continues with the acute kidney injury team, critical care outreach team and resuscitation team on escalation using the Situation-Background-Assessment-Recommendation-Decision communication tool (SBARD), fluid balance monitoring, and observations competencies. The Pathway to Excellence programme will continue to drive and help to sustain improvements in managing sepsis.

Quality improvements in 2021/22 include:

- Sepsis and critical care outreach teams have combined to strengthen clinical leadership
- Sepsis team now comprises a mixture of clinical and teaching roles
- The introduction of out of hours emergency cannulation and phlebotomy team
- Implementation of digital fluid balance chart which is embedded in Nervecentre
- Improved awareness and early confirmation of optimum antibiotics, taking account of allergies.
- Sepsis recognition is now included in the scenarios presented in the yearly update of ILS provided by the resuscitation team

- Completion of root causes analysis investigations of all peri-arrest calls, to identify and feedback early sepsis care learning
- The pilot of our electronic medicines prescribing system (ePMA) to facilitate more accurate measurement of doses of antibiotics and intravenous fluid therapies administered

Priorities for 2022/2023 include:

- Improve staff training compliance for ED and IP wards to 90% by October 2023.
- The sepsis team will provide teaching sessions for CSW, OSCE and Pre-registration nurses' induction programmes.
- Empower staff to act on sepsis and commence the "Nursing Actions" elements of Sepsis 6 (Blood culture collection, VBG collection to check urgent lactates, urine output monitoring) and commence IV fluids, IV antibiotics, and administer oxygen once prescribed by the attending doctor.
- Improve and assess staff competency in completing the Sepsis 6 care bundle within 60 minutes from trigger by supervision, training, and encouraging leadership via link nurses. Improvements in compliance should be seen by September 2022.
- Include an e-learning programme (Role Essential Training) for Sepsis in ENH Academy.
- Improve staff competency in recording observations accurately.
- Educate staff in the importance of accurate input and output monitoring as well as proper documentation in the digital fluid balance chart (to be included in the CSW Induction).
- Incorporate the Sepsis Assessment and Sepsis 6 Bundle in Nervecentre.
- Expand the sepsis awareness programme, including recognition of signs and symptoms in paediatric and maternity patients.
- Roll out 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 (or where a body cavity is accessed for example, endoscopy). 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.

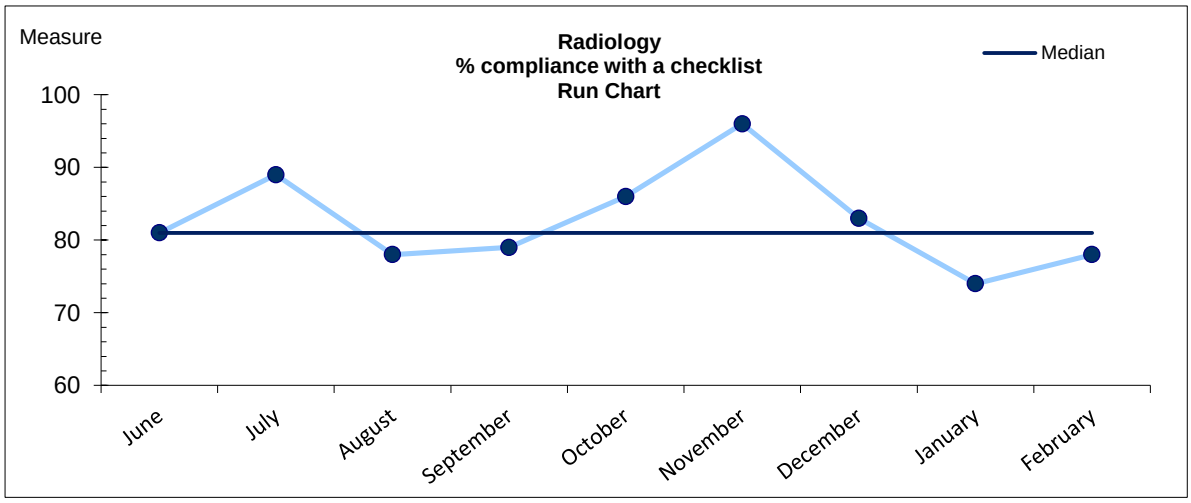
The re-designed LocSSIP paperwork for theatre has now been successfully embedded and is in use in all theatres throughout the Trust (excluding maternity who have separate LocSSIP paperwork). A new audit scheme has been developed for use in theatres and in non-theatre areas which can be uploaded directly to the online IQVIA system. The audit has two sections: one which follows an individual patient through (looking at the handovers, the sign in, time out and sign out), and one which follows the list pathway looking at the huddles and debriefs for the team.

The initial data from theatre shows a median of 74% compliance for the list pathway and 88% for the patient pathway. Previous audit methodology focused on retrospectively auditing notes to assess compliance with LocSSIPS. The new approach is more observational and is designed so staff from neighbouring areas can audit their peers and there can be quality improvement in both directions, as well as demonstrating safety. The audit data will be accessible on-line and can therefore be easily used both corporately for assurance and locally for quality improvement.

A similar audit has been developed for use in non-theatre environments where lists of procedures take place. This has been trialled in radiology and will be introduced in 22/23 to the other clinical areas.

Radiology have moved from auditing 100% of the paperwork to a regular sampling approach. This has shown a median of 80% compliance with completion of the WHO checklist (figure 13). Interventional radiology has made NatSSIPs and the development of their LocSSIPS a focus following the declaration of a Never Event for wrong site treatment.

Figure 13



Endoscopy conducts a large audit of their documentation which includes compliance with completing the WHO checklist. Results have shown showing a mean score of 99% for upper GI endoscopy and 98% for colonoscopy.

LocSSIPS have also been introduced in dermatology, radiology, urology, ophthalmology, critical care and other clinical areas. The focus for 22/23 will be to identify remaining areas which do not use LocSSIPS for their invasive procedures and break down barriers to implementation.

Human factors simulation sessions will be launched in theatres in May 2022, which can then be replicated in other areas throughout the Trust.

2.4 Deteriorating patient and cardiac arrest

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

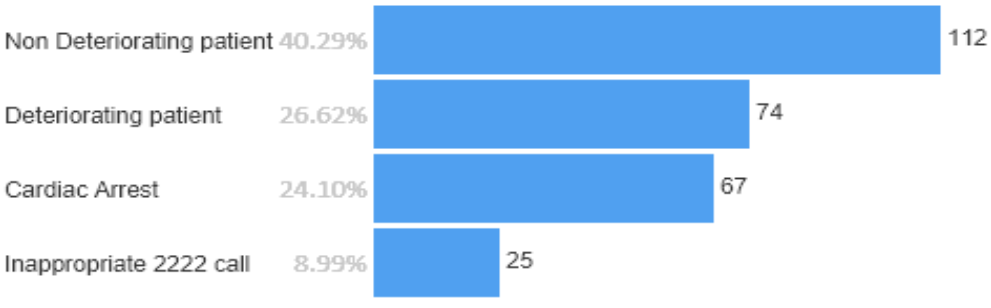
Nationally, more than three quarters of in-hospital cardiac arrests are preceded by a physiological deterioration, indicating an opportunity to recognise, manage and prevent further deterioration and subsequent cardiac arrest.

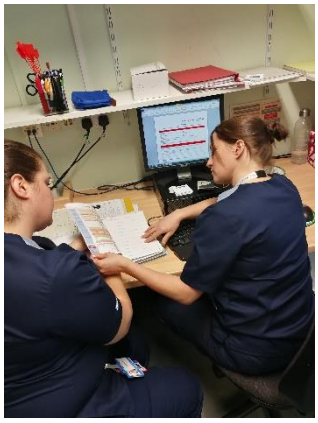
The National Confidential Enquiry into Patient Outcome and Death (NCEPOD 2012) reported that over one third of cardiac arrests were potentially avoidable due to the predictability of the event. National enquiries and datasets highlight the survival rate associated with an in-hospital cardiac arrest is less than 20%. Early recognition and identification of patient deterioration can therefore prevent cardiac arrests and improve patient survival outcomes or allow for a natural transition to end-of-life care if death is inevitable.

During 2021-2022, an average of 0.9 per 1000 patient admissions to Lister Hospital site resulted in physiological deterioration requiring the assistance of the 2222 emergency response team and 0.8 per 1000 patient admissions suffered a cardiac arrest.

27% of all the 2222 team attendances were in response to patients with signs of physiological deterioration, 24% were cardiac arrests and the remainder were sudden collapses with no early warning indicators (40%) and a few unnecessary calls (9%) (figure 14).

Figure 14





Following each cardiac arrest a Rapid Incident Report (RIR) investigation is undertaken to review patient care and any learning is fed back to the teams involved and discussed at the Trust's Serious Incident Review Panel (SIRP).

From that review of cardiac arrests in 2021/2022 we have identified that 60% of all inpatient cardiac arrests (excluding the Emergency Department and cardiac suite) had abnormalities in their physiological national early warning (NEWS) indicators preceding the event. 37% of these patients with early warning signs were identified as having a missed opportunity for optimisation of their treatment plan. An earlier discussion with the patient about their options for care would also allow their wishes to be taken into consideration, including supporting a peaceful natural death without cardio-pulmonary resuscitation (CPR) were this to be the appropriate choice.

Timeliness of Observations and Effective Escalation

Over the past year, the **Deteriorating Patient Committee** has taken the opportunity to reflect on the events of the pandemic and review the priorities for the next year. A key priority remains the timeliness of patient observations and improving escalation. This will require identifying how we support staff to undertake patient observations, within the allocated frame times, to recognise concerns and escalate as needed.

A pilot of targeted improvement work has started on one of our 'planned care' wards, which has identified measures to support improved timeframes for taking observations, and work will continue to embed new processes, which can be then be rolled out Trust-wide for all areas.

There is a Trust-wide drive to support staff training and assess the competency in performance of physiological observations for all clinical staff, including a dedicated neurological competency for registered nurses and nursing associates. These competencies incorporate the new elements of the NEWS2 guidance; the hypercapnic module and new confusion modules. Hypercapnia is a build-up of carbon dioxide in the bloodstream and mainly affects people with Chronic Obstructive Pulmonary disease (COPD), the module allows for adjusting observations for patients with this physiological change.

In order to capture reliable data around our NEWS2 training compliance, the Trust will be re-launching the NEWS2 training module into our e-learning domain. This allows clinical staff to undertake the learning which is then recorded within their learning profile.

For both of these learning priorities we aim to be 95% compliant by December 2022.

Additional classroom learning can be difficult to facilitate since the pandemic. Therefore, to embed the learning from the observation competency assessment and from the NEWS2 e-learning, clinical experts from our Critical Care Outreach Team (CCOT) will be undertaking sessions on the ward, working alongside the staff to support them in their bedside learning. This will include the ABCDE assessment, SBARD communication, performing of observations, fluid balance chart management and education. This will be trialled in the coming months and if successful will become a regular rostered occurrence.

This year the Trust will be launching the Call 4 Concern© initiative. With the reopening of patient visiting, it has been acknowledged that it is not only healthcare professionals that can recognise deterioration in their patients, but also the patients' family and/or carers. Call 4 Concern© will allow members of patients' family/carers to contact our Critical Care Outreach Team if they are concerned about deterioration in the person they are visiting. The aim is to launch in July 2022, and external communications will be provided to our service users, in the weeks building up to the launch.

The Data

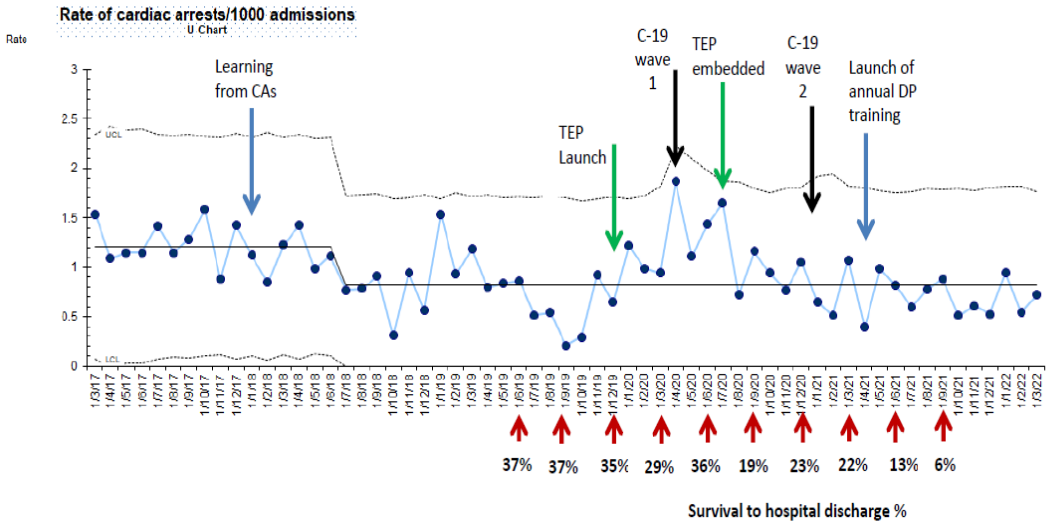
2222 emergency team and cardiac arrest data is routinely submitted to the National Cardiac Arrest Audit (NCAA) database.

Historically the Trust has collected and examined cardiac arrest data. In January 2018 the Trust began deep dive reviews into cardiac arrests and learning was shared following these events. A reduction of 43% was seen within six months and this reduction has been sustained. The chart in figure 15 demonstrates the sustained reduction of in-hospital cardiac arrests to an average rate of 0.8 per 1000 patient admissions (previously 1.2 per 1000 patient admissions).

The reduction in cardiac arrests demonstrated an improvement in the recognition and management of deteriorating patients. In order to further improve and prevent patients from deteriorating, it was recognised that understanding the data was essential. In January 2020, a review of all 2222 calls began, to establish the number of deteriorating patients requiring the 2222 emergency response team. The data can be seen in figure 16

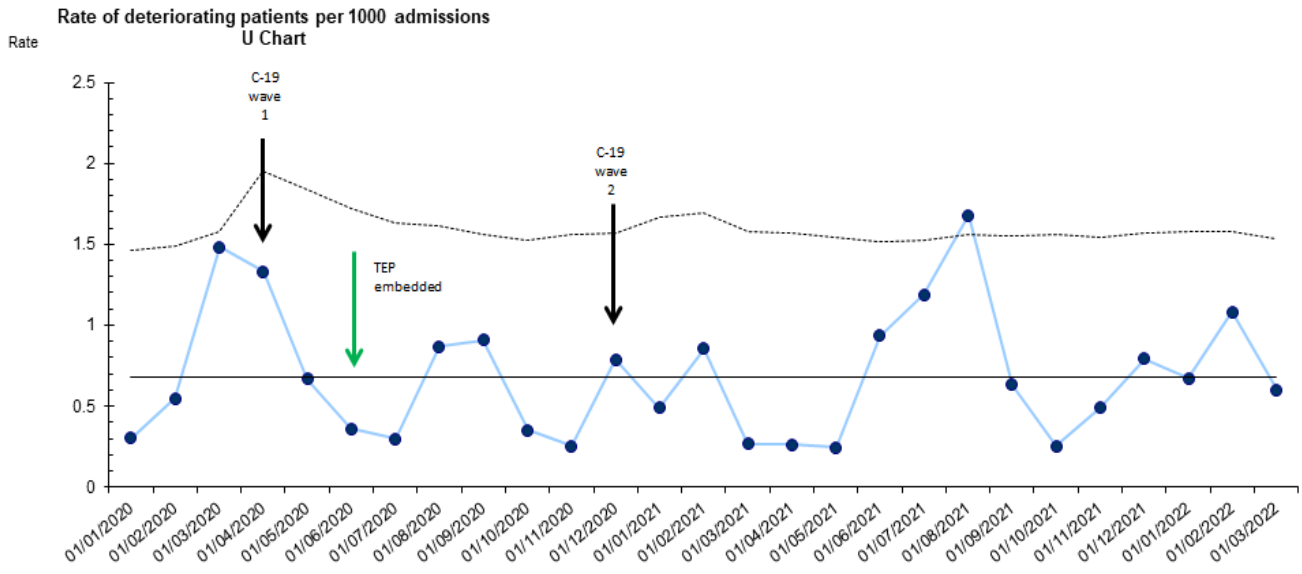
Examination of the data is currently underway to understand changes, peaks and troughs; this will be scrutinised against the acuity levels of in-patients and the number of referrals to the Critical Care Outreach Team (CCOT).

Figure 15



The chart in figure 15 shows the Trust's survival to discharge rate following cardiac arrest, highlighting a lower survival rate since the summer of 2020. Understanding the data can be challenging and further investigation is ongoing. Initial examination of the data reveals that prior to the summer of 2020 less than 50% of all cardiac arrests were either sudden unpredictable events (with no preceding warnings) or appropriate for CPR and with all care in place to try and prevent deterioration. More recently there has been an increase in this category of cardiac arrests, with an average 60% during the first two quarters of 2021/2022.

Figure 16



When cardiac arrests occur suddenly or are appropriate for CPR and with all care in place to try and prevent deterioration, these would be considered unavoidable. The physiological factors causing the cardiac arrest will determine the outcome. If all causes have already been reversed to prevent deterioration, but the heart still stops, the performance of CPR and advanced life support is unlikely to favour a positive outcome.

A patient that suffers a witnessed sudden collapse such as a myocardial infarction (heart attack), with good quality CPR and reversal of the underlying cause (clearing a blocked artery in this example) may favour a positive outcome.

It is certain that early identification of patients for whom advanced CPR would not restart the heart, should be managed with optimal end of life care rather than futile attempts to resuscitate inappropriately. This in turn will impact survival rates.

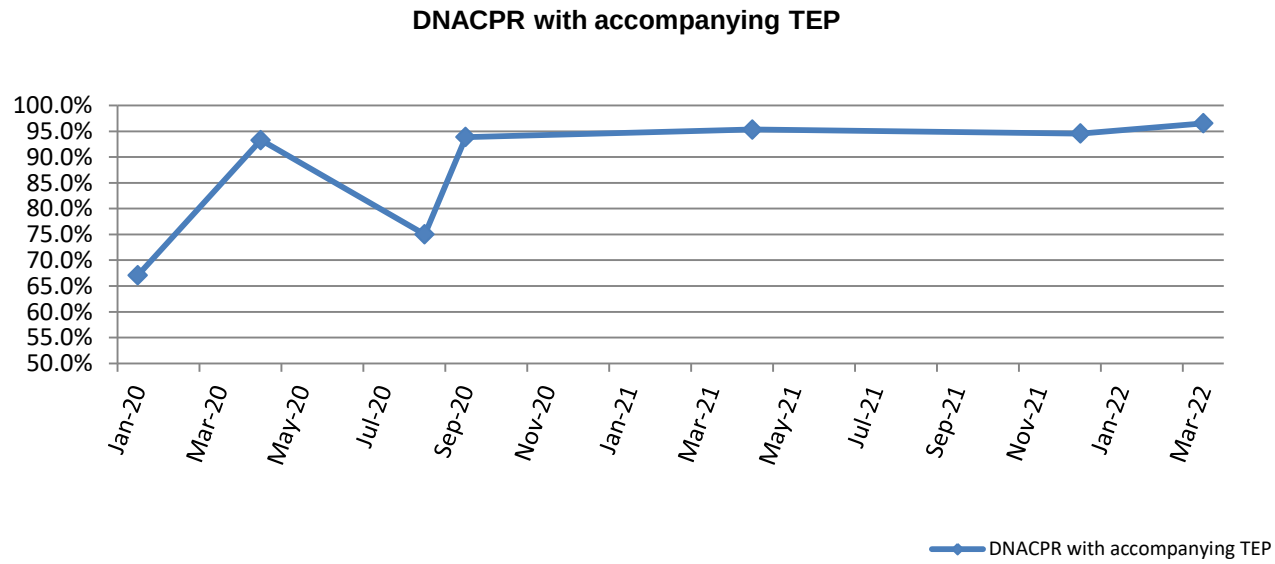
Do not attempt cardio-pulmonary resuscitation (DNACPR) and treatment escalation plans (TEP)

In October 2020 the Department of Health and Social Care (DHSC) requested a review of DNACPR following concerns during the Covid-19 pandemic. Recommendations and actions were set by the Care Quality Commission (CQC) to improve DNACPR decision making process in a report; 'Protect, Connect, Respect – decisions about living and dying well' (2021). Universal Principles for Advance Care Planning (ACP) was jointly published by a coalition of partners in response to the CQC report (2022).

The Trust has undertaken a gap analysis against the CQC recommendations following this review and report.

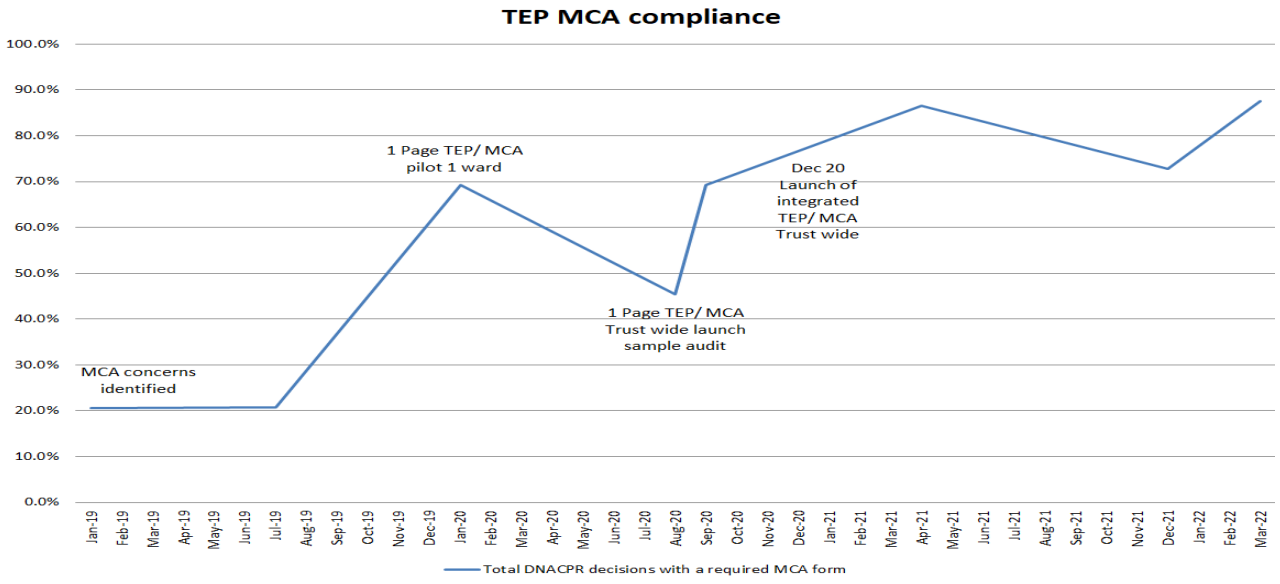
Following the launch of the Trust Treatment Escalation Plan (TEP) in December 2019, the completion of the documentation sits at 97% compliance along with the DNACPR documentation (figure 17).

Figure 17



In January 2020 a pilot of a combined TEP and Mental Capacity Assessment (MCA) document, showed an initial compliance of 69%. In December 2020 the launch of a fully integrated TEP/MCA led to a sustained increase in compliance of 87%; this improvement journey can be seen in figure 18.

Figure 18



People must always be at the centre of their care, including advance care planning and DNACPR decisions (CQC, 2021).

An audit of documented discussions with patients and their loved ones (March 2022), in relation to 'Do Not Attempt Cardio-pulmonary Resuscitation' (DNACPR) decisions, revealed that 97% of decisions were documented as discussed. The content of discussion was clear in 86% of these cases. 89% indicated decisions were discussed with relevant others where the patient was deemed not to have mental capacity to be involved in decisions relating to their care, 71% of these cases had clear documented content recorded in the medical

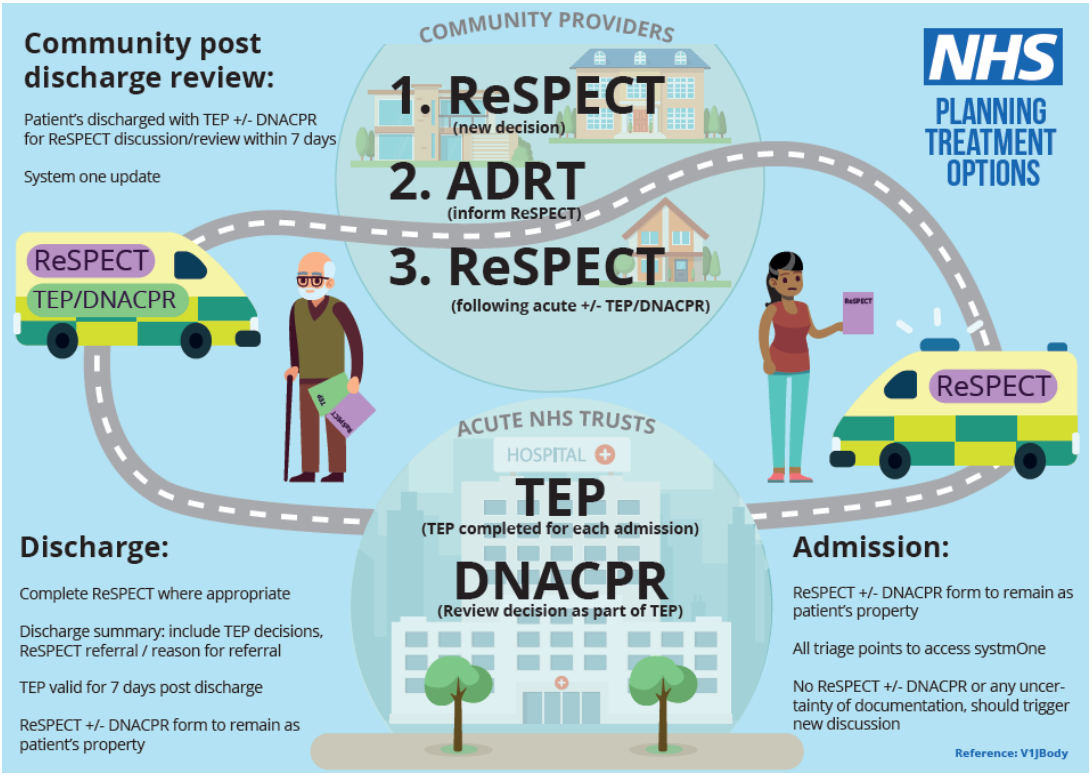
records. Improvement is required to ensure that patients and/or their loved ones are involved and clearly understand the decisions relating to their care.

Improvements and changes during Covid-19 and in 2021/22

TEP / DNACPR

The Trust is currently working alongside the integrated care providers (ICPs) for East and North Herts to launch the national ReSPECT form (Recommended Summary Plan for Emergency Care and Treatment) across the whole region for both hospital and community care.

Figure 19 demonstrates a roadmap for integrating systems, supporting the ICPs improvement.



The ReSPECT form improves upon and replaces the DNACPR and TEP forms and promotes early shared decision making and patient involvement. It considers multifactorial options for patients, including suitability for CPR, and specifically focuses on the wishes of the patient in the event of an emergency. It enables clinicians to better understand the wishes of a patient and to make better decisions relating to the patient's treatment options, particularly in the absence of capacity. The Trust is currently piloting the forms and assessing how they are best used to improve patient care.

Safety and Education

The Covid-19 pandemic required new ways of working to keep patients and staff safe. The National Resuscitation Council (UK) Guidelines changed to protect staff, patients and public from the contraction or spread of the virus.

The biggest change was the need to don personal protective equipment (PPE) prior to commencing any aerosol generating procedure (AGP). These procedures are deemed a risk as they lead to the viral particles being sprayed in the air.

In order to effectively ensure the timely response to a patient's deterioration and the need for PPE during CPR (several interventions with AGP), over 1000 front facing clinical staff were trained within the first four weeks of the pandemic, with approximately 2500 staff subsequently trained in total. To allow for social distancing and lack of face-to-face or classroom sessions, a training video was produced and shared on the ENHT intranet (Knowledge Centre). This video is still used for education in the mandatory training sessions.

In addition, in the past year all clinical staff working with acute inpatients attending their induction or annual resuscitation training receive multi-disciplinary training in the recognition and management of the deteriorating patient. This training includes NEWS2 observation performance & escalation, SBARD communication, the A-E assessment & management, with an additional focus on sepsis and anaphylaxis (emphasis due to increased Covid-19 vaccination), targeted to their job roles.

Improving the knowledge and skill in response to AGPs:

In response to the Resuscitation Council UK (RCUK, 2020) COVID-19 guidance and incident reports highlighting issues relating to incorrect PPE and the deployment of the resuscitation trolleys into contamination zones usage during cardio-pulmonary resuscitation (CPR), further

work was undertaken to improve the staff safety and to ensure the appropriate responses to patient deterioration with AGPs.

In-depth, human factors reviews of care were undertaken, where recommended PPE procedures were breached and key themes highlighted.

Questionnaires were completed by clinical staff across a mix of COVID and non-COVID wards and wards with and without incidents. A quality improvement initiative was implemented to address problems identified.

On-going support on the pilot wards was provided. The learning has been shared in subsequent resuscitation training sessions.

Figure 20

EMERGENCY SHIFT PLAN

Ward: Date:

NHS East and North Hertfordshire NHS Trust

Name	Grade	CPR 1st resp.	Correct FFP3 Avail.	PPE buddy (don/doff aware)	Early	Late	Night

KIT CHECKS	Early	Late	Night
Resus trolley checked and ready for use			
CPR 1st Responder PPE			
Action taken if no staff Fit test passed (Continue overleaf if required)			

WHAT PPE DO I NEED?	Standard PPE	Enhanced PPE
Lay patient flat	✓	✓
Assess patient ABC	✓	✓
Call 2222	✓	✓
Apply defib pads to patient	✓	✓
Shock if appropriate	✓	✓
Apply O2 to patient	✓	✓
Start compressions (CPR responder)	x	✓
BVM (skilled users only)	x	✓
Suctioning	x	✓

ALL PATIENTS, ALL AREAS:

DO NOT START CPR WITHOUT WEARING ENHANCED PPE

NO NOT TAKE RESUS TROLLEY INTO SIDE ROOM OR BAY

RS/2222 Handover/Sept 2020

Improvements can be seen in figures 21, 22 and 23:

Figure 21

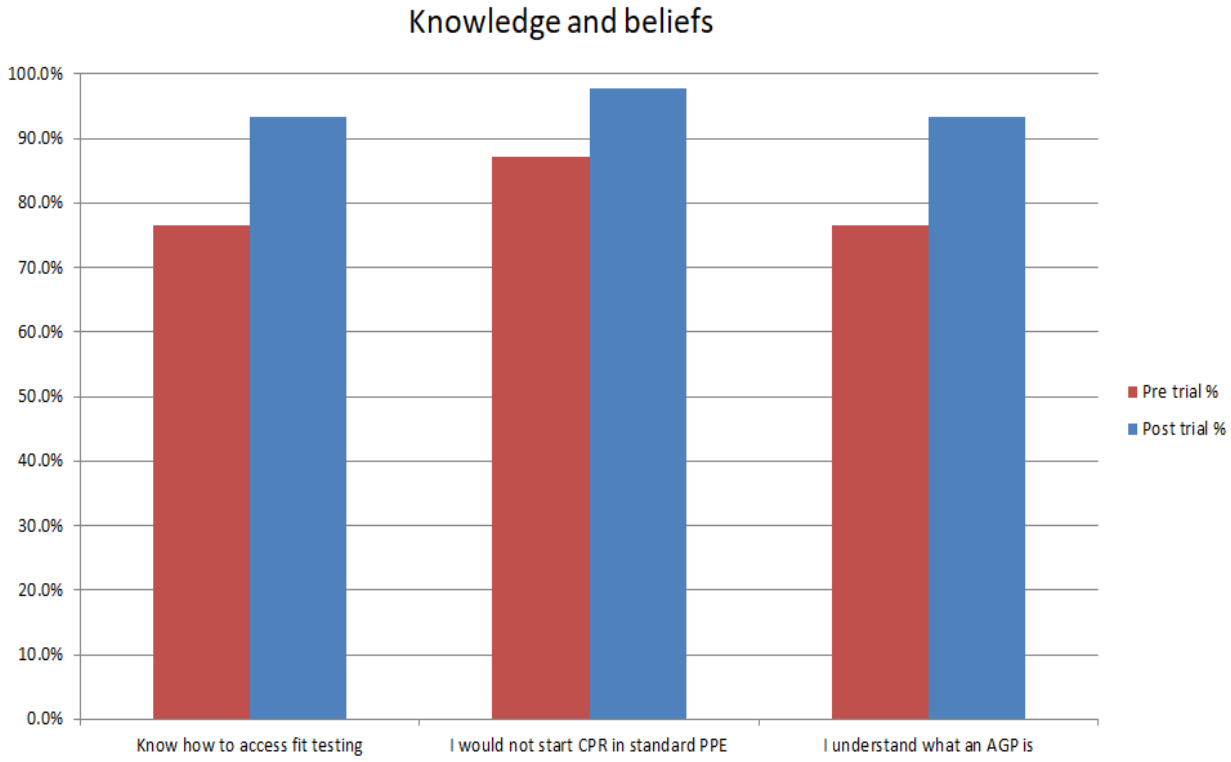


Figure 22

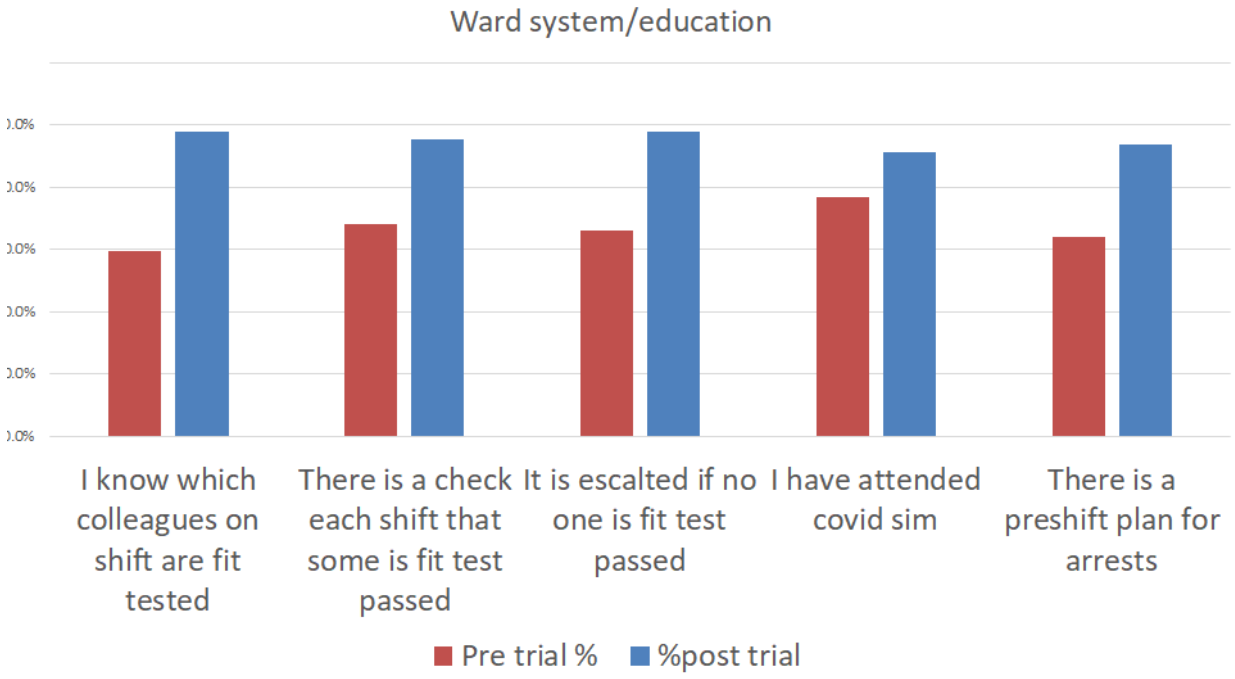
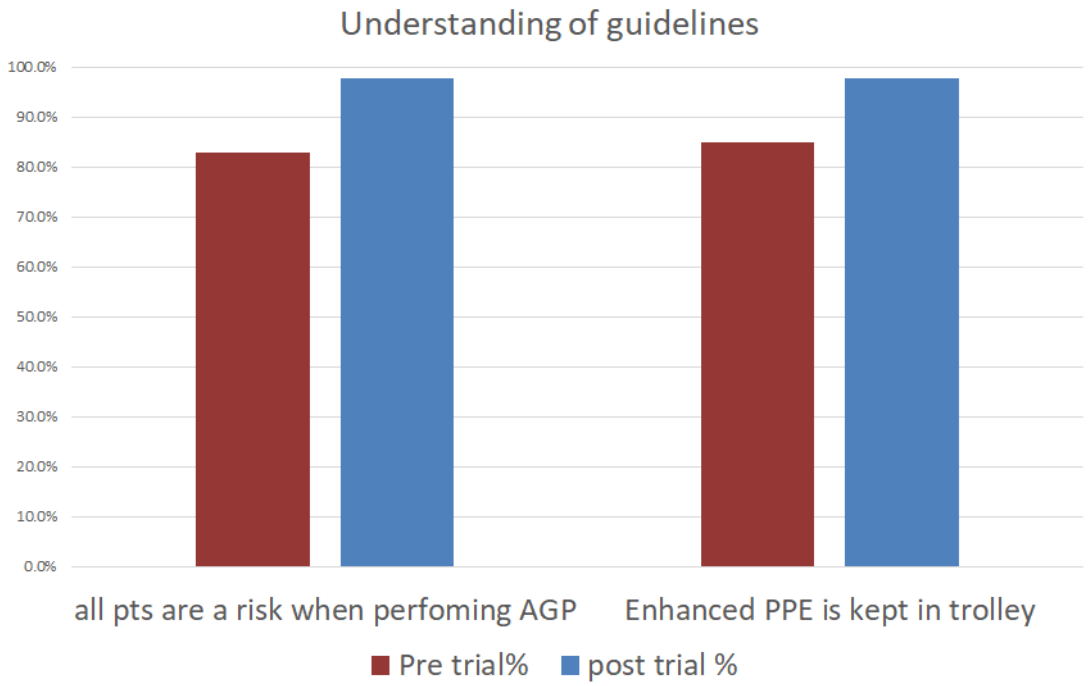


Figure 23



Improvements initiated following trial:

- A new pre-shift emergency plan allocation sheet (figure 20), to establish emergency response procedure, for each shift.
- Poster and first responder PPE kits for top of emergency trolley, to improve response time for responding to patients with correct PPE.
- Development and trial of floor stickers to remind staff of safe distance for emergency trolley, so as not to contaminate kit.
- Meetings with ward leaders/stakeholders to engage and gain buy in, using initial human factor findings for open discussion to enhance safety culture.

Planned quality improvements for 2022/2023:

Understanding response and to clinical deterioration:

We will be performing a human factors framework analysis of antecedent care preceding cardiac arrests, 2222 calls, cases of failure to rescue and inappropriate escalation of care/attempts at DNACPR. This work aims to identify key factors that influence the performance of observations, escalating, the use of structured communication and factors that influence TEP and DNACPR decision making, including communication barriers with patients and families.

