Public Trust Board

Lister Education Centre, Lister Hospital, Stevenage

05/07/2023 10:30 - 12:30

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1. Chair's Opening Remarks For noting	Trust Chair		
2. Apologies for Absence For noting	Trust Chair		
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5. Actions Log For noting	Trust Chair		15
6. Questions from the Public For noting	Stuart Dalton - Head of Corporate Governance	10:35-10:40	
7. Staff Story For discussion	Thomas Pounds - Chief People Officer	10:40-10:55	
8. Chief Executive's Report For discussion	Adam Sewell-Jones - Chief Executive	10:55-11:05	16
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9. Board Assurance Framework For discussion	Stuart Dalton - Head of Corporate Governance	11:05-11:10	31
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10.	University Status Annual Report	Justin Daniels - Medical Director	11:10-11:15	62
For approval				
11.	2022/23 Strategy Delivery Report	Kevin O'Hart Director of Improvement	11:15-11:20	75
For discussion				
12.	Strategic Transformation Update	Kevin O'Hart - Director of Improvement	11:20-11:30	85
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13.	Maternity & CQC progress	Amanda Rowley, Director of Maternity	11:30-11:40	100
For discussion				
14.	Patient Safety Incident Plan (Paper to follow)	Theresa Murphy - Chief Nurse	11:40-11:45	106
For approval				
15.	Quality Account	Theresa Murphy - Chief Nurse	11:45-11:55	132
For Approval				
16.	Committee Terms of Reference changes	Stuart Dalton - Head of Corporate Governance	11:55-12:00	210
For approval				
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PERFORMANCE				
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For discussion				
18.	System Performance Report	Martin Armstrong - Chief Finance Officer & Deputy CEO	12:20-12:25	266
For discussion				
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19.	Finance, Performance and Planning Committee Report to Board	Chair of FPPC		307
For noting				

20.	Quality and Safety Committee Report to Board	Chair of QSC	311
For noting			
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23.	Annual Cycle	Trust Chair	320
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24.	Any Other Business	Trust Chair	
For noting			
25.	Date of Next Meeting - Wednesday 6 September 2023	Trust Chair	
For noting			

East and North Hertfordshire NHS Trust

Agenda item: 4

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 3 May 2023 at 10.30am in the Post Graduate Centre, Mount Vernon Cancer Care Hospital, Northwood

Present:	Mrs Ellen Schroder	Trust Chair
	Mrs Karen McConnell	Deputy Trust Chair and Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Dr David Buckle	Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Dr Justin Daniels	Medical Director
	Ms Lucy Davies	Chief Operating Officer
	Ms Theresa Murphy	Chief Nurse
	Mr Thomas Pounds	Chief People Officer
	Mr Kevin Howell	Director of Estates and Facilities
	Mr Mark Stanton	Chief Information Officer
	Mr Kevin O'Hart	Director of Improvement
From the Trust:	Mr Stuart Dalton	Head of Corporate Governance
	Ms Eilidh Murray	Assistant Director of Communications and Engagement
	Mrs Alison Gibson	Director of Operations and Performance
	Mrs Caroline Dilks	Divisional Nursing Director
	Mrs Alison Gledhill	Programme Director
	Ms Sarah Simmons	Deputy Head of Communications (via MS Teams)
	Ms Julia Smith	Assistant Trust Secretary (Minutes)
Members of the Public:	Mr Norman Phillips	Patient Story
	Ms Zoe Tidman	HSJ

No	Item	Action
23/001	**CHAIR'S OPENING REMARKS** Ms Schroder welcomed Mr Phillips, who would present the staff story. She welcomed Dr Daniels as Medical Director to his first Trust Board meeting. She recognised the input of Dr Chilvers in his role as Medical Director over the previous five years and thanked him for his hard work, dedication, and commitment.	
23/002	**APOLOGIES FOR ABSENCE** No apologies for absence were received.	

East and North Hertfordshire NHS Trust

23/003 DECLARATIONS OF INTEREST

There were no new declarations of interest made.

23/004 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 1 March 2023 were **APPROVED** as an accurate record of the meeting.

23/005 ACTION LOG

The Board **NOTED** the current Action Log.

23/006 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

23/007 PATIENT STORY

Mr Phillips introduced himself to the Board as a 71-year-old full time carer for his wife who has Multiple Sclerosis, and he had been her career since 2012. He explained that he had been a patient of the Trust for three life saving events and had no issues with any of the treatment he had received. The only issue he had was following surgery he was recommended for discharge with a manual pump which was halted by the consultant.

Mr Phillips explained that an area for improvement within the Trust would be improving relationships with unpaid carers. He had joined a group called patient friendly hospital, but it had not restarted following the Covid lock down.

Mr Phillips explained to the Board that in 2021 his wife had been admitted to Lister 16 times in less than 12 months. He said going through the Accident and Emergency (A&E) route as a patient with a long-term condition was challenging as she would be tested for a diagnosis when it was not required. He said over one year she had spent 90 days in hospital. He commented that the hospital process focused on the condition rather than the patient.

Mr Phillips explained that another group, Carer friendly hospital added value and would be beneficial if it was re-implemented. He suggested that students spent time with carers to learn how to positively communicate with carers. He said work on admission prevention for patients who do not need to be admitted to hospital would add value to these patients. He said training staff on how to deescalate a situation would also be beneficial for patients, carers and staff.

Mr Phillips explained that in cases similar to his wife treatment was not an issue, but the variable levels of care created challenges. Mrs Schroder commented that the NHS had changed and worked more cooperatively to deliver the best care for patients. Mr Phillips

commented that under Hospital at Home there was a dedicated GP who had the knowledge and ability to influence whereas the surgery GP's had to triage patients who were then added to a waiting list.

Dr Buckle thanked Mr Phillips for sharing his story and explained as a retired GP and carer he could empathise.

Mr Sewell-Jones thanked Mr Phillips and explained that one of the Trust's four priorities focused on providing a single service. He recognised that the NHS was fragmented, and improvements were being made but they could be made faster. He agreed there was a requirement to ensure trainee staff understood the issues. He said the Trust was developing a communication strategy for patient and carer engagement.

Dr Carter thanked Mr Phillips and explained that it was the kind of story the Board valued hearing.

Ms Moore thanked Mr Phillips and explained that there had been internal staff changes which would support work with carers. Mr Pounds commented that within the workforce there were staff caring for family members and that their stories were being shared. Mrs Schroder commented that the Trust recognised the areas that could be improved.

Dr Daniels thanked Mr Phillips for sharing his story. He said the point about A&E was interesting as increasing numbers of patients presented with issues that were neither an accident or emergency which was down to the modelling and pathways which he agreed needed reviewing.

The Trust Board **RECEIVED** and **NOTED** the content of the Patient Story.

23/008 CHIEF EXECUTIVE'S REPORT

Mr Sewell-Jones welcomed Dr Daniels to his first Trust Board meeting as the new Medical Director.

Mr Sewell-Jones explained that the Trust had worked through two episodes of Junior Doctors industrial action. He thanked the clinical staff for reskilling and changing schedules and to the senior nurses for the support they provided. He recognised the managers and administrative staff who had undertaken planning and support to ensure patients continued to receive safe care. Mr Sewell-Jones explained that every cancellation had resulted in a difficult conversation with every patient and every cancellation re-booked professionally with staff in support of the Junior Doctors. He said the dispute was yet to be resolved and the impact would become more difficult every time there was industrial action.

Mr Sewell-Jones explained that the Trust had reviewed the ventilation systems in relation to the use of Entonox gas, particularly in the Maternity unit and the systems had been compliant. He said the highest level across the Trust was 0.81ppm which sits significantly lower than the Work Exposure Limit of 100ppm. He confirmed the greatest risk was to staff working in those areas for long periods of time but there had been no risk within the Trust. Support had been offered to neighbouring partners.

Mrs Schroder asked whether the consultants had been balloted in relation to industrial action. Dr Daniels explained that the ballot would be later in May but there were no details available.

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

23/009 BOARD ASSURANCE FRAMEWORK

Mrs Schroder commented that the Digital risk had not been anticipated. Mr Stanton explained that the element for the Digital risk related to non-delivery and the software as a service had historically been through capital funding and would now be allocated to revenue where there would be a significant gap. Mrs Schroder asked if it was retrospective. Mr Stanton explained due to the model of software it would be moving forward. Mrs Schroder asked if NHS England were aware of the plans and Mr Stanton confirmed they were and funding would be supported.

Ms Moore asked about the management and performance of Digital at a divisional level and asked if the wording could be revised. Mrs Schroder agreed and asked Mr Dalton to reword with Mr Stanton. **Head of Corporate Governance**

The Board **RECEIVED** and **NOTED** the Board Assurance Framework.

STRATEGY AND CULTURE REPORTS

23/110 2023/24 STRATEGIC OBJECTIVES

Mr Sewell-Jones informed the Board that the vision had been refreshed in the previous year which had set-out the strategic areas. He said the management team were suggesting eight objectives for the current year with four guiding themes all of which would shape the Executive Directors' and Chief Executive's objectives.

Mr Sewell-Jones explained that pathways to excellence was prestigious however the fundamentals of care required focus. He said the Chief Nurse would work on a blended approach. He said the focus had to be on regulatory compliance ensuring the Trust was fit for purpose and the focus would be Ockenden and CNST for

maternity along with CQC for the whole Trust.

Mr Sewell-Jones explained that thriving people would focus on increasing recruitment and retention with a drive for more people in permanent positions and an ambition to achieve 8% of the pay bill on temporary workforce.

Mr Sewell-Jones explained that complaints were not where they were required but satisfaction was higher.

Mr Sewell-Jones said there would be a focus on an end-to-end emergency care pathway and to ensure the transformed pathway delivered against the needs of the service user. He said a focus on high intensity users of care services had been agreed across Place for a single practice to change the experience of the highest 20 users.