Improved education:

We will be launching an inaugural training plan for new clinical support workers (CSWs). This education aims to provide CSWs with the requisite knowledge and skills in performing observations, recognising clinical deterioration, and escalating concerns effectively.

Escalation module and Hospital at Night

In alignment with the 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 handheld 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 the summer of 2022. This shall be monitored and tracked through both our Harm Free Care & Deteriorating patient collaborative groups.

2.5 Safeguarding Adults and Children

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

Safeguarding adults and children remains an integral priority of patient care within the Trust, and we continue to undertake our duties under the statutory frameworks of the Care Act (2014), Children's Act (1989 and 2004), Working Together to Safeguard Children (2018) and the Mental Capacity Act (2005)

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

Over the last year, the safeguarding team have taken pride in participating in various local and national campaigns across the Trust, and using social media to highlight the importance of safeguarding and that safeguarding is everyone's business. The following section identifies the activities and how we have worked together with our internal and external stakeholders:

- White Ribbon Campaign and 16 days of Action
    - Progress towards accreditation continues
    - 16 days of promotion for domestic abuse including staff awareness stalls, promoting the practice of recognition and response to domestic abuse for both staff and patients across Trust sites
    - Launch of the joint REFUGE and NHS Domestic abuse training package
- Modern Slavery Day held on 18 October 2021- an opportunity to raise awareness of the Trust strategy and a focus on homelessness and sexual exploitation
- Transitional Safeguarding - hospital youth worker project and voice of the young people

- Mental Health
    - Communication passports to support frequent attenders and transition
    - Care Education and Treatment Reviews to support collaborative working
    - Frequent attenders work and frequent attenders plans includes safeguarding risks
    - Hospital youth worker project
        - Funding extended
        - Development of QR codes to support signposting onto additional services
    - Mental health first aid training
    - Trauma informed care commissioned for unscheduled care settings
    - Tablet devices to support apps and surveys, access to youth programmes, referrals to Beacon for Trauma support
- Multi Agency Risk Assessment Conference (MARAC)– new process implemented to include community services in the MARAC
- Multi Agency Child Exploitation – sharing information for multi-agency risk assessment and safety plans
- Safer Sleep campaign – risk assessment tool, and review of resources available to reduce sudden unexpected death in infancy.
- The Myth of Invisible Fathers – in response to national panel report. Research project into the role of fathers/partners in children's lives
- Medical Neglect – in response to local learning the policy was re-launched with particular focus on 'Was not Brought' ; i.e. children or vulnerable adults who are not brought to hospital appointments as opposed to 'Did Not Attend' (DNA)
- Liberty Protection Safeguards – working group resumed in preparation for launch of national standards
- Independent Sexual Violence Advisor (ISVA) – successful bid and recruitment for a hospital based ISVA. New model developed and introduced successfully.
- Patient Initiated Follow Up (PIFU) - for Ear Nose Throat (ENT) introduced, with those vulnerable identified with clear pathways of care.
- Multi Agency Supervision pilot with Children's social services
- Midwifery and Health Visitor information sharing pathway.

Other team projects and highlights include:

- Safeguarding Champions relaunch – with a focus on visibility
- Frequent attenders – safeguarding representation
- Qlikview data for paediatric liaison service
- Daily learning visits – key areas Children's Emergency Department and Children's Assessment Unit
- Weekly adult Emergency Department training – for doctors and nurses

Activity:

- Supported 675 adults who experienced abuse in the community
- Included in the above number were 184 victims of domestic abuse with the majority of concerns raised to contacts with our Emergency Department.

- Processed and held accountability for 493 Deprivation of Liberty (DoLs) applications made on behalf of inpatients.
- 330 Child protection medical examinations undertaken (18% increase on previous reporting year)
- 677 known children referred to children's social care and 149 unborn babies were referred.

Safeguarding is most effectively delivered through strategic and organisational multi-agency arrangements with key partners working collaboratively to achieve a shared vision. The Trust safeguarding team, along with the Chief Nurse are key members of the Hertfordshire safeguarding boards and partnerships – with work this year looking at task and finish groups for sudden unexpected death in infancy, procedure updates, child protection medicals, consent for medical procedures and Children Looked After (CLA).

Strategies to recognise and respond to Modern Day slavery continue to be developed and implemented into everyday practice at ENHT. Work such as recognising homelessness as a risk factor, and sexual exploitation were a key focus, and on Modern Day Slavery day, work promoting this abhorrent crime reached over 150 staff. The successful appointment of a hospital based Independent Sexual Violence Advisor (ISVA), further strengthens the recognition and support we can provide to victims.

The Trust continues to demonstrate on-going commitment to safeguarding training ensuring all staff receive the required levels under guidance of the intercollegiate documents for children and adults (including FGM). The current safeguarding training is designed to ensure that every member of staff is aware of their safeguarding responsibilities, is able to recognise abuse and knows the response required to act upon the concern. The Safeguarding Training passport for level 3 safeguarding children continues to be embedded in practice, and the adult level 3 passport was launched, offering the same blended learning opportunities to safeguarding practice. Compliance for the uptake of all training modules is monitored via the Safeguarding Committee and reported on a quarterly basis. Due to the pandemic, fluctuations in compliance were seen and this remains a focus for 22/23.

We have continued to provide safeguarding supervision for designated staff groups, however this has been challenging due to the acuity and staffing pressures throughout the year. This is monitored at Joint Safeguarding Committee and continues to be a priority area of focus for 22/23.

Learning from case reviews continued with work around medical neglect, bruising, and professional curiosity. The Trust has continued to receive positive reviews from the Clinical Commissioning Group (CCG) in its annual adult assurance and children's compliance against section 11 of the Children's Act (2004) visit.

Ensuring reduction of harm of patients with known learning disability:

The care of individuals with a learning disability (LD) in the organisation is overseen by the Trust's safeguarding team and the Health Liaisons team who work in tandem with our clinical areas to support service users who have a learning disability during inpatient stays and outpatient service interactions.

The Health Liaisons team consists of learning disabilities nurses who offer specialist advice to clinical areas on the development of reasonable adjustments, which are individualised to meet the needs of each patient.

Our Learning Disability (LD) committee manages the Trust's LD strategy which is based on achieving improvement recommendations set out in 'NHS England's guidance on learning disability improvement standards for NHS trusts', June 2018.
Team projects and clinical highlights in 2021/22 relating to the care of individuals with LD include:

- Robust LD alert flagging system and virtual ward system remains in place.
- Members of the Health Liaisons team continue to support individuals with an LD during hospital stays and at outpatient appointments.
- The Health Liaisons team attend site safety meetings daily and appraise the wider team on actions to be taken relating to individuals with an LD to both improve patient experience and safety.
- Easy read appointment letters for individuals with an LD were introduced in the Trust during 2021.
- 89% of Trust staff have completed the Health Education England's eLearning module on learning disability awareness since its introduction in April 2021.
- The Trust remains active members of LeDeR review groups and improving health care outcomes group.
- The Trust's learning disability and autism policy has been reviewed in 2022 and includes both local and national learning from LeDeR reviews which will improve patient care in the future.
- We offer flexible visiting for inpatients with a learning disability and work in partnership with the carers/ family members of these individuals to enhance patient experience.

2.6 Venous Thromboembolism (VTE) Risk Assessment

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

The stage 1 risk assessment is completed on admission. The stage 2 reassessment is completed at consultant review or within 24 hours after admission and subsequent assessments are performed when the patients' clinical condition changes.

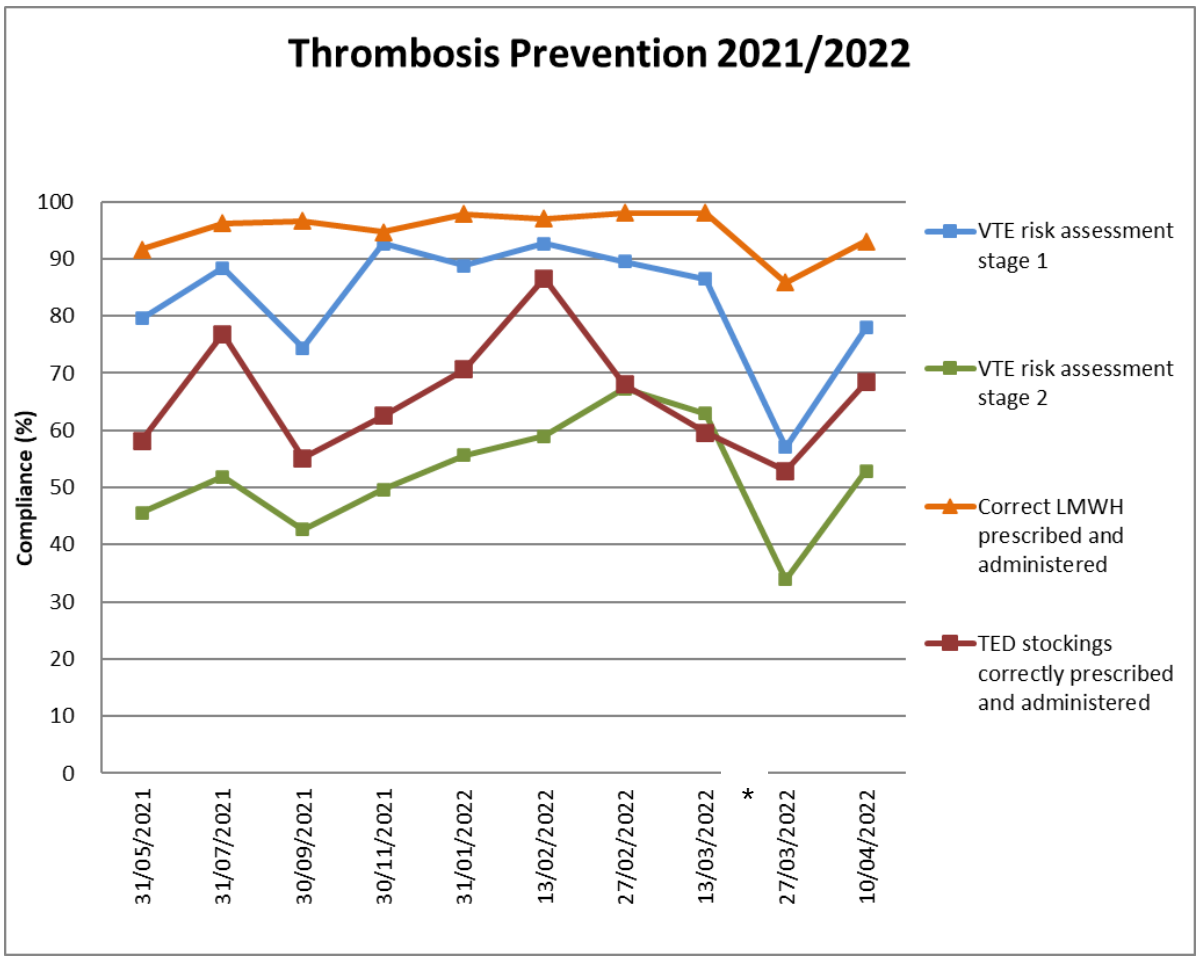
VTE risk assessments are audited regularly by the pharmacy team. The frequency of data collection changed from bi-monthly to alternate weeks at the end of January 2022. The audit is achieved through random sampling in real time in the patient setting, with regular reporting at ward and divisional meetings and at the Trusts Thrombosis Action Group which reports into Patient Safety Forum and subsequently into Quality and Safety Committee. The VTE data forms part of the Trust's quality report which is sent to the Clinical Commissioning Group (CCG), NHSEI and CQC. Results from the audits can be seen below.

Table 1: Aim and results for VTE compliance

	Aim	Mean achieved (April 21-March 22)
Improved compliance with VTE risk assessment stage 1 and stage 2	>95% compliance with stage 1 and stage 2 onwards	Stage 1: 83.5% Stage 2 onwards: 50.8%

The graph below demonstrates the Trust performance against the audit criteria throughout the year.

Figure 24: Audit data of clinical areas' compliance with VTE prevention 2021/2022.



The asterisks (*) on Figure 24 denotes the start of the implementation of ePMA, first full ePMA data set is 27/3/22.

At the beginning of the financial year 2021/22 we achieved 79.6% of stage 1 assessments and 45.6% for stage 2, this slowly increased until February 2022 when we achieved 89.5% for stage 1 and 67.3% for stage 2, however we didn't achieve the 95% target. The results for compliance against stage 1 and 2 assessments then declined in March 2022 due to the roll out of ePMA but have since started to climb again to 77.9% and 52.9% respectively. A similar trend is also seen with the correct prescribing of anti-coagulants such as LMWHs and use of mechanical thrombophylaxis with TEDs where results improved for the correct anti-coagulation prescription from 91.6% to 98% and stockings from 58.2% to 68% both of these also reduced in March 2022 but have started to climb again to 93.1 and 68.4% respectively as the processes are begin to embed into clinical practice.

Root Cause Analysis (RCA) investigations are undertaken when potential hospital associated thrombosis (HAT) cases are identified. There was one serious incident in August 2021 related to hospital acquired thrombosis.

Thematic learning identified from HAT cases has included:

- Importance of accurate documentation of weight to ensure the correct dose of chemical prophylaxis is prescribed.

- Poor documentation for recording if anti-embolism stockings (AES) are being worn and fitted correctly.
- As platelets improve chemical prophylaxis isn't always reviewed and restarted.
- Poor managed on bridging therapy with warfarin when INR is sub-therapeutic.
- Incorrect doses of anticoagulation in patient with acute kidney injury particularly with regards to increasing the dose back as renal function improves.

VTE remains a Trust priority and is a targeted area for improvement and a focus of the Harm Free Care Group and the Trusts Thrombosis Action Group. The aims of the VTE quality improvement work are;

- To reduce serious harm form Hospital Acquired Thrombosis by 50% from 4 per year to 2 by March 2023.
- VTE Risk assessment 1st and 2nd 85% by Dec 2021 and 95% by March 2023.
- TED stockings 85% by Dec 2021 and 95% by March 2023.
- LMWH administration shall be achieved and sustained at 95% by March 2023.

Since the quality improvement work began in July 2021 the following changes and improvements have been made:

- Reviewed and strengthened the VTE/HAT governance structure, this is in line with the Trust priority regarding VTE prevention.
- VTE training became essential training for relevant clinical staff, which is now monitored through ENH Academy and compliance reported at the Thrombosis Action Group meeting.
- VTE has been incorporated into the ward accreditation programme and has been a fundamental standard from August 2021. Wards must achieve the following standard for the initial assessment and the re-assessment for a ward to receive an award; Bronze 65-84.9%, Silver 85-89.9%, Gold 90-94.9%, Platinum > 95%. Since the indication the following wards have been issued accreditations; 10A have been awarded silver, AMU-2 and 11A have been awarded Gold.
- A transformation project was undertaken with support from the transformation team to review the HAT process to establish a more sustainable cycle that supports rapid review of HATs to support investigation and establish any potential harm and identify subsequent learning. This has led to a reduction in the number of outstanding HAT RCAs across the Trust.
- The successful appointment of a VTE lead practitioner.
- The Trusts VTE policy was reviewed, updated and relaunched.
- Increased frequency of data capture for the VTE audit to support the quality improvement project and identification of trends in data.
- Established regular clinical engagement to share VTE data, improvement work and learning from HATs.

The above changes were beginning to show some early signs of improvements in the VTE data as demonstrated in the graph above. In March 2022, the Trust rolled out ePMA which included VTE assessments. The roll out of ePMA was successful and when established will support improvements in VTE such as better documentation of assessments. The team will now focus on embedding the ePMA VTE processes into clinical practice and realising the benefits of a digital system.

Improvement priorities to ensure we meet our aims of > 95% of patients have a stage 1 and stage 2 VTE risk assessment by March 2023 include:

- Understand the impact of ePMA on VTE assessments and embedding the processes into clinical practice. For instance, the utilisation of the ePMA clinical indicator page to identify patients with outstanding VTE assessments.
- Review the VTE digital options appraisal at 3 months to identify the appropriate way forward
- Working with informatics and digital systems to support optimisation of managing thrombosis prevention in clinical areas, e.g. reviewing the possibility of digital Nervecentre flags to prompt VTE assessment completion and establish if retrospective data capture from Lorenzo ePMA is possible for audit purposes.
- Progression towards the appointment of a VTE consultant in 2022/2023 to support the improvement work through strengthened clinical leadership
- Continue to improve patient engagement and review VTE patient information.
- Continue to monitor training figures for VTE and report the results at the Thrombosis Action Group.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.

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	20/21	21/22	22/23
3.1	Improving discharge processes	Reduce number of discharge summaries not sent to GP within 24 hours of discharge	Stabilise	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	Meet all national standards	Meet all national standards	Meet all national standards
		Improve delivery of 7 days services	Agree trajectory and monitor implementation	Agree trajectory and monitor implementation	Agree trajectory and monitor implementation
		Reduce delays in ED 4 hour waiting time	>90%	>90%*	>90%*

*shadow monitor against the proposed new clinical standards for ED

3.1 Improving discharge processes

	Aim	2019/20	2020/21	2021/22
Reduce number of discharge summaries not sent to GP within 24 hours of discharge	90% reduction	28.49%	17.04%	24.52%
Patients discharged by midday	>15%	15.11%	13.14%	13.66%
Reduce proportion of beds occupied with length of stay > 14 days	<19%	4.85%	5.09%	6.02%

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. This has been created into Lorenzo DS bite size learning modules designed to inform doctors on how to complete a DS, including the quality of DS being completed.
- Review of templates standardising format, creation of nurse led summaries
- Daily monitoring through improved data
- Improvement to process, removing unnecessary steps in the discharge process.

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 2021/22.

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 for 2021/22 with actions reviewed from the previous internal audit 2020/21 for various team improvement, not only the reduction in the quantity of outstanding summaries but the quality of how they are written.

The overall assessment on adequate and effective governance, risk and control process shows reasonable assurance.

Whilst the number of outstanding discharge summaries may have reduced, the Trust should continue improvement by addressing the older discharge summaries pre December 2021.

The backlog for 2021/22 is now at 477. For unplanned care - 57 Medicine - validated, 253 Paeds/Bluebell - unvalidated, 167 validated for Planned Care. Please see the breakdown below.

This is a significant decrease in performance over the last year and is mainly due to depleted workforce and the return to 'normal' hospital working post Covid-19.

Overall figures for the Trust 21/22 excluding ED and deceased patients

Mid-day discharges

The number of patients arriving at the Emergency Department (ED) 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 patients through the department will be hindered. To maintain an effective and efficient flow of patients within the ED beds need to be made available on the wards to facilitate patient transfers.

Good planning to ensure medication, transport and discharge summaries 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 which supports a better patient experience. On average 13.66% of discharges occurred before midday which is a slight increase from last year.

metric	Apr 2021	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
% of discharges before midday	15.0%	15.1%	14.6%	13.8%	14.9%	16.5%	15.0%	15.2%	14.7%	14.1%	14.0%	14.8%

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 6.02 % of beds were occupied by patients where the length of stay was more than 14 days; a slight increase from the previous year.

Metric	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22

Proportion of beds occupied by patients with length of stay over 14 days	16.6%	15.9%	18.5%	19.5%	20.1%	20.1%	20.5%	22.4%	22.9%	22.8%	24.5%	22.9%
Proportion of beds occupied by patients with length of stay over 21 days	8.9%	8.1%	9.6%	9.9%	11.0%	9.8%	10.2%	12.7%	12.5%	12.8%	14.4%	13.0%

ENHT Discharge Programme

An expanded ENHT Discharge Improvement Programme has been established this year to address some of the broader challenges in relation to discharge.

The objective of the ENHT Discharge Improvement Programme is to create improvements in the efficiency of discharge, contributing to improved patient flow, through the creation and implementation of an ENHT discharge policy and processes with standardised, consistent ways of working that align to national guidance. It is key that:

- Every ENHT employee understands their value and contribution to discharge
- Patient outcomes and experience are improved
- Patient flow is optimised to make most efficient use of acute services

The main objectives of the programme are to:

- Support improved flow through hospitals
- Ensure patients do not stay in beds longer than they need to
- Support safe care
- Reduce levels of bed occupancy
- Improve urgent and emergency care pressures
- Contribute to elective care recovery

There are 4 work streams within the Programme:

- **Work stream 1:** Foundations – define and implement the basic administrative and digital processes.
- **Work stream 2:** Ward Processes – Introduce standardised procedures through Trust SOPs which will facilitate and support earlier decision making and empowering teams to make good decisions on discharge
- **Work stream 3**: Interdependent processes – Identify the interdependent services critical to discharge flow and ensure alignment of these to the discharge policy.

- **Work stream 4**: Complex Discharges – work with system partners on those discharges which are more complex, working with partners to influence improvement

The ENHT Discharge Improvement Programme has set the following Key Performance Indicators (KPIs) for 2022/23:

- Proportion of discharges before midday – target 30% (excluding day cases, maternity & paediatrics)
- Proportion of discharges before 3pm – target 60% (excluding day cases, maternity & paediatrics)
- Proportion of discharges before 5pm – target 80% (excluding day cases, maternity & paediatrics)

3.2 Improve access

	Aim	21/22 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%)	72.78%

Improve cancer performance

Cancer performance was sustained over the course of 2021/22. The 62-day cancer target was achieved for all months, except for January 2022 and March 2022 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 two week wait for suspected cancer, the 31-day subsequent Anti-cancer drugs and 31-day subsequent treatment (radiotherapy) standards in every month of 2021/22. Also for the breast symptomatic and 31 day first treatment the Trust has achieved the standards 10 out of 12 months.

The Trust did not comply with the new faster diagnosis standard for 2021/22 on confirming or ruling out diagnosis within 28 days, which was achieved 6 out of 12 months.

Improve delivery of 7-day services

The Trust continues to work towards delivering the national 7-day standards. A consultation with staff involved in providing the consultant general internal medicine rota is planned for summer 2022 when an increase in capacity and hours covered is proposed. The aim is to improve continuity of consultant led review of patients admitted overnight and to ensure all inpatient specialties attend weekday morning handover. A further assessment against the four main standards will be undertaken following the consultation.

An assessment against the four main standards is shown below:

Standard	Requirement	2019/20	2020/21	2021/22	Comment
2	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission	Not met	Partly met	Partly met	Full 7-day consultant input not yet delivered on all wards
5	Inpatients must have scheduled 7-day access to diagnostic services	Met	Met	Met	
6	Inpatients must have timely 24-hour access to key consultant-directed interventions	Met	Met	Met	Interventional radiology is provided on an ad hoc basis
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	Not Met	Partly met	Partly met	Full 7-day consultant input not yet delivered on all wards

Reduce delays in Emergency Department 4 hour waiting time

The Emergency Department (ED) has seen a significant increase in the length of stay in the department. This is due to a combination of reasons which the Trust is working hard to address with system partners. Adult emergency activity has returned to and exceeded pre-pandemic levels. This has been replicated nationally with an increase of 28.5% of ED attendances on March 2021 and an increase of 2.1% in emergency admissions.

During the Covid-19 pandemic there was a change in patient behaviours and access to other services. There has been an increase in communication reminding the public about pharmacy support, GP appointments, NHS111 and the Urgent Treatment Centre option. Average length of stay (LOS) in the department for admitted patients has increased due to the current bed pressures, including a high level of patients who do not meet the criteria to reside within the Trust. Due to the increased length of stay of patients within the emergency department, there has been an increase of patients discharged from ED that would ordinarily have been discharged from an assessment ward, impacting on non-admitted performance and Trust activity. Mental health is also a significant contributory factor to the increased length of stay.

This therefore results in a deterioration in the Trust performance against the 4 hour standard. Other factors have been the complex pathways due to Covid-19 e.g. swabbing of patients and time for results, red / yellow segregation of patients and risk assessment of staff which resulted in some staff being able to flex between areas, impact on community provision for ongoing care needs and the capital build work.

Figure 25

Trust performance ED 4 hour standard

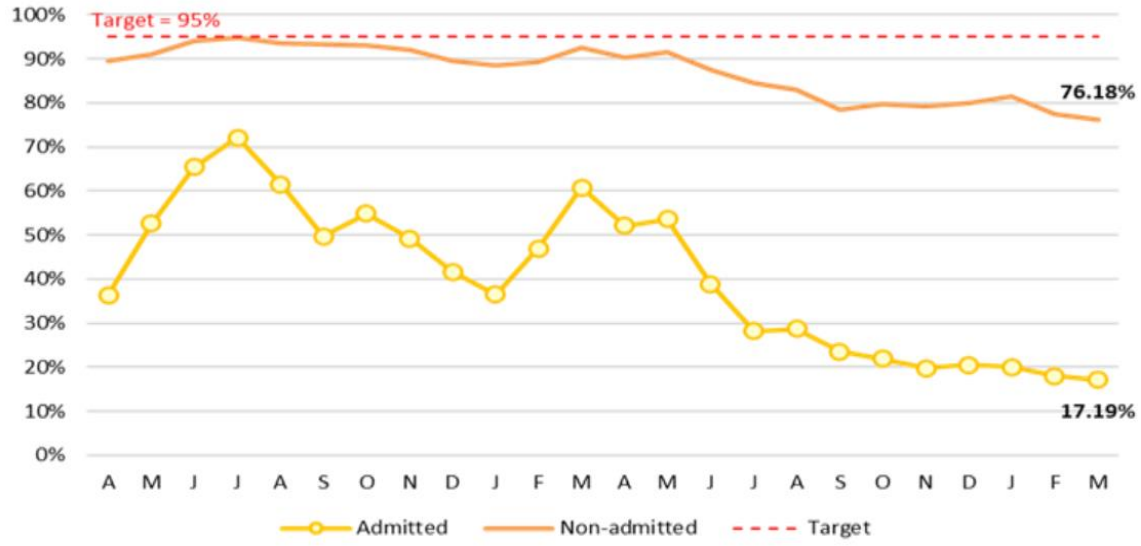
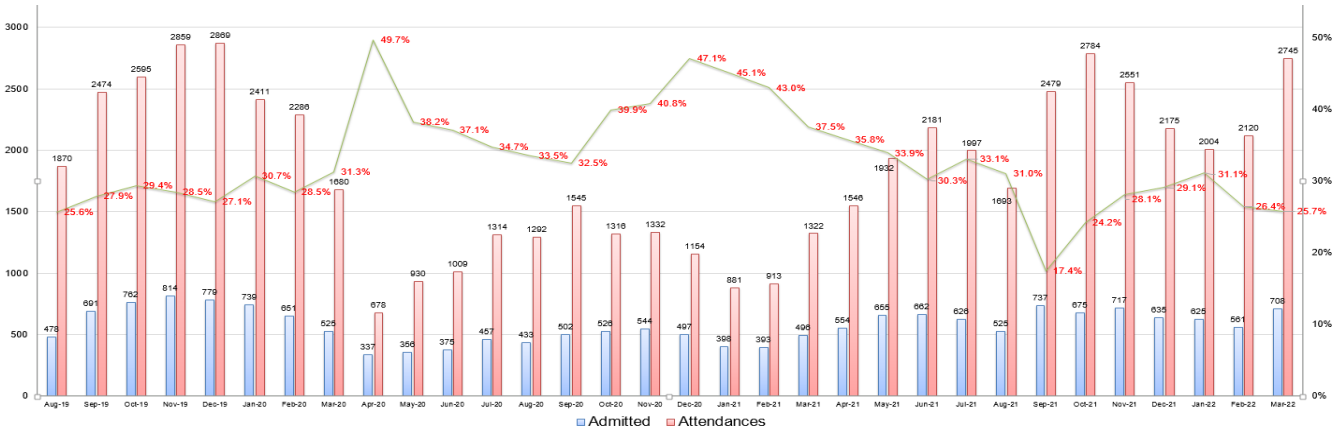


Figure 26

Attendance and Admission Trends in Children's ED: 2019 – 2022

The data below reflects activity in paediatrics compared to pre Covid-19 levels:

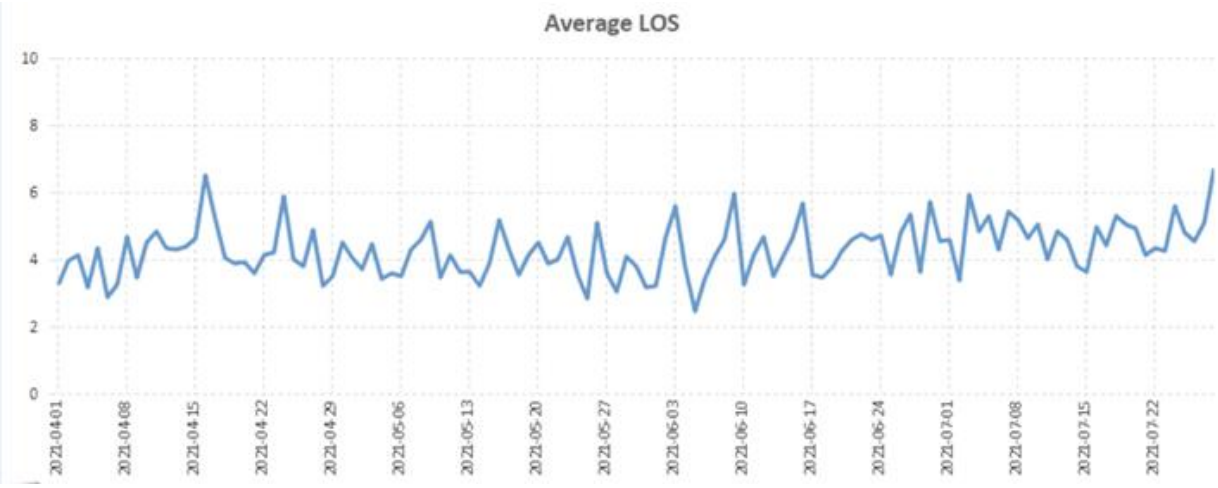


Length of Stay (LOS) emergency

The length of stay has remained fairly constant throughout the year with an average LOS of 4.73 days. Work is ongoing to review and benchmark against the HRGs and work with the ICS partners on prevention of admission, criteria to admit and hospital at home to facilitate earlier discharge and less demand on inpatient beds.

Figure 27

Average Length of Stay (LOS)



Priority four: Patient and 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	20/21 (%)	21/22 (%)	Aim: 22/23
4.1	Patient feedback	Maintain Friends and Family Test scores (average) for inpatients, out-patients, maternity (birth) and emergency department	IP 95.84 OP 97.57 Mat 96.47 ED 94.58	IP 96.69 OP 95.52 Mat 95.90 ED 85.98	IP >95% OP >95% Mat >93% ED >90%
4.2	PALS Responsive ness (new and replaces always events)	PALS response closed within 5 days	79.2%	70.0%	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.	Demonstrable involvement of patients and carers	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	Launch	1945 virtual Visits 2322 messages 2447 photos	Continue to monitor the uptake of this service and ensure if it is accessible to all who require it.

Indicator	Measure	2021/22	Trust previous result 2020/21
Maintain Friends and Family Test scores >90% (average) for inpatients, out-patients, maternity (birth) and emergency department	Patients	IP 96.69% OP 95.52% Mat 95.90% ED 85.98%	IP 95.84% OP 97.57% Mat 96.47% ED 94.58%

*Maternity indicator is a measure relating to birth experiences only

4.1 Patient feedback

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 (>90%) was achieved in all of the survey areas apart from the Emergency Department (ED).

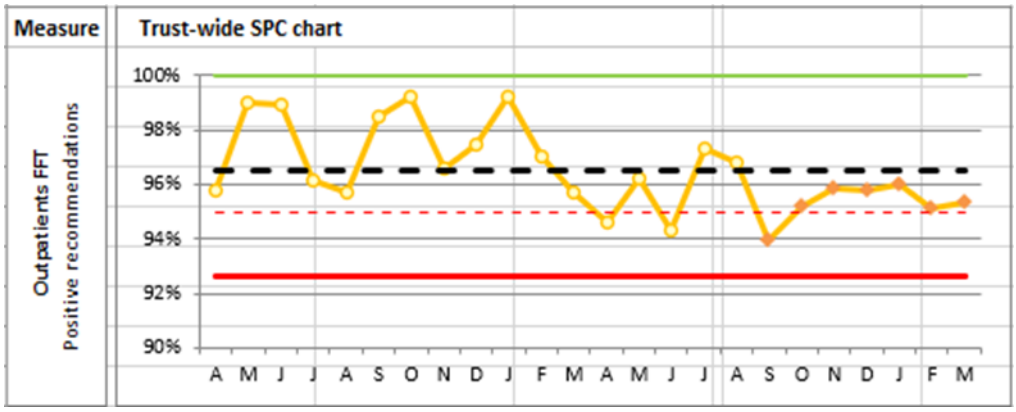
The comments from inpatient/day case patients were mostly positive with patients feeling they were treated with respect and dignity and were given information they could understand. They found staff to be friendly, caring and knowledgeable. Negative comments continue to relate to the environment, food standards and menu choice, noise at night and patients saying they thought there was not always enough staff.

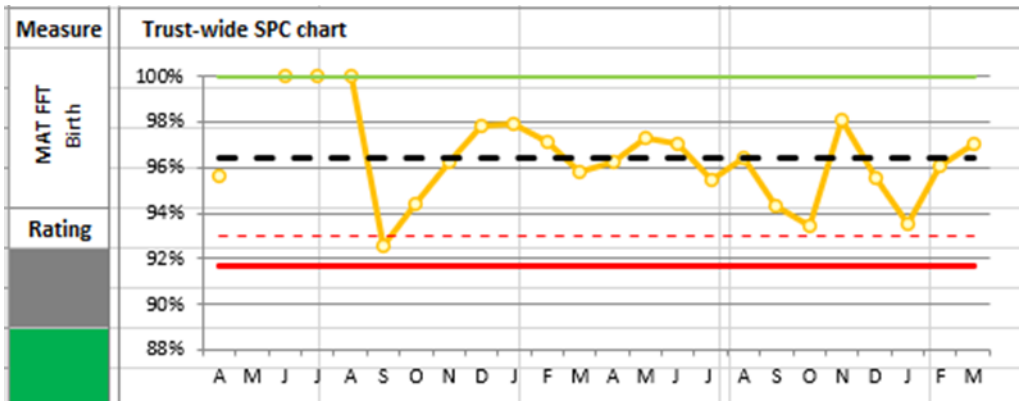
Positive feedback far outweighed the negative comments from patients attending the outpatient department. These included positive comments about the cleanliness of the areas and praise for staff for being kind, helpful and polite. Information about treatment and reasons for it were clear and well explained. Negative feedback concerned waiting times and patients having to wait long past the appointments given. The cost of car parking continues to be frequently mentioned.

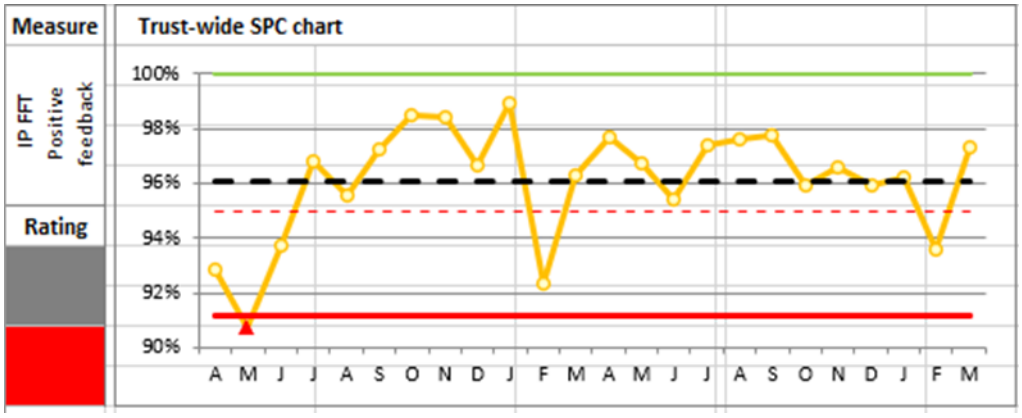
Women were generally positive about their birthing and postnatal experience in the maternity unit, and of the care they received from community midwives. Feedback was given about staff being calm, supportive and reassuring. Many women commented positively about the help and support received from staff with feeding their baby. However, some women found the wards too busy with not enough staff to provide the attention they felt they needed. Women often commented that they would have liked their husband/partner to be able to stay for longer and to have comfortable chairs whilst there.

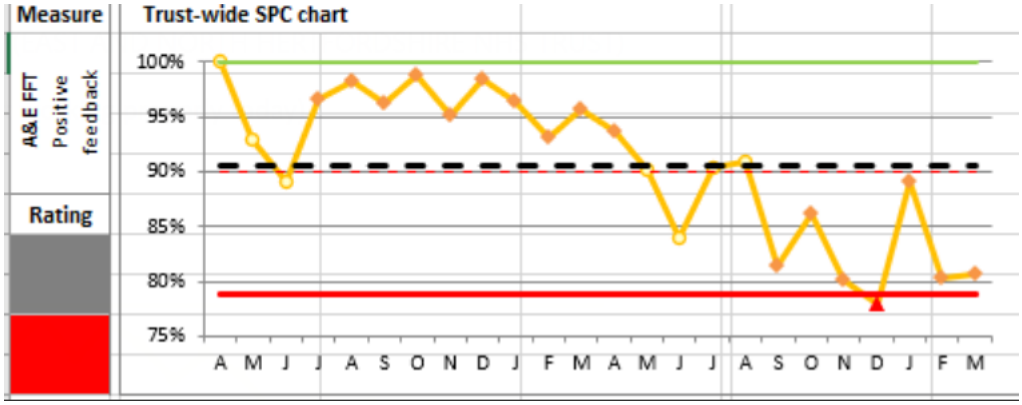
Patients in ED gave mainly positive feedback in relation to staff who were caring and supportive. The communication from staff was also good, particularly with clear explanations regarding treatment. Negative feedback included length of waiting times, the area being crowded with not enough seating, and the lack of refreshments available.

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 charts below.


Measure
Trust-wide SPC chart
Outpatients FFT Positive recommendations
100%
98%
96%
94%
92%
90%
A M J J A S O N D J F M A M J J A S O N D J F M


Measure
Trust-wide SPC chart
MAT FFT Birth
Rating
100%
98%
96%
94%
92%
90%
88%
A M J J A S O N D J F M A M J J A S O N D J F M


Measure
Trust-wide SPC chart
IP FFT Positive feedback
Rating
100%
98%
96%
94%
92%
90%
A M J J A S O N D J F M A M J J A S O N D J F M


Measure
Trust-wide SPC chart
A&E FFT Positive feedback
Rating
100%
95%
90%
85%
80%
75%
A M J J A S O N D J F M A M J J A S O N D J F M

	2019-20	2020-21	2021-22	Aim
Inpatient / Day Case FFT response rate	43.73%	23.34%	23.21%	40%
Maternity response rate (birth)	25.14%	17.71%	12.61%	30%
Emergency department response rate	3.67%	5.75%	0.95%	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.

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 (due to Covid-19 pandemic)

A Trust wide involvement register is being developed to ensure a diverse range of service users and carers are invited to work with the Trust in sharing their experiences and knowledge to develop and improve the services we provide.

A co-production shared decision making council is being set up. The Council plans to measure the number of projects and programmes that involve service users as part of the project delivery group.

The ‘keeping in touch’ team have worked relentlessly over the last year to provide families and friends the opportunity to virtual visit and send messages and pictures to their loved ones during Covid-19 when visiting has been restricted. In the last year 1945 virtual calls have been facilitated in 26 clinical areas with global reach to 18 countries outside of England. The team also delivered 2322 messages and 2447 photos to patients from families and friends.

Volunteer’s services have continued to support patients across the hospital during this year, with 101 registered response volunteers. During this time there have been many roles that the response volunteers have been involved in such as:

- Befriending services
- Assisting contacting loved ones
- Mealtime help
- Restocking supplies
- Pharmacy and laboratory runs

The response volunteers have also supported in delivering the Staying in Touch letters to patients and have provided continuous interaction with patients during the last year by taking out the activity trollies around the wards. Volunteers will approach each patient asking if they would be interested in participating with some of the activities that we provide such colouring, crosswords, Sudokus or word searches. There are also creative activities such as making greetings cards from one of our specially made kits, or simply enjoying some company and a chat.

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. From March 2021 the PACE team have been visiting the inpatient wards and asking the WMTY question.

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 2022 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 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 27 relevant health services. The ENHT has reviewed all the data available to them on the quality of care in 27 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

During 2021/22 there were 57 national clinical audits and 7 national confidential enquiries covering relevant health services that ENHT provides.

During that period ENHT participated in 96% of the national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

The two tables below show:

- The National Clinical Audits and National Confidential Enquiries that ENHT was eligible to participate in during 2021/22
- The National Clinical Audits and National Confidential Enquiries that ENHT participated in during 2021/22, and for which data collection was completed during 2021/22, 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.

National Clinical Audits Project Name	**Participated**	**% Cases Submitted by March 22**
Case Mix Programme (CMP)	Yes	Continuous data collection
Chronic Kidney Disease Registry	Yes	Continuous data collection
Elective Surgery (National PROMs Programme)	No	
Emergency Medicine QIPs - Pain in Children (Care in emergency departments)	Yes	22 cases
Falls and Fragility Fracture Audit Programme (FFFAP) - National Audit of Inpatient Falls	Yes	Continuous data collection
Falls and Fragility Fracture Audit Programme (FFFAP) - National Hip Fracture Database (NHFD)	Yes	Continuous data collection
Inflammatory Bowel Disease (IBD) Audit - Biological Therapies Audit	Yes	Continuous data collection

LeDeR - Learning Disabilities Mortality Review collection	Yes	Continuous data collection
National Adult Diabetes Audit (NDA) - National Core Diabetes Audit	Yes	Continuous data collection
National Adult Diabetes Audit (NDA) - National Diabetes Foot Care Audit	Yes	Continuous data collection
National Adult Diabetes Audit (NDA) - National Diabetes in Pregnancy Audit	Yes	Continuous data collection
National Adult Diabetes Audit (NDA) - National Diabetes Inpatient Audit Harms (NaDIA-Harms)	Yes	Continuous data collection
National Asthma and COPD Audit Programme (NACAP) - Adult asthma secondary care	Yes	Continuous data collection
National Asthma and COPD Audit Programme (NACAP) - Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	Yes	Continuous data collection
National Asthma and COPD Audit Programme (NACAP) - Paediatric - Children and young people asthma secondary care	No	
National Audit of Breast Cancer in Older People (NABCOP)	TBC	Continuous data collection
National Audit of Cardiac Rehabilitation	Yes	Continuous data collection
National Audit of Care at the End of Life (NACEL)	Yes	40 cases
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) - Clinical Audit	Yes	Continuous data collection
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) - Organisational Audit	Yes	Continuous data collection
National Cardiac Arrest Audit (NCAA)	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management Devices and Ablation	TBC	Continuous data collection
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	TBC	Continuous data collection

National Comparative Audit of Blood Transfusion - Audit of Blood Transfusion against NICE Guidelines	Yes	Continuous data collection
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Continuous data collection
National Emergency Laparotomy Audit (NELA)	Yes	Continuous data collection
National Gastro-intestinal Cancer Audit Programme (GICAP) - National Bowel Cancer Audit (NBOCA)	Yes	Continuous data collection
National Gastro-intestinal Cancer Audit Programme (GICAP) - National Oesophago-Gastric Cancer Audit (NOGCA)	Yes	Continuous data collection
National Joint Registry - Ankle replacement	Yes	Continuous data collection
National Joint Registry - Elbow replacement	Yes	Continuous data collection
National Joint Registry - Hip replacement	Yes	Continuous data collection
National Joint Registry - Hospital performance	Yes	Continuous data collection
National Joint Registry - Implant performance	Yes	Continuous data collection
National Joint Registry - Knee replacement	Yes	Continuous data collection
National Joint Registry - Shoulder replacement	Yes	Continuous data collection
National Joint Registry - Surgeon performance	Yes	Continuous data collection
National Lung Cancer Audit Programme	Yes	Continuous data collection
National Maternity and Perinatal Audit (NMPA)	Yes	Continuous data collection
National Neonatal Audit Programme (NNAP)	Yes	Continuous data collection
National Paediatric Diabetes Audit (NPDA)	Yes	Continuous data collection
National Perinatal Mortality Review Tool	Yes	Continuous data collection

National Prostate Cancer Audit (NPCA)	Yes	Continuous data collection
National Vascular Registry - Carotid Endarterectomy	Yes	Continuous data collection
National Vascular Registry - Elective AAA Repair	Yes	Continuous data collection
National Vascular Registry - Lower Limb Angioplasty/Stent	Yes	Continuous data collection
National Vascular Registry - Lower Limb Bypass	Yes	Continuous data collection
National Vascular Registry - Lower Limb Major Amputation	Yes	Continuous data collection
Respiratory Audits - National Outpatient Management of Pulmonary Embolisms Audit	Yes	100%
Respiratory Audits - National Smoking Cessation Audit	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP	Yes	Continuous data collection
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes	Continuous data collection
Society for Acute Medicine Benchmarking Audit	Yes	100%
Transurethral Resection and Single instillation intra-vesical chemotherapy Evaluation in bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.	Yes	TBC
Trauma Audit & Research Network	Yes	Continuous data collection
Urology Audits - Management of the Lower Ureter in Nephroureterectomy Audit	Yes	Continuous data collection

National Confidential Enquiries Project Name	**Participated**	**% Cases submitted**
Child Health Clinical Outcome Review Programme - Transition from child to adult health services (NCEPOD)	Yes	7 (70%) 3 in progress
MBRRACE Maternal mortality surveillance and confidential enquiry (Maternal, Newborn and Infant Clinical Outcome Review Programme)	Yes	Continuous data collection
MBRRACE Perinatal confidential enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	Yes	TBC
MBRRACE Perinatal mortality surveillance (Maternal, Newborn and Infant Clinical Outcome Review Programme)	Yes	Continuous data collection

Medical and Surgical Clinical Outcome Review Programme - Crohns disease (NCEPOD)	Yes	No audit cases received as yet
Medical and Surgical Clinical Outcome Review Programme- Epilepsy study (NCEPOD)	Yes	6 (100%)
NCEPOD - Alcohol Related Liver Disease (Organisational) (Medical and Surgical Clinical Outcome Review Programme)	Yes	1 (100%)

The reports of national and local clinical audits were reviewed by the provider in 2021/22 and ENHT has outlined intended actions to improve the quality of healthcare provided in Annex 2.

Research and development

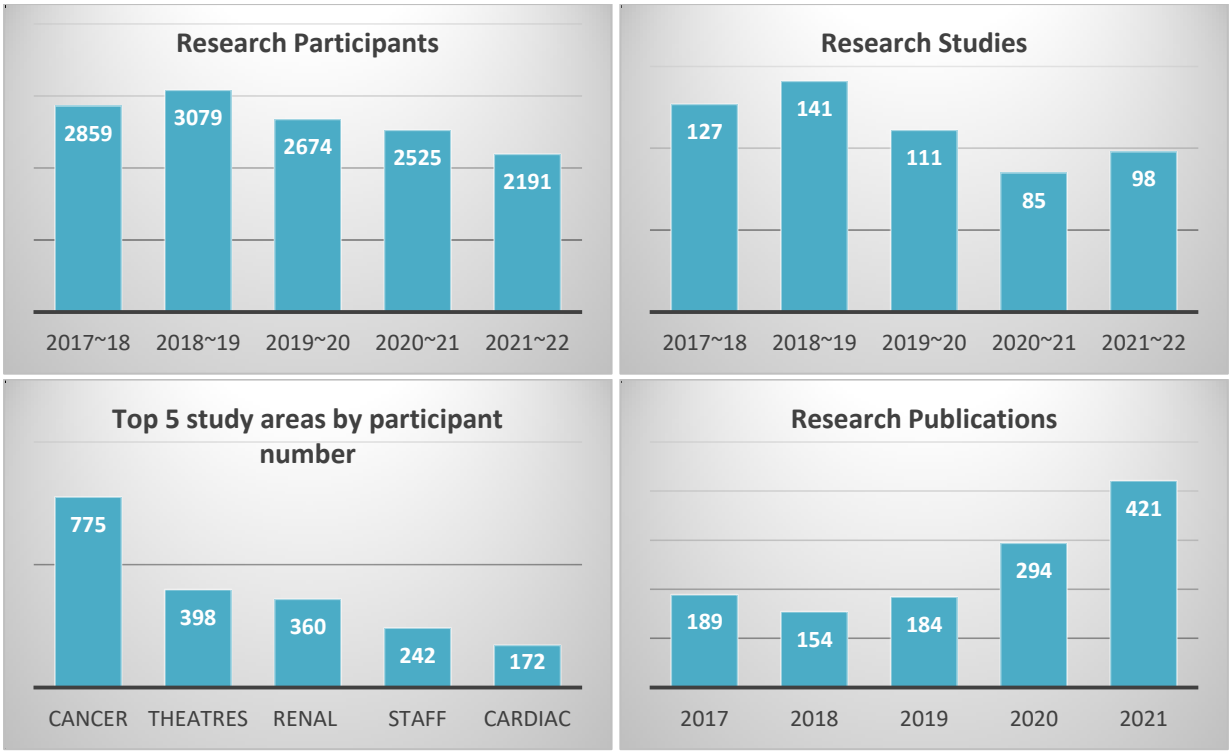
In 2021/22 2350 patients were recruited to participate in research at ENHT. All research at ENHT is approved by a designated NHS research ethics committee. These 2350 patients received relevant research-related health services, provided by or sub-contracted by ENHT during 2021/22

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 and 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 and Care Research (NIHR) which has a national vision ***"to improve the health and wealth of the nation through research***".

The research activity in 2021/22 relating to studies adopted to the NIHR Portfolio can be summarised in the graphs below (please note that this is less than the total research activity as not all research studies are adopted). The number of studies we could open and the number of participants taking part in research was less than recent years due to the impact of Covid-19. The top 5 areas of highest research activity are shown below with cancer having the greatest number of participants (775). It is worth noting the increase in research publications over the last two years and to acknowledge that 42 of these in 2020 were jointly written with the University of Hertfordshire – a great sign of partnership working.



Helping address the Covid-19 challenge

Covid-19 research at the Trust has directly led to treatment innovations, such as GenoMICC, a large UK-wide study examining genetic susceptibility in critical care patients with Covid-19. GenoMICC has now found 23 genetic associations and identified a causal role for coagulation factors and platelet activation in critical Covid-19, providing answers for why some people with Covid-19 suffer blood clots. We have also innovated by developing new studies around treating hearing loss as a result of Covid-19.

In addition to research directly on Covid-19, we also created novel approaches to dealing with the Covid-19 related backlog of patients requiring treatment. DELTA - integrate**D** diagnostic solution for **E**ar**L**y de**T**ection of oesophageal c**A**ncer is a project s based on the use of the innovative Cytosponge approach - a '*Sponge on a string'* test that samples cells from the oesophagus without the need for gastroscopy. The use of Cytosponge can help with early detection and treatment of oesophageal cancer with improved health outcomes and cost savings. It also offers a much quicker and patient-friendly approach when compared to gastroscopy (a tube into the stomach and previous standard of care). This benefits patients in terms of their experience and health outcome around oesophageal adenocarcinoma (OAC) diagnostics, as it can be nurse-led, is quick to do (which means cost-savings as fewer expensive gastroscopies are performed), and backlogs can be quickly cleared.

Public involvement and research participation

Our Patient and Public Involvement in Research Panel have continued to meet online three times a year since the start of the pandemic and will resume in-person meetings in May this year. This group of around 15 patient and public members have provided input into a range of Trust-sponsored research, and also received training about ongoing research (including both methodology and scientific training) that encompasses a range of Covid-19 and non-

Covid studies at ENHT. We have shared our research activity across a range of fora within and outside the Trust to foster engagement.

We were also delighted to welcome the former CEO of the Health Research Authority, Teresa Allen, to join our Research and Development Board as a public representative; she brings a wealth of experience and provides a public voice to contribute to our activities.

Results from our 2021/22 Participant in Research Experience (national) Survey (PRES), continue to demonstrate that patients had a good or very good experience taking part in research, with 107/135 reporting positive experiences. The main areas for improvement related to; provision of blood test results and information, more information about the study (especially for Covid-19 studies) during participation and after, and less repetition of asking for the same the information.

Examples of qualitative feedback from research participants:

- I was hopeful that the trial would give me time and keep me as fit as possible to enjoy the things that matter to me. I felt I was contributing to the advancement of treatment for the disease. The team were always polite, helpful and supportive. Can't fault the care
- Dedicated, professional research nurse X. Always courteous and contactable. Research staff have kept me informed of process thoroughly. During COVID 19 I have felt well looked after and safe
- Throughout my research experience I felt valued and cared for. The staff were very courteous and welcoming and I felt relaxed and informed when tests were taking place. Contact has been maintained between myself and the staff and I have been happy to contribute.
- The blood samples are taken at the same time I am in hospital receiving my Infliximab infusion so its convenient and doesn't take up any extra time. The surveys I complete are well written and designed and don't take too long to complete. All in all, a very easy study to take part in.
- X has always been kind and professional especially as part of the experience was during COVID. Her manner is lovely and communicates well. All COVID precautions have been kept. Telephone prior to appointments to ensure I feel ok to attend
- I was always treated with kindness and respect. Have nothing but respect for everyone involved with my care and treatment.

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 2021/22 as they were nationally suspended due to the pandemic.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is '**requires improvement**'. We are rated as '**good'** for caring and effectiveness and '**requires improvement'** for safe, responsiveness and well led. We are rated as '**requires improvement'** for use of resources.

The Trust is not fully compliant with the registration requirements of the Care Quality Commission. The CQC has not taken enforcement action against the Trust during 2021/22. The following conditions remain on the Trust's registration following the 2019 Inspection:

- 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

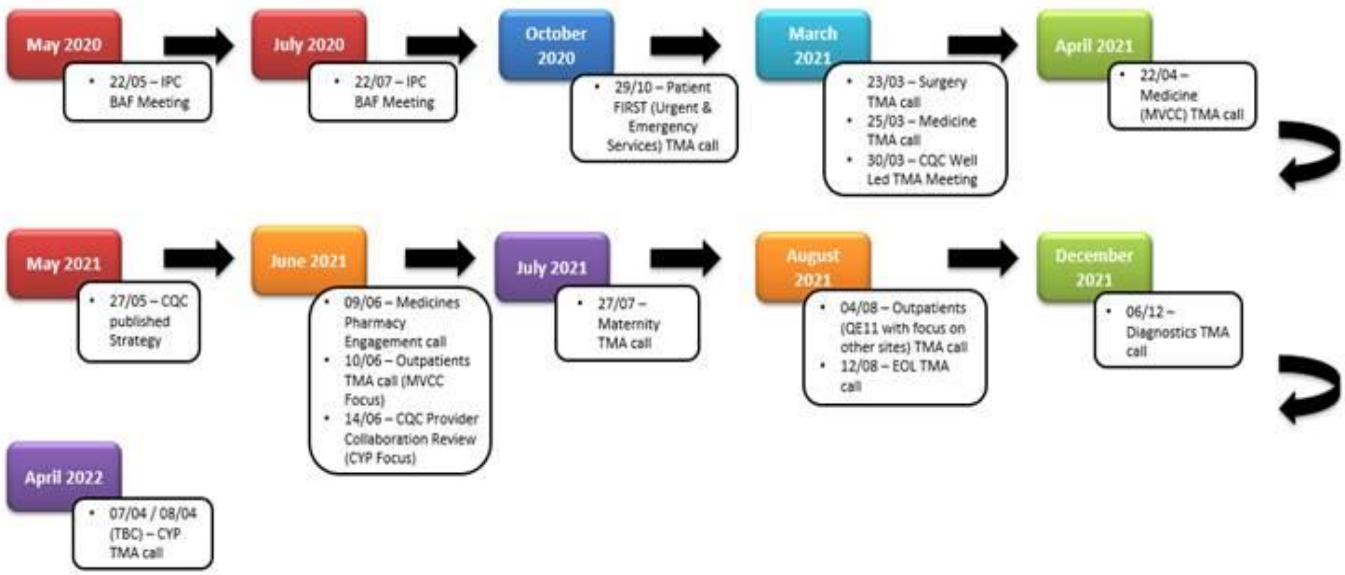
The Trust has participated in special reviews or investigations by the CQC during 2021/22 relating to the following areas; the system wide Children and Young People Provider Collaborative Review and a speciality investigation which was closed without any action following CQC's review of the Trust's information.

Since the last inspection undertaken by the Care Quality Commission in 2019, the Trust has not received an on-site inspection. During the COVID-19 pandemic, the CQC changed and evolved their approach to regulating. This new approach has ensured the CQC has had oversight of our Trust and services. The Direct Monitoring Approach focused on safety, how effectively a service is led and how easily people can access the service.

In 2021/2022 the CQC held the following virtual reviews:

- Under the Transition Monitoring Approach:
  - Medicine Core Service (MVCC), April 2021
  - Outpatients Core Service (MVCC), June 2021
  - Maternity Core Service (Lister), July 2021
  - Outpatients Core Service (Lister and QEII), August 2021
  - End of Life Core Service, August 2021

Transitional Monitoring Approach Timeline:



All the reviews were positively received, and no follow up information was requested.

To support these reviews with the Care Quality Commission each core service developed a gap analysis against the streamlined key lines of enquiry, including any gaps and mitigating actions.

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.

During 2021/22 we continued to adapt our compliance framework. This has five compliance pillars which are: Intelligence Monitoring, Communication & Engagement, Departmental Visit Programme, Proactive and Not Reactive. We have continued a streamlined programme of audits and reviews to support monitoring of compliance against standards, including retesting our previous actions from inspection. In April 2021 we formally recommenced our internal unannounced inspections to the clinical areas. These are held jointly with our Clinical Commissioning Group (CCG). In addition, the pathways to excellence programme support providing assurance on the continued progress against the fundamental standards in ward areas.

Data quality

East and North Hertfordshire NHS Trust submitted records during 2021/22 to the Secondary User Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The tables below provide an update of how the Trust has performed against a few of the data items presented in the data quality reports.

Reporting Period - April 2021 to February 2022 (up to Month 11) - extracted on the 17 March 2022, published 5 April 2022.

The information is intended to support data quality improvements by organisations delivering NHS services.

	Valid NHS Number	Valid General Medical Practice Code
Admitted patient care	99.9%	98.9%
Out-patient care	99.9%	100%

Patient Pathway	Provider % Valid	Region % Valid	National % Valid
Admitted patient care	54.6%	59.7%	68.5%
Outpatient care	47.7%	58.6%	67.0%

Ethnic Category	Provider % Valid	Region % Valid	National % Valid
Admitted patient care	95.3%	94.6%	95.4%
Outpatient care	90.4%	92.8%	93.3%

During the year 21/22:

The data quality (DQ) team have undertaken several on-going data quality improvement related programmes across the Trust to progress and improve patient experience, service delivery and patient flow, including accuracy of data recording.

The DQ team have worked on the following during this year:

- Continued to promote awareness of the importance of Data Quality (DQ) and set out expectations of staff responsibility, provide training and support.
- The monthly Data Quality Steering Group meetings were reinstated with attendance from all the divisions, supplemented with bi-weekly DQ surgeries.
- Published data quality training modules on the Trust's ENH Academy
- During the summer, the Ethnicity Dashboard was developed and is monitored at the Divisional Performance Review Meetings.
- Following the dashboard, the Ethnicity Leaflet was developed and distributed to all outpatient areas.

- Managed the recording of all insourcing / outsourcing.
- Led on correcting the data recording of the Trust's pre-operative assessment clinics.
- Set up a Trust wide Super User Group focussing on training and correction.
- Launched the Trust's Data Quality Dashboard- Phase 1.
- Started the monthly DQ Audits, which are presented to the Trusts' Audit Committee.

The DQ team will be taking the following actions to improve data quality across the Trust.

Plans for 22/23:

- Develop a suite of online training 5minute courses on the most common DQ corrections for ENHT Academy
- Running bi-weekly meetings inviting the services to manage their performance against the DQ Dashboard, ensuring accurate and appropriate recording of activity
- Floorwalking outpatient clinics to ensure key demographics i.e. Ethnicity are captured for Population Health Management
- Developing Phase 2 of the Trust's Data Quality Dashboard
- Continue the development of the monthly DQ Audits with a report / application on QlikView.
- Review the Trust's Data Quality Strategy and Policy by July 2022.

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.

The Trust declared a fully compliant 'standards met' position of the Data Security and Protection Toolkit 2020/ 2021 in June 2021. This was audited by the Internal Auditor and rated as 'substantial' assurance.

Progress with completion of the DSPT for 2021/22 is underway to meet the June 2022 submission and is monitored at the Trust's Information Governance Steering Group meetings which are held quarterly.

During 2021/22 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

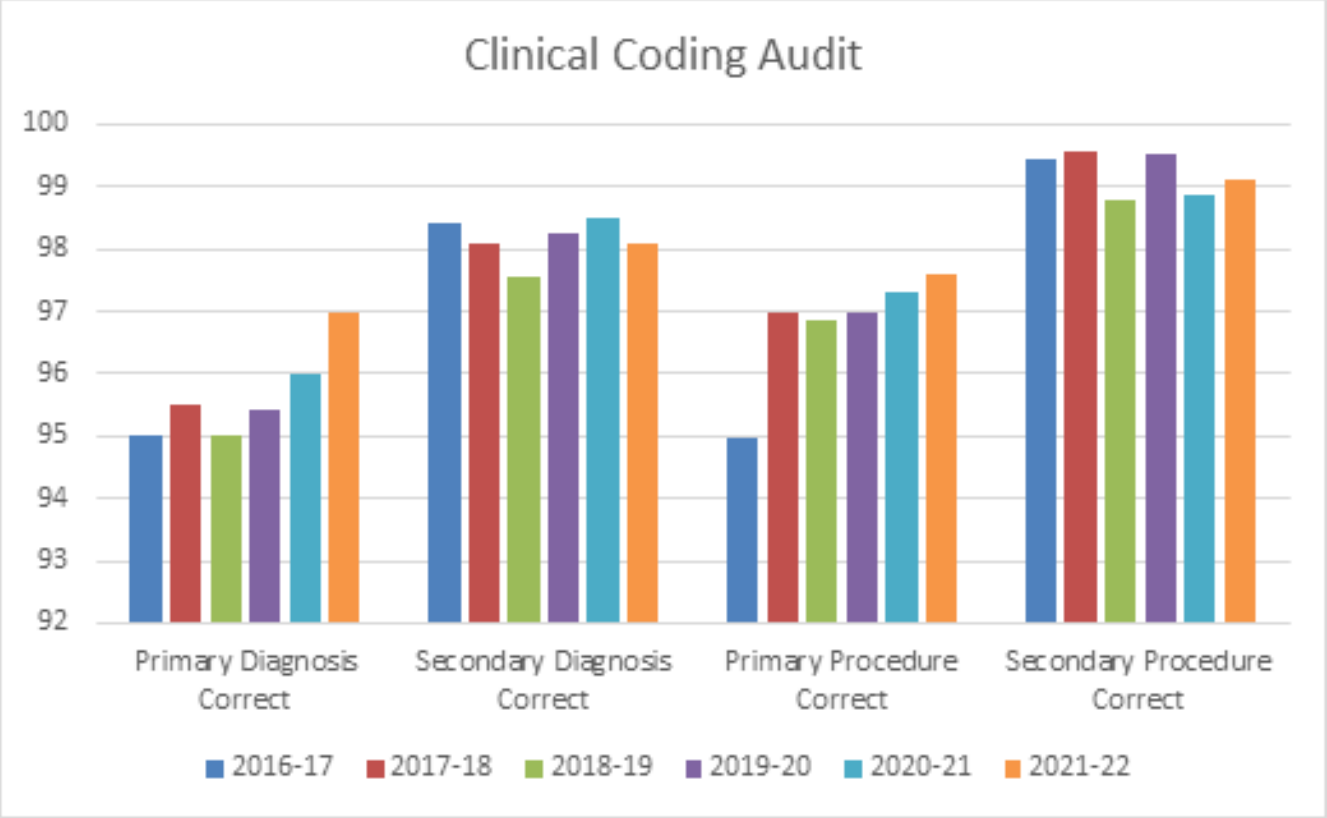
Clinical Coding is compliant with the Data Security and Protection Toolkit [DSPT] for the following standards:

- Data Security Standard 1 – Personal Confidential Data
- Clinical Coding Audit and Data Security Standard 3 – Staff Training

The Trust undertook a clinical coding audit in 2021/22 based on 200 consultant episodes. The Trust maintains its Level 3 outcome (highest level) and the comparative results are as follows:

Year	Primary Diagnosis Correct	Secondary Diagnosis Correct	Primary Procedure Correct	Secondary Procedure Correct	Level
2019-20	95.41	98.25	96.97	99.51	3
2020-21	96	98.5	97.3	98.89	3
2021-22	97	98.1	97.6	99.1	3

Figure 28 Clinical Coding Audit



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.

The Trust is committed to continuously seeking ways to strengthen our governance and quality improvement initiatives to support our learning from deaths framework.

While our mortality rates have remained strong, it is increasingly recognised that while monitoring these rates has a role to play in mortality governance, there is limited correlation between them and the quality of care provided by organisations.

In order to learn from deaths and improve the quality of our care, we recognise that it is vital that we have a robust process for reviewing the care received by our patients at the end of their life. We have reviewed our current processes and are currently introducing a number of reforms which we believe will build on the solid mortality review processes already embedded at the Trust, enabling us to further improve our learning framework and subsequently the quality of the care we provide.

Central to this work is the adoption of the Structured Judgement Review Plus format for review, developed by the “Better Tomorrow” team. “Better Tomorrow” is a new collaborative initiative hosted on the FutureNHS platform, whose aim is “To support effective learning from deaths in order to improve care for the living”. Additionally, it’s reporting approach has been designed in collaboration with NHSE’s Making Data Counts team and aligns with wider Trust data reporting initiatives. While the COVID-19 pandemic slowed the pace of reform, the project is now well under way, with adoption of the new process schedule for summer 2022.

Currently learning from our mortality review process, whether specific cases or themes, is shared across the Trust with clinical staff via clinical governance forums such as Rolling Half Days and is also shared with relevant working groups such as those focussing on Deteriorating Patient and End of Life Care. This is in addition to the direct learning and actions taken within specialties where a concern has been raised and discussed. As we implement the new SJR+ format for mortality review and reform associated systems and processes, part of our focus is on developing our mortality reporting and communications framework. Our aim is to build on our existing processes to make our learning even more accessible to the staff who can make a difference.

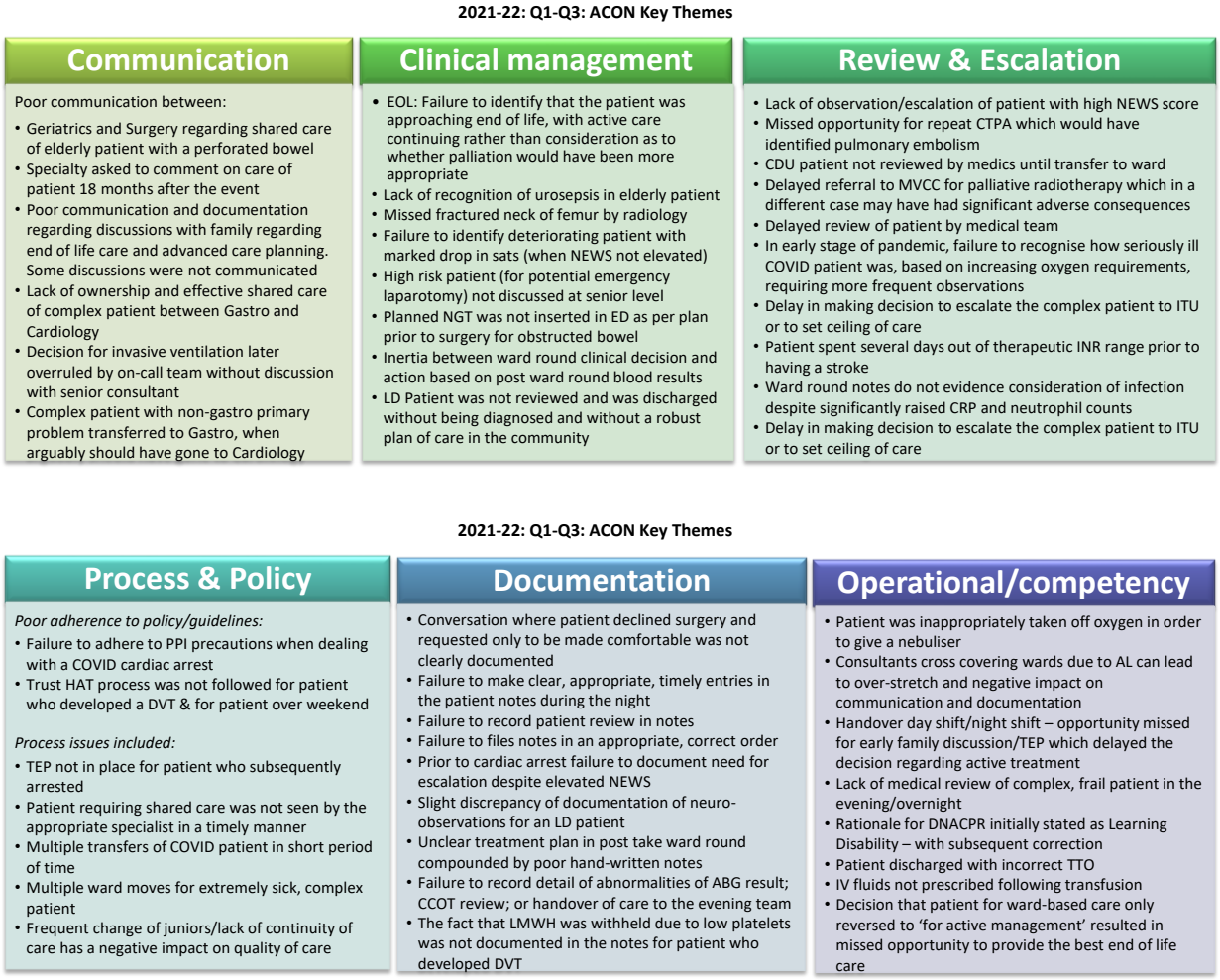
Mortality review process

1. 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.
2. 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.
3. 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. Learning themes are shared with wider Quality Improvement initiatives such as Deteriorating Patient Collaborative and End of Life Care, where they are captured as key drivers for change ideas.

The figure (29) below provides outline detail drawn from areas of concern considered in the first three quarters of the year.

Figure 29



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	2021-22 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 2021-22, 1341 of ENHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 311 in the first quarter; 345 in the second quarter; 341 in the third quarter; 344 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 2022, 809 case record reviews and 54 investigations have been carried out in relation to 1341 of the deaths included in item 27.1. In 48 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: 176 in the first quarter; 190 in the second quarter; 237 in the third quarter; 206 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting 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.	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter; 0 representing 0% for the second quarter; 0 representing 0% for the third quarter; 0 representing 0% for the fourth quarter. [Note: this does not mean that no 2021-22 deaths will be identified within the item 27.3 definition, but that by 31 March 2022 no concluded ACON investigations had fallen within this definition. As detailed in 27.8 below, investigations concluded after the end of the current reporting period will be reported in next year's Quality Account]. These numbers have been estimated using the Trust's Mortality Review process. 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.	0: 2021-22 deaths have 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 2022. [Refer to note in 27.3]
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 27.4).	0: 2021-22 deaths have 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 2022. [Refer to note in 27.3]
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.	0: 2021-22 deaths have 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 2022. [Refer to note in 27.3]
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.	82 case record reviews and 15 ACON investigations completed after 1 April 2021 which related to inpatient 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.	0 *[of the 15 investigations reported in 27.7 above]* representing 0% of the patient deaths before the reporting period *[ie 2020-21]* 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 previous reporting period, taking account of the deaths referred to in item 27.8.	1 representing 0.6% of the patient deaths during 2020-21 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]*.

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

Performance against national core indicators

The Summary Hospital-level Mortality Indicator (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 October 2021 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 12th out of all acute non-specialist trusts (122).

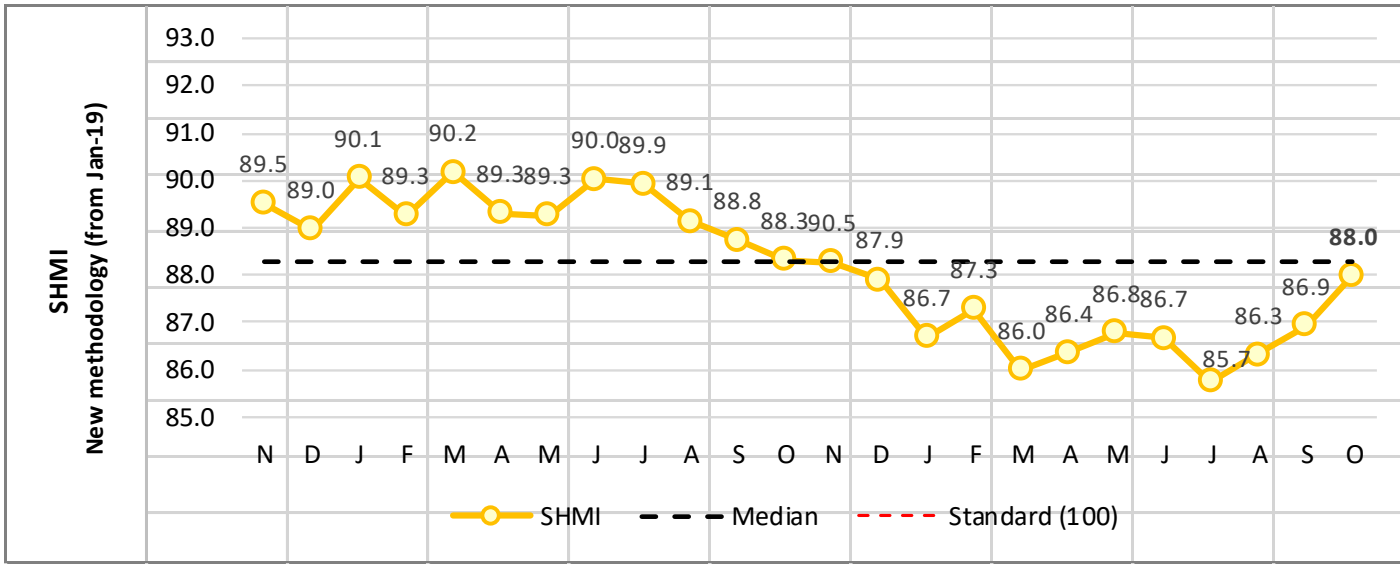
NHS Digital has excluded COVID-19 activity from the SHMI metric. Of note is that the fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, which provides some assurance that our response to COVID-19 has not generally resulted in a disproportionate increase in deaths within 30 days of discharge.

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	0.8719	Dec 20-Nov 21	0.8791	0.7161	1.1949	0.99
	Banding	3 – Lower than expected		3 – Lower than expected	-	-	N/A
% deaths with palliative care code	N/A	38		33	11	64	N/A

*NHS Digital, published 14 April 2022

Rolling 12-month SHMI: November 2019 – October 2021

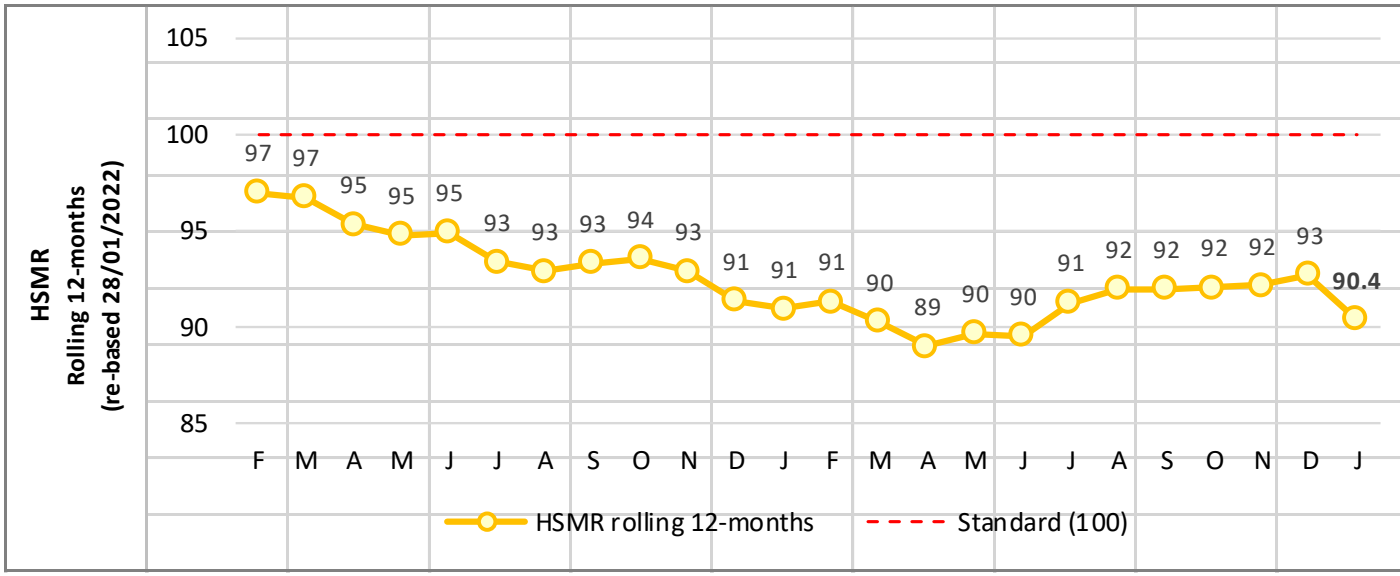


Note: In the chart above the observed to expected deaths have been multiplied by 100 (comparable to HSMR methodology) so that '100' and is comparable to the '1' as described above, where the number of observed deaths exactly matches the number of expected deaths.

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, for example, 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 consistent 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 2022 is 90.4 placing the Trust in the best performing quartile of Trusts i.e. the Trust has lower mortality numbers compared to 75% of peer hospital Trusts. The figure appears higher than last year's reported figure due to a long awaited rebase by our provider, CHKS, which generally shifted rates upwards. The Trust is currently still within the first quartile of acute trusts.