Mr Sewell-Jones highlighted the new quality improvement system and the expectation that benefit would be delivered within the financial year.

Mr Sewell-Jones asked that the Board recognise the eight business areas needed to be delivered in addition to business as usual, and these 8 priority areas would lead transformation.

Mrs Schroder commented that the numbers needed to be a stretch but also realistic.

Mr Silver commented he was happy with the objectives and said that ambulance waits were missing and would like to see this area included. Mr Sewell-Jones agreed to update the objective. — Chief Executive

Ms Moore asked where the previous year results would be reported. Mr Sewell-Jones explained that quarterly updates had previously been reported to Board and a closure report would be presented at the July Board.

The Board **RECEIVED**, **NOTED** and **APPROVED** the 2023/24 Strategic Objectives.

23/111 STAFF SURVEY RESULTS

Mr Pounds explained that the Trust had decided that 100% of responses would be electronic for this survey as previous years there had been a mix of electronic and paper. Staff had been encouraged to complete the survey in work time. He said the response rate had increased to 47% which was higher than the previous year and the median rate of 44%.

Mr Pounds informed the Board that the Trust had scored broadly average across the majority of the People Promise. He said the Always Learning section was highlighted as the area where staff

morale was furthest from the median and best. Mr Pounds explained that from the previous year, a number of areas had fallen below the average score and other Trusts in the region had scored better.

Mr Pounds explained that the Trust knew that at the time the survey was carried out the staff appraisal completion rate had been low. To address this a new system had been implemented for the current year which would see a positive impact on the future compliance rate. Mr Pounds said there would be focused attention to ensure the right staff were in the right areas. Staff understanding their responsibilities with clear direction and clear objectives was critical.

Mr Pounds explained that overall nurses and midwives were positive with no major outliers. He said medics, estates and ancillary staff were disenfranchised which would require a more detailed level of understanding. Mr Howell noted that that estates and ancillary covered a significant number of staff and the detail would need to be understood.

Mr Pounds highlighted emergency care and theatres as areas where staff were feeling the most pressured within the Trust.

Mr Pounds explained that another area where there had been a large disparity was from staff with protected characteristics. He said the gap was closing but it needed to close faster.

Mr Pounds informed the Board that the Workforce team were working with staff on developing a charter.

Mrs McConnell commented that the positive scores by staff group were interesting and questioned whether the approach undertaken was gathering all information, particularly in relation to medical and dental and whether the issues within these groups were actually being identified.

Mrs Schroder asked whether the survey included the Junior Doctors. Dr Daniels explained that depending on the timing of their moves between Trusts would determine who they completed the survey for, he said it was a complicated process for them, but they were entitled to complete the survey.

Mr Sewell-Jones commented that the survey was a snap-shop of time and the information dated very quickly. He said the Trust needed to understand what could be done better and where improvements could be made. He said local line managers would be key to how staff were feeling.

Mrs Schroder commented that the response rate of 47% was very encouraging and work needed to continue to encourage more staff to complete the survey. She said organisations with higher

response rates generally had better results.

The Board **RECEIVED** and **NOTED** the Staff Survey results.

ASSURANCE AND GOVERNANCE REPORTS

23/112 SCHEME OF DELEGATION AND STANDING ORDERS

Mr Dalton explained the paper had been presented for Board approval and was an enabler of wider work to maximise a compliance culture and addressed the risk of non-compliance.

Mrs Schroder confirmed that the Audit and Risk committee had reviewed the documents in detail and had recommended to the Board for approval.

The Board **RECEIVED**, **NOTED** and **APPROVED** the Scheme of Delegation and Standing Orders.

23/113 LEARNING FROM DEATHS REPORT

Dr Daniels explained that HSMR and SHMI were as would be expected for the Trust. He highlighted two alerts, Leukaemia which related to small numbers of patients for which there had been concerns around coding and would be reviewed; the other related to Cardiology which was being reviewed.

Dr Daniels informed the Board that he had reviewed the maternal deaths over the last five years and there were no issues. He said he would also undertake a review of neonate deaths.

Mrs Schroder commented that mortality was an improving position and the Trust scored well against peers. She said the Trust had worked hard on improvement and should be proud.

The Board **RECEIVED** and **NOTED** the Learning from Deaths Report.

PERFORMANCE REPORTS

23/114 INTEGRATED PERFORMANCE REPORT

Mr Armstrong explained that the report was discussed in depth at committee meetings. He said the month 1 report would transition to the use of a balanced score card with four quadrants.

Ms Murphy explained for infection, prevention and control 20 of 73 cases of c.diff had been appealed and the number had reduced to 67 with some cases still to be decided against a trajectory of 59.

Ms Murphy explained that the one case of MRSA had been unavoidable and was being reviewed.

Ms Murphy informed the Board that in relation to Covid deaths, all patients had comorbidities. She said the Mortality Committee would identify the detail.

Ms Murphy explained that there had been some improvement in the 1-hour observations, and the 4-hour observations would make a significant difference. She said observations were under the fundamentals of care programme along with Sepsis which was highlighting good results.

Ms Murphy explained that there had been a round-table discussion about the recording of VTE. She said the best performing Trusts carried out a single assessment unlike the Trust who managed a double assessment. She said the Trust would implement a single assessment and if the patient deteriorated a second assessment would be undertaken, this would support improvement.

Ms Murphy informed the Board that there had been focused work on the 21-day response to PALS enquiries to provide real-time feedback and work on processes. She said the complaints team had daily cadence meetings and were looking at trends and themes. Work was underway with the divisional governance teams and training around the management of complaints was underway.

Dr Daniels explained that the readmission rates and elective length of stay were both in a positive position however non-elective length of stay performed less well and spending longer in ED coincided with patients staying longer in hospital.

Dr Daniels informed the Board that the maternity data highlighted although smoking rates in pregnant women were low, the Trust was not making an impact in reducing the number and improvement was required as there was an impact on babies. He said breast feeding initiation rates also needed to improve.

Dr Daniels explained that the 4-hour standards required improvement. He said Cancer performance was positive but there were issues with Stroke. He had met the Stroke team and an issue with flow was identified, a conversation about ring-fencing Stroke beds had begun.

Mr Pounds highlighted the vacancy rate had maintained towards the end of the financial year at 9.1% and the strategic objective target was 5%. He said the doctor's rate had achieved 5% and nursing was a continuing improving picture at 7.6%. A lot of work was focused on retention and investing in staff in their first six months with the Trust.

Mr Pounds explained that the Grow Together process was live and would start with senior staff with an expectation that 90% of staff will

have completed their conversation by August 2023. He said the performance framework would highlight any outside of the timeframe.

Ms Davies explained that urgent and emergency care had been busier in March than prior months and the team maintained the ambulance handover times.

Ms Davies informed the Board that the cancer performance remained strong for the 62 day wait pathway and the Trust remained at the same Tier as the previous month. She said the 78-week waits had achieved better than expected,

Ms Davies said the position was stable for diagnostics, but performance required improvement. She said gastro and T&O were challenged areas.

Mr Armstrong informed the Board that the Trust had closed the financial year with a £6.1m deficit, he said it was disappointing for the break-even, but the system had achieved its obligation.

Mr Armstrong explained that the annual accounts had been submitted and would be tested through to the end of June.

Mr Armstrong explained that there was a continuation of the CIP delivery not being where it should be and that was a material variance. He said it was an area for improvement for the new financial year.

Mr Armstrong highlighted medical staffing costs as a key driver of the deficit and said there was an improvement plan.

Dr Carter commented that one case of MRSA in three years was an impressive position and the Trust was well supported by the IPC team. Mrs Schroder commented that it was interesting that c.diff had increased post Covid.

Mr Silver commented on the new covid variant numbers increasing in the hospital and asked if anything new should be done in relation to testing. Ms Murphy explained that work to strengthen clinical decision making was underway but if there was any risk or perception of risk a PCR test would be carried out. She said clinical judgement was being used and if there was any doubt the patient was isolated.

Mr Silver commented on the upward trend in HSMR and SHMI since August 2021. Dr Daniels explained that the trend was difficult to determine. He said more work was required to understand the relationships.

Dr Buckle asked when it would be reasonable to see a reduction in the number of inpatients who did not meet the criteria to reside. Dr

Daniels explained that leaving patients in the ED did not help the target or the patient outcome. He said if the processes were correct the right patients would be in the right locations and there would be an improvement. He said lessons needed to be learnt from the industrial action on where senior clinicians were placed. He continued that a significant difference was evident when clinicians were at the front of the process. Thought around the whole system was required to ensure patients received the best possible care and were admitted only when appropriate. He said this would highlight an improvement in mortality. Ms Davies explained that the distribution of junior medical staff during twilight hours was being reviewed.

Mr Sewell-Jones confirmed that 15 of the 20 c.diff cases being reviewed had been upheld which put the Trust in a stronger position.

Mr Sewell-Jones informed the Board that the HR Virtual Assistant had been shortlisted for an HSJ award and there was external interest in what the Trust had delivered. Mr Pounds explained that the Trust was leading the way in the area. He also informed the Board that the Trust had been nominated for am NHS Pastoral Care award for the support of international nurses.

The Board **RECEIVED** and **NOTED** the Integrated Performance Report for month 10.

23/115 SYSTEM PERFORMANCE REPORT

Mrs Schroder commented it was important for the Board to understand the financial and performance position across the ICS and for the Board think of the Trust within the system.

Mr Armstrong explained that the report was presented at the March ICB Board meeting therefore the data was relatively old. He said the System pressures mirrored the Trusts in relation to diagnostics, mental health, and the impact on emergency flows.