Rolling 12-month HSMR: February 2020 – January 2022



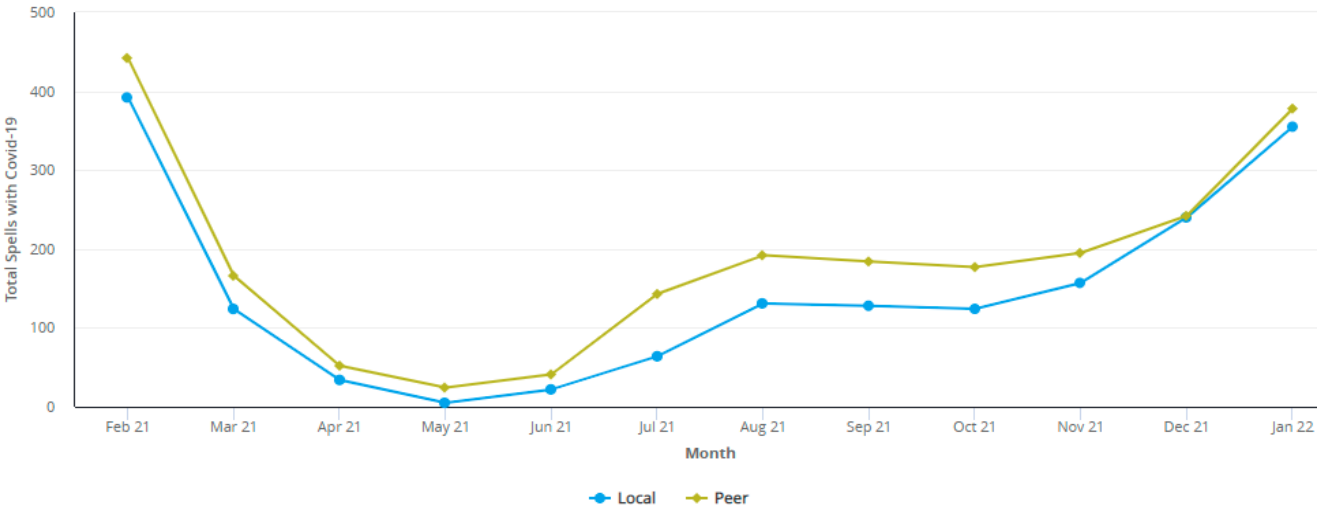
Covid-19

The multi-layered effects of the Covid-19 pandemic have made meaningful analysis and comparisons regarding mortality data challenging. For example, in-patient numbers and case-mix have varied during the pandemic.

At the same time, the following observations can be made.

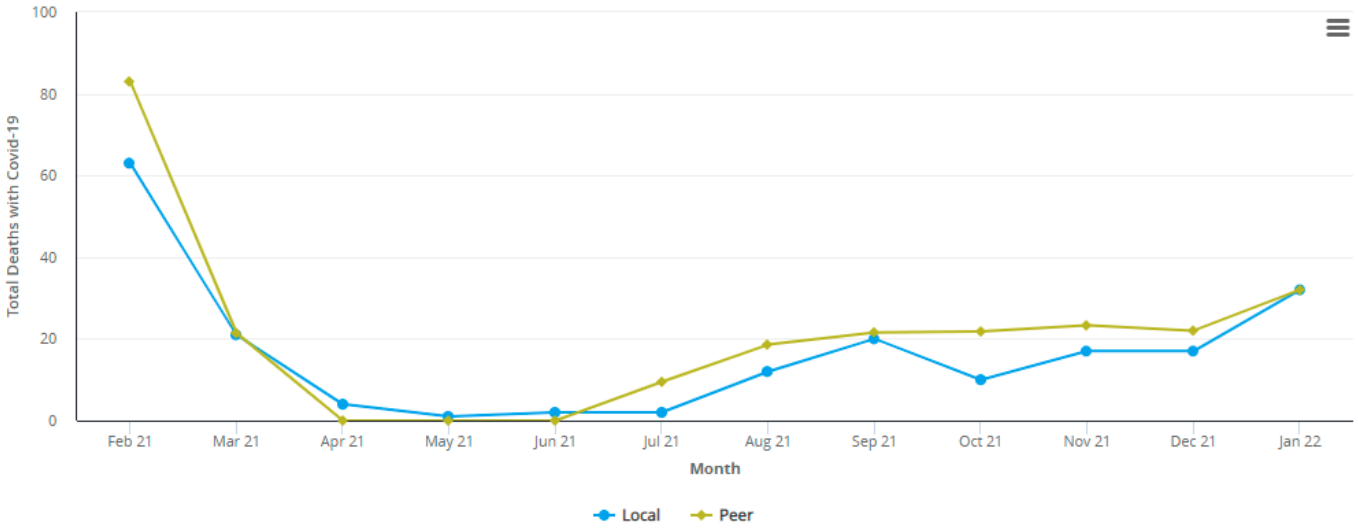
The Trust's position has been closely aligned with national peers for both spells and deaths reported with Covid-19, as demonstrated by the following charts:

Spells with COVID-19 (Peer: National): Feb-21 to Jan-22



Source: CHKS

Deaths with COVID-19 (Peer: National): Feb-21 to Jan-22



Source: CHKS

Our reported number of deaths for the year 2021-22 are as follows:

Covid deaths 1 Apr 2021 to 31 Mar 2022	**Definition**
160	Patients who had a positive test or were clinically coded as COVID. These deaths are reported to NHS Digital so underpin our publicly reported mortality rates.
139	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.

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)

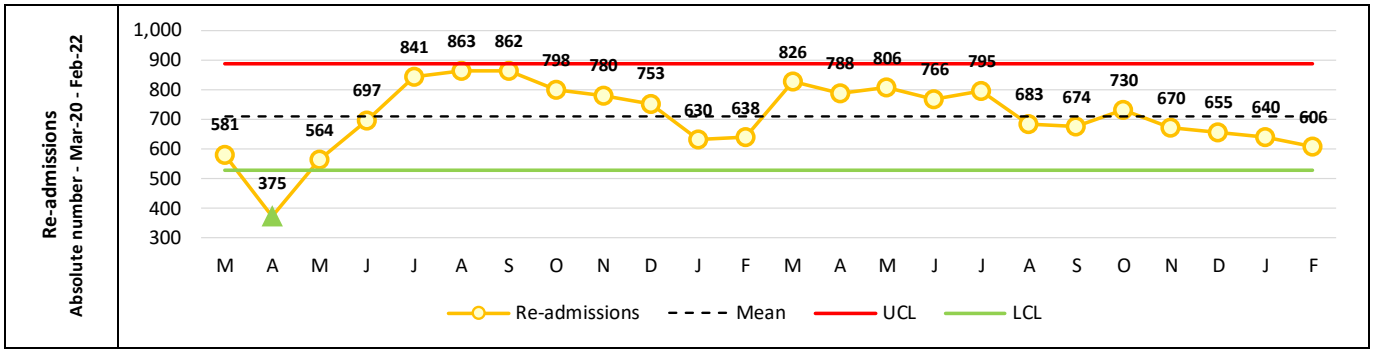
There is no national data available at the time of publication.

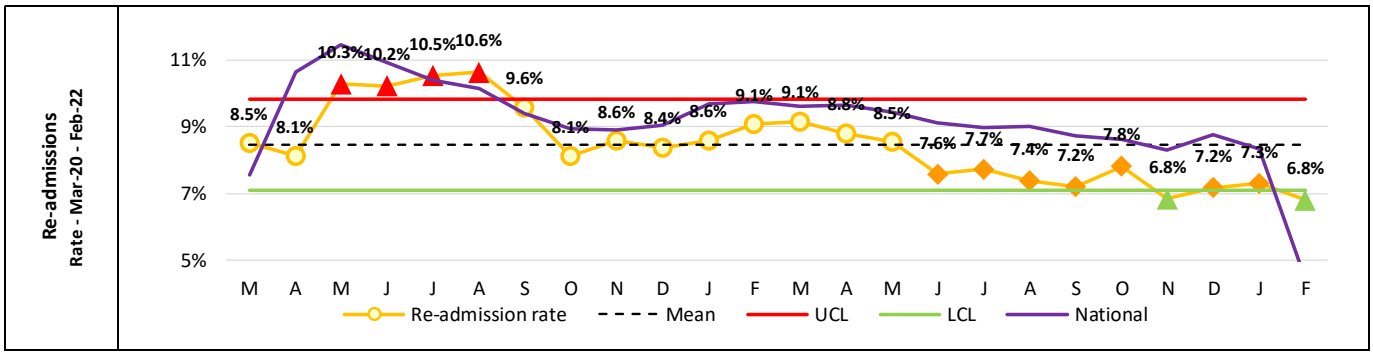
Emergency readmissions

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. with the Trust tracking just below the national average Since September 2020. This has stayed consistent since then. 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, and people who were discharged from an NHS acute hospital in November 2020. This year, for the first time, participants of the survey were offered the choice of responding online or via paper-based questionnaires. The sampling month also moved from July to November. As a result, the 2020 survey results are not comparable to previous years. (The CQC Inpatient Survey for 2021 was paused due to the Covid-19 pandemic).

581 patients responded to the ENHT survey, a considerably improved response rate of 50% (compared to 41.4% in the 2019 survey). Our Trust response rate was better than the average response rate for all Trusts at 46%.

Inpatients were asked what they thought about different aspects of the care and treatment they received. Based on their responses, the CQC gave the Trust a score out of 10 for each question (the higher the score the better). 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.

Overall, the Trust scored **about the same**, reporting a similar performance to most other Trusts that took part in the survey. Out of the 45 questions, 43 were scored **about the same** (96%), and 2 were scored **somewhat worse than expected** (4%).

Top patient experience scores:

These are the five results for our Trust that are highest compared with the average of all Trusts. These were calculated by comparing our Trust's results to the average of all Trusts:

Question	Trust Score	Average score of other Trusts
Were you ever prevented from sleeping at night by noise from other patients?	6.8	6.2
How did you feel about the length of time you were on the waiting list before your admission to hospital?	8.1	7.7
During your hospital stay, were you ever asked to give your views on the quality of your care?	1.6	1.3
Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	7.2	7.1
Were you ever prevented from sleeping at night by noise from staff?	8.1	8.0

Lowest patient experience scores:

These are the five results for our Trust that are lowest compared with the average of all Trusts. These were calculated by comparing our Trust's results to the average of all Trusts:

Question	Trust Score	Average score of other Trusts
How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	6.9	7.5
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	7.4	7.8
Were you given enough notice about when you were going to leave hospital?	6.8	7.2
Before you left hospital, were you given any written information about what you should or should not do after leaving hospital?	6.9	7.3
How clean was the hospital room or ward that you were in?	8.8	9.2

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.

CQC Maternity Survey:

This year's survey shows results have declined in many areas nationally, likely reflecting the impact that the Covid-19 pandemic has had on services and staff. Results show that areas particularly affected were; involvement of partners, choice, information provision and staff availability. Despite the pressures of the pandemic, the majority of women continued to report positive experiences of maternity care, particularly during their labour and birth.

Statistically significant improvements since 2019 have been seen in questions asking about continuity of carer. 41% of women said they saw or spoke to the same midwife every time

during their antenatal check-ups, up from 37% in 2021. Postnatally, 30% said they saw or spoke to the same midwife every time, up from 28% in 2019.

351	351	60%	54%	41%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (210)	Average response rate for similar organisations	Your previous response rate

The majority of women continued to report positive experiences about their interactions with staff. For example, 86% of women said they were 'always' spoken to in a way they could understand during their antenatal care; 85% said that they were 'always' treated with respect and dignity during labour and birth and 71% said that they were 'always' treated with kindness and understanding while in hospital after the birth.

69% of women said that during their antenatal check-ups, the midwife asked them about their mental health. Postnatally, 95% said that the midwife or health visitor asked them about their mental health. Most women (83%) said that if they needed this, they were given enough support for their mental health during their pregnancy.

Most improved scores	Trust 2021	Trust 2019
B16. Provided with relevant information about feeding their baby	76%	70%
D2. Discharged without delay	59%	55%
B13. Given the help needed by midwives (antenatal)	96%	92%
C22. Involved enough in decisions about their care (during labour and birth)	97%	93%
C13. Had skin to skin contact with baby shortly after birth	91%	90%

Most declined scores	Trust 2021	Trust 2019
B5. Given enough information about where to have baby	68%	82%
F17. Received suppport or advice about feeding their baby during evenings, nights or weekends	67%	80%
B7. Felt midwives or doctor aware of medical history (antenatal)	77%	88%
F6. Saw the midwife as much as they wanted (postnatal)	67%	78%
F14. Told who to contact for advice about mental health after having baby	75%	85%

The Trust will be focussing on improving these key areas; information provided, support and advice given to mothers and families.

CQC Cancer Survey

This year's survey was voluntary and we were one of only 55 trusts in the country to participate. This means that scores have not been compared nationally this year and that we are unable to split the results between trust sites.

Overall (statistically) the results are static. Patients' average overall rating of care was good which shows that despite the pandemic, cancer patients continued to receive care and treatment.

Statistically significant improvements are evident in questions about communication, with an increase in the number of positive responses where patients felt hospital staff didn't talk about them as if they were not there (an increase of 10% from the previous survey in 2019). Additionally,79% of patients felt there were enough staff on duty to care for them, which is an increase of 21% from 2019 and may be attributed to the significant work on safer staffing within the Trust. There was an increase in the numbers of patients who felt waiting times in clinic were appropriate. This is likely related to the increased use of virtual consultations and changes to patient pathways due to the pandemic.

	Question	2019	2020
Q30	Hospital staff didn't talk in front of patient as if patient wasn't there	78%	88%
Q34	Patient thought there were always or nearly always enough nurses on duty to care for	58%	79%
Q59	Patient felt length of time for attending clinics and appointments for cancer was about	45%	68%

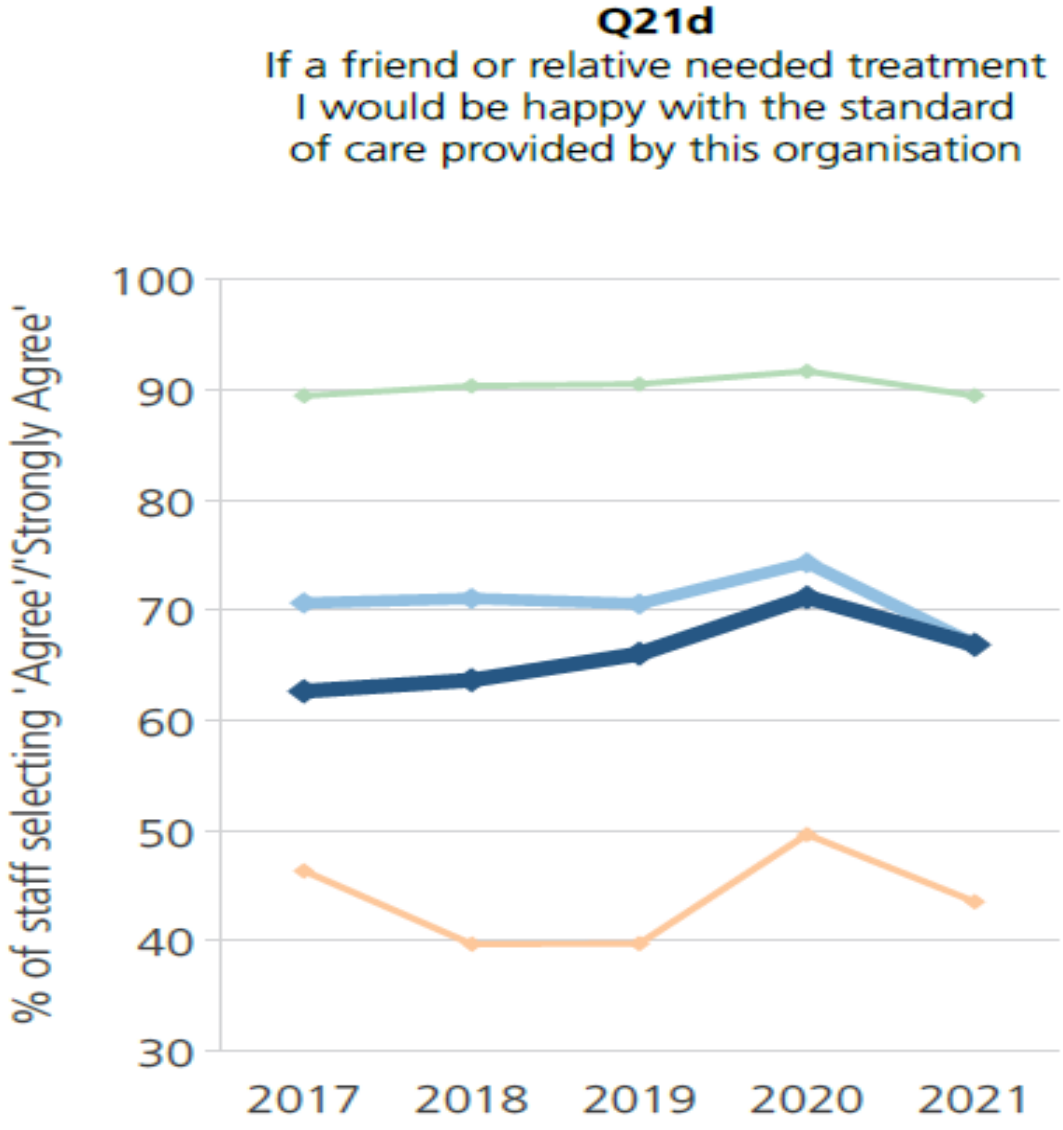
The only statistical reductions noted were in questions about clinical trials, in that trials were not discussed with patients. However, the majority of clinical trials were suspended during the time period of this survey. Another area that scored lower than the previous survey related to patients not feeling as supported by their General Practitioner, which was down to 35% from 41% the year before.

The key areas the Trust will be focusing on going forward is the information and support provided to cancer patients along all stages of their cancer journey. We will continue to work with the numerous teams who care for these patients as well as involving patients themselves so we can improve services.

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	66.9%	2021/22 Q2	71.2%	89.5%	43.6%	66.9%%

2647 staff completed the NHS national staff survey in 2021 representing a 42% response rate. Of those surveyed, 66.9% of staff state they would recommend the organisation as a place to receive treatment. This represents a slight decline this year, which is representative of the picture across the NHS as a whole and our score this year is also in line with the national average.



Best	89.5%	90.4%	90.5%	91.7%	89.5%
Your org	62.7%	63.7%	66.0%	71.2%	66.9%
Average	70.7%	71.1%	70.6%	74.3%	66.9%
Worst	46.4%	39.7%	39.8%	49.7%	43.6%

Throughout the survey there are again mixed scores with a higher proportion of questions showing no changes from 2020 results. When benchmarked by the national average score, we are however in line with the national average score for our sector for most themes apart from two themes where we are 0.1 points below average, namely, compassion and inclusion: and 'each voice counts'. However, we are above the national average score by 0.1 points for 'flexible working'

Going forward it is now our priority to increase on improving staff experience in the areas identified with a focus on areas such as safe and healthy workplaces, working flexibly, recognition and reward and we are always learning.

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 94% A/E 80% Mat 96%* OP 95%	Feb 2022	IP 97% A/E 94% Mat 94% OP 96%	100% 100% 100% 100%	77% 29% 67% 81%	94% 77% 94% 93%

*Maternity indicator is a measure relating to birth experiences only

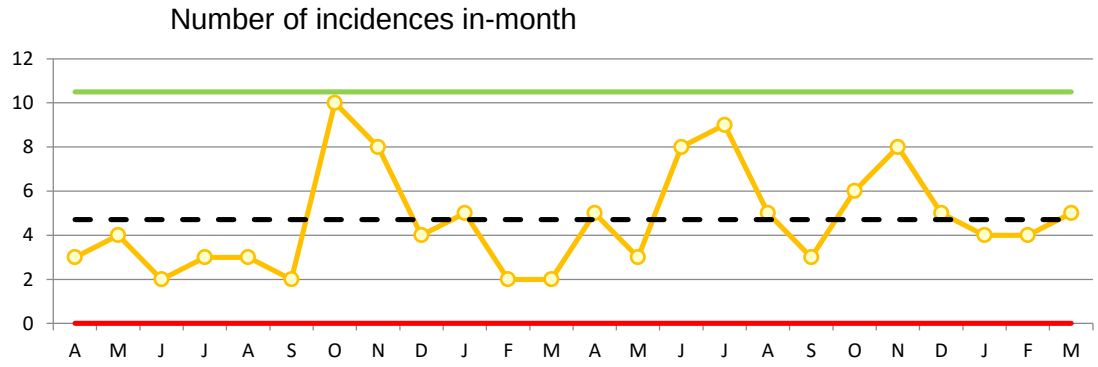
The Trust considers that this data is as described, as it is based on data submitted directly by patients to the national surveys programme. The Trust has taken the following actions to improve uptake and score; promotion of the survey within the inpatient and outpatient services, working with the inpatient services towards the accreditation within the pathway to excellence programme and adding QR codes to access the survey in and around the Trust. The feedback received is continually reviewed to identify themes and trends to produce improvement initiatives alongside our quick responses which are displayed monthly on our "you said, we did" boards.

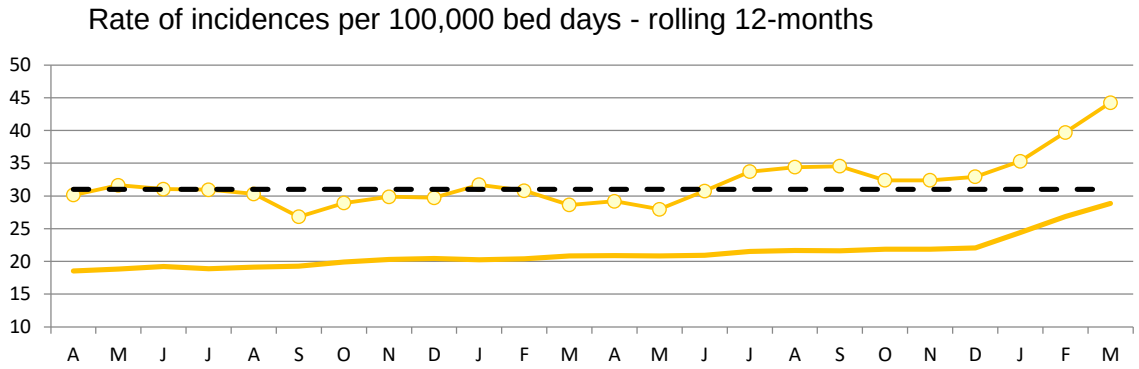
Venous Thromboembolism (VTE)

The national bench making data collection continues to be 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.





When more than one Clostridium difficile Infection (CDI) is identified in the same location and within a certain time period, ribotyping is requested: and continues to demonstrate that there has been no cross transmission thus far.

The Trust reported a total of 59 healthcare-associated infections (HCAIs) for April 2021-March 2022. This is above the Trust ceiling target of 52 HCAIs for April 2021- March 2022. 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.

The Trust will carry out a representative proportion of post infection reviews (PIRs), as agreed with the CCG, in order to identify any inadequate areas of practice. The MDT rounds should restart in May 2022 to provide support for the wards where CDIs have occurred. The current Trust position for April 2021- March 2022 is 59 HCAIs with total of 10 further appeal cases to be presented. This is likely to bring us in line with our ceiling. The Trust has a continued focus on Infection Prevention and Control; please refer to the MRSA section for further details.

Patient safety incidents

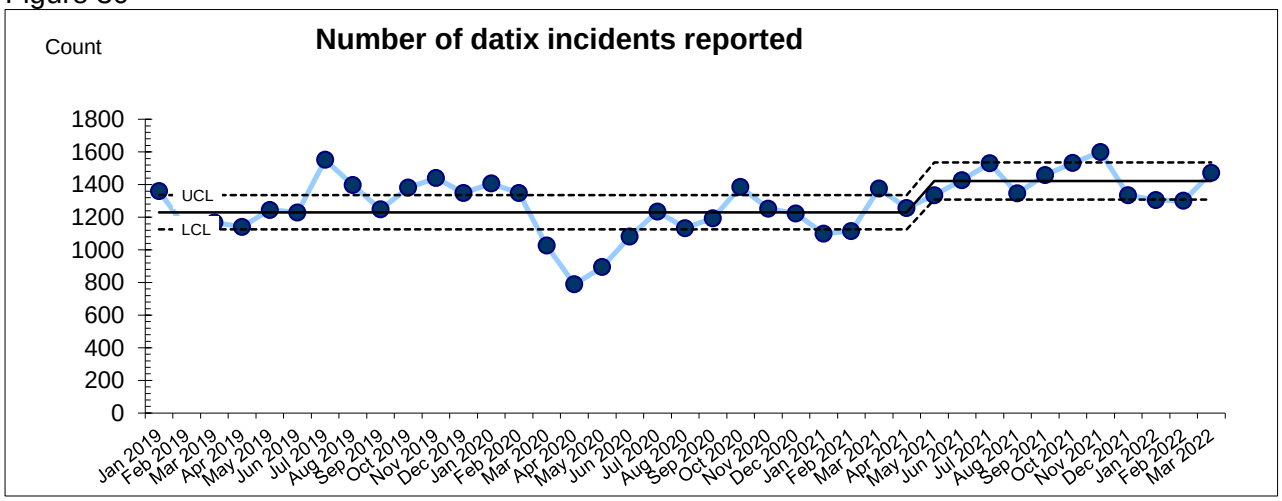
Incidents are reported on the electronic reporting system, Datix. The patient safety incident data is uploaded into a national system where incident reporting patterns, types of incidents can be analysed. The rate of incidents is the number reported per 1,000 bed days.

Between 1 April 2021 – 31 March 2022 the Trust reported a total of 13,543 patient safety incidents. This can be seen in figure 30.

Prior to COVID-19, there was an average of **1230** incidents reported each month. Nationally, there was a reduction in incident reporting seen at the beginning of the pandemic between March 2020 – June 2020. This was reflected locally; our incident reporting at the beginning of the pandemic (March 2020) noted a statistically significant decrease to our monthly reporting, with April 2020 showing the lowest number of incidents reported for a month at 789. As the pandemic progressed through the second wave there was only a marginal decline in incident reporting. As the graph below (figure 30) demonstrates, incident reporting levels have been gradually increasing since then and on average, they have sustained an increased reporting trend since May 2021, compared to pre-pandemic average of 1303 per month to a current average of **1406** incidents per month.

Of note over the last six months there has been a steadily improving trajectory of reporting and in April 2021 we saw a step change. It is recognised that the biggest driver to improvement in reporting is feedback; the ways in which we can improve our feedback are being explored. Teams are being encouraged to ensure incidents are part of local discussions at quality huddles and team meetings.

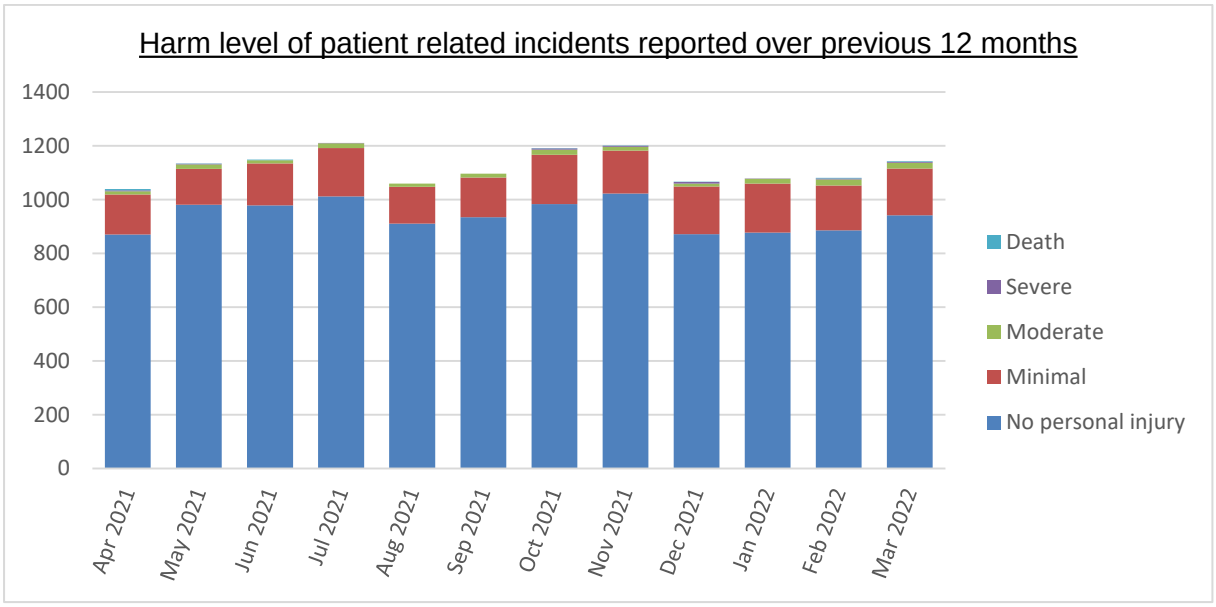
Figure 30



Of the total incidents reported in 2021/22 financial year (13,543) 80% relate to patient safety incidents and 12% relate to staff. Within staffing incidents, the top 3 themes are violence and aggression, staffing and health and safety / security incidents.

Between 1 April 2021 and 31 March 2022, 98% of patient safety incidents reported (n=13215) resulted in no or minimum harm.

Figure 31



Part 3

3.1 Review against selected metrics

Patient safety

Indicator	19/20	**20/21**	**21/22**	**Aim 22/23**
Never events	3	3	**5**	0
MRSA Bacteraemia (post 48 hours)	6	0	**0**	0
Number of inpatient falls	816	652	**672**	10% reduction
Number of inpatient falls resulting in serious harm	14	11	**19**	25% reduction
Number of preventable hospital acquired pressure ulcers	151 (0.62 PU per 1000 bed days) 2 cat 4	235 (1.21 PU per 1000 bed days) 1 cat 4	**205** **(1.05 per 1000 bed days)** **1 cat 4**	0.85 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.

	2019/2020	**2020/21**	**2021/22**
Wrong site surgery	1	2	4
Retained object	1	0	1
Oxygen tubing to air	1	1	0
Total	3	3	5

There were 3 Never Events declared relating to Invasive Procedures in this period, two relating to wrong site treatment and one to retained dressing following surgery. The wrong site treatments occurred in radiology, plastic surgery and in ophthalmology outpatients. All areas have conducted a significant review and implemented changes to their procedures and LocSSIPS (and department inductions about LocSSIPS) following these events. In addition, areas are exploring suitable de-briefing tools, updating staff awareness of the WHO checklist, reminder of appropriate escalation when patient safety incident occurs and ensure learning is cascaded across the surgical and theatre teams. The retained dressing was erroneously thought to be an absorbable dressing and there was no handover or plan for its removal.

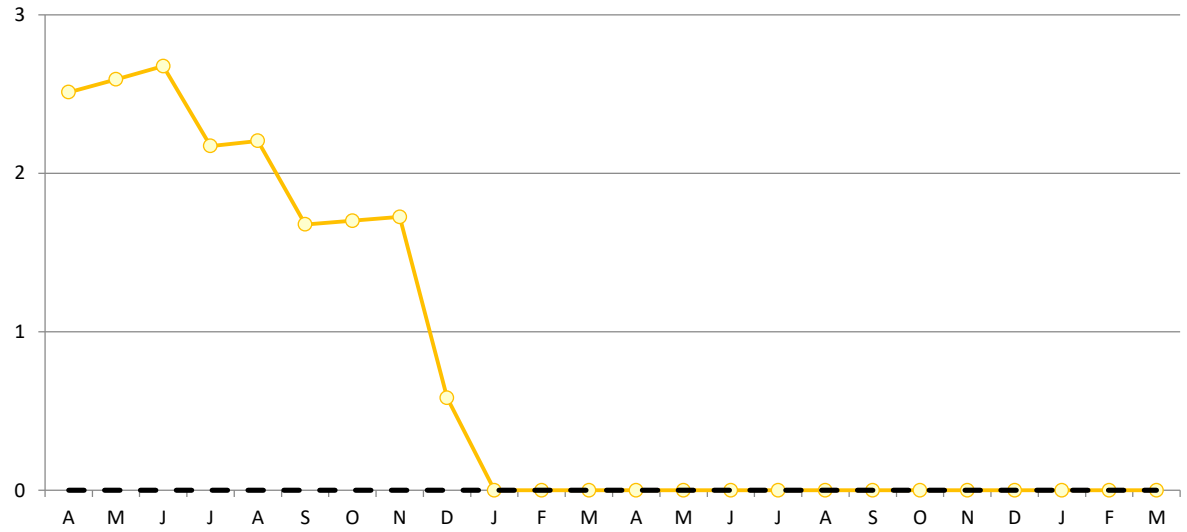
Within Planned Care, a programme of simulation training across theatres is planned in recognition of the Human Factors elements influencing of Never Events that have occurred within the Trust. These will be monthly live sessions focussing on debriefs, the WHO checklist and situational awareness. In addition a survey has been sent out to all staff working across theatres exploring psychological safety. The results will be incorporated into the monthly situational awareness training sessions and a further survey will be undertaken in six months' time to review the progress that has been made and to identify any further areas that need improvement. Plans are also in progress for a Patient Safety day on 23 September 2022; this is currently being led by the Planned Care team. It is anticipated this will include external speakers from both healthcare and the airline industry, a patient story from someone who has been the subject of a Never Event and a member of Trust staff who has been directly involved in a Never Event. The day will focus on patient safety culture and behavioural culture of staff.

Across Trusts in the Eastern region, wrong site surgery has consistently been the most common Never Event declared over the previous 3 years with 59 being declared. The second most common theme is that of retained foreign object, of which 32 were declared. The Healthcare Safety Investigation Branch (HSIB) undertook a national learning report about Never Events, looking at the strength of barriers and hierarchy of controls. The HSIB noted that the Covid-19 pandemic had exacerbated the risks surrounding Never Events. They made three recommendations; national review of the Never Event list, find strong and systemic barriers where barriers are not currently possible or strong enough and review of NATSIPS. NHSE/I are currently undertaking a Never Event review, which includes specific focus groups looking at the barriers that are in place to prevent them occurring and are intending to review and revise the Never Event policy and framework later this year.

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 reported a total of 0 MRSA bacteraemias for April 2021-March 2022 for the second time since 2015/16 and it in line with the Trust ceiling target of 0.

Rate of incidences per 100,000 bed days - rolling 12-months



The Trust reported a total of 0 MRSA bacteraemias for April 2021- March 2022, for the second year running. This sustained improvement is as a result of collaborative efforts to identify areas of learning regarding Aseptic Non-Touch Technique (ANTT) practice and vascular access. Involvement in national improvement work has also positively impacted Trust bacteraemias.

The work needed to develop a Trust wide ANTT competency was largely stopped due to Covid-19 pressures. However, an ANTT competency, which is owned and facilitated by Medical and Nurse Education and supported by the IV access leads and IPC, is still required.

The Trust will focus on devising and implementing a robust ANTT competency alongside other vascular access training.

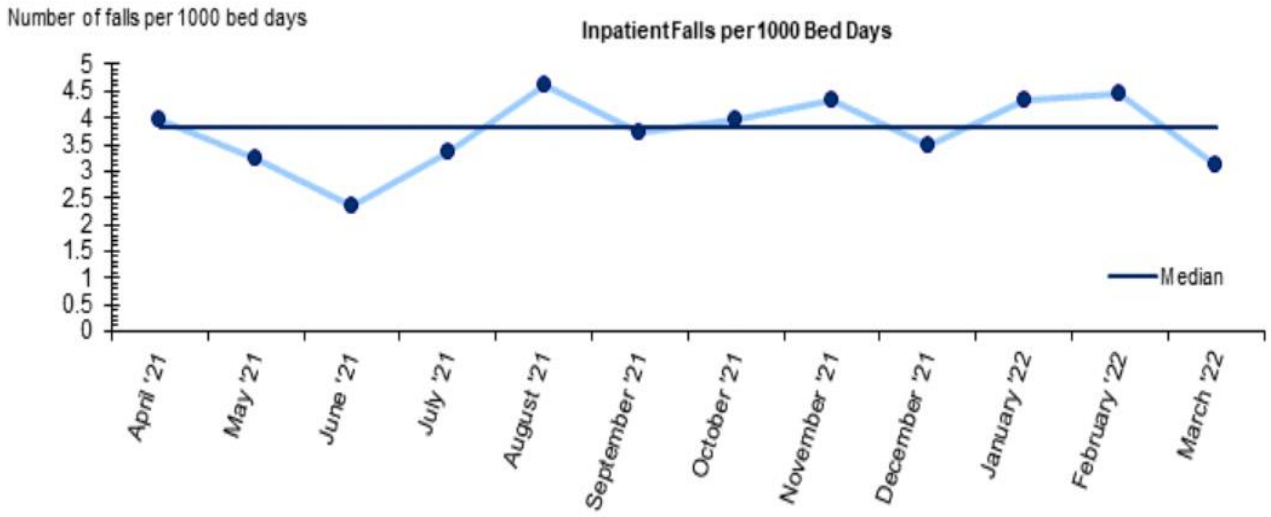
Key priorities for 2022/23 include:

- Devising and embedding 'Living with COVID-19' Trust IPC principles.
- Refocussing Trust IPC practice on standard infection control precautions and transmission-based precautions to appropriately prepare for seasonal changes.
- Embedding the newly released national IPC manual
- Continuing and escalating the post infection review (PIR) process for Hospital-acquired E.coli BSIs with rationalised PIRs for Hospital-acquired C.difficile
- Supporting surgical site infection quality improvement within the Planned Care Division

Inpatient falls

The Trust has sustained an average falls rate of 3.78 per 1000 bed days which is lower than the previous year (4.30). This represents a 12.01% reduction from the previous year. We are still recording a lower falls rate compared to the national average of 6.6 (NHSI).

Figure 32 Rate of Falls per 1000 bed day



During 2021/22 there were 672 inpatient falls. This represents a 3.07% increase when compared to 2020/21. We have also seen an increase of 18.71% occupied bed days compared to the previous year.

Number of inpatient falls resulting in serious harm

Learning from incidents

The Trust has a number of measures in place aimed at minimising the risk of falling. These include risk assessments on admission and mitigation actions such as the use of bed rails, low rise beds and high observation interventions such as Baywatch or 1:1 nurse ratio.

When falls resulting in serious harm have occurred, a safety investigation learning review is undertaken which is called a 'round table'. These reviews are attended by nursing, medical, therapy and pharmacy staff to identify learning themes to prevent future harm.
Learning identified during 2021/22 includes:

- Unwarranted variation in the reliability of timely completion of falls risk assessment,
- Challenges in providing reliable compliance with Baywatch interventions
- Sometimes delays to medical review following the occurrence of inpatient fall
- The quality of documentation related to completion of MCA and DOLS

Financial Year	# IP Falls	Reduction year on	% trend	Falls with Serious Harm
2019-2020	747			14
2020-2021	652	95	12.72% ↓	11
2021-2022	672	+20	3.07% ↑	19

We have been working closely with the Trust's Harm Free Care collaborative to improve our compliance with falls training and education. This will include the medical workforce, post falls escalation and management, and developing escalation tools to support all staff to communicate safety critical information through ward channels such as huddles and board rounds. We are also working closely with the safeguarding team to ensure staff are aware and supported with MCA/DoLS completion through practical competency-based learning and simulation, including when patients have fluctuating capacity.