Mr Armstrong highlighted that Community Paediatric waiting times across the system also reflected the Trusts challenges. He said the Trust performed well against the Theatre efficiency and for parts of 2022/23 the Trust had good elective delivery.

Mrs Schroder commented that there were interesting comparisons on Stroke across partner organisations.

Mrs Schroder encouraged the Board to use the reports and the Executive Directors to understand the system detail of their own areas.

The Board **RECEIVED** and **NOTED** the System Performance Report.

East and North Hertfordshire NHS Trust

BOARD COMMITTEE REPORTS:

23/116 FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and Planning Committee meetings held on:

28 March 2023

25 April 2023

23/117 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on:

29 March 2023

26 April 2023

22/187 AUDIT AND RISK COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Audit and Risk Committee meeting held on 4 April 2023.

22/188 PEOPLE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report of the People Committee meeting held on 18 April 2023.

22/189 ANNUAL CYCLE

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

22/190 ANY OTHER BUSINESS

No other business was raised.

22/191 DATE OF NEXT MEETING

The next meeting of the Trust Board will be on 5 July 2023.

Ellen Schroder
Trust Chair
May 2023

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

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 5 MAY 2023

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
3 May 2023	23/009 – Board Assurance Framework	Digital risk wording	Revise wording	Completed – see updated BAF	Stuart Dalton	July 2023
3 May 2023	23/110 – 2023/24 Objectives	Ambulance waiting times needed to be included	The objective to be updated to include ambulance waiting times	Completed – added under Seamless Services	Chief Executive	July 2023

East and North Hertfordshire NHS Trust

Chief Executive's Report

June 2023

June has continued to be a busy month for the hospital across many domains, a number of which are explained in detail in meeting papers this month. I outline some of the highlights under our key strategic themes below.

Quality

We received an unannounced inspection visit by the Care Quality Commission (CQC) over 20 and 21 June. This was a full inspection of core services at the Lister Hospital covering medicine, surgery, maternity and emergency care. They will return on 18 and 19 July to complete the well led element of the assessment.

Headline feedback was received at the end of the on-site element and inspectors were particularly struck by how caring and kind all staff were. A series of data requests have been made and this will then be followed by the receipt of the draft report at an unspecified point in the future.

Attached to my report is the record of the verbal feedback received following the visit.

Thriving people

Industrial action continues to impact on service provision across the Trust. The British Medical Associate (BMA) have announced they are holding a five-day walk out of all junior doctors in England. This means those taking action will not attend any shifts starting after 6:59am on 13 July until the same time on 18 July. They will be joined in the action by members of the Hospital Consultants and Specialist Association (HCSA).

The BMA have also announced its intention to call for a 48 hour walk out of consultants from 7am on 20 July.

I want to pay tribute to the way in which staff have responded to support colleagues taking such action on previous occasions, whether providing clinical cover or managing services. This industrial action will be the most extended to date and include our most senior clinical staff. There will inevitably again be impact on planned services as we strive to ensure urgent services are as safe as we can make them.

We celebrated Estates and Facilities Day this month which included executive director and other senior leaders working alongside estates and facilities colleagues. I was fortunate enough to work with James, cleaning Ward 7A. It was good to spend time better understanding his role and observing fantastic care being delivered by our clinical and support staff.

On 22 June we marked the 75th anniversary of the arrival of the ship HMT Empire Windrush at Tilbury docks in 1948, bringing more than 800 passengers from the Caribbean. It was a moment that shaped modern Britain and particularly the NHS. It allowed the opportunity to celebrate the Black British contribution to our society today as well as reflect on the struggles so many faced.

Today marks the 75th birthday of the NHS and celebrations will take place up and down the country. It coincides with our Thank You Week, that includes events all week to thank our staff, including the much-anticipated annual staff awards this evening.

Seamless services

Vascular services in Hertfordshire and West Essex are to benefit from investment of over £10m to create a new 'hybrid theatre' at Lister Hospital – funded by the Department of Health and Social Care, and the Hertfordshire and West Essex Integrated Care Board.

Due to open in Spring 2024, a central specialist vascular surgery 'hub' will ensure round-the-clock access to the early diagnostics, decision-making expertise and emergency procedures necessary for the successful treatment of vascular conditions.

Outpatient, day surgery and minor treatments will continue at the Princess Alexandra Hospital and Watford General Hospital.

As vascular services are very specialised, consolidating services and concentrating a sufficient number of procedures and specialists into a main surgery hub helps to sustain clinical expertise and improve outcomes for patients.

Continuous Improvement

Following a competitive process seeking an improvement partner to help us develop our quality management system, the non-profit Virginia Mason Institute has been chosen and will work with us over the next three years to support us build this capacity and capability. As well as being recognised as an international leader in healthcare quality and safety they have been working extensively with NHS organisations over several years to share their learning and expertise. Surrey and Sussex Hospitals NHS Trust will be our NHS partner with the Virginia Mason Institute.

NHS England letter regarding elective care 2023/24 priorities

Enclosed below is a letter from NHS England to all Trusts. NHS England requested all Trust Boards consider the letter and review the Trust's answers to the checklist NHS England created. The Trust's response is set out after the letter using NHS England's template.

Adam Sewell-Jones
Chief Executive

Classification: Official

Publication reference: PRN00496

NHS England

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS regional directors
- Cancer alliance managing directors
- ICB chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 May 2023

Dear Colleagues,

Elective care 2023/24 priorities

Thanks to your continued focus and effort on elective care and cancer recovery we have managed, through the exceptional efforts of your teams, to drive a significant reduction in the number of long waiting patients over recent months.

Despite a very challenging environment, where ongoing industrial action has seen planned care particularly hard hit, the number of patients waiting over 78 weeks has decreased from 124,911 in September 2021 to 10,737 at the end of March 2023, and the number of patients with urgent suspected cancer waiting longer than 62 days has decreased from a peak of 33,950 last summer to 19,023 at the end of March 2023.

We now look ahead to further reduction in 78 week waits, following the disruption from industrial action and delivering our next ambitions, as set out in Operational Planning Guidance, of virtually eliminating 65 week waits, reducing the 62-day backlog further, and meeting the Faster Diagnosis Standard, by March 2024. This letter sets out our priorities, oversight and support for the year ahead as well as including a checklist for trust boards to assure themselves across the key priorities (annex 1).

First, we should acknowledge the progress made over the last year or so:

- Since the beginning of February 2022, the NHS has treated more than 2m people who would otherwise have been waiting 78 weeks by the end of March 2023 (ie: the “cohort”).
- The number of patients waiting 65 weeks has reduced from 165,885 in September 2021 to 95,001 in March 2023.

- The cancer 62 day backlog has reduced year-on-year for the first time since 2017.
- The NHS has seen a record 2.8 million referrals for urgent suspected cancer, with the early diagnosis rate now higher than before the pandemic.
- In February 2023, the NHS achieved the faster diagnosis standard (FDS) for the first time since it was created.

Your leadership, collaboration with colleagues and across providers, innovation and tenacity has led to these improvements for patients and should give confidence for the future, despite the continued complexity of the environment that we are all working in.

Recognising the challenges and the complexity you are all dealing with, we thought it would help to set out the key priorities for the year ahead:

1. **Excellence in basics**
   - Maintaining a strong focus on data quality, validation, clinical prioritisation and maximising booking rates have contributed massively to our progress. We need to retain a clear focus on these things.

2. **Performance and long waits**
   - Continue to reduce waits of over 78 weeks and those waiting over 65 weeks.
   - Make further progress on the 62-day backlog where this is still required in individual providers, whilst pivoting towards a primary focus on achieving the Faster Diagnosis Standard.
   - To support this, we have reviewed and refreshed our tiering approach to oversight, so that we can be sure that we are focusing on those providers most in need of support. This refresh has been communicated to tiered providers.

3. **Outpatients (productivity actions annex 2)**
   - We know there is massive potential in our outpatient system to adjust the approach, engage patients more actively and significantly re-focus capacity towards new patients.

4. **Cancer pathway redesign**
   - In 2023/24 Cancer Alliances have received a funding increase to support implementation of priority changes for lower GI, skin and prostate pathways (included in annex 1). All trusts should now have clear, funded plans in place with their Alliance for implementation.

5. Activity

- Ensure that the increasing volume of diagnostic capacity now coming online is supporting your most pressured cancer pathways. ICBs have been asked to prioritise CDC and acute diagnostic capacity to reduce cancer backlogs and improve the FDS standard, as set out in the letter from Dame Cally Palmer and Dr Vin Diwakar.
- Generally, we all need to see a step up in activity over the coming months, as we recover from the ongoing impact of industrial action.

6. Choice

- A major contributor to our collective progress over this last year has been the way organisations and systems have worked together to accelerate treatment for long waiting patients. This includes work with the Independent Sector (IS) who have stepped up to help in this endeavour. We know this will continue to be important this year and we encourage all systems and providers to crystalise their plans to work together (including IS) early in the financial year to give us the best chance of success.
- We expect that patient choice will be an increasingly important factor this year, as set out in the Elective Recovery Plan, with some technological advances to support this. We will communicate this more fully when plans have been finalised.

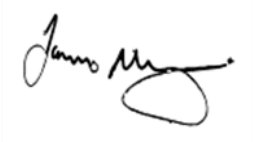
Moreover, it is crucial that we continue to recover elective services inclusively and equitably.

- Systems are expected to outline health inequality actions put in place and the evidence and impact of the interventions as part of their planning returns. Disaggregated elective recovery data should support the development of these plans.
- A collective effort is needed to continue to address the recovery of paediatric services. Provider, system, and regional-level elective recovery plans should set out actions that will be put in place to accelerate CYP recovery and ensure that elective activity gap between CYP and adults is reduced, a best practice toolkit has now been published to help achieve this.
- Systems are expected to continue to recover specialised service activity at an equitable rate to that of less complex procedures, ensuring a balance between high volume and complex patient care requirements.