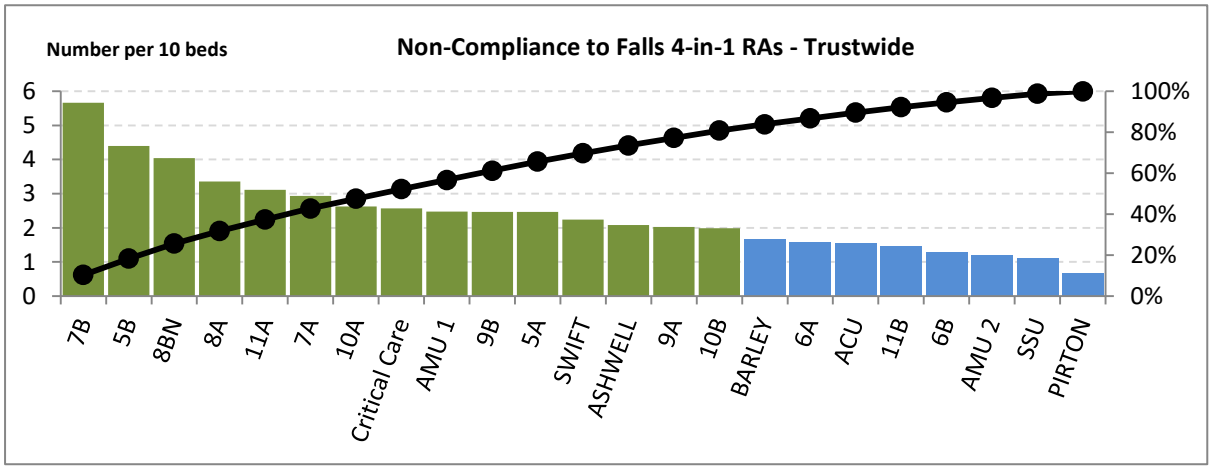
Work underway:

Harm Free Care Falls Priority Aim:

- **Falls Risk Assessment**

  Priority Theme 1: Falls risk assessment should be done within 4 hours of admission as per NICE Falls guidance. In quarter three of 2021, we launched falls risk assessment as part of digital nursing 4-1 falls risk assessment, KOPS programme. Timely assessment of inpatients falls risk remains a challenge and the

pareto chart below shows significant variation in compliance up to 50% on most inpatient wards.



All wards 'green' are demonstrating a reduction in new digital falls risk assessment compliance.

Work Underway: This is ongoing Trust-wide improvement work aiming to improve compliance and digital adoption by engaging staff in completing falls risk assessment in a timely manner. We will also be looking at launching falls care plans as part of the KOPS programme in the coming months.

- **Assessment Areas (AMU 1)**
  - **Priority Theme 2:** Assessment areas have a quick turnaround of patients admitted from different specialties. This poses a challenge in managing patients with different needs. AMU set an aim of reducing serious harms from falls by 50% and achieved this goal for 2022/21
  - **Work Underway**: Falls posters aiming at informing and educating patients, are going to be trialled in the area using PDSA tools as part of their quality improvement journey.
- **Baywatch**
  - **Priority Theme 4**: Compliance with Baywatch has been an ongoing challenge which has a negative impact in managing high risk falls patients.
  - **Work Underway:** Falls prevention training is now live on ENH academy which includes Baywatch education. We will provide bespoke Baywatch training for areas with poor Baywatch compliance

Achievements: The quality improvement project on ward 8A was successful in achieving a reduction of falls over the past year. We have also successfully tested and implemented the alcohol withdrawal proforma which will improve the timely prescription and administration of appropriate medication for patients withdrawing from alcohol, thus reducing the risk of falls for this group of patients.

Next steps: Quality Improvement work for falls this year will focus on the aim of reducing Trust-wide falls with serious harm by 25% by April 2023. The overarching goals will be to improve communication amongst ward staff, compliance with Baywatch and involve service users in co-designing the falls improvement work.

Inpatient pressure ulcers

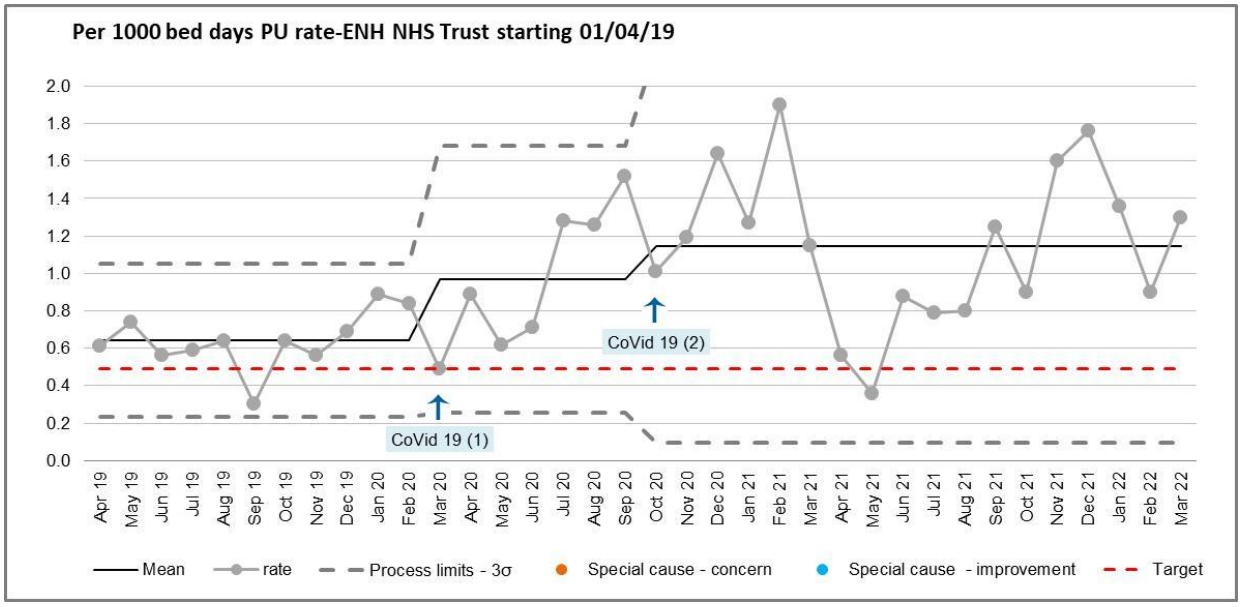
The Trust is committed to the prevention of harm caused to patients whilst in hospital, particularly from Hospital Acquired Pressure Ulcers (HAPU). All HAPU are investigated via a root cause analysis (RCA) investigation to capture any learning.

HAPU identified by ward staff are reported to the Tissue Viability Team (TVT) via our incident reporting system Datix. These incidents are then triaged by a Tissue Viability Nurse (TVN) and the skin damage is validated to ensure accurate reporting of harm and expert wound care planning to enable wound healing.

The Trust has reported 205 HAPU for 2021-22 which is a 12.7% reduction on our previous year's data.

	2019/20	2020/21	2021/22
Number of patients with reportable HAPU	151	235	205

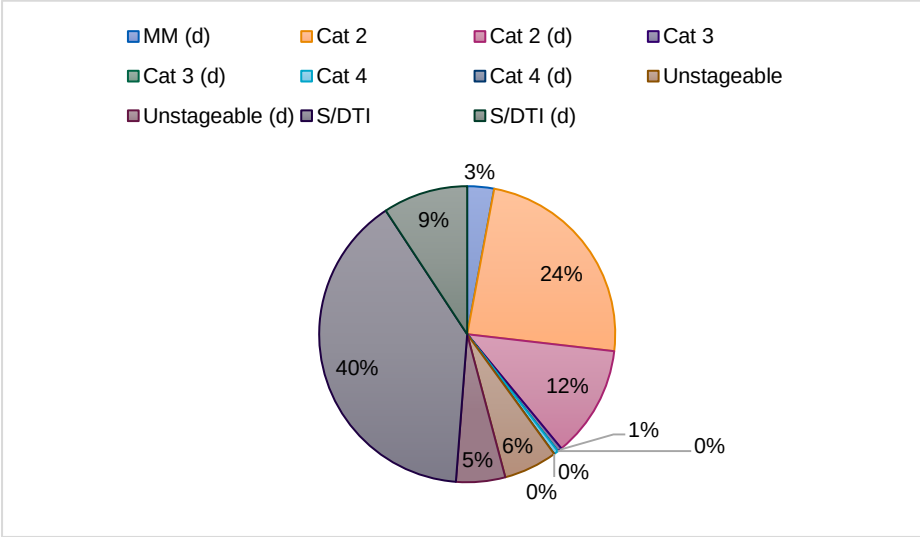
In the chart below, time series data demonstrates the rate of pressure ulcers (PU) per 1000 bed days. Due to the 2018 NHS Improvement pressure ulcer reporting changes, 2019-20 has become our new baseline year as the number of PU categories we are required to report on, has increased.



PU Categories

The most prevalent category for 2021-22 has been suspected deep tissue injury (SDTI) accounting for 48.8% of total reportable pressure ulcers. 22% of these SDTI were directly related to the use of a medical device. All other categories and prevalence can be seen in figure 33 below.

Figure 33



Category	Total number
MM (D)	6
Cat 2	49
Cat 2 (D)	25
Cat 3	1
Cat 3 (D)	0
Cat 4	1
Cat 4 (D)	0
SDTI	81
SDTI (D)	19
US	12
US (D)	11
Total	205

**(D) = Medical Device Related; MM = moisture membrane; SDTI=suspected deep tissue injury; US=unstageable*

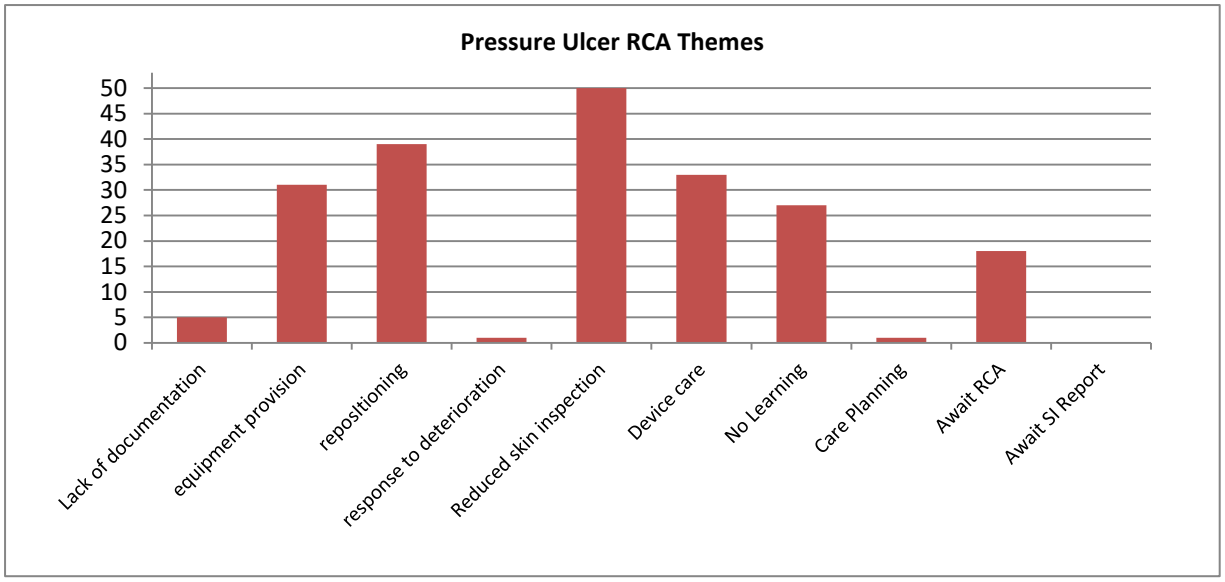
PU Learning

Every HAPU is investigated by a Tissue Viability Nurse (TVN) to enable identification of gaps in care so that learning can be identified and improvements delivered. A Root Cause Analysis (RCA) investigation is performed at the time of validation and outcomes are fed back directly to ward staff. Category 3 and 4 PUs are escalated via the Serious Incident Review Panel for consideration and possible Serious Incident investigation. The diagram below details the themes associated with this year's PU data. Our most prevalent themes are reduced skin inspection (24.4%) and repositioning (19%). One category 4 PU was escalated for Serious Incident investigation in 2021/22.

In compliance with the NHSI PU recommendations, the terms 'unavoidable' and 'avoidable' are no longer used. In 27 ulcers (13%) we were unable to determine any learning for ward staff as all care was delivered and documented in line with trust standards and best practice.

The Trust has seen a reduction of medical device related pressure ulcers within critical care, from 56 in 2020/21 and to 37 in 2021/22, as a result of the quality improvement projects and increased awareness of QI methodology.

	Total pressure ulcers within critical care	Medical device related pressure ulcers within critical care
2020/21	75	56
2021/22	43	37



Harm Free Care priority aim

Through the Trust Harm free Care Collaborative, the Tissue Viability Team will continue to 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 sustain the reduction in reducing medical device related pressure ulcers within critical care
2. To improve the quality of repositioning care on general wards in collaboration with the clinical practice team
3. To improve the quality of SSKIN care documentation to facilitate delivery of care across the Trust. (This was paused during 2021/22 due to the impending implementation of a new digital care planning system)

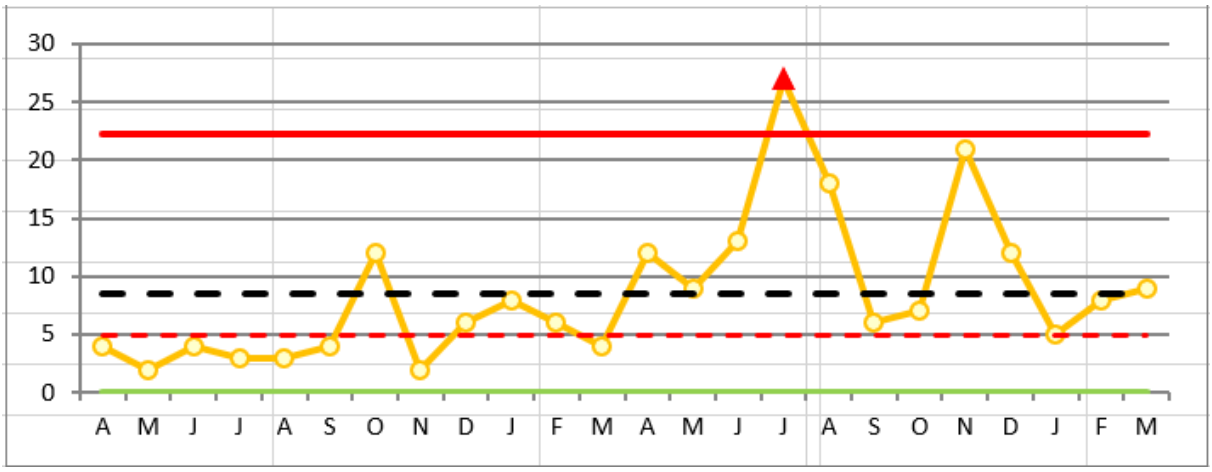
Serious incidents

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.

During 2021-22, the Trust formally declared 147 Serious Incidents (SIs). The chart below (figure 34) shows the average number of serious incidents reported each month is eight, with common cause variation of SIs reported each month in Q3 and Q4.

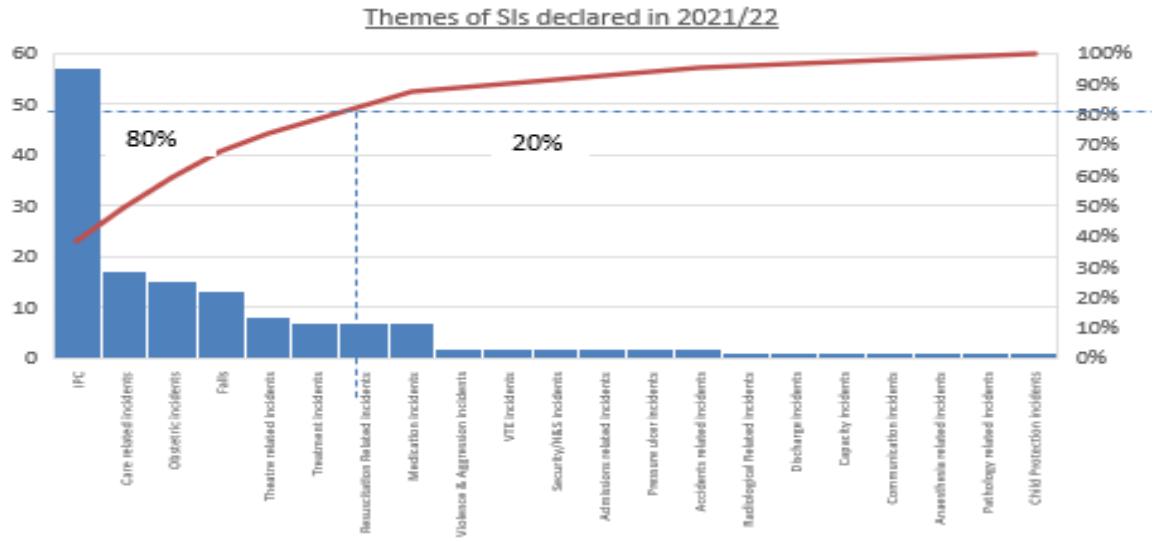
Figure 34
Monthly reporting number of serious incidents
(A pril 2020 March 2022)



The total number of cases declared was a marked increase from the previous year and is attributable to the hospital onset hospital acquired Covid-19 cases being declared. Of the 147 cases, 5 were Never Events, 14 were referred to HSIB for investigation and 4 were subsequently downgraded.

The graph below demonstrates the themes of SIs from 2021/22. As expected, infection prevention and control issues are the most common theme and this reflects the hospital onset hospital acquired Covid-19 cases. It is noted that there has been an increase in SIs relating to falls. In conjunction with this, there is a focus on ongoing continuous improvement through the Trust Harm Free Care Collaborative, with improvement objectives of; training and education, risk assessment compliance and post falls escalation and management. In addition to this, the Trust-wide use of revised digital falls documentation is being reviewed, along with an ongoing audit of the escalation process following falls.

The rapid assessment and documentation of patient care following a falls is being included in doctors' escalations programme of work and communication and escalation tools are being developed to support staff to have different conversations when Baywatch is in progress and conflicting, demanding task requests occur.



These themes are embedded within patient safety and patient experience improvement priority programs such as:

- The Deteriorating Patient Collaborative,
- Harm Free Care Collaborative
- Patient and Carer Experience (PACE) Improvement programs

The round table discussion format has been shown to be successful as a learning forum, attendance is mostly senior staff and it is an opportunity for staff involved in the incident and other frontline staff to be involved in the process. This can help provide early feedback to both those directly involved and also those more senior staff from the wider teams. This process is now embedded. The focus for 2022/23 is to streamline the process to improve the timeliness of reports being finally approved and shared with the patient/family.

Most investigations identify learning points where improvements are required. Some examples of actions completed or underway include:

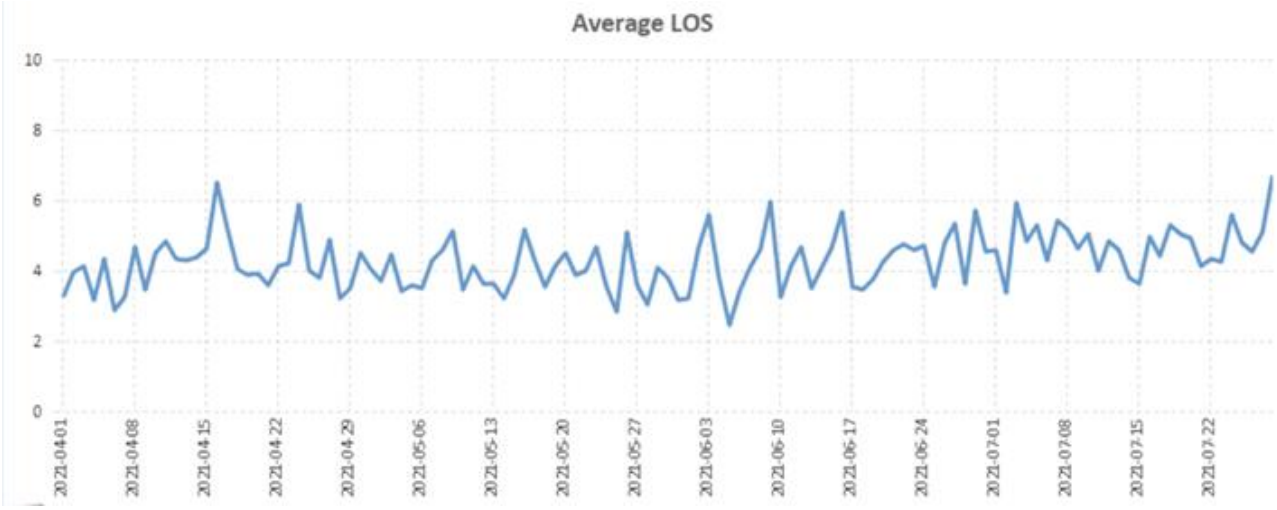
- Raise awareness of the Access Policy, including two week waits referrals and access plan, to review the consistency of the booking process between the Haematology Service and Contact Centre and to consider streamlining the booking process with the use of Contact Centre
- A LocSSIP, SOP and IVT treatment booklet were created and implemented within Ophthalmology
- The Trust's Harm Free Care programme has prioritised improving awareness of VTE risk assessment and prevention. This work includes structured daily safety huddles, site safety and hospital at night communication pathways.

Clinical effectiveness

Indicator	19/20	20/21	21/22	Aim (22/23)
Length of stay (non-elective / emergency)	3.78	4.04	**4.73**	≤4.3
Stroke – thrombolysis rate	11.2%	11.9%	**8.3%**	≥11%
Crude mortality – rolling 12 month rate	11	16	**11**	Reduce

Length of stay (LOS)

The length of stay has remained fairly constant throughout the year with an average LOS of 4.73 days. Work is ongoing to review and benchmark against the HRGs and work with the ICS partners on prevention of admission, criteria to admit and hospital at home to facilitate earlier discharge and less demand on inpatient beds.



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.

Domain	Metric	2021-22 Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Trend
Stroke	% of all stroke patients who receive thrombolysis	11%	11.3%	3.2%	3.4%	8.2%	4.2%	9.2%	12.5%	7.7%	4.1%	11.4%	12.9%	11.4%	
	%of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	70%	14.3%	0.0%	50.0%	57.1%	0.0%	16.7%	42.9%	33.3%	66.7%	62.5%	33.3%	50.0%	

A task and finish group has been established to support whole-system review of the thrombolysis pathway and to review improvement plans for recovery of performance. This has supported an improved performance apart from some months in relation to the

overwhelming pressure within the Trust and the clinical indication 'not safe to proceed treatment'. A review was undertaken of all patients that didn't meet the thrombolysis pathway, which indicated arrival outside the thrombolysis window and/or clinical need not to proceed, i.e. the patients required other treatment before thrombolysis could be safely administrated.

Considering the changes to all services due to COVID-19 both ambulance and ED triage, scanning protocols and swabbing process 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. This is also supported by the ISDN South region implementation plans of the National Stroke Service Model (May 2021).

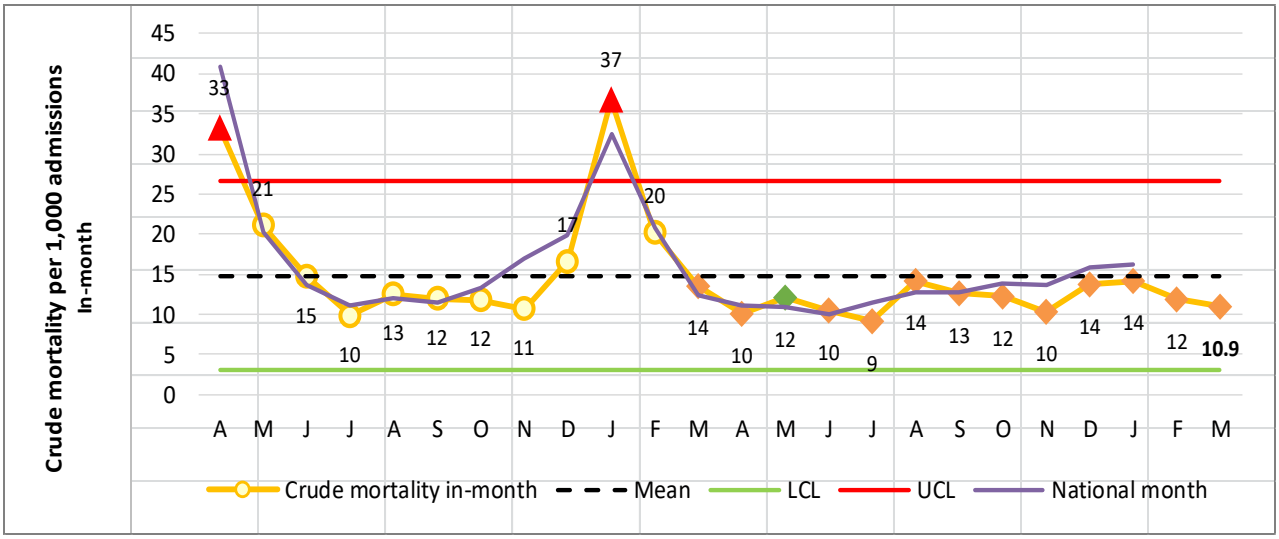
Crude mortality

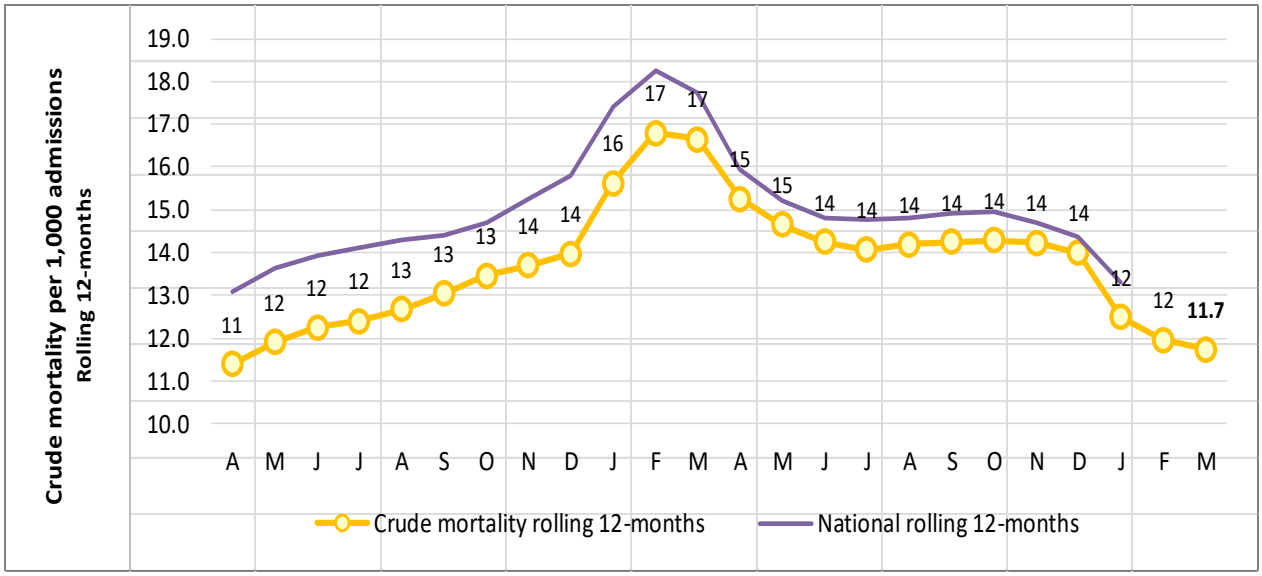
Crude mortality is based upon the number of patients who die in the Trust whilst an inpatient. It is measured per 1,000 admissions.

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 over recent years have resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work, together with a continued drive to improve the quality of our coding.

While the Covid-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average, with our rolling 12 month rate consistently tracking below the national rate.





Patient experience

Indicator	19/20	20/21	21/22	Aim (22/23)
Number of formal complaints	1058	656	777	<previous year
Number of PALS concerns	3693	2935	3614	N/A
Number of PALS concerns closed within 5 days / %	2607 70.5%	2931 79.2%	2529 78%	80%
Complaints – response within agreed timeframe	82%	89%	72%	≥80%*

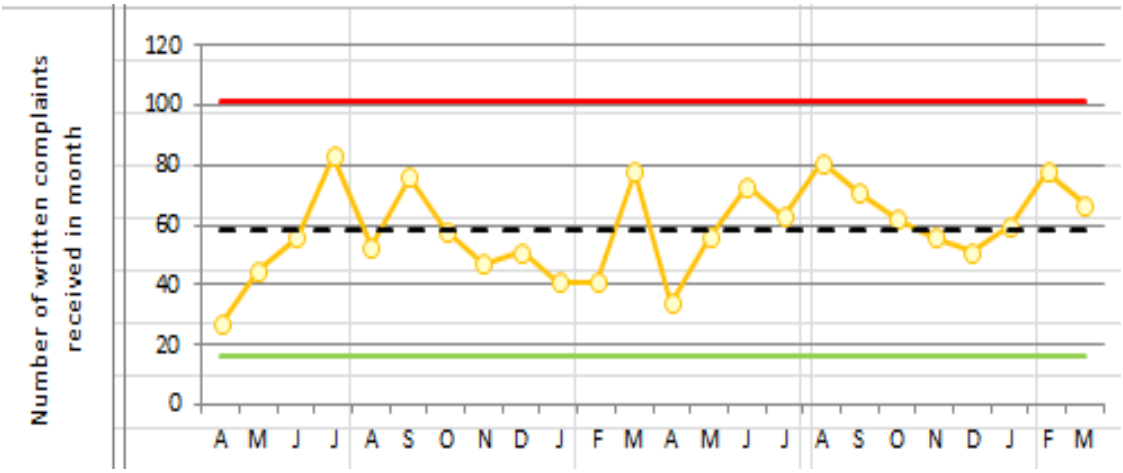
Source: Datix internal system & information held by local teams

*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.

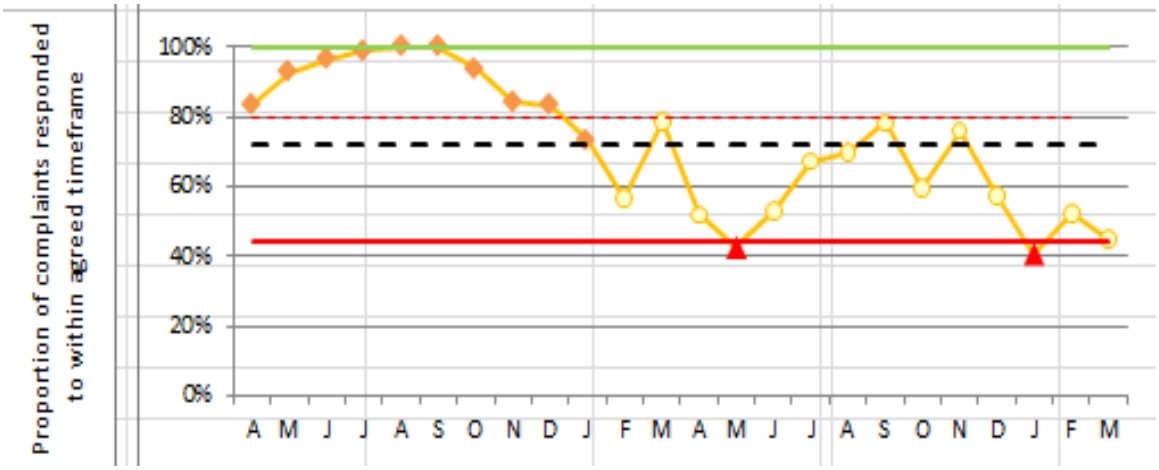
In 2021/22 777 formal complaints were received across all services (from 656 in 2020/21) within the Trust, and 3614 informal PALS concerns (from 2935 PALS 2020/21) were received.

The volume of written complaints received per month is shown below. Although numbers have risen slightly from last year, the volume has not reached pre-pandemic levels and on average between 60-70 written complaints were received each month.



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, however the target continued to be challenging during 2021/22 due to the operational pressures within divisions during the pandemic and subsequent recovery phase.

The Trust is currently reviewing its Complaints processes and will conduct a service review in 2022/23. We remain committed to improving the quality and timeliness of responses through adopting the NHS Complaint Standards (PHSO 2021) and supporting divisions with complaint responses throughout the ongoing recovery stage of the pandemic.



The Patient Advice and Liaison Service and the Complaints Team received several contacts about the impact of visiting restrictions (due to Covid-19) on some of our patients. Throughout the pandemic, birthing partners were still able to support women in active labour. Face to face visiting was also facilitated for vulnerable patients and those at the end of life. All information regarding the visiting restrictions was made available on the Trust website and updated regularly.

Several contacts were made by patients chasing their appointments and consultations as the pandemic started to wane. These enquiries were dealt with by the Patient Advice and Liaison Service and were mostly resolved promptly.

Formal complaints were raised by relatives during the pandemic highlighting several communication issues; for example, not being kept up to date with care and treatment plans about their loved ones who were inpatients. The 'Here to Help' team was set up during the pandemic and deployed staff to call family members and update them on the location of loved ones and pass on messages.

Formal complaints were raised about patients attending the ED and the triage process which determined their priority and approximate waiting times to be seen. Patients felt they could be exposed to Covid-19. The triage process was continually reviewed to keep all patients and staff as safe as possible. Staff and patients were all encouraged to wear face masks to help prevent the spread of Covid-19 and patients were swabbed on attendance and before being admitted as inpatients.

As the Trust moved to the recovery stage and (visiting) restrictions started to be relaxed, patients were invited to attend appointments in person. Social distancing remained in place to protect both staff and patients. Due to social distancing, less patients were able to be seen in face to face clinics at any given time. The Trust reviewed access and made adjustments to implement infection control measures and improve the number of patients that could attend each clinic.

There have been recent contacts from patients who were concerned about the impact of Covid-19 on their waiting time for treatment or a procedure. Each patient is assessed on clinical need and both the Patient Advice and Liaison Service and the Complaints Team work closely together, communicating with patients and staff and managing expectations about waiting times which are under constant review.

Staff

The following table represents some indicators relating to staff.

	Plan	**Actual***
Permanent staff (whole time equivalent)	5918	5880
Vacancy rate	6%	6.6%
Turnover rate	12%	14%
Appraisal	90%	46%
Statutory / Mandatory training 100% complaint	90%	87%

*March 2022

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 last year our subject matter experts supported by our capability team have converted most face-to-face training to online learning events. With the development and implementation of our online learning platform which went live in May 2021 we have enabled all our staff to have easier access to training and implemented an improvement plan which has led to improved compliance with essential learning from 46% in March 2021 to 87% in March 2022.

In April 2022, we implemented a new grow together (appraisal) process and window with all appraisals now taking place between April and August 2022, rather than at various periods during the year. All appraisals were paused from January 2022 to meet the new window requirements and we expect our compliance to improve in line with this revised targeted approach.

National staff survey

The national staff survey was carried out between September and November 2021. 2647 staff completed the survey representing a response rate of 42%. The overall findings are shown in the chart below.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.1	5.8	6.6	5.9	5.2	6.0	6.6	6.8	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,639	2,639	2,597	2,614	2,489	2,628	2,634	2,640	2,641

Reference: https://www.nhsstaffsurveys.com/results/

For 2022/23, we will focus on making improvements on

- We work Flexibly
- Safe and Healthy
- Recognised and rewarded
- We are always learning

The survey results show improvement in questions such as staff experience of bullying and harassment and staff feeling secure in raising concerns. However, our lowest scoring themes are in areas such as ‘Recognised and Rewarded’, ‘Safe and Healthy’, ‘Always Learning’ and ‘Work Flexibly’ as well as ‘Morale’.

The trends for EDI has seen our position improve in several areas such as ethnicity, disability, age and in opportunities for career progression. However, areas such as religion and gender have shown a decline. While the EDI lead and our network groups have made some significant changes in engaging the wider Trust in a host of initiatives, such as inclusion ambassadors on recruitment panels and a reciprocal mentoring programme, as well as a number of annual celebratory and recognition events, to improve in this area, ongoing intervention is needed to continue to support organisation wide change.

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. However, this year we have seen an increase in the number of staff feeling able to report incidences of bullying where it is experienced and a decline in the numbers experiencing bullying from line managers compared to 2020. The Trust is undertaking a number of initiatives to improve culture including an ongoing values refresh programme, as well as introduction of and continued interventions to improve the psychological safety of staff. This will include training more Mental Health First Aiders, introducing a Care Support Pyramid, training Freedom to Speak Up Champions and recruiting a Freedom to Speak Up Guardian, running reflective space sessions and Schwartz rounds with a focus on providing psychological safe environments to listen, reflect and share feedback.

The staff flu vaccine campaign is detailed in Annex 3.

3.2 Performance against national requirements

National standards

The indicators in this section form part of the NHS Improvement Single Oversight Framework.

	19/20	20/21	**21/22**	**Aim 22/23**
Max 18 weeks from referral in aggregate – patients on incomplete pathways	77.4%	60.36%	**58.78%**	≥92%
Four hour maximum wait in A&E	80.2%	Not Met 83.47%	**72.78%**	≥95%
62-day urgent referral to treatment of all cancers	79.82% (full year)	Met 86.13% (full) year)	**86.6%**	≥85%
Maximum 6 week wait for diagnostic procedures	99.48% (to Feb)**	Not met 33.07% (Full year)	**39.27%**	>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 under the national average, though it is recognised that waiting times increased substantially as a result of the Covid-19 pandemic. The Trust is making good progress in reducing long waiters and achieving on cancer targets.

Freedom to Speak Up / Raise Concerns

The Trust is committed to achieving the highest possible standards of quality and continues to develop a great place to work that supports and encourages an open and just culture. This is where staff feel safe and able to speak up about any issues which may affect their experience at work and in turn may hinder them from delivering safe and high quality individualised care to our patients.

Current 2022/2023 plans include a refreshed Freedom To Speak Up (FTSU) vision and strategy to reflect our organisation's commitment to 'Speaking Up'. This is being led by our newly appointed full time FTSU Guardian.

This strategy will be underpinned by our core values and behaviours and will foster a workplace culture that has psychological safety at the heart of all interactions

Our Trust has various avenues for colleagues to raise concerns including line managers, divisional leaders, Employee Relations Advisory Service (ERAS), Trade Unions, Speak in Confidence and the FTSU Guardian. A priority for 2022/23 is to design and deliver a refreshed FTSU awareness campaign, in collaboration with the staff experience hub to effectively inform staff of the various support services available to them. This will include targeting pivotal areas such as:

- Induction: FTSU Guardian or FTSU Champion will participate in our Trust corporate induction to ensure all new starters are aware of their obligations as advocated by Freedom to Speak Up and the support available to fulfil this obligation.
- A regular communication rhythm: Provide regular and diverse communication to ensure that everyone is aware of how they can speak up and the benefits of speaking up
- Training for managers programme: Ensure managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively

- Governance and monitoring: Ensure monitoring and evaluation of the number and nature of concerns is timely and supported by appropriate governance.
- Shared Learning: Ensure that key learning related to concerns is articulated to all in an open and transparent manner, while respecting confidentiality

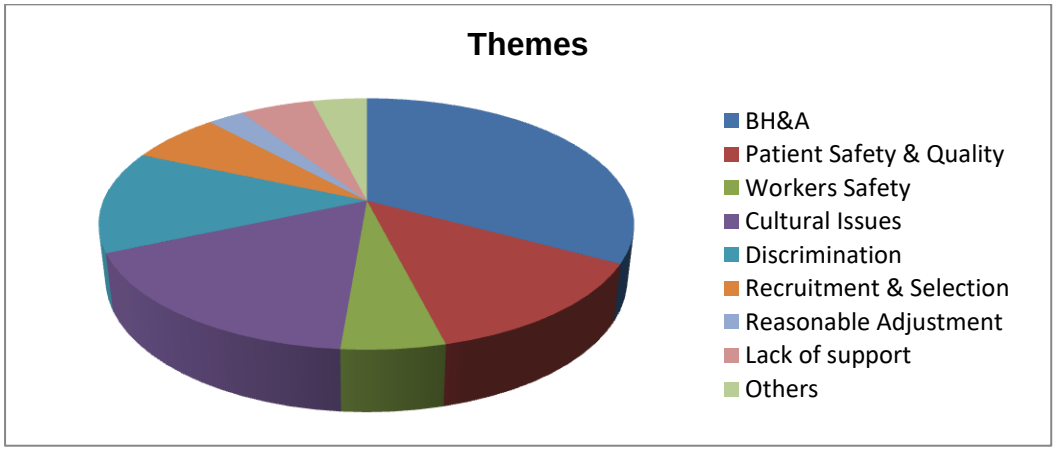
A gap analysis against NHS Improvement guidance shall be undertaken to support the development and design of ENHT FTSU strategy and priority plan. The new National FTSU strategy is being developed by the National Guardian's Office (NGO) and this will be comprehensively considered before reviewing and updating our current policy. We plan to launch a new ENHT FTSU strategy in Sept 2022 that will crucially incorporate the NGO recommendations to promote psychological safety in the work place and speaking up.

The Freedom to Speak Up Office

The Trust appointed a full time Freedom To Speak Up guardian in Dec 2021. The FTSU case numbers for 2021 increased significantly from 30 in 2020 to 90 in total in 2021.

Bullying and harassment has been a predominant theme, as illustrated in figure 35 below. Other major themes were patient safety and quality; discrimination and cultural difference, both of which can cause issues within the working environment.

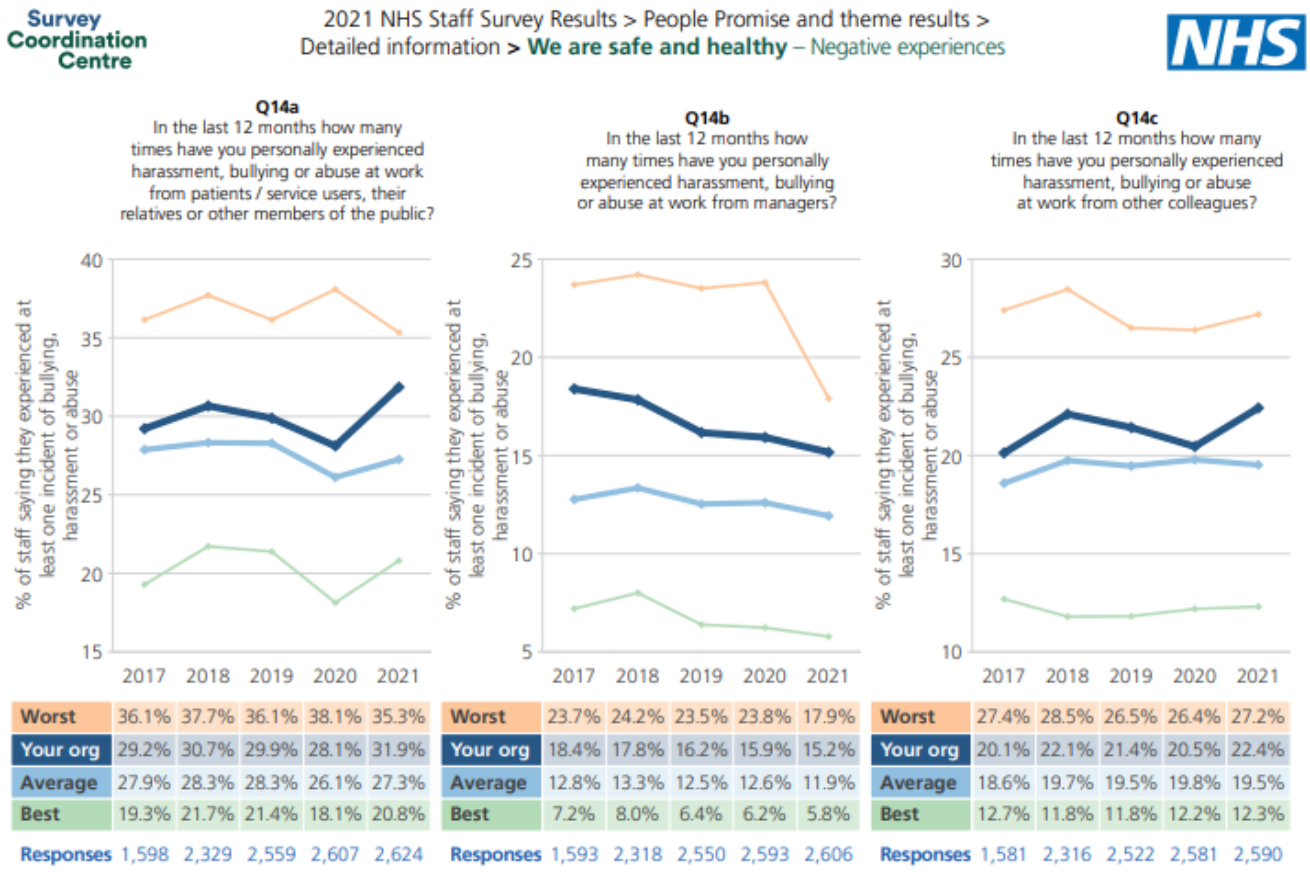
Figure 35 Themes reported in 2021/22 through the Freedom to Speak up Office



Recent staff survey results (2021) whilst evidencing some improvement, demonstrate that bullying & harassment continues to be an issue with our organisation and our scores are higher than the national average score (figure 36).

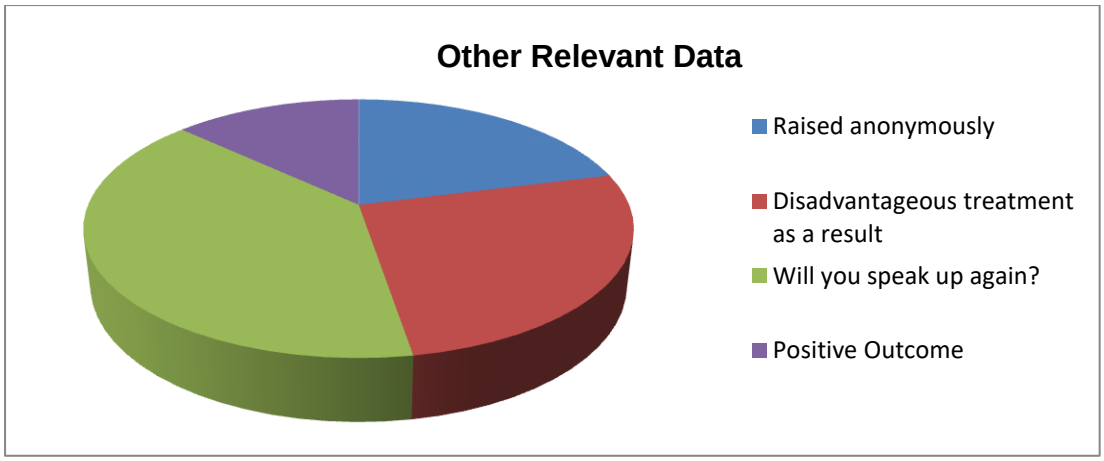
Whilst it's encouraging to know that our colleagues are speaking up, we have more work to do to achieve our goal of 'speaking up becoming business as usual'. We need to continue to foster speaking up culture and do more to support colleagues who have the courage to speak up.

Figure 36



The data in figure 37 below gives some assurance that 33%, (a third of all cases) of colleagues who have spoken up are willing to speak up again. The report also showed 22% of our colleagues have suffered some detrimental effect as a result of speaking up. Likewise, 17% of cases were raised anonymously; this presented a challenge in terms of investigating the matter as well as providing effective feedback. 11% of colleagues reported a positive outcome they were satisfied with, which could mean others may not be satisfied.

Figure 37



Black, Asian, Minority Ethnicity Pilot, NHSE/I

East and North Hertfordshire NHS Trust volunteered to be one of the pilot sites after undertaking a FTSU Board review with Advocacy & Learning team colleagues.
In May 2021 NHSE/I set out a proposal to work collaboratively with three pilot sites and other NHSE/I colleagues to:

- Raise awareness of FTSU with BME workers and build confidence in the speaking up process.
- Advise on how the FTSU guardian recruitment process can be more inclusive
- Understand some of the specific challenges that BME staff face to speaking up and what would make it easier for them to speak up
- Support organisations to develop an action plan for continuous improvement.

The 2 x 2 half day workshops were held on 28 October 2021 and 3 November 2021: one in the morning and the other in the afternoon. The workshops followed the same format for each session and had the following attendance;

- Workshop 1: 16 attendees
- Workshop 2: 11 attendees
- Workshop 3: 17 attendees
- Workshop 4: 24 attendees

Workshops 1 to 3 were aimed at BME workers and Workshop 4 was open to workers from all ethnicities.

The main observations coming from the pilot were as follows:

- Participants from this pilot were not as vocal as other pilots. When explored in greater depth there were no real reasons for that but it was noted by facilitator.
- There were a couple of concerning stories of issues that happened during Covid-19 and BME staff being penalised for this.
- There was less acknowledgement of champions. Some staff were not aware of FTSU champions and guardians and publicity of FTSU could be more forthcoming
- The fourth workshop was open to all workers and there was a marked difference in the type of conversation at that workshop. It was noted that a number of participants were from a higher band and the issues discussed were more around managers and senior leaders, whereas lower banded attendees' focus was around their own managers and more HR type issues.
- It was noticeable from the fourth workshop that attendees in breakout rooms did not have as many major issues with their managers

Recommendations and actions shall be included as strategic priority actions though 2022/23 FTSU office progression.

Freedom to speak up champions

Our organisation's commitment to ensuring an open, civil, inclusive and collaborative culture will be evidenced through our Trust's FTSU champions, who will work with FTSU Guardian in collaboration with the staff engagement team to play a key role in encouraging staff to raise concerns at the earliest opportunity. The FTSU Guardian will support our champions and the people team will help develop a network of FTSU champions throughout the organisation.

FTSU champions will:

- Act as an independent and impartial source of advice to staff at any stage of raising a concern.

- Champion and raise awareness of FTSU and the value/ benefits to staff experience and patient safety.
- Be visible and accessible to staff within their departments.
- Raise the FTSU profile by attending Trust events and meetings
- Instil confidence that concerns will be listened to and addressed, regardless of job role or personal background/characteristics.
- Escalate and report issues to the FTSU Guardian in a timely manner, and in particular report serious issues (such as those with legal, safeguarding or professional implications) to the FTSU Guardian or a senior manager without delay.
- Ensure confidentiality is maintained on all issues raised.
- Support the FTSU Guardian with providing feedback to staff on the outcome of investigations into the concerns they have raised.

Rota gaps

Gaps to rotas of doctors and dentists in training are monitored on a monthly basis. The table below shows the total number of rota gaps across all specialties in the financial year April 2021 to end March 2022.

The average junior doctor rota gap is similar to last year, with an average of 11.5 per month.

Month	Total Vacant Trainee Posts
April 21	**2**
May	5
June	8
July	10
August	8
September	8
October	12
November	12
December	19
January 22	18
February	20
March	16

Actions continue to be taken to improve vacancies:

Direct

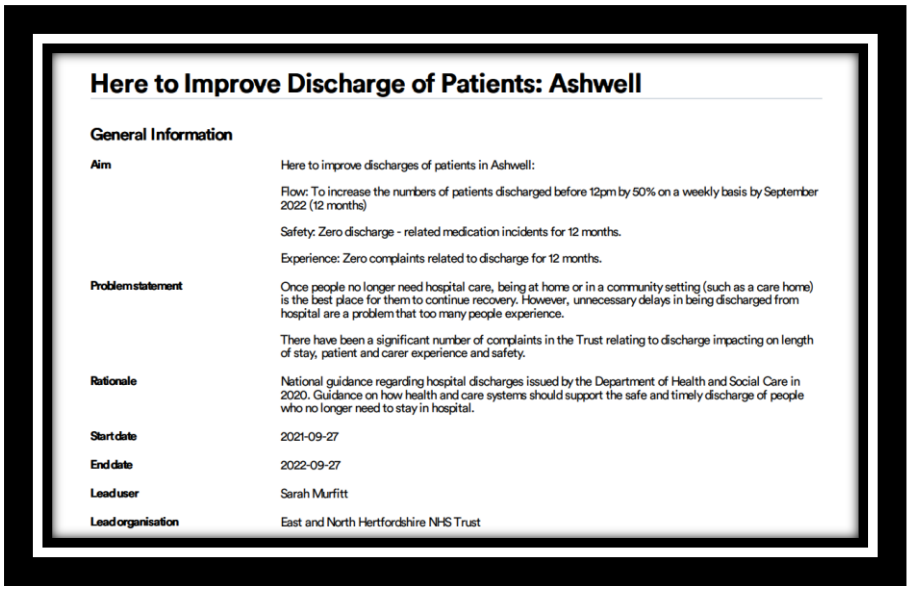
- Recruitment of Trust Grade, Clinical Fellows in temporary posts
- Recruitment of other training grades (e.g. MTI – medical training initiative for foreign doctors)
- Recruitment of temporary Locums to cover gaps and provide the clinical service

Indirect

- Improve or enhance training posts to make posts more attractive to schools
- Reconfiguration of rotas to optimise the number of trainees on each

Annex 1 Examples of Quality Improvement (QI) projects and initiatives

Discharge QI project

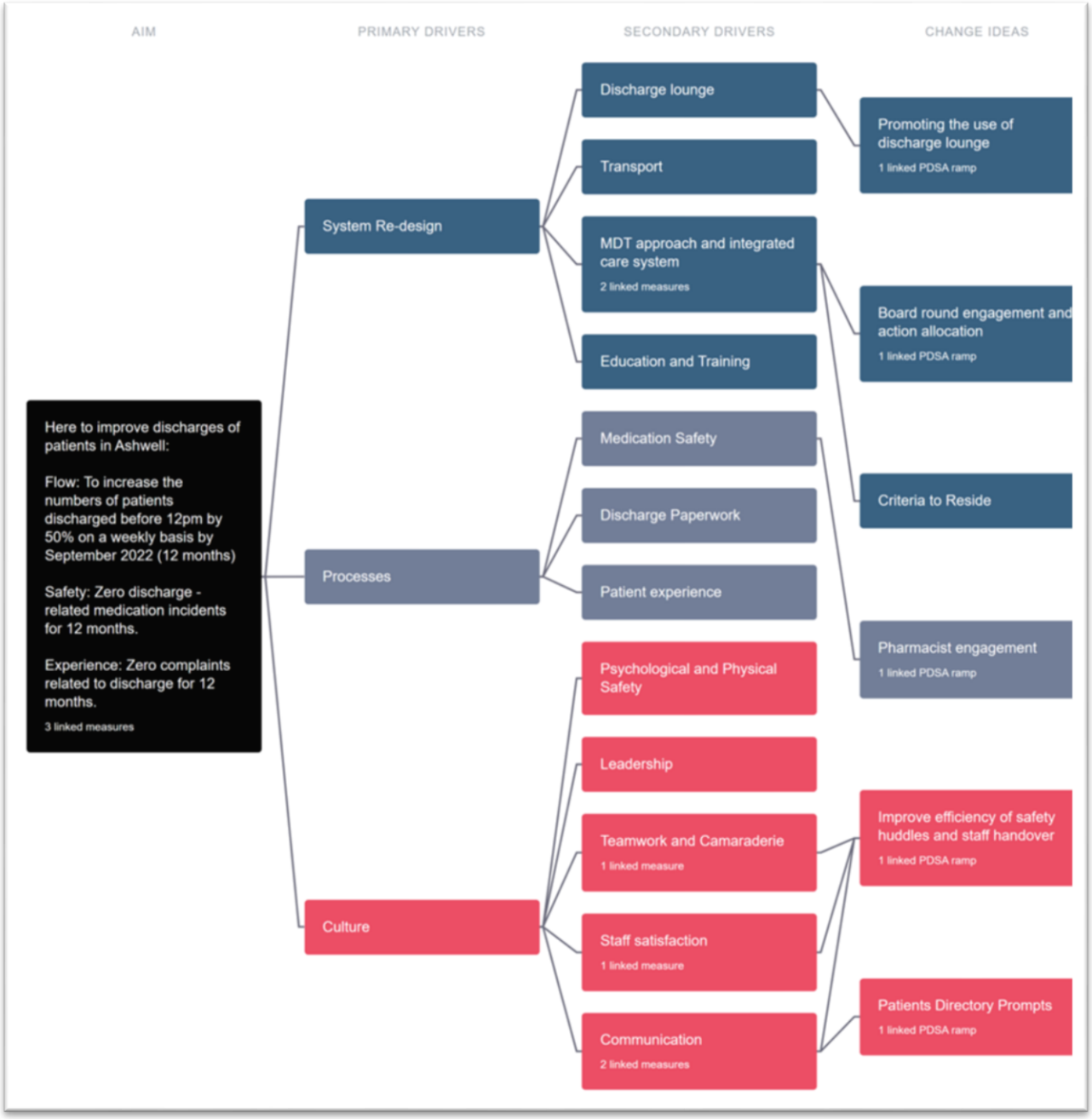


Here to Improve Discharge of Patients: Ashwell

General Information

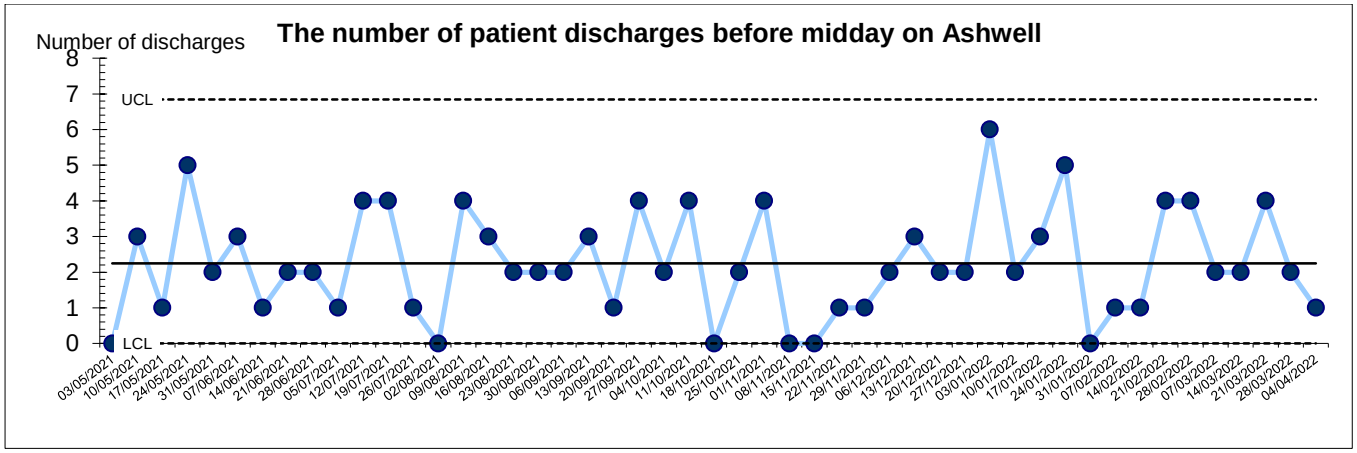
Aim	Here to improve discharges of patients in Ashwell: Flow: To increase the numbers of patients discharged before 12pm by 50% on a weekly basis by September 2022 (12 months) Safety: Zero discharge - related medication incidents for 12 months. Experience: Zero complaints related to discharge for 12 months.
Problem statement	Once people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place for them to continue recovery. However, unnecessary delays in being discharged from hospital are a problem that too many people experience. There have been a significant number of complaints in the Trust relating to discharge impacting on length of stay, patient and carer experience and safety.
Rationale	National guidance regarding hospital discharges issued by the Department of Health and Social Care in 2020. Guidance on how health and care systems should support the safe and timely discharge of people who no longer need to stay in hospital.
Start date	2021-09-27
End date	2022-09-27
Lead user	Sarah Murfitt
Lead organisation	East and North Hertfordshire NHS Trust

Below is a driver diagram of primary drivers in the system identified to support improving the quality and safety of discharges from the hospital, influencing across wider health care systems.

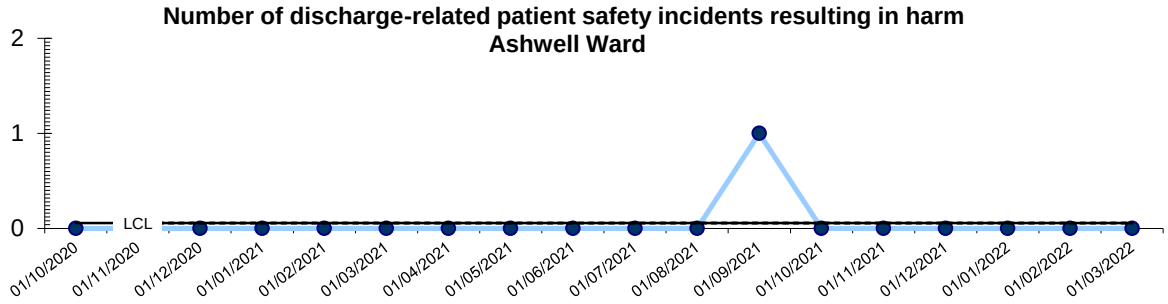


Discharge quality improvement family of measures:

1. **Patient Flow:** Improving the timely discharge of patients before midday on Ashwell ward. The chat below shows common cause variation between 1-6 patients, and an average of 2 patients each day discharged before midday.

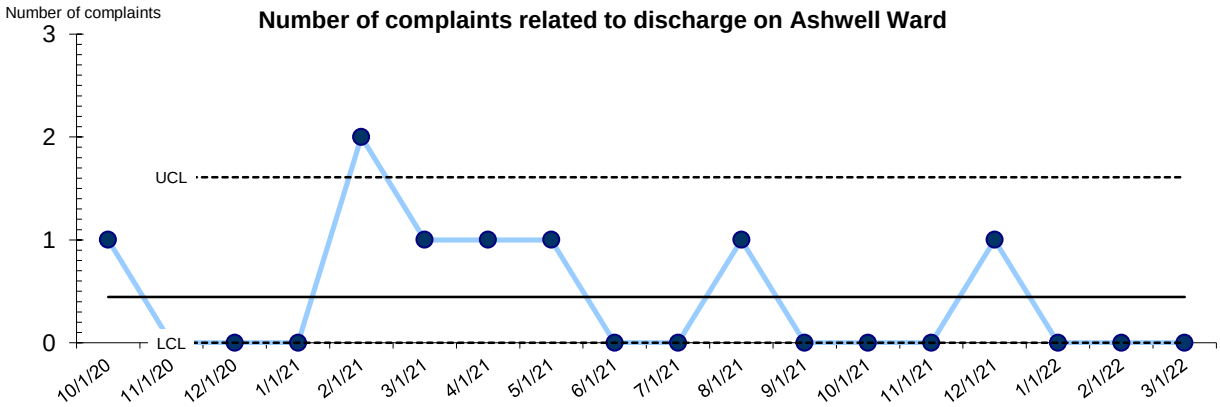


2. **Patient Safety:** The Ashwell ward leader started this project following an incident resulting in harm to a patient in September 2021. To date, the ward has not had any further discharge –related incidents resulting in harm to patients.



3. **Patient experience –** formal complaints

Formal complaints are tracked through the complaints team; the chart below shows Ashwell ward received 6 complaints related to discharge in the first 6 months October 2020-June 2021, and only 2 complaints related to discharge July 2021 – March 2022



Evaluation of the improvement project

Challenges:

- Communication between team members
- Data collection was a challenge and some data cleansing is required
- Staffing sickness
- Capacity of team members to test new ideas

Enablers:

- Very motivated and committed team and leader
- Involvement of clinical and non-clinical team members
- Respect for other team members time and boundaries and have been completing the actions agreed upon.

The impact of the project will be reviewed at completion in 2022. There have been nil discharge-related medication errors in the last 5 months on Ashwell ward. Qualitative feedback has been positive about medications for discharge being completed earlier in the process.

Learning and next steps:

- Collaboration between all members of the team is essential.
- Coaching reported as an enabler.
- Improving QI capability among team members may lead to faster progress.
- The board rounds have been successfully implemented.
- The team allocated a communication space to post updates about the project. This allowed the team to celebrate learning and learn from failures.
- Currently, the 'criteria to reside' portion in nerve centre is not completed consistently as the ward has no dedicated patient flow coordinator.

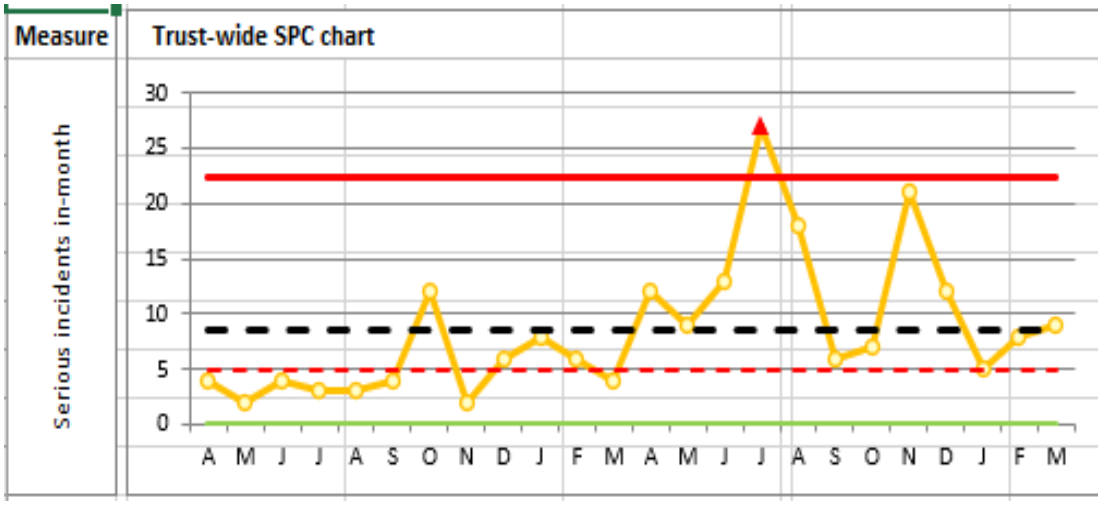
Progress on Outcomes/HFC Programme Goals 2021/22:

Refer to table below for progress on HFC Programme April 2021/22:

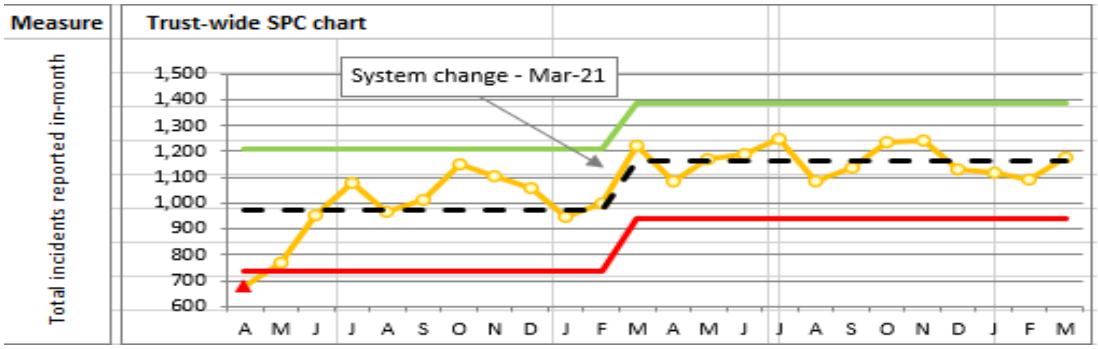
HFC Goals 2021-2024	July 2021	March 2022
1. All 6 HFC safety work streams to complete minimum 1 QIP by April 2022, target 6 QIPs by April 2022 with a minimum IHI score of 3.5 – 5	• Currently QIPs with IHI score of 1.5 -2.5	• 2 QIP : 1.5 • 2 QIP: 2.5 • 3 QIP: 3 - 3.5
2. 100% of HFC leads completed bitesize QI and coaching/ leadership in QI training by April 2022, [Based on Dosing formula], by April 2022,	• All HFC leads completed bitesize training • 3/6 have access to IHI licenses	• All HFC leads access to IHI licenses • All HFC leads have access to QI coaching (minimum two/month)
3. All HFC leads have involved minimum of 1 service user in QIP, target 7 (including programme partner), by April 2022	• 2/7 involved (including programme partner)	• 3/7 involved in QI projects (including programme partner)

The aim of the programme was a 50% reduction in Trust wide serious incidents (moderate and serious harm combined) from monthly average of 8-4 by April 2022.

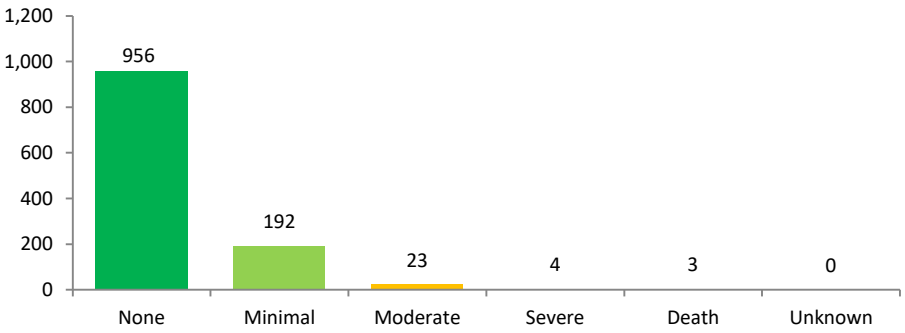
The chart below shows an average of 8 Serious Incidents (SIs) were reported per month, with a variation seen in July 2021, due to an increase in the reporting of hospital onset Covid-19 infections.



A 5.50% improvement in Trust wide incident reporting has been seen through an increased monthly average of 1110 to 1665 average per month, by March 2022.



97% of all incidents reported were low or no harm.



Summary of HFC Programme:

Enablers:

- Improved improvement capability and standardised use of our methodology i.e. 7 Step model of continuous improvement has proven successful. HFC programme score progressed from IHI score of 2.5 to 3 indicating over 20% improvement in 4/6 harm specific processes.
- Use of data to drive better clinical decisions
- Governance in place to deliver the programme
- Regular QI coaching for HFC leads and project teams has demonstrated a strong positive relationship between benefits of coaching and progress with projects

Barriers:

- Variation in organisational capacity and conditions for undertaking improvement
- Significant variation remains in Trust wide site safety communication and safety culture amongst frontline teams. This learning has been identified during PDSA cycles of testing on various wards, highlighting variation in awareness of risks, communication and responsiveness to safety critical information on wards.
- Variation in multidisciplinary team working on wards

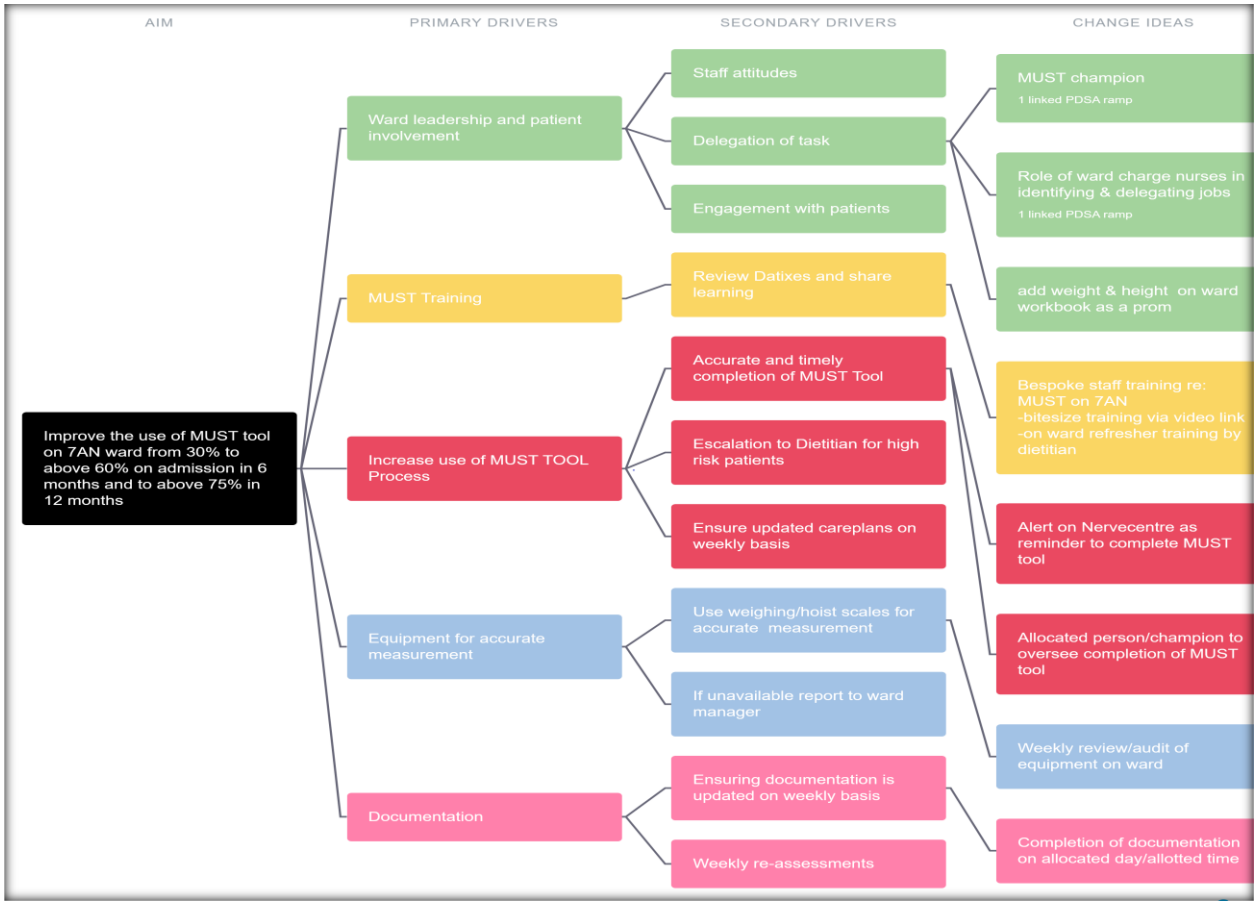
Example of Nutrition & Hydration QI project in HFC programme: ward 7A

Background: Use of MUST (Malnutrition Universal Screening Tool) is important to reduce risks associated with malnutrition and dehydration such as impaired wound healing, increased risk of infection, longer hospital stay as well as poor patient experiences. National guidance suggests malnutrition accounts for approximately 30% of hospital admissions and costs the NHS £19.6 billion per year. The Trust wide audit of the use of MUST in March –April 2021, demonstrated a compliance of only 30-40% of MUST on level 7 and 9B wards on admission. Learning themes identified: variation in accurate measurements, lack of equipment and poor documentation of follow up care plans. Additionally, a lack of MUST measurement plan and formalised training for MUST were other areas identified as requiring improvement. This triggered a quality improvement (QI) project on 7a ward to improve safety and effectiveness of processes on the ward.

AIM: To improve use of the Malnutrition Universal Screening tool on 7AN ward from 30% to > 60% on admission in 6 months and to > 75% in 12 months.

Project Team: 7AN ward team adopted the 'Here to Improve' seven step model for continuous improvement to structure the project with support from a QI coach and partnered with Hertfordshire Community Trust (HCT) colleagues i.e. Acute Dietician lead who provides an in reach service to ENHT.

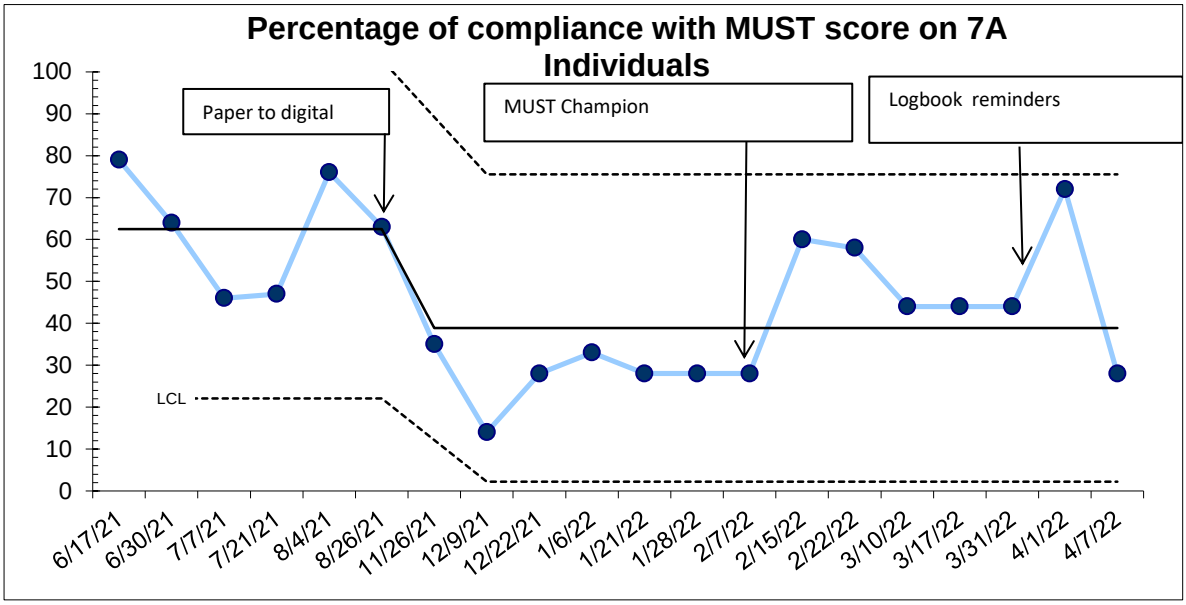
The driver diagram below highlights the primary drivers in the system identified to drive improvements through tests of change.



Measures: The % of patients with a completed MUST risk assessment on admission to the ward within 24 hours.