Included with this letter is the board checklist (annex 1). This tool has been designed to be the practical guide for boards to ensure they are delivering against the ambitious objectives set out in the letter above.

Thank you again for all your efforts since the Elective Recovery Plan was published. Together, we have made laudable progress in reducing long waits and transforming services, as set out in the plan. We can all take confidence in this as we move on to the next stages of the recovery plan and continue to improve care for patients. If any support is required with these actions, please let us know.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
NHS England

Chair
Getting It Right First Time (GIRFT) programme

	Assurance Statement	
1.	**Excellence in basics**	
	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	Currently over 65 weeks - 7184 have not been validated at all, 2578 validated but not validated in last 12 weeks, 4951 are ASI's and the referral is not in Lorenzo yet so unable to record a validation date. The RTT validation team currently validate all patients over 38 weeks every 12 weeks and this is monitored on QV. Date of Last PAS validation is recorded within the Waiting List Minimum Data Set
	Are referrals for any Evidence Based Interventions still being made to the waiting list?	Some clarity around this may be required with NHSE on the new guidance which was due to be published on 28 May which will focus on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology. Once circulated this will be reviewed to ensure we are following any new guidance
2	**Performance and long waits**	
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	This is closely managed against trajectories. With the exception of community paediatrics there are plans in place to virtually eliminate 78 weeks with the exception of patient choice.
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	Our trajectories to eliminate RTT waits of over 65 weeks by end of March 24 have been finalised. Currently it is anticipated only Community Paeds will not be compliant.
3	**Outpatients**	
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	Services are cognisant of the need to reduce f/up activity, where possible has been taken this into consideration, however the planning for 23/24 has been completed based on demand and with the clinical risk within the f/up waiting lists in mind. Work to stabilise the f/up waiting times/PTLs needs to be completed to

		enable reduction in this activity type to be managed safely. PIFU is also being rolled out to facilitate the reduction in FU.
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Services are working on trajectories to reduce 1st appt waits in line with D&C plans. The trust has 31 RAS's in 21 specialties, with an ambition to implement in all specialities to ensure referrals are streamed appropriately.
4	**Cancer pathway re-design**	
	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	The colorectal service is fully compliant with the downgrading of referrals in line with guidance for those pts who are referred appropriately. GPs are contacted for pts with a missing FIT.
	Where is the trust against full roll-out of teledermatology?	A pilot with 2 GP's is underway and due to be completed in July the outcome of which will be reviewed. Working with the ICB and Cancer Alliance on system wide implementation of Tele-Dermatology. Consideration of CDH model for Tele-Dermatology being consider pending the outcome of the pilot.
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	Currently limited capacity for MRI prostate pathways (mpMRI) to scan within 7days. Service is working with Urology to support one-stop clinic where MRI is done in the morning and Tp biopsy in the afternoon.
5	**Activity**	
	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	Yes – cancer coding available to identify patients and prioritised. There are also cancer escalations on a weekly basis
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	Yes –cancer cases are prioritised

	How does the Trust compare to the benchmark of a 10- day turnaround from referral to test for all urgent suspected cancer diagnostics?	The overall 10-day turn around time for Histo is currently not achieved, however the site specific tumours are achieved.
	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery? Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	Waiting well is in place –  HCNS - Opthalmology Marc  HCNS Final Report Lister Hospital Orth *[These attachments are lengthy and therefore are not added separately to this Board assurance report. But demonstrate compliance with NHS England's request]*
	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	For May currently at 84.9% - Year to date 84.1% Day case rate 93.2%
	Is full use being made of protected capacity in Elective Surgical Hubs?	No current hub capacity
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	Yes, activity is in line with national optimal utilisation standards for imaging.
	Are any new Community Diagnostic	CDC open at the New QEII since April

	Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??	2022 providing additional capacity across various modalities. Activity delivery performance monitored weekly by NHSE. Workforce is in place to provide the commissioned service provision. Working of reducing DNAs which is monitored through access board. Elective Surgical Hub is in development.
6.	**Choice**	
	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	Not at this time DMAS is being used to request support where appropriate.
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	IS Capacity has been built into our annual plan – DMAS in place, also have contracts in place with the IS they are in annual review and sign off process currently
7.	**Inclusive recovery**	
	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	The specialist commissioning waiting list has been included in our overall demand and capacity modelling and therefore in our plans to achieve national operational elective targets in 2023/24. The Trust already performs well in terms of the delivery of high volume low procedures and is working with the two other acutes in the system to develop an elective hub at St Albans over the coming 12-18 months which will create further capacity for high volume low complexity procedures, freeing up further theatre capacity on the main acute site for more complex patient care.
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning	We have completed an analysis of our current PTL at an individual basis (which is now updated on an daily basis on the live PTL), and reviewed dimensions such as

	return? Was this supported by disaggregated elective recovery data?	deprivation, age, gender, ethnicity, dementia and learning disability status. The main inequalities that have been identified relate to paediatric patients (both community paediatrics but also paediatric surgical specialties), who make up a larger proportion of our longest waits than should be expected. Work is being undertaken within specialties to ensure appropriate theatre lists are available for paediatric patients, and work is ongoing with system colleagues in order to review processes and pathways with regards to improving access and reducing waiting times for community paediatrics.
	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	Acute Paediatrics (0-16yrs), there are extra clinics via ERF which are taking place to reduce delays inbeing seen. We have adjusted templates to reduce the number of follow ups seen and increase the amount of news. We are in discussions to introduce PIFU to our general paediatric service. Community Paediatrics (0-16yrs, 19 yrs if in special schools) – the increase in referrals over the past three years has led to higher demand than capacity is available for. Several meetings are underway inc. with NHSE to determine the best way to manage these CYP on their neurodiverse journey

Annex 2: Outpatients (OP) productivity action

As set out in the 2023/24 Priorities and Operational Planning Guidance, systems are expected to deliver in line with the national ambition to reduce follow-ups by 25% against the 2019/20 baseline by March 2024. To note this excludes appointments where a procedure takes place. Further technical guidance (that covers other exclusions) is here.

Expected actions

In order to work towards achieving the 25% follow-up reduction target, trusts are expected to focus on the following within the first quarter of the year:

- • Embed OP follow-up reduction in trust governance mechanisms
- • Engage with clinical leads for specialties about the significance of the 25% follow-up reduction target, building on GIRFT guidance
- • Review clinic templates to ensure they are set up to enable a 25% reduction in follow-up appointments
- • Validate patients waiting for follow-ups to identify any who do not need to be seen
- • Ensure continued and expanded delivery of patient initiated follow up (PIFU) in all major OP specialties, particularly accelerating uptake in specialties with the longest waits (ENT, gynaecology, gastroenterology and dermatology)
- • Ensure patients who no longer need to be seen in secondary care are appropriately discharged, in line with clinical guidelines
- • Work to reduce appointments that are missed by patients (DNAs), in line with NHS England guidance, including by: – Understanding the most common reasons why patients miss appointments, building on available national support
- – Making it easier for patients to cancel or reschedule appointments they don’t need eg through sending a response to an appointment reminder
-
- • Local analysis of patients on multiple pathways or those with multiple follow-ups.
- • Consider conducting a retrospective clinical review of a sample of OP follow-up activity in at least two specialties with the longest waits, to identify where an alternative pathway of care could have been used (eg discharge, PIFU, appointment met through alternate means).

Payment

Reducing OP follow-ups is incentivised by the NHS payment scheme, where follow-up appointments are covered by a fixed payment element, and first appointments are covered by a variable element. 10

Support available
Competing priorities will always make it difficult to focus on making these changes. Continued support will be available through:

- • Data packs for each tiered trust, and top ten other trusts with high OP follow up reduction opportunity
- • Clinically-led conversations with tiered trusts from National Clinical Directors, GIRFT clinical leads, and OP clinical leads
- • Operational support to amend clinic templates
- • Support to improve equity of access through the national Action on Outpatients programme.

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	9
Report title	**Board Assurance Framework (BAF)**			**Meeting Date**	5 July 2023
Presenter	Stuart Dalton, Head of Corporate Governance				
Author	Stuart Dalton, Head of Corporate Governance				
Responsible Director	Martin Armstrong, Deputy CEO			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The paper presents the BAF. Key points to highlight are:

- Following May Board approval of revisions to the 23/24 BAF, the two new risks the Board asked to be added to the BAF have been fully developed and reviewed by FPPC and are presented for particular consideration and feedback. Both new risks have been scored as 16:
  - New Risk 6: autonomy and accountability
  - New Risk 10: digital transformation
- There are no risk score changes proposed.
- Due to the June People Committee needing to be postponed until 18 July, there has not been a People Committee meeting since the last Board. Therefore, there are no changes to the risks that the People Committee has oversight over.
- Following discussions with The Board Chair, Chair of the Audit & Risk Committee and the Chief Executive, it has been agreed to alternate presentation of the BAF with the Corporate Risk Register to the Board. The Corporate Risk Register will be presented to the September Board after Audit & Risk Committee consideration on 11 July.

Impact: where significant implication(s) need highlighting

Covered above

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

N/A - BAF

Report previously considered by & date(s):

Since the BAF was reviewed at the last Board, the BAF risks have been reviewed by their respective lead committees, bar People Committee-owned risks which will be reviewed at the next People Committee on 18 July.

Recommendation	The Board is asked to **NOTE** the BAF update

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East and North Hertfordshire NHS Trust

BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic Risk	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory
Consistently deliver quality standards, targeting health inequalities and involving patients in their care					
1.	**Workforce requirements**	Chief Nurse (Medical Director) (Chief People Officer)	Quality & Safety	12	⟷
2.	**Population/stakeholder needs**	Chief Nurse (Medical Officer)	Quality & Safety	12	⟷
3.	**Financial constraints**	Chief Financial Officer	Finance, Performance & Planning	20	⟷
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
4.	**Workforce shortages and skills mix**	Chief People Officer	People	12	⟷
5.	**Culture, leadership and engagement**	Chief People Officer	People	16	⟷
6.	**Autonomy and accountability**	Chief Operating Officer	Finance, Performance & Planning	16	
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
7.	**Immature place and system collaborative processes and culture**	Deputy Chief Executive (CFO)	Finance, Performance & Planning	16	⟷
8.	**Improving performance and flow**	Chief Operating Officer	Finance, Performance & Planning	16	⟷
9.	**Trust and system financial flows and efficiency**	Chief Financial Officer	Finance, Performance & Planning	12	⟷
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	**Digital Transformation**	Chief Information Officer	Finance, Performance & Planning	16	
11.	**Enabling Innovation**	Director of Transformation	People	12	⟷
12.	**Clinical engagement**	Medical Director (Chief Nurse)	Quality & Safety	12	⟷

Section 2 Strategic Risk Heat Map

Current risk scores in **black**
Target risk scores in ***grey***

Impact						
	5				3	
	4			1; 9; 11; 12 3; 6; 7; 12	5; 6; 7; 8; 10 10	
	3			1; 2; 5; 9; 11	2; 4;	
	2			4; 8		
	1					
	I x L	1	2	3	4	5
		Likelihood				

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.

Impact Level	Impact 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

Likelihood	**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**

NHS East and North Hertfordshire NHS Trust

Our Trust mission

Providing high-quality, compassionate care for our communities

Our guiding themes

Quality
Consistently deliver quality standards, targeting health inequalities and involving patients in their care.

Thriving people
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability.

Seamless services
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners.

Continuous improvement
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities.

Objectives 2023-24

- Embed fundamentals of care/pathway to excellence programme within all inpatient areas across the Trust
- Improve overall Trust regulatory compliance and deliver Maternity Improvement plan to meet requirements of CQC, Ockendon review and NHS Resolutions
- Improve our overall recruitment and retention rates to ensure that temporary workforce make up no more than 8% of the pay bill
- Ensure all staff have a quality Grow Together conversation and are fully compliant with statutory and mandatory training
- Transform end-to-end urgent care pathways supported by a new urgent and emergency care model to deliver the A&E four-hour standard of at least 76% and improve median ambulance handover times to under 30 minutes by March 2024
- Deliver Care Closer to Home pilots at individual GP Surgery and East and North Hertfordshire level targeting better meeting the needs of the highest intensity users of health services
- Implement a Quality Management System supported by an expert strategic partner with first quality and financial improvements delivered by March 2024
- Increase elective activity through productivity and investment, supported by a more digitally-enabled central booking service

Vision to 2030

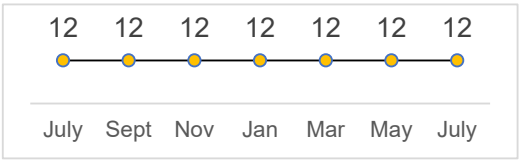
To be trusted to provide consistently outstanding care and exemplary service

Section 3 –Strategic Risks

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			Risk score 12
Strategic Risk No.1: **Workforce requirements**			
If we fail to have sufficient high-quality staff in the right places with effective rostering and ratios	***Then*** we will not be able to deliver the needs of the population and standard of care that are required	***Resulting in*** poor performance, poor patient experience; failure to ensure the best possible health outcomes and quality of life; and a loss of trust	

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	3	12
Target	4	2	8

Risk Trend



Risk Lead	Chief Nurse (Medical Director) (Chief People Officer)	Assurance committee	Quality and Safety

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans • Thematic review of complaints relating to staffing **Operational Systems and Resources** • Local recruitment and retention plans • Detailed establishment reviews across Nov/Dec 2022 • International recruitment plans • Training needs analysis reviews (capability building) • Fill rates and reviews • GROW appraisal and talent system weekly review via hot topics for nursing and midwifery/AHPs • Apprenticeship schemes • Change policy and toolkit • Pre and post reg training programs **Governance & Performance Management Structures** • Accountability and Review Meetings (ARM) • People Committee	**Internal Committee-level assurances** • Integrated performance report key indicators • Deep Dive recruitment briefs and reviews reports • Freedom to Speak up prevalence thematic analysis reports • Positive leadership rounds (January 2023) • Board members walk rounds to be piloted with positive leadership rounds (April 2023) • Deep dives for each division to establish staffing plans/budgeted WTE – ED, maternity and planned care. Check and challenge sessions for on rota staffing reviews due March 2023. **Third line (external) assurances** • Staff survey results • External benchmarking with Integrated Care Partnership, Integrated Care Board and other partners • Ad hoc feedback: Health Education England / Professional Bodies / Academic body (pre and post reg) partners feedback • Care Quality Commission engagements session feedback reports • Patient feedback (national) survey
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
No substantive care support worker development programme	Redesign of service delivery pathways and development of new roles including 'grow your own' skills/talent - *by end of Q1 2023/24* - Heath care support worker care certificate programme in progress at onboard phase. BEECH course now in progress for CSW management of the deteriorating patient

Recruitment and retention plans required for professional groups with identified high vacancy rates, e.g. pharmacy, administration	• Ongoing review of establishments in progress in relation to shift patterns and budget alignment *due by Q1 2023/24.* • E-roster establishment review ongoing – by end Q2 23/24 • Plans to continue collaboration with the ICS for international nurse recruitment for 22/23- bid successful March 2023, recruitment plans TBC • Virtual training sessions and drop in events continue to take place in April and May 2023 and are set to continue during the appraisal cycle to support GROW conversations • Scoping with university to deliver ward managers development programme– aim to deliver Q4 2023/24 • CPO and CNO supporting deep dives in safer staffing across CNO safer staffing paper was presented to TMG March 2023 and QSC April 2023.
National and local cost of living and employment picture, which may make recruitment more challenging	National workforce strategy to be published by end of 2023. Support for staff with cost-of-living bundle of interventions already in place (community shop; blue light card refund; discounted vouchers, discounted fuel & increased excess mileage rate, lunch vouchers etc) – keep under review

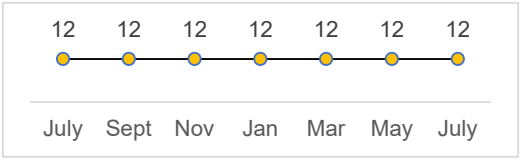
Current Performance - Highlights
The following points are highlighted from the Integrated Performance Report: • Successful bids with ICS for international nurse recruitment for 23/24 • Good governance actions in progress to review reporting structures, and clarity of roles and responsibilities. • Development in system for GROW conversations completed and new cycle has started in April 2023 • Refreshed and reviewed induction programme in place for new joiners to ENHT with clearer development and work continues to enable early access to systems for e-learning to achieve day 1 ready in the future • Developmental programme for ward manager with support of University • New roles and pathways under development e.g. physician associates, health care support worker pathways, nurse prescribing roles

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
	To be added once Corporate Risk Register work is complete (this applies to all the BAF risks)	

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		Risk score 12
Strategic Risk No.2: **Population/stakeholder needs**		
If we do not address health inequalities nor meet the expectations of patients and other stakeholders	***Then*** population/stakeholder outcomes will suffer	***Resulting in*** loss of trust, loss of funding opportunities and regulatory censure

	Impact	Likelihood	Score
Inherent	4	4	16
Current	3	4	12
Target	3	3	9

Risk Trend



Risk Lead	Chief Nurse (Chief Medical Officer)	Assurance committee	Quality & Safety Committee

Controls	Assurances reported to Board and committees
Partnership Arrangements • NHSE/I Recovery operational plan • Integrated Care Board agreements • Health watch. March 2023 maternity engagement focus • Provider collaborative • Elective HUB development / Community diagnostic HUB • Maternity Voices Partnership • Maternity Improvement Senate. Established and in place **Strategies and Plans** • Quality Strategy • National Patient Safety Strategy • National patient Experience Strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance'. EnHance being implemented **Governance and Performance Management Structures** • Accountability review meetings • Patient and Carer Experience Group • Patient initiated Follow Up programme. Pilot follow up planned for SDEC. • Risk management group **Quality Management Processes** • Clinical harm reviews - cancer and non-cancer • Learning from incidents • Triangulation of incidents and complaints at divisional level. Triumvirates asked to present triangulation work. April 2023 QSC • PSIRF discovery phase to scope PSIRF plan • Model hospital information on service line and specialty standards **Sharing best practice**	**Internal Committee-level assurances** • Elective recovery programme escalation reports • Cancer board escalation reports • Accountability Review Meetings escalation reports • Integrated performance reports to Board/ Committees • Executive Programme board escalation reports Sub Board Committees – assurance reports to board: • Patient and Carer Experience • Finance and Performance Committee • Audit and Risk Committee **Third line (external) assurances** • NHS Annual specialty patient surveys (ED, cancer) reports • NHS Friends and Family survey results • Care Quality Commission assessment reports • HSIB reviews/reports • NHSE regulator review meeting escalation reports • Peer reviews of selected services • National patient survey