Change ideas: Teams have developed a theory of change and Plan-Do-Study-Act (PDSA) cycles to test change ideas such as role of MUST champion and role of shift charge nurses to put reminders in the log book as a way of prompting staff to complete their risk assessments. Currently data has demonstrated common cause variation, figure 38 and learning from PDSA cycles are being incorporated in further tests of change.

Figure 38



Summary: Over the year, focus has been on building awareness and engaging ward staff. The project teams have developed a robust measurement plan for MUST, and a Trust wide MUST training package is on ENH Academy

Wins: The QI approach was systematic and supported the development of a measurement plan and a Trust wide MUST training package. The project IHI score has progressed from 0.5 – 2.5 over the last year and the team has put structures and processes in place with plans to continue to test ideas for the year ahead.

Enablers/Learning: from QI work (enablers) has further resulted in

- An increase in collaborative and integrated partnership working with our Hertfordshire Community Trust (HCT) colleagues over the last year.
- Team engagement in 'change' through embedding weekly debrief QI team meetings, has resulted in early signs of collective engagement and ownership of the project from frontline staff.
- Consistent support and involvement of ward leader and matron has been crucial to the delivery of the work on the ward.

Challenges/Barriers to Improvement:

- Variable capacity and time i.e. variation in conditions to deploy and test improvement ideas on ward
- Staff engagement has been challenging on the ward
- Silo working and variation in how communication re QI work/learning has been cascaded to all frontline staff on the ward

Feedback from HCT Acute Dietitian lead on using QI and partnership working with ENHT.

‘’Initially I had little experience of QI work so it has been a learning curve. Previously quality improvement work has been attempted within the department but with little understanding or knowledge of how these improvements can be sustained longer term. Therefore, it has been interesting to understand the theory behind successful quality improvement in terms of how to test an idea, ways to engage staff with the project and developing some resilience so if one idea doesn’t work, there will always be another idea or angle to approach from.’’

Trust wide Nutrition and Hydration Quality Improvement plans

1.Awareness on Nutrition and Hydration – In March 2022, as part of Nutrition and Hydration week, the dietetic team targeted some of our inpatient wards to try and understand what staff felt about MUST and check their understanding of it and any barriers they were facing. This feedback will inform the future improvement work .

The team had also put some key messages in our Trust wide bulletin; the aim was to endorse ‘Nutrition and Hydration’ week and our focus on MUST was to create more awareness around the tool. Over the summer ward dieticians will continue to raise awareness and offer refresher/bitesize sessions to ward staff.

2. Capability building update: The Trust wide MUST training package is ready to go live on our ENH academy over the summer. Data on ENH academy will be monitored for uptake of training by staff. Plans to add an additional video are also in place to focus on how to complete MUST on Nerve centre .Our aim is to improve adoption of digital MUST assessments and care plans as part of our ‘Keeping our patient safe’ digital programme - Also, it has been agreed that the nutrition assessment nursing proforma (NAP) is going to be joined with the MUST tool which should lead to better compliance rates as staff will be prompted to fill in the assessment and MUST tool following some preliminary questions in the NAP.

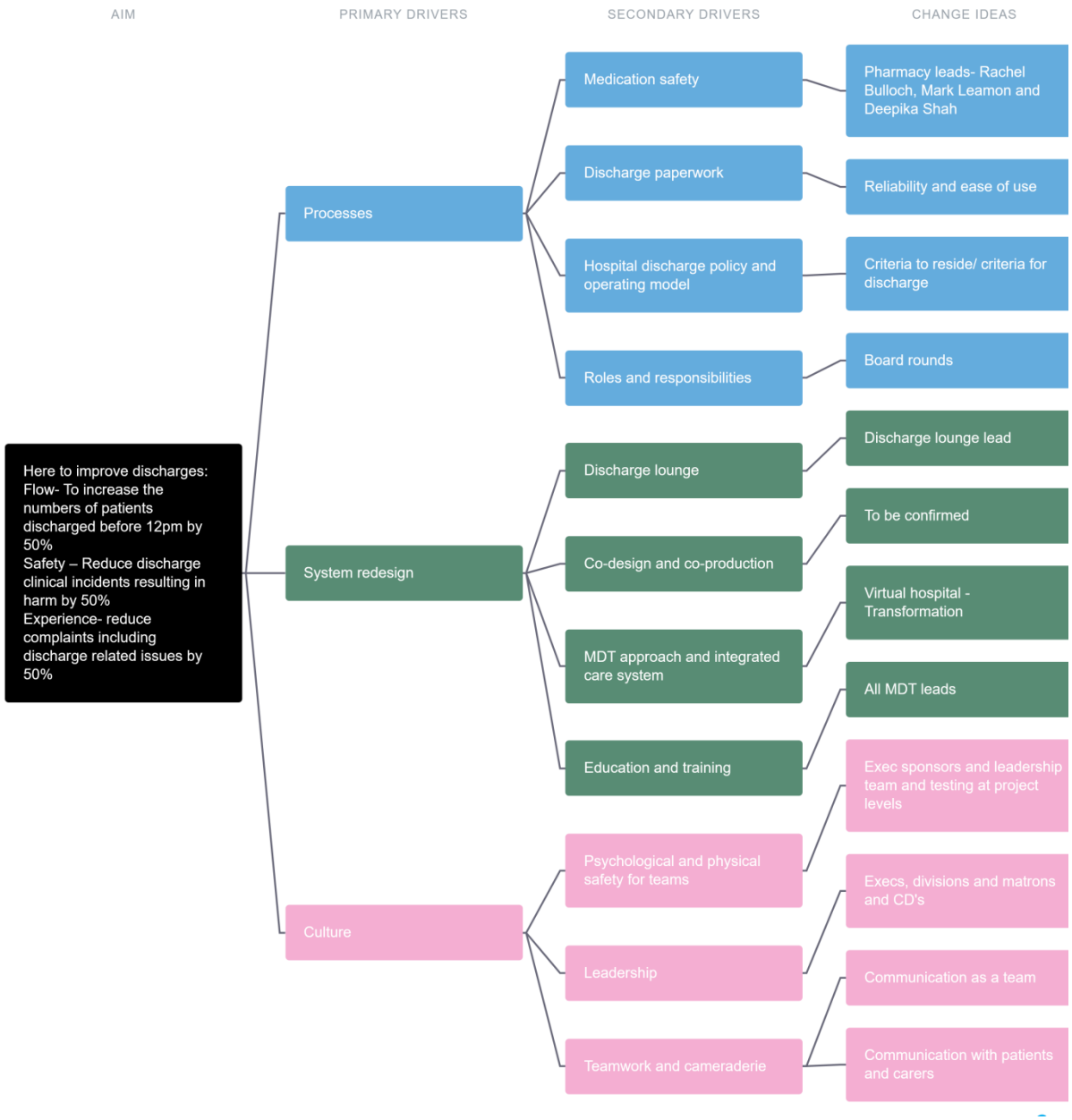
3.Additional Quality Improvement plans: QI work on testing a process for developing a volunteers feeding competency framework is to commence on Elderly care wards. A pilot QI project begins over the summer of 2022 aiming to provide safe Nutrition and Hydration care for patients with general feeding needs supported by our volunteer service.

Discharge programme

Aim: Improving the flow, safety and experience of discharge by end of March 2022

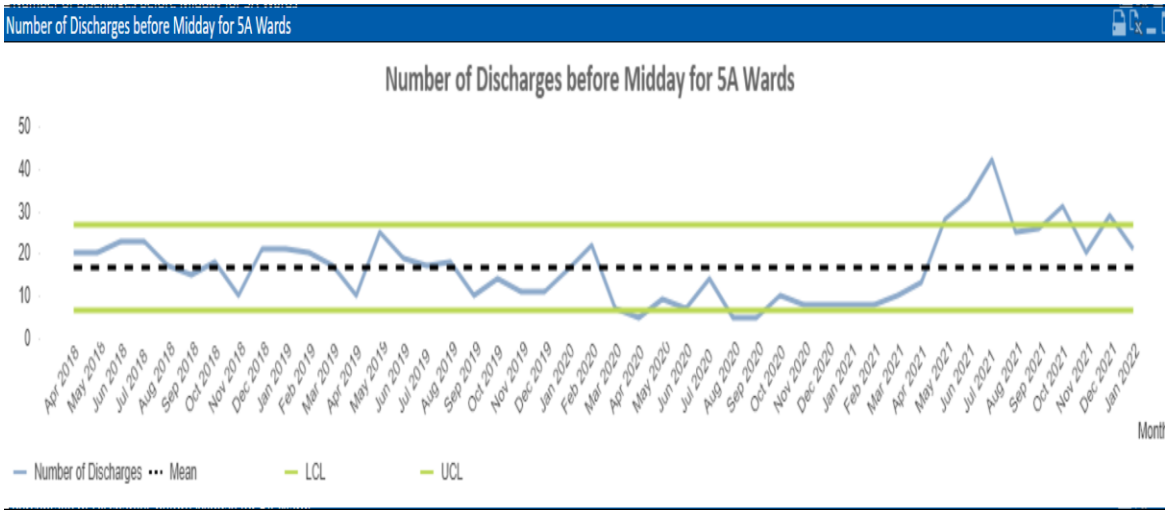
- Flow- 1 discharge before 12pm daily
- Safety – Reduce discharge clinical incidents resulting in harm by 50%
- Experience- Reduce complaints including discharge related issues by 50%

Driver diagram:



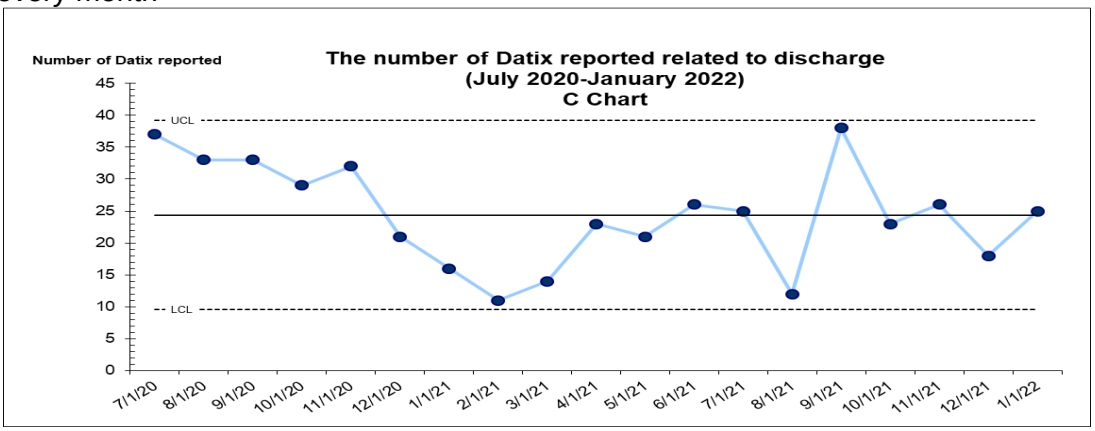
Measurement

1. Flow- discharges before 12. This was improved on ward 5A and no change on Ashwell or 8A and the number decreased on 6A and 10B

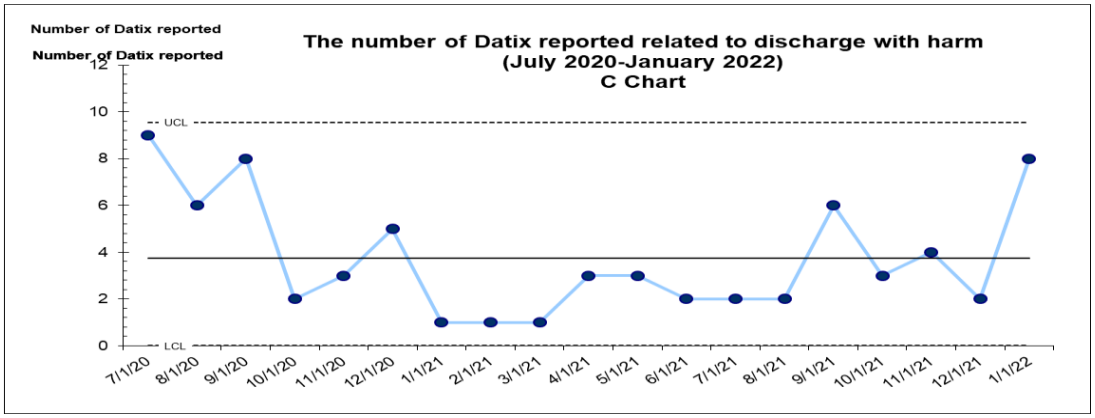


2. Safety:

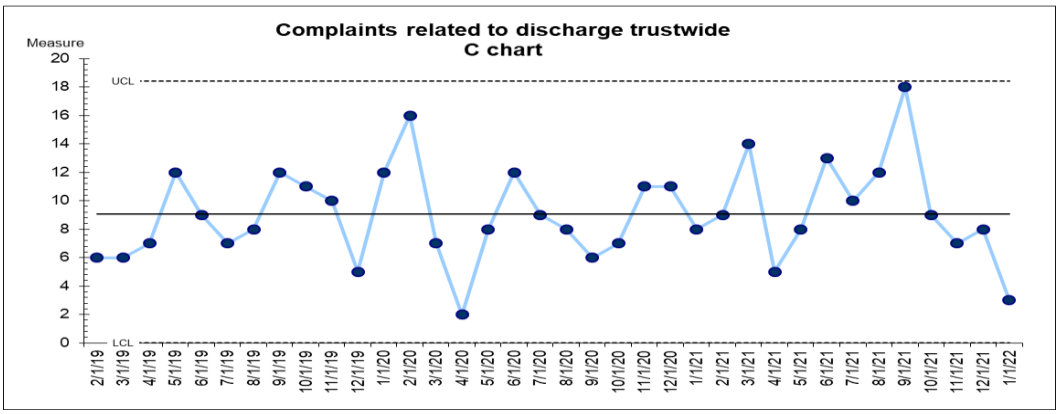
Incidents related to discharge- no change in numbers in the Trust overall with a mean of 24 every month



Incidents with harm related to discharge also showed no change apart from during Covid-19 which we suspect was due to a reduction in reporting overall



3. Experience- no reduction in the number of complaints related to discharge



Barriers to improvement:

- National guidance only which needed to be adapted for local use, no local discharge policy and clear definitions of board round, MDT, EDD
- True collaboration and identification of what good looks like from board to ward could not be agreed
- Digital-Ease of use of the digital passport, discharge letters on Lorenzo
- Capacity to do improvement work as a team
- Fatigue and burnout in our team
- Communication and messaging about operational pressures and how clinicians should respond can be improved
- Accuracy of data to be investigated- local records of those discharged to discharge lounge and those recorded on Qlickview show discrepancies

Enablers for improvement:

- Focus on safety and experience resonates with teams
- Communication between the teams and the patients and carers can lead to improved safety and experience
- Training required in national policy terminology and implementation
- Digital systems supporting human factors

Deteriorating patient programme

The sepsis, critical care outreach, acute kidney injury and resuscitation teams work together with our associate directors of safety to run improvements in their teams. They are also required to support the Trust to make improvement towards the outcomes of our deteriorating patients. Plans to run a collaborative across the Trust have been affected by the capacity to do this in our clinical teams. These subject matter experts and teams offer training and support to the clinical teams in the Trust however this is yet to be formalised into a larger number of improvement projects. The teams are testing and learning ideas on ward 7B around improving reliability of observations and escalations based on these observations.

Learning has included:

- The need to simplify some procedures, for example procurement of safety equipment by ward leaders.

- Safety risks emerge /become apparent when training capacity is reduced within clinical teams
- Reduced capacity for multi-disciplinary teams to work together to test new ideas for change.

Patient and carer experience programme

In 2021-2022 we set up and ran the 'what matters to you?' volunteer team. This was in response to several different circumstances:

- Visiting remained restricted due to Covid-19 infection prevention and control guidelines/policy.
- Demand for acute services was high
- Capacity was often affected by isolation required for Covid-19 positive staff members
- Well-being of the teams was a consideration due to the pandemic and the resulting stress levels inside and outside of work

We acknowledged all of these factors may have an impact on patient and carer experience. To this end we set up the 'what matters to you?' team with the help of some funding for a coordinator from the East and North Hertfordshire Charity. The role of the coordinator was to set up a team of volunteers to do three things:

- Book and carry out virtual visiting
- 'What matters to you' conversations- ask, listen and do what was within their remit and handover to the clinical teams if this was outside of their remit
- Data collection for improvement- support the collection of Friends and Family Test (FFT) data and 'what matters to you' data in order to drive patient and carer experience projects

Outcomes and measures are covered in the patient and carer experience sections of this report.

Annex 2 Clinical Audit- actions to improve healthcare

The reports of 15 national clinical audits were reviewed by the provider in 2021/22 and ENHT intends to take the following actions to improve the quality of healthcare provided.

National clinical audits reviewed by the provider in 2021-2022	Actions ENHT intends to take to improve the quality of healthcare provided
NCEPOD - Know the score - A review of the quality of care provided to patients aged over 16 years with a new diagnosis of pulmonary embolism (15779)	• Discuss BNP protocol with Cardiology & Medical Director • Discuss formalising a PE treatment network at Divisional Board
MBRRACE-UK Perinatal Confidential Enquiry Stillbirths and neonatal deaths in twin pregnancies (15867)	• Update trust guideline • Implement the Perinatal Institute Bereavement notes checklist • Contract agreed with Cambridge for perinatal pathology
MBRRACE: Confidential Enquiries Maternal Deaths & Morbidity - Saving Lives, Improving Mothers' Care (audit period 2016 to Sept 2018) (15870)	• Update trust guideline
MBRRACE-UK Perinatal Mortality Surveillance Report (15872(2))	• To undertake a review of 2020 PM uptake, including ethnicity and deprivation for discussion at next PMRT meeting
NCEPOD Acute Bowel Obstruction Delay in Transit: A review of the quality of care provided to patients aged over 16 years with a diagnosis of acute bowel obstruction (Published January 2020) (15905)	• Provide consistent hydration status measurement & documentation across all wards • Agree joint clinical network pathways of care that enable improved access to stenting services
NCEPOD Time Matters: A review of the quality of care provided to patients aged 16 years and over who were admitted to hospital following an out of hospital cardiac arrest (16093)	• To procure targeted temperature management equipment
National Diabetes Audit, 2019-20 Type 1 Diabetes, England and Wales (16118)	• Business plan agreed to expand workforce to increase numbers on pump
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) Children and young people asthma clinical and organisational audits 2019/20 (16167)	• To procure Feno device • Review clinic capacity • Review requirement for specialist nurses
MBRRACE-UK Perinatal Mortality Surveillance Report 2019 (UK Perinatal Deaths for Births from January to December 2019) (Published 14th October 2021) (16394)	• Training on signs of life for incorporation into annual bereavement training programme
The National Hip Fracture Database Report 2020, Falls and Fragility Fracture Audit (FFFAP). Based on data: between 2017 and 2019 (16689)	• To increase pre & peri- operative use of assessment benchmark/bone protection table & anaesthesia run chart
National Perinatal Mortality Review Tool: Learning from Standardised Reviews When Babies Die - Third	No actions required as meeting audit recommendations

Annual Report. (Published: 13th October 2021) (16752)	
National Diabetes Inpatient Audit (NaDIA) Harms 2020 - Annual Report (16788)	• Formal Clinical Governance meetings in progress with leads to improve identification of people with diabetes on admission to hospital
NCEPOD - Inspiring Change: A review of the quality of care provided to patients receiving acute non-invasive ventilation (9341)	• Include a mandatory audit of all acute non-invasive services to the annual clinical audit plan • To review appointment of clinical lead for NIV
Adolescent Mental Health, Focusing on Self Harm (NCEPOD) (9642)	• Plan to upgrade to electronic patient records • To review appointment of clinical Mental Health lead for children and young people • Plan for compatible MH and ENHT software
Maternal, Newborn and Infant Programme: Learning from SARS-CoV-2-related and associated maternal deaths in the UK (COVMBRACE2)	• Remote Consultations for bookings.

The reports of 107 local clinical audits were reviewed by the provider in 2021/22 and ENHT intends to take the following actions to improve the quality of healthcare provided.

Local clinical audits reviewed by the provider in 2021-2022 *(*101 audits listed as 4 audits were audited and re-audited and 1 audit was audited and re-audited twice in 2021-22)*	**Actions ENHT intends to take to improve the quality of healthcare provided**
Use and documentation of tourniquets in operative management of distal radius fractures	Improved documentation of type of tourniquet & pressure parameters to be included in the intraoperative notes.
(Re-Audit of 17674) To assess the appropriateness of cases treated by our local Urgent Eye Care Service during COVID-19, post-intervention	Improve nurse education re eye emergencies, triage and management to empower the nursing staff workforce to deal with ≥50% of the presenting patients without recourse to an Ophthalmologist.
5 years of NovaSure ablation what have we learnt?	Share learning at Clinical Governance meeting as reminder to Hysteroscopists to check endometrial biopsy results.
An Audit into the timing of diagnosis provision on MRI Lumbar spine for a suspected cauda equina syndrome (CES) at Lister Hospital	To raise awareness of CES guidelines. We have updated the proforma for T&O doctors, with information regarding local guidelines for MRI/CES imaging. We have also provided additional CES pathway information via the survey we distributed to ED and T&O staff. The audit results and relevant information were also presented to the department and shared with Radiology clinical director and MSK lead who are currently involved in the a CES

	pathway committee, set up to formulate an up to date trust wide clinically led pathway.
An audit on follow-up for paediatric patients diagnosed with transient synovitis	Trust guidelines fully met no actions identified for improvement.
Anaemia in elderly care - how well were investigations carried out?	Improve staff awareness on what investigations need to be carried out for each anaemia subtype and which teams to contact for further aid on treatment/invasive investigations
Antenatal Care	To improve Midwives: - transcribing of booking bloods and anomaly results into the green notes, - where safe to do so undertake 36/40 C02 monitoring, - ensure staff aware of new Antenatal guideline and it's recent amendments to enhance compliance with the Ockenden asks
Assessing the standard of T&O written operation notes: an audit & departmental quality improvement	Improve operative note recording, typed operative notes will provide better standard of care in relation to clarity of instructions, availability of notes for all responsible clinicians at any time.
Asthma Discharge Care Bundle (Paediatrics)	Improve paediatric staff awareness in of the care bundle (presentation and print our forms for the Children's Assessment Unit and Bluebell ward
Audit of adequate documentation of risk consent in neck of femur fracture patients in accordance to British Orthopaedic Association Guidelines	Improve the documentation of the risks of surgery explained and consented by patients undergoing surgery for fractured neck of femur.
Audit of emergency obstetric anaesthesia practice & outcomes	Trust guidelines fully met no actions identified for improvement.
Audit of Intraoperative Notes for Tooth Extractions under Local Anaesthetic at Lister Hospital	Design and implementation of notes proforma to ensure all the necessary information is documented.
Audit of provision of general anaesthesia for obstetric procedures	Identify process to enable all obstetric general anaesthetic cases to be reviewed. Add RCoA specified adverse effects to Epidural Audit System.
Audit of tonsillectomy day-case and readmission rates	Performance within national standards, no actions identified for improvement.
Audit on compliance with national acitretin prescribing guidelines re-audit	Audit results to be shared and acitretin prompt to be recirculated.
Audit on guidelines for management of Squamous Cell Carcinoma Re-audit	Share audit results, and remind the surgical excision is appropriate for the clinical features of the tumour and clearly documented in the medical notes - with team and create posters for minor op theatre room.
Audit on Post dural Puncture Headache (PDPH)	Improve CLU Anaesthetic staff awareness of RCOA quoted risk of PDPH and achieve appropriate clinical training to achieve this outcome.

Baby Friendly Assessment re-audit - Infant Feeding: Mother interviews using the UNICEF audit tool	Increase antenatal and postnatal conversations which give women the information to make informed decisions and help them be successful at breastfeeding.
BAD Photodynamic therapy Re-audit	Review protocol and increase staff awareness re initial clearance rates of actinic keratosis, Bowen's disease and superficial BCC at 3 months after last treatment.
Blood Pressure Monitoring Audit	Increase staff awareness of need for more consistent blood pressure monitoring at the time of admission.
Cancellation of Orthopaedic elective theatre patients due to urinary tract infection - An Audit	Current pathway fully met no actions identified for improvement.
Clinical Audit Of Change In Practice With Intracorporeal Ureteric Stents At Lister Hospital	Reduce incidence of blocked stents by routinely use Bander stent for every patient.
Combined Audit - EP C, EP I.1 & EP I.3 for Treatment	Remind staff of importance of checking Treatment Verification Log
Combined Audit - EP C, EP I.1 & EP I.3 for Pre-Treatment	Confirmation of consent and pregnancy task to be added to the pre-treatment pathway on Carepath. Reminder training for Radiographers re process for checking patients have been giving written information.
Covid Mortality among Neck of femur fracture and Periprosthetic fracture patients during the 2nd wave - A review and re-audit	To improve covid testing pre-op and to ensure patients get uninterrupted Orthogeriatric input post-op.
Criteria Led Discharge Form Audit	Improve clarity of documentation re when a patient is safe for discharge to empower nurse led discharges were possible.
DESCENT: Departmental Evaluation of Scrotal Imaging Considering European and National Testicle Guidelines	Addition to be made to ICE requests to prevent inappropriate ultrasound scan requests being made and review scan requests process with GP liaison team.
Do you know what 'nil by mouth' really means?	Remind staff that correct medications need to be given for nil by mouth patients and need to predict theatre timings to reduce prolonged period of nil by mouth for patients.
Early management of Tonsillitis/Quinsy patients within 1 hour of presentation in ED to reduce number of hospital admissions	Review process for ensuring all tonsillitis/quinsy patients receive initial treatment in A&E to reduce unnecessary admissions.
EP A Pt 1 - Patient Identification Compliance - pre-Treatment	Revisit training of photo ID process to improve cross checking patient photo among other radiographers prior to upload. Amend protocol to ensure camera photos always deleted immediately after upload.
EP A Pt 2 - Patient Identification Compliance	Organise refresher training/presentation of patient identification procedure
EP B.1 - IR(ME)R Operator Audit	Competency framework to be

	implemented to define each bioengineers scope of practice.
EP B.4 - IR(ME)R Justification and Authorisation of Concomitant Exposures	Refresher training for all operators to improve justification, authorisation and documentation of additional imaging.
EP D.1 Radiotherapy Dept Policy Developing Standard Operating Procedure Documents	Procedure fully met no actions identified for improvement.
EP D.3 Clinical Audit	Procedure fully met no actions identified for improvement.
EP F - IR(ME)R Procedure for Diagnostic Reference Levels Audit	Procedure fully met no actions identified for improvement.
EP K Reduction of probability and magnitude of Radiation Incident	Improve follow up and evidence for acceptance testing and clinical trials audits.
EP L IR(ME)R Procedure Incident Reporting	EP L IR(ME)R Procedure Incident Reporting and EP L document to be updated to reflect update to procedure.
EP M IR(ME)R Non Medical Exposures Audit	Audit criteria fully met no actions identified for improvement.
EP N IR(ME)R Procedure Comforters and Carers Audit	Procedure fully met no actions identified for improvement.
Excision rate audit for BCC and SCC - reaudit	Audit criteria fully met no actions identified for improvement.
External Cephalic Version (ECV) re-audit	Update leaflet and procedure to increase awareness re all scans performed within last two weeks are valid for ECV purpose.
Febrile Neutropenia - New Risk Stratification Pathway	Refresher training for clinical team to cover identification of eligible patients for the NRS pathway, improving early IV antibiotic administration and use of oral antibiotics.
Flexor Tendon Repair Audit	Revisit importance of; meticulous care in writing the op notes, coding documentation for the procedures and measuring the range of movement for the affected joints and the TAM. Repeat audit annually.
Foreign Body Artifact causing dilemma in X-Ray based diagnosis of Hand Injuries	Reminder to all staff to ensure removal of jewellery prior to Hand X-Rays to avoid issue in X-Ray based diagnosis of Hand Injuries.
Fragility risk assessment and Re-audit	Refresher training to increase awareness of FRAX score and fragility risk assessment.
Gestational Diabetes Management (GDM) re-audit	Add 1 more Joint weekly clinic to manage the increasing demand and to enhance patient experience by reducing the movement of patients between different clinics.
GP 31 Scheduling of Treatment Task Carepaths	Review and rewrite parts of document and implement recommended changes to current site specific Carepaths - GP 31.
GP23 – Carepath Tasks for Radiotherapy Patients	Audit criteria fully met no actions identified for improvement.

GP3 Uniform Policy in the Radiology Department	Staff reminder of no coloured undershirts and correct below the elbow hygiene technique.
GROW GAP re-audit	Further targeted training for Community Midwives on saving babies lives care bundle.
Guidelines for management of cutaneous warts re-audit	To share and discuss the re-audit results with the team as guideline refresher training.
Intensive Care Unit - Re-audit of review of the post-take ward rounds	Update clerking proforma with parent team information/involvement. Update the Induction booklet to help train newcomers of their responsibilities.
Intrathecal morphine versus diamorphine in spinal anesthesia for Cesarean sections	Refresher training on measures to reduce postoperative nausea and vomiting to be undertaken.
Intrathecal morphine versus diamorphine in spinal anesthesia for Cesarean sections (Re-Audit)	Procedure fully met no actions identified for improvement.
IR(ME)R EP B.3 - Referral Form Audit	Update to form to include - Histology section available on all sites, Treatment Planning Scan parameters sub-headings with drop downs. Rewording of referring to modality and Cardiac Device to be located under one subheading on all Casper forms.
Major Obstetric Haemorrhage (MOH) Re-audit	To improve documentation of early escalation and MOH call.
Management of Polyhydramnios and Oligohydramnios	Update guideline to reflect current clinical practice re place of NG tube for neonate/ feeding. Departmental teaching to highlight role of checking combined screen, anomaly scan and drug history in oligohydramnios.
Manual vacuum aspiration (MVA) re-audit - one year service review and patient feedback survey	Audit criteria fully met no actions identified for improvement.
Monitoring and analysing recurrent attendance to DAU	Procedure/protocols fully met no actions identified for improvement.
Monitoring liver functions after methotrexate usage in managing ectopic pregnancy/ PUL	Protocol/pathway fully met no actions identified for improvement.
MRSA and COVID-19 swabbing prior to admission to CAU and Bluebell Re-Audit	Incorporate IPC reminder on Team time and at handover. Already part of IPC induction for doctors.
Neurology Advice and Guidance Safety	To fine tune communication to GPs re referring back to our Trust if onward referral to originating trust is unsuccessful and where the GP has organised an MRI for suspected inflammatory disease, that any abnormalities should be discussed urgently with department.
Non-Melanoma Skin Cancer Surgical Excision Audit	To share and discuss audit results with team as clinician refresher training of surgical excision margins.
Outcomes of patient presenting with Cauda Equina Syndrome (CES) with time frame to MRI and tertiary	To propose a business model aimed at delivering out of hours emergency MRI for

referral outcomes	suspected cauda equina for discussion at departmental level.
Out-patient management of patients with differentiated thyroid cancer who have undergone radio-iodine treatment	Protocol fully met no actions identified for improvement.
Paediatric Pyelonephritis acute antimicrobrial prescribing	Refresher training for staff re reviewing antibiotic resistance and reassess antibiotic prescribed, documenting advice provided and prescribing of analgesia in acute pyelonephritis.
Palliative Care Response to Referrals Audit	Audit criteria fully met no actions identified for improvement.
PC 15 - Care of Patient during Radiotherapy Treatment	Procedure fully met no actions identified for improvement.
Postnatal VTE Risk Assessment and Prophylaxis, including LMWH prescribing and Mechanical Thromboprophylaxis	Guideline refresher training and format of the perinatal institute postnatal notes guidance.
Pre-Operative Management of our Testicular Cancer Patients: How are we doing? And Re-audit	Formal pathway to deliver timely Testicular Cancer Quality Performance Indicators.
Prevention of Admission Audit	Development of same day emergency care (SDEC) and hot clinics. Integration of the acute medical take within the Emergency Departments.
PROMPT: PROstate Medications Post TURP (Transurethral Resection of Prostate)	Update discharge summary advice for doctors and urology handbook re including advice to stop drugs post TURP.
PT 13 - Pelvic CT scanning audit	Add to work instructions and provide refresher training for staff.
PT 14 - Head & Neck Scanning	Procedure fully met no actions identified for improvement.
PT 19 - Activity Capture in Aria 15	Procedure fully met no actions identified for improvement.
PT 51 Responsibilities of Radiographer 2 and Radiographer 1 in CT during scanning and Re-audit	Protocol to be reconfigured to accurately reflect tasks of each radiographer. Revised Protocol to be brought to staff notice and training implemented
PT4 – CT Simulation Breast	Procedure fully met no actions identified for improvement.
Quality of Chest x-rays	Regular monthly 24 hour audits and results to be shared with radiology department. The results of this audit to be shared with lead radiographer and to be discussed in morning meetings. To r-audit in 6 months' time.
Re-audit of babies admitted with Jaundice to Children's assessment unit	Clear documentation of discussions between paediatric and surgical teams during admission and to conduct joint ward rounds with paediatric and surgical teams.
Review of management of nasal fractures in the acute clinic	Discuss audit findings with team and agree process for all patients booked for MUA under general anaesthetic to have Specialty Registrar review.
Rheumatology Advice Line (Lister and QEII)	Increase coverage of advice line Monday

	to Friday with job plan review. Consider impact on nursing and admin team in patient numbers and work flow with increase in consultant WTE. Contact BT/switch board so call time on advice line can be recorded.
RT 11 Radiotherapy Department Procedure for non-adaptive gynaecological patients	Reminder to staff re checking of the Treatment Verification Log.
RT 14 Adaptive Bladder Treatment Technique	Reminder to staff re checking alignments prior to moving the patient.
RT 16 Real Time Position Management (RPM) on the VARIAN TruBeam	Procedure fully met no actions identified for improvement.
RT 18 Radiotherapy Treatment Technique Audit – SINGLE ISO Breast tumours in DIBH	Reminder to staff at next Team Leads meeting re using rendered images for all patients receiving Breast treatment.
Scaphoid fracture audit	Review and agreed change to scaphoid pathway to reduce waiting time for CT/MRI.
Sepsis six compliance in ED	Restructure the preceptorship and pre-registration/newly qualified Nurse training to include IV and sepsis training. Wards to consider running a sepsis study day. Sepsis training to be included in Emergency Departments Team time.
Stillbirth Audit July 2020-2021	Reminder to staff re documentation standards required for IUD diagnosis. Commence placental histology at Addenbrookes. Recruit preterm birth midwife role. Reintroduce CO monitoring post covid change.
Supracondylar fracture management during 1st and 3rd waves of COVID-19 pandemic	Share audit findings in team meeting and discuss documentation improvement requirement.
Surgical Site Infection rate in patients post elective clean neck surgeries.	To implement the surgical site bundle; considering the use of pre-operative antibiotics.
Telephone Consultations for patient satisfaction	Complete a review to measure the effectiveness of phone consultations.
The management of Covid in Pregnancy	All staff refresher training re; Documentation to include individual risk assessment for COVID infection, record of COVID vaccine advice, use of antenatal COVID risk assessment sticker in antenatal clinical records, COVID risks discussion, daily Obstetrical review and handover of COVID cases.
The management of urinary incontinence	Reminder to clinicians of NICE NG123 guidance and to use a validated urinary incontinence-specific symptom and quality-of-life questionnaire.
To assess the appropriateness of cases treated by our local Urgent Eye Care Service	Develop/introduce an up-to-date triage tool that is easier to use, and allows more accurate triage.

	Increase nurse education, improve telecommunication services between eye care providers and improve public understanding of eye emergencies and where to seek help. Review transforming a 'walk-in' eye casualty into an acute referral clinic or a telephone triage service.
To investigate if all aspects of the VTE risk assessments in Ward 10b are completed accurately and correctly as per NICE & Trust Guidelines	Organise teaching sessions for medical juniors re VTE assessment requirements as per the NICE/trust guidelines. Display posters and leaflets/flyers on the ward for all staff explaining the importance of the VTE assessment and its correct/accurate completion. Complete a re-audit
TR3 Training Supervision & Competency for Therapeutic Radiographers Audit	Audit competency framework criteria fully met no actions identified for improvement.
VTE prophylaxis in Trauma and Orthopaedic In patients	Staff refresher training highlighting the issue to the Junior ward teams – On call teams to ensure the weight/estimated weight is always recorded at the time of admission.
VTE Risk Assessment and Administration of VTE Prophylaxis (and 1st cycle re-audit and 2nd cycle re-audit)	Education presentation to foundation trainees and reminder letter to surgical nursing staff re importance of VTE prophylaxis. Discussion with surgical nurses regarding feasibility of admission form/checklist Formal presentation and discussion in M&M meeting and reminder notification on Nervecentre to complete assessment and use/issue of TEDS.
VTE Risk assessment upon discussion and resultant VTE thromboprophylaxis prescribing	Refresher training for all staff re VTE assessment requirements as per the NICE/trust guidelines.
Waterbirth documentation on MLU	Audit guideline criteria fully met no actions identified for improvement.

Annex 3 Staff flu vaccine campaign

Vaccinating healthcare workers prevents the transmission of influenza (flu) to our patients, colleagues, our families, and our community. Immunisation is the most effective intervention to reduce harm from flu and reduce pressures on health and social care services. From October 2021 all employees were strongly encouraged to have the flu vaccine, the vaccine was also avaliable to volunteers, temporary workers, students and contractors working on Trust sites.

Vaccines were avaliable in booked appointments and drop in sessions at a vaccine hub at Lister. The vaccine hub was open 12 hours a day 7 days a week. Roaming clinics were also held in clinical areas of Lister, QEII, Mount Vernon Cancer Centre, Hertdford County and renal units. Vaccines were recorded on a live national immunisation and vaccination system (NIVS).

The flu vaccine was administered with COVID-19 booster vaccines, both vaccines were offered either in a single appointment or in two separate appointments, however, some people chose to only receive the COVID-19 booster and decline the flu vaccine. Reasons given for this include: concerns about side effects, beliefs that the flu vaccine is not effective or necessary.

Vaccine uptake

3,595 employees (63%) received the flu vaccine, this exceeds the East of England average of 61% and national average of 60.5%.
There was variation in uptake levels between some staff groups. Uptake was lower in staff under the age of 30, there was also lower uptake recorded in BAME staff, these variations are also seen nationally.
The uptake in the previous year was 70.5%, however, this is not directly comparable because the 2020-21 data only included frontline staff, but the 2022-23 data reflects all staff.

Plans for 2022-23

The national staff flu vaccine target for 2022-2023 is for 70-90% uptake in clinical and non clinical staff who have any contact with patients, this is included as one of the quality indicators in the 2022 to 2023 Commissionning for Quality and Innovation (CQUIN). This is an ambitious target, the plans for increasing vaccination uptake include:

- Involvement of key stakeholders and staff networks in planning and promoting vaccine uptake
- Offering a combination of booked appointments and drop in sessions suitable for all shift patterns
- Access to a central vaccine hub and mobile vaccination teams
- Recruiting a team of temporary workers to support the Health at Work Service to give flu vaccines
- A comprehensive communication plan involving webinars, posters, social media, news articles, huddles and friendly competition. Trust leaders, the network of wellbeing champions, staff networks, staff side reps and infection prevention and control link practitioners will support the dissemination of information to support the campaign.
- Provision of uptake data by the Trust Digital team to enable the monitoring of uptake and identificaytion of departments or staff groups requiring additional support.