Transformation programmes, specifically: • Discharge collaborative • Complaints transformation • Outpatient and theatre transformation • ICS transformation programme	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Poor timelines in responding to concerns increasing	Complaints transformation programme – *already in progress*
• Unwarranted variation across specialty booking Follow Up processes • Waiting list initiative payment model	• Transformation programme is in place to support improvement in FUP processes • PSIRF improvement priorities shall be launched by end of Q2 2023/24 *Update: some learning collaboratives in progress. PSIRF to be signed off by Board by Sept 23* • Transition to new a learning from incidents framework - *by end of Q4 2022/23 Update: Moved to ENHance. PSIRF to be signed off by Board by Sept 23* • Pro-active Communication plan with public and partners *– already in progress Director of Communications leading on this due Spring 2023. JDs and adverts for patient safety partners.* • Getting to Good – service level governance development programme shall be designed and delivered by Q2 2023/24
Unwarranted variation on Clinical Harm Review – non-cancer backlogs	Business case for a digital solution - *in progress for >52weeks incidents. Clinical harm reviews include proactively contacting/ texting all patients to assess need for waiting list. The 2nd phase of the project is to text clinical harm review questions, this phase in in planning stage.*
Clearer processes required for harm reviews relating to time waited for procedure	Implement and embed quality assurance framework - *by end of Q4 2022/23 as above.*
Delayed in patient information of non-cancer diagnosis	Improvement priorities focusing on clinical outcome letter processes, to be embedded by end of Since the introduction of the negative result letters and CNS telephone appointments the position has improved and work continues to work with the tumour Leads and operational teams to improve the patient pathway.
Referral To Treatment (RTT) TIER 1 rating due to long waiting times status	Implementation of intensive recovery plan *by end of Q4 2022/23. [Awaiting update]*
Patient, public, stakeholder and partner engagement	Engagement strategy to be approved by the Board by Oct 23 Maternity community engagement session being planned, due to Q2 2023/24 Patient safety partner advert now live, aim to recruit and place by Q2 2023/24
Family liaison in patient safety incidents/bereavement	Planning phase in progress, due for completion Sept 2023
Quality governance assurance framework re-design (no surprises)	Draft plan in place, stakeholder engagement and sign off due May 2023
Patient-centred decision-making	Patient co-design and engagement plans in progress, scoping underway to imbed in patient co-design framework, aim Sept 2023

Current Performance - Highlights

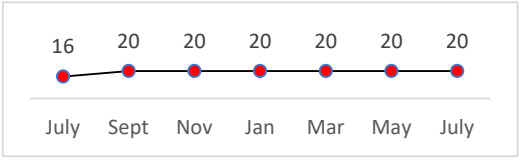
The following points are highlighted from the IPR most recent Board report:

- On average 94% of complaints are acknowledged within 3 working days
- Overall complaints responded to within agreed timeframe remain below agreed target and a priority for improvement

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		**Risk score 16**
Strategic Risk No.3: **Financial constraints and efficiencies**		
If costs increase significantly and/or far-reaching financial savings are required, and we do not deliver greater efficiencies	***Then*** we will need to make difficult decisions that could have a negative impact on quality and delivery	***Resulting in*** poorer patient outcomes, longer waiting times; reduced staff morale and reputational damage

	Impact	Likelihood	Score
Inherent	5	4	20
Current	4	4	16
Target	4	3	12

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Approved 23/24 Revenue, Capital, CIP & Activity Plan **Operational Systems and Resources** • Financial Reporting Systems – Finance Qlikview Universe • Detailed monthly CIP performance reporting • Monthly Finance Reports • Detailed bridge analysis of performance drivers **Governance & Performance Management Structures** • Monthly FPPC & Exec Committee Reporting • Monthly Divisional Finance Boards meetings • Monthly Capital Review Group • Weekly D&C / ERF delivery meetings • Monthly cost-centre / budget holder meetings • Bi-weekly ICS Director of Finance meetings • Ratified SFI's and SO's, Counter Fraud Policy • Consolidated ICS Procurement Service & Governance	**First and second line (internal) assurances)** • Monthly Finance Report / Key Metrics to FPPC • CIP report & productivity report to FPPC **Third line (external) assurances** • 23/24 Financial plan submitted to and approved by NHSE • Monthly financial reporting to NHSE & HWE System • External / Internal audit review of key financial systems and processes • Model Hospital / GIRFT / Use of Resources benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Risk to ~~Failure to~~ delivery of CIP savings at the level planned, placing financial pressure on the Trust and its system partners • Failure to remove COVID related cost investments in parallel with reductions in COVID income funding ~~The Trust is forecast to deliver an outturn deficit of £6.9m at year end.~~	• Monthly CIP report to Finance Committee and review at monthly divisional finance performance reviews.~~CIP Design and Delivery Framework approved at TMG (Oct)~~ • • Programme of establishment review sessions to recommence in July.~~CIP opportunities workshop (December)~~ • ~~Application of D&C and opportunities in 23/24 CIP programme work up in Feb and March.~~ • ~~Monthly financial reset meetings with divisions and Financial Reset Steering Group (In Place)~~
• Risk of non-payment of ERF overperformance by ICB and NHSE	• Weekly ERF delivery sessions with divisions in place~~Outturn ERF positions agreed with both HWE ICS and Specialist Commissioning, agreed in YE position~~.

	• Productivity framework in development, reporting to FPPC monthly
• Risk of sSignificant overspend against elements of the Trust's workforce establishment.	• Utilisation and Recruitment tools developed for use by nursing managersFinancial Reset – 'Medical Staffing' review to focus on this significant overspending area, follow up report to FPPC in February. • Allocate rostering system review to take place in July • Weekly and Monthly deployment framework will be included in July • Medi-rota management reporting development to commence in July
• Ratification of Medium-Term financial plan (MTFP) and assumptions – both Trust & ICS, triangulation with Risk around absence of a short- and long-term financial strategy for the system and stakeholders to address underlying deficitclinical strategy and improvement / transformation projects.	• Work plan proposed to ICS DoFs – 9th June setting out programme of activitiesDevelopment and implementation of MTFP planning framework with ICS partner organisations. Ongoing work programme extended by HWE ICS DoFs into 23/24
• Significant reductions in Trust productivity in 22/23 vs pre-pandemic levels. Significant increases in staff volumes and costs not related to activity change.	• The Trust has undertaken extensive run rate and associated bridge analysis. • This has framed areas for review and restatement for 23/24. This is formalized in a specific strand of budget setting activity. Further 'Establishment Growth' review sessions during JulyApril. • Productivity report to FPPC

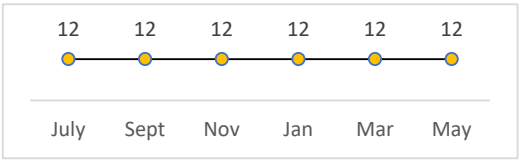
Current Performance – Highlights
The following points are highlighted from the Integrated Performance Report: • The Trust reports a YTD deficit of £4.8m, this is in line with the financial plan.Year End Outturn Position of £6.1m • As at Month 2 the Trust CIP plan is on trackReliance upon non recurrent reserves to support plan achievement year to date • Variable SLA income is behind plan at Month 2£6.8m YTD slippage against agreed CIP programme • Medical staffing budgets overspend of £6.3m YTD

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**		Risk score 12
Strategic Risk No.4: **Workforce shortages and skill mix**		
If global and local workforce shortages in certain staff groups persist or increase combined with not having the right skill mix	***Then*** the Trust may not have the required number of staff with the right skills in the right locations	***Resulting in*** a negative work experience for staff due to increased work burden and gaps in skills to deliver services

	Impact	Likelihood	Score
Inherent	4	4	16
Current	3	4	12
Target	2	3	6

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • Data accuracy between ESR and finance systems • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans and local Skill mix reviews • GROW and Succession plans • Tailored approach to nursing and medical and administration hotspots, with UK based campaigns supported by international recruitment plans **Learning and Development** • Apprenticeship schemes • Leader and Manager Development programmes **Recruitment and Retention** • Workforce Plans • NHSP and international recruitment • Various return to work schemes e.g. retire and return • Drive for 5% - recruitment and retention steering group • ICS retention pathfinders working groups **Staff Engagement & Wellbeing** • Thank you and engagement interventions • Staff Survey • Absence and referral rates • Take up of wellbeing services **Governance & Performance Management Structures** • Medical establishment oversight working group • Clinical oversight working group • Recruitment and retention group • Workforce reports – time to hire, pipeline reports • Executive Programme Board	**First and second line (internal) assurance** • IPR – to board and People Committee, including vacancy and turnover rates • WDES/WRES reports - to board and People Committee • Recruitment and Retention deep dives and reports – People Committee, ARM, Divisional Boards • Deep dives with focus on specific workforce areas **Third Line (external) assurances** • Equality data for workforce (WRES/WDES) • Staff survey results
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps

• How we prioritise delivery • Capacity to deliver scale of changes alongside day to day service delivery e.g. scaling up agenda 'v' local changes to improve services, rely on same resources to deliver both.	• Prioritisation of programmes through board and agreed by executives in line with annual planning cycle • Improving workforce plans at divisional levels to inform prioritisation of plans to Board in line with the annual planning cycle (planning cycle Sept-March) • Demand and capacity planning sessions support and inform the above
• Engagement and motivation to enable changes to be embedded e.g. where a change may mean we no longer deliver something ourselves and its delivered by others	• People change review report and updates which go regularly to divisional boards and sight being introduced to TMG on a regular basis (quarterly) • Support and development to managers leading change and supporting staff through change – scheduled regular development sessions throughout the year planned
• Competition for funding and resources across budgets to enable change at scale to happen	• Funding for large scale change to backfill release of experts to input early • Prioritisation agreed as above • Funding flows to support delivery requirements
• Capacity of key clinicians and senior leaders to work on the areas of change due to conflicting priorities	• Agreed protected time at outset of programme of change as an agreed priority – will require Programme Management Board and TMG sign-off
• Requirement for national and regional NHS workforce strategies as ENHT is dependent on these to ensure sustainable delivery of workforce changes	• Government commitment to produce NHS workforce strategy by Apr 24 • ICS workforce strategy produced January 23

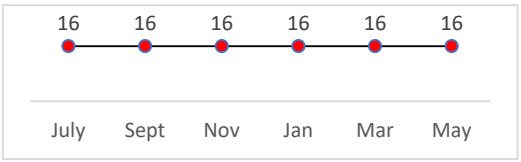
Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Plans to continue collaboration with the ICS for international nurse recruitment for 23/24 • Development in system for GROW conversations completed and new cycle commences from April 2023 • Refreshed and reviewed induction programme in place for new joiners to ENHT with clearer development and work continues to enable early access to systems for e-learning to achieve day 1 ready in the future • New roles and pathways under development e.g. physician associates, health care support worker pathways, nurse prescribing roles.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
6359	Risk that the failure to achieve the Trust target for staff appraisals of 90% compliance will have an adverse impact on staff engagement and on the effective line management of staff.	12
6848	There is a risk that the Trust will fail to develop an effective workforce plan and workforce model for each service that takes account of new/different ways of working and will also fail to make best use of the existing talent pool through developing staff to their full potential and enabling flexible working arrangements.	16

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score 16
Strategic Risk No.5: **Culture, leadership and engagement**			
If the culture and leadership is hierarchical and not empowering or compassionate and inclusive and, does not engage or listen to our staff and provide clear priorities and co-ordination	***Then*** staff experience relating to stress, bullying, harassment and discrimination will perpetuate and lead to ambiguity, information overload and staff fatigue.	***Resulting in*** staff disengagement, confused priorities, loss of purpose and low morale plus poorer staff morale and retention and ultimately poorer quality of services and patient outcomes and CQC ratings	

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	4	16
Target	3	3	9

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • People Strategy • ENHT Values • People policy reviews • Speak Up approaches • EDI Strategy • Leadership Development Plans **Learning and Development** • Core skill and knowledge programmes (management and Leadership) • Healthy Leadership, care support pyramid • Civility Matters • Mentoring and coaching programmes • Mandatory learning around inclusion, management and development of people • Speak up training **Recruitment and Retention** • Values assessment undertaken at application stage for senior roles and in shortlisting criteria • Pulse surveys • Feedback through local induction processes • Grievance and raising concerns policy and guidance **Staff Engagement & Wellbeing** • Core offer of support available linked to financial, physical, mental, spiritual and social wellbeing for all staff • Annual days to raise awareness of specific topics • Staff networks /Freedom To Speak Up/ Meet the Chief Executive • We have submitted our SEQOHS application for Health@Work services • Internal communications - all staff briefing, in brief and newsletter **Governance & Performance Management Structures**	**First and second line (internal) assurance** • Regular reports on progress against People Strategy • IPR **Third Line (external) assurances** • National staff survey results • WRES/WDES • Published equality data

• People Committee, staff side, Local Negotiating Committee • Divisional boards • Grow together reviews and talent forums • Staff networks	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement • Challenges in the level of organisational engagement across ENHT to make things happen and embed sustainable change	• Prioritise approaches for service areas and deliver development work by end of Q4. • Staff survey action plans support improvements happening locally and results are used to identify priority areas and specific support to low score areas • Cultural development work continues with senior leadership team
• Capacity to release staff and leaders to participate in development alongside day-to-day priorities	• Creative delivery and support to enable release and participation e.g. protected time; forward planned events and team talks • Dedicated agreement organisationally of time to develop e.g. to complete mandatory training
• Ability to resolve staff complaints quickly and easily	• People Policy reviews will be complete by March 2023 and a rolling programme for training managers in investigation, reports and hosting challenging conversations will follow during 2023/24 – on track
• Investment and support levels organisationally for EDI programmes and resources restricts progress	• EDI strategy produced by June 2023 • EDS2 published Mar 23 with action plan to be delivered throughout the year and longer term • Gender pay gap actions embedded in organisation (between 2023-25) • Wider delivery of programmes such as cultural intelligence and civility matters across the whole organisation

Current Performance - Highlights

The following key performance indicators are highlighted from Integrated Performance Report:

- Updated 2022 staff survey results are being issued with local cascade and progression of actions and renewed focus
- A suite of leadership and cultured development work is underway for use in the short and medium term
- Time to resolve disciplinary cases has improved and is being sustained to improve employee relations
- More work is underway to seek to resolve grievances informally and encourage early resolution.

Associated Risks on the Board Risk Register

Risk no.	Description	Current score
6092	There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered or enabled, impacting on the Trust's ability to deliver the required improvements and transformation, and impacting on the delivery of quality and compassionate care to the community.	16

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**			Risk score 16
Strategic Risk No.6: **Autonomy and accountability**			
If the desired autonomy with appropriate accountability approach is not achieved	***Then*** the Trust will fail to achieve local ownership and continue to face the same structural and culture challenges	***Resulting in*** the Trust being unable to deliver needed changes and improvements.	

	Impact	Likelihood	Score	Risk Trend
Inherent	4	5	20	
Current	4	4	16	
Target [DATE]	4	3	12	

Risk Lead	Lucy Davies, COO	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • People Strategy • ENHT Values • People policy reviews • Speak Up approaches • EDI Strategy • Leadership Development Plans **Governance & Performance** • Revised Scheme of Delegation • Balanced scorecard • Well-led review action plan **Management Structures** • New Divisional structure • ~~ARMs~~ • Divisional Performance reviews • Divisional boards • Grow together reviews and talent forums • Staff networks **Improvement Partner** • *[Controls to be added once Improvement Partner starts]* **Learning and Development** • Core skill and knowledge programmes (management and Leadership) • Healthy Leadership, care support pyramid? • Civility Matters • Mentoring and coaching programmes • Mandatory learning around inclusion, management and development of people • Speak up training **Recruitment and Retention** • Values assessment undertaken at application stage for senior roles and in shortlisting criteria • Feedback through local induction processes **Staff Engagement & Wellbeing** • Pulse surveys	**First and second line (internal) assurance** • Divisional Performance Dashboards • IPR • Balanced scorecard • Transformation programme report to FPPC • Regular reports on progress against People Strategy **Third Line (external) assurances** • Well-led review • National staff survey results • Internal audit re financial processes • WRES/WDES & published equality data

• Core offer of support available linked to wellbeing for all staff • Staff networks /Freedom To Speak Up/ Meet the Chief Executive (Ask Adam) • Internal communications - all staff briefing, In Brief and newsletter, leadership briefings	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Lower tiers operational & clinical restructure	• COO, CMO, CNO, CPO - By end of Mar 24
• Lack of agreed delivery plan [bar individual actions]	• People strategy
• Leadership culture modelling/enabling autonomy	• Exec development and teambuilding programme (CPO) – ongoing
• Communication beyond senior management (making it intelligible and gaining buy-in from wider staff)	• Communication plan for Quality Management programme -Dir Improvement and AD Comms – Nov 23
• Revised SFIs providing the framework for devolved financial decision-making with accountability	• Producing revised SFIs (Deputy Finance Director) – by Oct 23
• The efficacy review and feedback of the performance framework (active cycle of learning) e.g. efficacy of pushing it down within the organisation	• Paper to FPPC 6 & 12 months after launch of balanced scorecard and whether changes/improvements are needed
• Agreed priorities for Virginia Mason/Improvement Partner	• When VM begins to actively look at how it links with our performance activity & to ensure any new arrangements are embedded into our performance framework

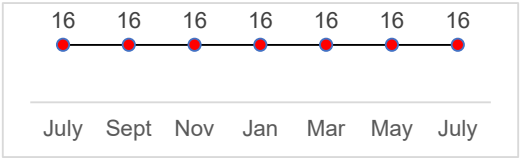
Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Speaking up • Complaints responded within agreed timeframe • Appraisal rate • CIPs achieved • Staff Survey results

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 16**
Strategic Risk No.7: **Immature place and system collaborative processes and culture**		
If the emerging ICS and place-based models do not develop at pace and we are unable to develop mutually collaborative approaches with partners throughout the system	***Then*** collaboration will stall, and partners will not trust us and vice versa	***Resulting in*** not delivering improved ways of working, missing the opportunities to improve health services and patient outcomes system-working offers; regulatory accountability and not achieving the system financial envelope.

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**4**	**4**	**16**
Target	4	3	12

Risk Trend



Risk Lead	Deputy Chief Executive	Assurance committee	FPPC

Controls	Assurances reported **to Board and committees**
Strategies and Plans • Clinical Strategy and Trust objectives • Joint strategic needs assessment • ICB and HCP strategies and priorities **Financial Controls** • Cross System pathway transformation commissioning priorities at PLACE/ICB/ICS **Governance & Performance Management Structures** • ICB Board • ICS Board • Place Board • Scrutiny committee • Health and wellbeing board • ENH Tactical Commissioning Group **Relationships** • Strong networks around specific subject areas eg. UEC, Cancer etc	**First and second line (internal) assurances** • Escalation reports to: Quality and Safety Committee; People Committee: Clinical Audit & Effectiveness sub-committee • Integrated performance reports to Board/ Committees • Well led framework assessment and review reports • Elective recovery programme escalation reports • Feedback from ICB CEO attending Board bi-annually **Third line (external) assurances** • NHSE Board feedback forums
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Defined governance frameworks	• ICB/ICS/Place leadership group reports. Material to be shared via Diligent • Key ICS risks relevant to ENHT are seen by the Board (Stuart Dalton Apr 24) • System reports to the Board (MA/SD Nov 23)
• Missed opportunities to influence joint strategic needs assessment	• Influencing policy design at ICB and HCP level. Trust to determine strategy and mechanisms for influencing • A structured comms and engagement approach to formally sharing information, current challenges and successes with both the ICS, and partners within it- both

	on an ad hoc basis, but also within comms leads meetings (Eilidh Murray Sept 23) • Seek agreement from partner Chairs that Company Secretaries agree a list of supporting strategies and other key board documents that will be shared and how these will be shared (Stuart Dalton Sept 23)
• Developing role, responsibilities, and relationships	• Participation in System and Place development groups • NED collaborative working: Trial groups of NEDs from respective partners around their key responsibilities eg Chair for audit, FPPC, quality and People Cttee, maternity and wellbeing champions etc. Trial to see if these add value. (MA Apr 24) • Explore shared back office functions across the ICS (MA Dec 24)
• Developing cross systems relationships with agreed values and behaviours	• Participation in System and Place development groups • Externally facilitated Board development session on involvement within the system, how best to collaborate and work in partnership (use of case studies) (LM Dec 23) • Clearly log and publicise what we do to help to counteract negative narrative. (MA/EM Mar 24) • Invite ICS and HCP to Board (SD Mar 24)
• The trust should engage with the ICS to ensure that its strategy is aligned with the ICS strategy as that is developed.	• Seek views from the ICS on how best the Trust aligns our strategy with the ICS's (Circulation of summarised Trust Strategy document to stakeholders. Subsequent engagement sessions agreed and iteration where required) (LM Nov 23) • The Trust strategy to cover how it delivers the ICS strategy (iterate the Trust strategy chapters where appropriate) (LM Sept 23) • For ICS strategy and its BAF to be reviewed periodically by the Board) (SD Apr 24)