Annex 4 Research and development

Examples of research projects carried out by the Trust

Cancer research
The Research team at East and North Hertfordshire NHS Trust were announced as winners of the inaugural Cancer Research Excellence Team Award at the regional 2021 National Institute for Health Research (NIHR) Clinical Research Network (CRN) Cancer Conference.

The CRN Eastern Cancer Research Excellence Awards recognise individuals and teams who demonstrate outstanding contributions in delivering NIHR cancer research. The East and North Hertfordshire NHS Trust team were recognised for their enormous efforts to ensure cancer research continued in the face of the challenges presented by the pandemic, including offering significant opportunities to patients to take part.

The award was accepted by Phillip Smith, Associate Director of Research, and Carina Cruz, Lead Research Nurse, on behalf of the Trust. On winning this prestigious award, Phillip said:

"We all know that research is a team game when it comes to the set-up and delivery of studies and that it is more of a community endeavour when you think about those who choose to participate. It can be unfair to identify any individual because this would favour those whose activity is more visible or deemed to be more important. So this is why I've nominated a team of teams: from delivery to research office to pharmacy to pathology and so on and on. A very large number of people have worked really hard in times of exceptional difficulty to ensure that cancer research has been able to continue over the last 12-18 months during Covid."

Some examples include:

- Continuation of cancer research during Covid. 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) in 2020/1.
- Patients suffering from a rare cancer of the eye can now hope for increased survival rates thanks to a new treatment trialled at the Mount Vernon Cancer Centre https://www.enherts-tr.nhs.uk/news/breakthrough-in-treatment-for-rare-eye-cancer-at-mount-vernon-cancer-centre/
- Enrolling 85 patients into the Delta Trial (integrateD diagnostic solution for EarLy deTection of oesophageal cAncer) as part of a service redesign at Lister Hospital. https://www.bbc.co.uk/news/uk-england-cambridgeshire-57404797
- High recruitment (>350 recruits) to the Lung Exo-DETECT (Lung Cancer Detection using Blood Exosomes and HRCT) at Lister Hospital over the last 18 months.

Cardiology Research

Anticoagulants (blood thinners) are used in patients with atrial fibrillation to reduce the risk of clots forming which can lead to stroke. However, these medications can significantly increase the risk of bleeding. A new class of medications, selective factor XIa inhibitors, may be able to prevent clot formation without increasing the risk of bleeding.

The Cardiology team at the Lister Hospital were the highest recruiters in the country into the two Phase 2 studies examining the optimal dose of a novel factor XIs inhibitor in patients with atrial fibrillation (PACIFIC-AF trial) and inpatients with a recent heart attack (PACIFIC-

AMI trial). The results published in the Lancet in April 2022 indicate that this approach can reduce the risk of bleeding, compared to the best current anticoagulants used in patients with atrial fibrillation.

Full details available here https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00456-1/fulltext#articleInformation

Annex 5 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).
2021/22 continued to be significantly affected by the Covid-19 pandemic, and all organisations across our healthcare system have continued to adapt services to deliver safe care to our patients including a new focus on recovery of services. The CCG recognises the work of the Trust and thanks all of their staff and volunteers for their efforts and dedication 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 2021/22 despite the Covid-19 pandemic; and recognises where further improvements are needed.

During the course of 2021/22 the CCG have worked closely with ENHT, meeting regularly to review quality and safety, including risks relating to the pandemic. The CCG also re-instated Quality Assurance Visits to seek assurance regarding the quality of care provided, and where identified improvements were needed, provided relevant support to embed change.

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 2021/22 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 2021/22 ENHT 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 initiatives being undertaken. This is particularly key in relation to recognition of deteriorating patients and the Harm Free Care programme. The CCG also welcomes the progress made by the Trust with the Clinical Excellence Accreditation Framework.

The CCG notes the recent improvements in relation to sepsis care and will continue to seek assurance that the improvements will be sustained going forward. The CCG does however remains concerned regarding venous thromboembolism (VTE) risk assessment completion and will be looking for improvement over the coming year.

Recognising that there have sadly been a high number of Covid-19 related deaths nationally and locally, it is positive that non-Covid-19 mortality rates have remained stable

overall and SHMI data reported throughout the year has remained in the 'lower than expected' range. Where any outliers are identified the Trust has worked pro-actively to identify any improvements required. It is also encouraging to see the work being done to reduce mortality and ensure learning and robust processes are in place.

In relation to Infection Prevention Control (IPC), it is positive to see that the Trust reported no MRSA bacteraemia cases for 2021/22. However cases of C.difficile have been above the annual ceiling. The CCG will continue to have oversight and seek assurance regarding this for 2022/23.

During 2021/22 the Trust reported 5 Never Events; an increase from the 3 reported the previous year. The CCG are pleased to note the ongoing improvement work because of identified learning and would expect to see a reduction in Never Events occurring in 2022/23. We will continue to seek assurance that learning has been identified, and that relevant actions and improvements are being implemented to prevent reoccurrence.

The timeliness of the serious incident reports and complaint responses has seen a decrease in performance during 2021/22. However, the CCG acknowledges the additional pressures that have impacted on this, and the work planned by the Trust in 2022/23. The CCG looks forward to seeing improvements in this area to ensure patients and families receive timely responses.

Previously there has been significant work undertaken by the Trust to improve the quality and timeliness of discharge summaries. Whilst the CCG recognises the continued focus that the Trust has had in relation to this, we note that performance has declined. The CCG expects this to be an ongoing focus for 2022/23 and would like to see a continued focus on the timeliness of both discharge summaries and clinic letters sent to primary care to support patient care.

Cancer performance was sustained over the course of 2021/22. 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 that improvements continue to be made and would now like to see the Trust build on this in order to consistently deliver all key cancer standards.

The 2021 annual staff survey results for the Trust remain similar to the national average in many areas. However, despite some improvement, bullying and harassment continues to be a theme. The CCG recognises the ongoing work to make the necessary improvements, including appointing a full time Freedom to Speak Up Guardian, and will continue to seek assurance regarding this area.

The CCG supports the Trust's 2022/23 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, the CCG wishes to see ongoing improvement in the timeliness and quality of discharge summaries which is essential to support ongoing safe care in the community, as well as an ongoing focus on staff wellbeing and improvement in the staff survey results.

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 the place based Health Care Partnership, 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 2022/23.

Sharn Elton
Managing Director
May 2022

Hertfordshire

Quality Account 2021/2022

On behalf of the Hertfordshire Health Scrutiny Committee I would like to thank East & North Herts Trust (ENHT) 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.

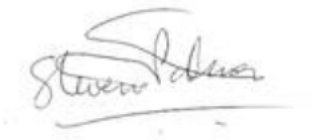
Members of the committee have been appreciative of the support ENHT has provided during this challenging period this has included, for instance regular attendance at Committee meetings, providing written updates when requested and briefings when concerns have been raised by the community. The contribution from the trust has meant the committee has maintained its overview of the health system across the ICS. It has enabled our health scrutiny members to hear about the impact on services and how the health system is seeking ways to address on-going needs and additional pressures.

Despite the demands of the pandemic and recovery there has been regular communication between the Health Scrutiny Committee, Scrutiny Officers and ENHT over the last 12 months. ENHT has supported the scrutiny process when approached and the Committee look forward to working with the Trust in the future.

Yours sincerely

Dee Hart
Chairman Hertfordshire Health Scrutiny Committee

Healthwatch Hertfordshire values the relationship with East and North Hertfordshire NHS Trust and welcomes the opportunity to support the development of the new patient involvement model. We look 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, June 2022

Annex 6 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

30 June 2022 Date Chair

30 June 2022 Date Chief Executive

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Public Session		Agenda Item	22.1i
Report title	Finance Performance and Planning Committee		Meeting Date	6 July 2022
Presenter	Finance Performance and Planning Committee Chair			
Author	Corporate Governance Officer			
Responsible Director	FPPC Chair		Approval Date	
Purpose *(tick one box only)* [See note 8]	To Note	☒	Approval	☐
	Discussion	☐	Decision	☐

Report Summary:

To appraise the Trust Board of decisions made and significant items discussed at the Finance Performance and Planning meeting on 24 May 2022.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

The discussions at the meetings reflect the BAF risks assigned to the FPPC.

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to note the report.

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING
24 MAY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 6 JULY 2022

The following Non-Executive Directors were present:
Karen McConnell (Chair), David Buckle and Biraj Parmar.

The following core attendees were present:
Martin Armstrong, Lucy Davies, Thomas Pounds, Adam Sewell-Jones, Michael Chilvers and Mark Stanton.

Matters Considered by the Committee:

Finance Report Month 1
The Committee received and noted the month one Finance report.

The Committee were informed that the first month had been a challenging start to the financial year. The Finance Performance and People Committee approved a balanced financial plan in March 2022. Nationally there was a £4bn deficit. The Trust was subsequently asked to identify cost pressures and the estimated impact of inflation, and a draft provisional plan of £9.9m deficit was submitted in April. NHSE have confirmed that £1.6bn will be made available nationally and the Trust is working with HWE ICS partners to determine its share of the funding. The largest contribution to the April shortfall was caused by not meeting the Elective Recovery Fund income expectations. A deep dive will be undertaken in June 2022 to fully understand the risk going forward.

CIP Performance Report
The Committee were informed that CIP shortfalls had been the second largest contributor to the deficit in month one. Cancer division had a strong performance, with Planned and Unplanned Care divisions having a shortfall. Planned Care division are addressing this; however the Unplanned Care division have found this more challenging. The Committee noted the governance of the CIP as an area of concern which requires strengthening going forward.
The Committee noted the risks within the CIP plan and mitigations in place.

There will be deep dives in the coming months to review Planned and Unplanned Care CIPS.

It was noted that some expenditure that should have been made in 2021/22 had not been made, resulting in expenditure being recorded in 2022/23. Controls will be strengthened to ensure this is not repeated in the coming year.

Infrastructure Investment Proposal

The Committee received and noted an overview of a potential project to develop additional retail space, car parking and office accommodation on the Lister Hospital site. It was agreed that the proposal would create good opportunities for the Trust. Potential risks were noted and discussed. The Committee were in support of taking this proposal forward.

Performance Report Month 1

The Committee received and noted the Responsive Report and recognised that as from April 2022, this is now being presented in a different way which allowed for better scrutiny of the data. The Committee highlighted a number of the parameters including ambulance arrivals, handover times and patients attending with mental health issues.

The Committee noted that Emergency Department (ED) demand has been higher than pre-pandemic levels with an increase in both admitted and non-admitted patients and in those who do not meet the criteria to reside. The Chief Operating Officer has been working with divisions to manage the funding that is currently in the system but will be removed from the system this year. The new ED capital build opened within the last month.

It was noted that there will be better focus on diagnostics in the future which has not had good control in the past.

GP Referrals

The Committee received and noted a report on GP referrals which looked at the referral patterns at a high level. It was noted that there had been little change in the overall levels of referrals from 2020 to 2022, with levels of GP referrals returning to 90% of pre-pandemic levels. The potential usefulness of the data for helping to tackle health inequalities was noted.

Cancer Deep Dive

The Committee received and noted a comprehensive deep dive on the Cancer division by the Cancer team. It was noted there had been two cancer strategies running in parallel to each other. The Mount Vernon Cancer Centre (MVCC) is in the last year of a five year cancer strategy for the site. During this time the organisation had a strategic refresh resulting in a cancer strategy for 2022-2027 focussing on cancer care at the Lister Hospital site. This should drive quality and accessibility of cancer care across the whole pathway.

The Committee noted the good work of the team to secure and sustain key improvements in cancer care and were assured that the Cancer team understood the ongoing risks. The risks were clearly outlined along with plans for sustaining strong performance and for improvement of cancer services in response to changes in clinical practice and where needed.

Community Diagnostic Hub

The Committee were updated on progress with the Community diagnostic hub. The Committee noted the workforce and operational challenges and that revenue funding had been agreed for 2022/23 for additional elements ie extended radiology at the QE11, DEXA, Fibroscan and Echo pathways. A phase two funding bid has been completed for submission to NHS England (NHSE), which should be approved in June 2022.

Procurement Service Update

The Committee received and noted the quarterly procurement update which highlighted key points for consideration. . The budget for 2022/23 was approved in March and represents a run rate of 2.8% for inflation. Performance metrics have been put in place and savings are forecasting favourably. Time taken to process requisitions has improved.

Elective Surge Hub Update

The Committee received an update on the proposals for an elective surge hub. The Trust has been engaging with the ICS in order to develop and seek regional approval for capital investment to create an elective surge hub for the Herts and West Essex system in order to reduce waiting lists across ENHT, PAH and WHHT. Progress was discussed and next steps noted.

Ringfencing of Stroke beds Update

The Committee noted the importance of the ring fencing of stoke beds and steps taken to date to secure them..

MVCC Business Case Update

The Committee were advised of the options and the project arrangements currently in place. The NHSE leadership team have asked for further option appraisal work to be undertaken in respect of the consideration of responses to the clinical risk report that reviewed service provision at MVCC in 2018. The option appraisal work would include greater in-depth analysis in respect of the do minimum option and the partial dispersal option. These streams of work will be undertaken in May and June with a report to NHSE in July. The Committee approved the proposed approach.

Queen's Speech Impact and Issues

The Committee received and noted a paper highlighting what impacts should be expected in the next twelve to eighteen months from the Queen's Speech.

Board Assurance Framework

The Committee received and noted the latest version of the Board Assurance Framework and the risks that had been assigned to the Committee.

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Karen McConnell
Finance, Performance and Planning Committee Chair
June 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board – Public Session		Agenda Item	22.1ii
Report title	Finance Performance and Planning Committee		Meeting Date	6 July 2022
Presenter	Finance Performance and Planning Committee Chair			
Author	Corporate Governance Officer			
Responsible Director	FPPC Chair		Approval Date	
Purpose (*tick one box only)* [See note 8]	To Note	☒	Approval	☐
	Discussion	☐	Decision	☐

Report Summary:

To present the report from the FPPC meeting on 28 June 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

The discussions at the meetings reflect the BAF risks assigned to the FPPC.

Report previously considered by & date(s):

N/A

Recommendation	The Board/Committee is asked to note.

FINANCE, PERFORMANCE AND PLANNING COMMITTEE MEETING
28 JUNE 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 6 JULY 2022

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

The following core attendees were present:
Adam Sewell-Jones, Martin Armstrong, Lucy Davies, Rachael Corser, Michael Chilvers and Mark Stanton

Elective Recovery
The Committee received a deep dive on elective recovery. The key milestones for the current year, progress to date and elective programme recovery risks were discussed.

The Committee noted that all 17 theatres were now running at full capacity and noted the increase in activity that would come on stream as Procedure rooms are opened at the Lister Hospital and subsequently the QE2 later this year.

The FPPC were advised of three transformation groups, Surgical pathways, Outpatients and the Community Diagnostic Centre, which aim to improve patient experience, quality, safety, efficiency and throughput.

The challenges presented by the increase in patients awaiting diagnostics were discussed together with actions including collaboration with ICS colleagues to support mutual aid. Progress on PIFU and on the waiting well initiative were also noted together with some early work on equity of access.

The Committee learned that by the end of the year the aim was to reduce reliance on temporary staff.

Performance Report Month 2
The Committee received and noted the Responsive Report and noted a decrease in patients spending more than twelve hours in the emergency department (ED), despite the numbers attending ED increasing. The importance of flow of patients through the hospital on ambulance and ED wait times was noted.

The Committee learned that work is ongoing to improve discharges of patients before noon. There was concern about the number of patients who were medically optimised but still reside within the hospital and a lack of social care provision in place, to enable patients to be discharged.

Nursing Establishment Review
The Committee received and noted the Nursing Establishment Review which was undertaken in April 2022. Data was collected over a 20 day period on all inpatient wards. The data was then analysed. Non ward based areas were also reviewed. Further work will be needed on revised shift plans and the Committee will be updated with this in September.

The Committee discussed recruiting up to 22% headroom to support winter planning. The FPPC supported this with caveats that good governance must be in place.

Finance Report Month 2

The Committee received and noted the month two Finance report. The Committee were informed the month two position was reported against the provisional £9.9m deficit plan. From month 3 the reported position will be against the revised break even plan submitted in June 2022. Year to date the Trust is reporting a £4.4m deficit against a £4.4m deficit plan. The Committee noted the key risks being the CIP, staffing costs and ERF.

CIP Performance Report

The Committee received the CIP report and noted the year to date target of £2.6m of which £1.4m had been delivered. There was concern about the level of non-recurrent CIPs.

Improving NHS Financial Sustainability

The Committee received and noted a paper outlining conditions the Trust will need to meet, relating to the receipt of additional funding notified during the 2022-23 planning round.

An internal audit must be undertaken for Audit Committee reflecting the requirements of the HFMA Publication “Improving NHS Financial Sustainability: are you getting the basics right?” This will identify any areas of weakness and provide recommendations. A systematic review of inflation figures in plans must also be undertaken. The Committee noted the steps being taken to ensure compliance with these requirements.

Capital Programme Update

The Committee noted that capital spend was lower than expected for month two and were assured that the pace of spending on capital will increase by the end of month three.

Sele Lodge Land Sale Proposal

The Committee discussed the proposal and approved the continuing work.

Board Assurance Framework

The Committee received and noted the latest version of the Board Assurance Framework and the risks that had been assigned to the Committee.

_____

Karen McConnell
Finance, Performance and People Committee Chair
July 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	22.2i
Report title	Quality and Safety Committee Report to Board		**Meeting Date**	6 July 2022
Presenter	Chair of Quality and Safety Committee			
Author	Assistant Trust Secretary			
Responsible Director	Chair of Quality and Safety Committee		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To appraise the Trust Board of the decisions made and significant items discussed at the Quality and Safety Committee held on 25th May 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

Report previously considered by & date(s):

[

Recommendation	The Board is asked to Note the report.

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QUALITY AND SAFETY COMMITTEE MEETING – 25 MAY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 6 JULY 2022

The following Non-Executive Directors were present:

Peter Carter, Ellen Schroder, Val Moore, David Buckle

The following core attendees were present:

Michael Chilvers, Rachael Corser, Lucy Davies, Adam Sewell-Jones

Matters Considered by the Committee:

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework (BAF). The Committee noted that a BAF development session with the Executive Directors had taken place early in the month and this would be discussed further through the Board Seminar in June 2022.

New and Emerging Risks

The Committee received and noted the New and Emerging Risks. The Committee discussed the national emerging risk regarding a drop in midwives' morale following the Ockenden final report. The Committee noted the ongoing risk of the Adult and children's Emergency Department (ED) due to skill mix, lack of nursing staff in the Children's ED, overcrowding and the number of mental health admissions. The issues around the refurbishment of Cath Lab 2 were highlighted and the associated risks required divisional approval. The Committee heard that the increased acuity of patients and long waits were leading to self-discharge, violence and aggression within bith Children's services and the ED

End of Life Care Deep Dive

The Committee received and noted the End-of-Life Care Deep Dive report. Key points discussed included:

- The Specialist Palliative Care team provided 7-day service covering Lister patients aged 18 and over; their aim is to reduce the proportion of inappropriate hospital deaths by identifying End of Life patients earlier.
- The Specialist Palliative Care team were the only team recording preferred place of death but there was nowhere centrally to store the information so it had been recorded as free text within NerveCentre.
- Continuous improvement was a focus for the team with a series of measures including engagement across the medical and nursing teams to provide in-situ learning, the introduction of ReSPECT and the introduction of the Gold Standards Framework.

Dr Carter on behalf of the Board thanked Sonia and Maria for their work and asked that our thanks should be passed onto Kelly.

Quality and Safety Report - Month 1

The Committee received and noted the month 1 edition of the Quality and Safety Report.

Key points discussed included:

- There had been an increase in shift fill with staffing was on a positive trajectory however the number of completed Friends and Family tests had declined with the feedback remaining static. Complaints continued to increase as did PALS enquiries however work with the divisions was underway to provide cohesive responses.
- There had been a focus on IPC safety data sets and attention was drawn to the Trust was still reporting zero hospital-acquired MRSA infections, although no target had been set for MSSA the Trust had reported 5 hospital-onset cases, Sepsis compliance continued to improve but there had been a reduction in the recording of 1-hourly observations.
- Crude mortality benchmarking for the Trust was reassuring as positioned in-line with national average. The Trust's re-admission rate had improved and was tracking below the national average.

Clinical Harm Reviews Update

The Committee received and noted the Clinical Harm Reviews process update. The Committee was informed work was required to progress the backlog of reviews and WLI's were being used with the new ICS standardised rate. Very low levels of harm had been seen with one being declared as an SI.

Maternity Dashboard Exceptions and Maternity Safety Concerns and Neonatal Dashboard

The Committee received and noted the update Maternity reports. The Committee heard that a deep dive into the administration of antenatal steroids had determined that there were no issues for concern. Actions had been implemented to mitigate the staffing challenges which had resulted in positive feedback from service users. April saw a catch-up in foetal monitoring training and staff were supported to achieve their annual compliance.

The Committee noted the following reports:

- Integrated Performance Report for Month 1
- Mortuary Update
- Guardian of Safe Working Hours
- MHRA Action Plan

Dr Peter Carter
Quality and Safety Committee Chair
May 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	22.2ii
Report title	Quality and Safety Committee Report to Board		**Meeting Date**	6 July 2022
Presenter	Chair of Quality and Safety Committee			
Author	Assistant Trust Secretary			
Responsible Director	Chair of Quality and Safety Committee		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To appraise the Trust Board of the decisions made and significant items discussed at the Quality and Safety Committee held on 29th June 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

Report previously considered by & date(s):

[

Recommendation	The Board is asked to Note the report.

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QUALITY AND SAFETY COMMITTEE MEETING – 29 JUNE 2022

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 6 JULY 2022

The following Non-Executive Directors were present:

Peter Carter, Ellen Schroder, Val Moore

The following core attendees were present:

Michael Chilvers, Rachael Corser, Lucy Davies, Kevin Howell

Matters Considered by the Committee:

Board Assurance Framework

The Committee received and noted the latest edition of the Board Assurance Framework (BAF). The Committee noted that the 2022/23 BAF would be presented at the Board meeting in July.

New and Emerging Risks

The Committee received and noted the New and Emerging Risks. The Committee were informed that there would be a new approach to the management of corporate risks with the Quality and Safety Committee maintaining management and oversight of clinical and quality risks. A new and refreshed corporate risk register including mitigations would be presented to the September Board meeting.

Mount Vernon Cancer Care (MVCC) Update

The Committee received and noted the MVCC update. The Committee was informed that the Clinicians had attended a workshop where they had been supported to be open about patient care and those patients unable to receive care at MVCC due to it not being an acute site. Standard operating procedures had strong adherence from staff to ensure safe care was provided to patients. Patient admissions and transfers were audited, and the information shared with NHSE monthly. Two Serious Incident's had been reported since the independent clinical review which had initiated improved levels of reporting and it was confirmed to the Committee that the level of harm at MVCC was low.

Mortuary Update

The Committee received and noted the Mortuary update. The Committee was informed that the Quality Workstream oversight of the Mortuary would continue until all issues had been resolved. The Committee heard that the key pillars of care had been reviewed, the incidents detailed, concerns raised, and learning captured and shared. Processes continued to be refreshed, this included improved processes for patient identification and communication as well as improvements to pathways. The Committee was informed that the processes around deceased patients was the biggest focus for the quality workstream.

Quality and Safety Report - Month 2

The Committee received and noted the month 2 edition of the Quality and Safety Report.

Key points discussed included:

- Sepsis compliance continued to improve; in contrast, observations had deteriorated, to address this improvement programs were being delivered and July would see a rapid

improvement week where the task team model would be used to support teams.

- Covid management was moving out of super-surge and the Trust was working with System partners to adopt new ways to manage the infection.
- The process around Learning from Deaths was being updated and there was work being done on predicting mortality rates once MVCC moved out from the Trust.
- With the changes at MVCC in the near future there was an opportunity to review the reporting structure of the Palliative Care team to ensure more patients achieve their preferred place of death and appropriate individualized personal care.
- An improvement programme was underway to have zero outstanding complaints by the end of the financial year.

Clinical Harm Reviews Update

The Committee received and noted the Clinical Harm Reviews process update. The Committee was informed that work to clear the backlog was slow due to limited clinical resources within Divisions and balancing the risk against the requirement for elective recovery and the management of urgent and emergency care. The implementation of the digital solution for live clinical reviews was slowed down by the volume of projects the Digital team were trying to implement across the Trust. The Committee was reassured that the Trust's positions was not unique, and all Trusts were facing similar issues.

Learning From Deaths Report

The Committee received and noted the Learning from Deaths report. The Committee was informed that the high-level indicators illustrate the Trust's sustained positive performance on mortality; there had been some outlying areas where reviews would be carried out. The Committee heard that learning was key and data from the CCG audit had been valuable as it had identified a small number of areas for focus.

Patient Experience, PALS, and Complaints Annual Report

The Committee received and noted the Patient Experience, PALS, and Complaints annual report. The following points were highlighted to the Committee:

- Over 300 volunteers were back on site by the end of March having updated all mandatory training and security checks.
- The Admiral Nurse had supported 335 families; mandatory dementia training had been rolled out across the Trust.
- Complaints and PALS enquiries were higher with an 18% increase in formal complaints.
- Friends and Family Test scores were rising and being reintroduced into daily practice.

Quality Account

The Committee received and noted the Quality Account. The Committee were informed that the objectives would be measured and there would be a level of refinement over the coming months.

Safeguarding Adult and Children's Annual Report

The Committee received and noted the Safeguarding Adult and Children's Annual Report. The following points were highlighted to the Committee:

- Safeguarding continued to be embedded into all staff daily practices.
- The Trust had engaged in multi-agency working and developed strategies and strengthened processes to support this.
- Referrals to children's services remained high however services were being introduced at an earlier stage as it was more beneficial to the patient than crisis intervention.
- Adult safeguarding concerns had increased, and the Trust had received its highest number of concerns recorded.

Health and Safety Annual Report

The Committee received and noted the Health and Safety Annual Report and Annual Fire Statement. The committee were informed that the Health and Safety report was combined with Estates and Facilities specialist areas and provided either limited or reasonable assurance across all areas of the Trust. It was highlighted to the Committee following previous concerns about staff attendance at fire safety meetings that the last meeting had received full attendance across the Trust.

Maternity Services Assurance Report

The Committee received and noted the Maternity Services Assurance report and appendices. The Committee received updates on the following maternity areas:

- Maternity Dashboard
- Perinatal Quality surveillance
- Maternity staffing headline concerns
- Maternity risks and mitigations
- Maternity Continuity of Carer and LMS implementation assurance
- Maternity SI reports and action plans

The Committee noted the following reports:

- Integrated Performance Report for Month 2
- Nursing Establishment Review

Dr Peter Carter
Quality and Safety Committee Chair
June 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	22.3
Report title	Charity Trustee Committee Report to Board		**Meeting Date**	6 July 2022
Presenter	Chair of Charity Trustee Committee			
Author	Corporate Governance Officer			
Responsible Director	Chair of Charity Trustee Committee		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To appraise the Board of the funding approvals made and the significant items discussed at the Charity Trustee Committee held on 7 June 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

N/A

Report previously considered by & date(s):

None

Recommendation	The Board/Committee is asked to Note the report.

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CHARITY TRUSTEE COMMITTEE MEETING HELD 7 MARCH 2022

SUMMARY REPORT TO BOARD

The following members were present: Dr David Buckle (CTC Chair), Odunayo Basorun (Financial Controller).

It was noted that the Charity Trustee Committee meeting was not quorate.

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
Safe Space Project: create a safe space environment for all patients in Children's ED, particularly for those with complex health needs and mental health illness.	£90,000	Approved, subject to further detail on who would benefit.
Audio and Visual Equipment at the Lister Education Centre: purchase new equipment for teaching rooms to replace old equipment.	£25,300	Provide summary of questions raised in the meeting to Dr Buckle to enable him to make recommendations to the Committee members before next CTC meeting.
Trust Thank You: provide a marquee, general foodstuffs and pay external providers to deliver staff information sessions across all ENHT sites.	£20,000	Approved

Other outcomes:

Charity Strategy Update

The Charity Trustee Committee received and noted the Charity Strategy which was approved in March 2022 and was being shared again to allow the Committee an opportunity for feedback. The Committee noted this was a clear document that was accessible to a range of audiences.

Charity Impact Report 2021/22

The Committee received the Charity Impact report which will be circulated to donors as part of the donor care plan. Funds have performed well with mitigations in place for community fund raising which has not performed as well.

Major Projects Update

The Charity Trustee Committee received and noted the Major Projects update which highlighted the Sunshine Appeal. There will be a match funding campaign where all donations made within 36 hours will be doubled. Individuals will be asked to sign up to be champions to promote this.

Charity Finance Report

The Committee received and noted the report for year ending 31 March 2022 and also April 2022. It was noted that fundraised income was lower than forecast, partly due to changes in timings of expected income. The running cost was lower than anticipated due to £250k legacy received. It was noted that the pandemic had a negative effect on the ability to raise funds.

Investment Portfolio Update

The Committee received the report on the Charity's investment portfolio. It was noted that Rathbones expect to increase funds by 3.5% over inflation in the coming year. The Committee will consider whether to draw down on the capital position each year.

External Audit Planning and Timetable

The Committee received and noted an update regarding the external audit planning and timetable. It was confirmed the audit will be completed by September/October 2022 with a draft report due to be presented to the Committee for approval in December.

Any Other Business

The Charity Trustee Committee will consider whether to appoint a third Non-Executive Director.

Dr David Buckle
Chair of the Charity Trustee Committee
June 2022

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	22.4
Report title	People Committee Report to Board		**Meeting Date**	6 July 2022
Presenter	Chair of People Committee			
Author	Corporate Governance Officer			
Responsible Director	Chair of People Committee		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To appraise the Trust Board of the decisions made and significant items discussed at the People Committee held on 17 May 2022.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk: *Please specify any links to the BAF or Risk Register*

Report previously considered by & date(s):

[

Recommendation	The Board is asked to Note the report.

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PEOPLE COMMITTEE MEETING – 17 MAY 2022

SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 6 JULY 2022

The following Non-Executive Directors were present:

Biraj Parmar, Ellen Schroder, Jonathan Silver, Val Moore

The following core attendees were present:

Thomas Pounds, Mel Gunstone, Bridget Sanders, Kevin Howell, Amanda Harcus, Celina Mfuko, Chinyama Okunuga, Eilidh Murray, Lucy Davies

Matters Considered by the Committee:

People Report

The committee received and noted the People Report. The Committee heard that setting clinically owned objectives had commenced and that everyone within the Trust should have received their Grow Together review conversations by the end of August 2022.

Voice of our People: Carers Network

The People Committee received a presentation on the Carers Network. The Committee were informed of data relating to how many people within the UK have caring responsibilities and how this relates to work life balance. The Committee heard of two examples of the Trust's staff where the ability to work flexibly and take carers leave has enabled those individuals to fulfil their duties within their job alongside their caring responsibilities and noted that without the support of their manager, they may not be able to continue to work at the Trust.

The Committee noted that the larger proportion of carers are aged over 50 and that consideration is needed as to how individuals could be supported with caring responsibilities to improve retention.

People Strategy Review

The People Committee received and noted the People Strategy review where key strategic priorities were highlighted. Although the fundamentals of the strategy will remain the same, it will be improved to ensure the Trust is able to demonstrate that staff views are being listened to and acted upon.

The Committee learned about the principles of Work Together Grow Together, Thrive Together and Care Together.

The importance of retention and recruitment were discussed.

Staff Survey Review

The Committee were presented with the highlights of the key findings from the 2021 National Staff Survey and next steps relating to staff engagement and to increase future response rates. The Trust plans to make completing the survey easier and ensuring that individuals have time to complete it.

The divisions will be carrying out a deep dive into engagement and what changes have taken place as a result of the Staff Survey.

Retention Deep Dive

The Committee received and noted the retention report with analysis on retention within the Trust. The Trust has been successful with recruitment, however there have been more people leaving the Trust than being recruited.

It was noted the Trust's reporting of turnover rates is inconsistent with the rest of the ICS. The Trust currently reports turnover which includes fixed term contracts and dismissals and it was proposed the Trust should report voluntary turnover only.

Work is being carried out to improve retention of clinical support workers, where there is biggest vacancy rate.

It was also noted that retirement rates have been higher than pre-pandemic years.

Resourcing Progress Report

The Committee received and noted the Resourcing progress report. They were informed the biggest challenge being the vacancy rate for clinical support workers. Retention plans have been put in place. It is anticipated there should be a reduction in the vacancy rates within the next six months.

The Committee learned the Trust is working towards achieving the Pastoral Care Quality Award being run by NHSE/I which it is anticipated will reduce vacancy rates.

The Committee were advised that an onboarding survey will be rolled out to international recruits to understand their experiences and that poor accommodation should be addressed.

Financial Wellbeing

The Committee learned about wellbeing packages introduced into the organization and discussed the rise in the cost of living.

Biraj Parmar
People Committee Chair
May 2022

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	22.5
Report title	Audit Committee Board Report		**Meeting Date**	7 July 2022
Presenter	Chair of Audit Committee			
Author	Assistant Trust Secretary			
Responsible Director	Chair of Audit committee		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

To present the report from the Audit Committee meeting held on 20 June 2022 to the Board.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

N/A

Report previously considered by & date(s):

N/A

Recommendation	The Board is asked to note the report.

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AUDIT COMMITTEE MEETING – 20 JUNE 2022

SUMMARY TO THE TRUST BOARD MEETING HELD ON 7 JULY 2022

The following Non-Executive Directors were present:
Jonathan Silver (Chair), Karen McConnell, David Buckle

Internal Audit Reports:

Summary Internal Controls Assurance Report
The Audit Committee received and noted the Summary Internal Controls Assurance report. The Committee was informed that the report amalgamated the work over the last year as well as the two final reports for Procurement and Discharge Summaries both of which received reasonable assurance.

The Committee was informed that the Discharge Summaries audit received two level two recommendations and four level three recommendations. It was noted that the backlog of discharge summaries would require investigation and the complete discharge process refreshing.

The Committee heard that the Procurement audit received one level two recommendation and one level three recommendation. IT was noted that the policy and procedure manuals needed to be realigned.

The Committee was informed that one report in draft was the ED audit on SDEC and that the ICT audit had been delayed. To address the delay the Internal Auditors had recruited two ICT auditors which would address their backlog.

The Committee was informed there was a new internal audit approach whereby as many as possible would be booked in early in the year to ensure any issues identified could be addressed sooner.

Final Internal Audit Annual Report and Head of Internal Audit Opinion
The Audit Committee received the final Internal Audit report and Head of Internal Audit Opinion. The Committee was informed that the Head of internal Opinion provided Reasonable assurance. It was confirmed that there were no items that were likely to change the outcome.

Internal Audit Update and Action Tracker
The Audit Committee received and noted the Internal Audit Update and Action Tracker. The Committee was informed there were 13 recommendations outstanding which included two from 2019. The Committee heard that the two outstanding recommendations from 2019 had been escalated to the Management team.

Anti-Crime Services Annual Report
The Committee received and noted the Anti-Crime Services Annual Report. The Committee was informed that the high-level overview had been submitted to the NHS Counter Fraud Authority. The Committee heard that the overall rating for Anti-Crime was green, there were two amber rating components which was an improvement on the previous year. The Committee was informed that the amber ratings related to fraud risk assessment and the case management system.

External Audit Reports:

Audit Completion Report 2021/22
The Committee received and noted the Audit Completion Report for 2021/22.

The Committee was informed that there had been changes to the planned audit approach and additional audit risks had been identified in relation to dilapidations and disclosures in the remuneration report. These had been reported previously as part on an Audit Plan addendum in May 2022.

The Committee was informed that there were no significant weaknesses to report in respect of the Trust's value for money arrangements.

The Committee was informed that the financial audit was substantially complete, and the audit certificate would be issued by the deadline of 24th June 2022.

Letter of Representation
The Committee received and noted fee proposal. The committee were informed that the fee had been agreed with management that incorporated the additional work related to the Trust's recently acquired status as a Major Local Audit.

The Committee was informed that the delay of receipt of the annual report had impacted the senior review timetables resulting in substantive work on that area of the audit being delayed.

Final Accounts 2021/22
The Committee received and noted the Final Accounts 2021/22. It was confirmed to the Committee by the External Auditors that there were no expected significant changes or material changes.

The Committee **APPROVED** the final Accounts 2021/22 subject to any remaining issues being non-material.

Annual Report and Annual Governance Statement 2021/22
The Committee received and approved the Annual Report 2021/22 and Annual governance Statement.

Other Reports:

Board Assurance Framework 2021/22
The Committee received and noted the 2021/22 BAF. The Committee were informed that the 2022/23 BAF was being finalised and would be discussed at the Trust Board meeting on July 6th 2022.

Cyber Security Report
The Committee received and noted the latest update regarding the Trust's cyber security position. The Committee were informed that due to Microsoft withdrawing support for Internet Explorer 11 (IE11), the Digital team were ensuring that clinical applications remained stable having either migrated to a new platform or continued securely on IE11.

Data Quality and Clinical Coding Report
The Committee received and noted the data quality and clinical coding report. The Committee noted that the data quality audits had been re-established and an area of focus had been Outpatients.

The Committee was informed that the Clinical Coding team had moved under the Medical Directors office which had proved positive for clinical and consultant engagement.

Quality Account Process Update
The Committee was informed that the Quality Account process had returned to its pre-pandemic format including the full breadth and depth of information. The Committee heard that an internal and external review had taken place and Commissioner feedback had been incorporated.

Jonathan Silver
Audit Committee Chair
June 2022

Draft Board Annual Cycle 2022-23

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 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
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
Elective 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 Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
Strategy Committee final meeting July 2022 before moving to Board Development		X		X								
EIC moving to People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		
Trust Strategy refresh and annual objectives										X		
Strategic transformation update				X				X				X
Integrated Business Plan						X						

Draft Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Annual budget/financial plan		*(X) from 2023*										
Long-term strategic infrastructure						X						X
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update				X		X		X		X		X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report								X				
Review of Trust Standing Orders and Standing Financial Instructions								X				
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review												X
Finance, Performance and Planning Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report								X				
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X				X				X		
Safeguarding and L.D. Annual Report (Adult and Children)				X								

Draft Board Annual Cycle 2022-23

Items	April 2022	4 May 2022	June 2022	6 Jul 2022	Aug 2022	7 Sept 2022	Oct 2022	2 Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Staff Survey Results		X										X
Learning from Deaths		X		X				X		X		
Nursing Establishment Review				X						X		
Responsible Officer Annual Review								X				
Patient Safety and Incident Report (Part 2)		X		X				X				X
University Status Annual Report						X						
QSC TOR and Annual Review								X				
Strategy Committee – move to Board Development in September												
Digital Strategy Update				X								
People Committee & Culture												
People & workforce strategy annual progress report										X		
Trust Values refresh				X								
Freedom to Speak Up Annual Report								X				
Staff Survey Results		X										
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
People Committee TOR and Annual Report								X				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X								