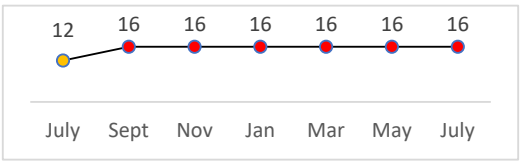
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • the IPR does not include any measures that specifically highlight the effectiveness or not of collaborative arrangements

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**			Risk score 16
Strategic Risk No.8: **Performance and flow**			
If we do not achieve the improvements in flow within the Trust and wider system	***Then*** the Trust's key performance targets will not be met	***Resulting in*** increased avoidable Serious Incidents, wider health improvements not being delivered and regulatory censure	

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	4	16
Target	4	2	8

Risk Trend



Risk Lead	Chief Operating Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Recovery plans (Elective, cancer, stroke), refreshed for 23/24 • Cancer Strategy and Cancer recovery plan, refreshed for 23/24 • Stroke recovery plan • System UEC strategy (incl ambulance and discharge flow) • UEC rapid action event (Sept 22), with resulting action plan monitored weekly by Execs • UEC Transformation Programme (including ambulance handovers), refreshed for 23/24 • Support from ECIST (Emergency Care Improvement Support Team) – improvement actions and plan agreed • Tailored support requested by ENHT and agreed from national & regional UEC teams and ECIST (April 23) • ENHT ~~participation~~will participate in EoE ED Peer Review (Dr Leilah Dare) scheduled for 25 May 2023 • New leadership from 17 April – Trust Director of Operations & Performance • Participation in the ICB Community Paediatrics and Neurodiversity Programme Board • Attendance at fortnightly Acute Planned Taskforce ICB meeting and monthly HVLC ICB meeting to ensure any learning or actions are taken • ~~UEC programme board – 6 workstreams~~ **Performance Information Controls** • ~~Refreshed format and accountability through the monthly divisional performance dashboards and meetings.~~ • IPR • Deep dives • Qlikview dashboards – used to provide immediate access to data across a number of domains to enable effective management of performance **Governance & Performance Management Structures**	**First and second line (internal) assurances** • Board (IPR; transformation reports) • FPPC (IPR & deep dives) • Board Seminars • Newly formatted divisional performance reviews commenced May 23 **Third line (external) assurances** • Quality & Performance Review Meeting (chaired by ICS with CQC) • Herts & West Essex ICS UEC Board • ENH performance meeting (chaired by ICS Director of Performance) • National Tiering system

• Operational restructure underway to further develop clinical and operational leadership, clear accountabilities, shared learning, QI approach • Transformation programmes at the Exec Programme Board • Divisional Performance Reviews • Divisional Board meetings • Regular tumour group meetings and improvement workstreams • System-wide Cancer Board chaired by Lead Divisional Director for Cancer • Specialty exception meetings	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• New NHSE performance metrics (62 days cancer and 65 weeks waits)	• ARM meetings – a revised format is currently being developed. – Completed • ~~Demand and Capacity undertaken at speciality level and plans developed for 65 week wait by March 2024. Trajectory to compliance for all specialities except Community Paediatrics - completed~~complete • ICB system work to address Community Paeds demand/ capacity mismatch – ongoing
• Scope of validation of Patient Tracking Lists	• ~~Increasing~~ validation of Patient Tracking Lists – by Quarter 4 22/23 – completed • ~~Work commencing quarter 2 with Dedalus to produce PTL~~
• Ambulance intelligent conveyancing lack of proactiveness	• System solution to intelligent conveyancing/ambulance intelligence will improve, but not fully address the challenge – ongoing • IC new SOP introduced May 23
• Lack of social care and community capacity to support discharge • Utilisation of Hospital at Home not yet optimal – further work being undertaken to increase uptake.	• Extending scope of hospital at home – not matching what we need (taking patients who are awaiting packages of care). This will partially address the challenge of timely discharge for medically optimised patients. – ongoing [timeline to be confirmed once known] • E referral introduced for Hospital @ Home
• Capacity to increase referrals to cancer pathways	• Review of ARM meetings to ensure effectiveness – by Quarter 4 –Completed
• Diagnostic wait times – Access Board, Cancer Board	• Demand and capacity analysis – Quarter 3 22/23 – Completed – presented to Jan 23 FPPC • Additional capacity in plan: CT, echo, ultrasound, DEXA, MRI and plain film – Quarter 4 22/23 – completed • WLI in place in endoscopy • Network IRefer Quarter 2/3 23/24 • Recruitment into ultrasound / MRI / CT / echo and neurophysiology
• Consultant Vacancy rates in some services (Anaesthetics, Orthopaedics)	• Recruitment plans are part of Divisional operating plans
• Willingness of consultants to undertake extra contractual sessions	• New rates agreed Feb 23. Further limited incentive agreed March 23, with agreement of anaesthetists to recommence extra contractual sessions from April 2023 • All theatres being utilized by the end of May 23

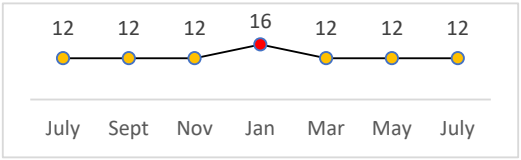
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • % of 62 day PTL over 62 days • 62-day/ 31-day cancer performance • 78 weeks RTT • 65 weeks RTT • Ambulance handovers • ED 4 and 12 hour performance • Diagnostic waits • 2 week waits • Stroke performance

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 12**
Strategic Risk No.9: Trust and system **financial flows and efficiency**		
If finances do not move around the system in recognition of costs incurred in new models of care	***Then*** our and our partner financial positions will deteriorate	***Resulting*** in the inability to fund planned service delivery and regulatory scrutiny

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	3	12
Target	3	3	9

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Agreed ERF targets for 23/24 with ICS. • Clinical Strategy and associated prioritisation and development framework. Linked to place priorities. **Financial Controls** • Monthly ERF & SLA activity reporting schedules **Governance & Performance Management Structures** • Identified Finance and Planning capacity to provide ~~Establishment of SFA team to provide strategic finance~~ transformation evaluation support • Bi-weekly ICS System Leaders meeting • Bi-weekly ICS DoFs and DDOFs meeting • Monthly E&N Herts Partnership Board & associated meetings • Elective Surgical Hub, Community Diagnostic Hub, Virtual Hospital and Heart Failure local and regional governance arrangements • PHM reporting mechanism to track changes in patient flows and associated costs and income • PHM steering and development group and link to place and system PHM development activity	**First and second line (internal) assurances** • System and Provider Collaboration reports to Trust Board advising on activity • Weekly D&C review sessions • Monthly project review sessions between Finance & Transformation Team. Transformation activity updates included in FPPC business cycle **Third line (external) assurances** • Consolidated ICS financial performance reports • Share further ICS performance reports as circulated by ICS.
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Risk of non-payment of ERF overperformance by ICB and NHSE	• Month ERF performance reports~~Outturn ERF positions with both HWE ICS and Specialist Commissioning agreed for 22/23~~.
• Establishment of transparent financial reporting environment across ICS partners	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Development of ICS financial risk management strategy	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation

• Determination of place based financial responsibilities	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Development of long-term financial plan for ICS	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Acute Provider Collaborative and associated business rules	• Approved by Trust CEOs – ~~Sep 22. CEOs to review and approve collaborative governance arrangements.~~ Move to implementation phase
• Further Board dialogue to be facilitated to help develop further metrics that can support assurance	• To be addressed through future board development sessions

Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • Performance against ERF income and activity targets • Delivery of CDC activity levels

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 16
Strategic Risk No.10: **Digital transformation**		
If the necessary digital transformation improvements are not prioritised, funded or delivered	***Then*** the Trust will lack the digital means to deliver its plans including using obsolete legacy systems that are unsupportable	***Resulting in*** 1) not delivering transformation plans that are crucial to improving efficacy and productivity 2) not achieving the nationally mandated minimum digital foundations

	Impact	Likelihood	Score	Risk Trend
Inherent	4	4	16	
Current	4	4	16	
Target [1/10/23]	4	3	12	

Risk Lead	Chief Information Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Board approved 23/24 Strategic Objectives • 23/24 Digital Roadmap • 2021 Digital Strategy Outline Case (SOC) methodology **Governance & Performance Management Structures** • Clinical Digital Design Authority **Quality Management Processes** • Trust Transformation Programme (VMI) **Training and Sharing Best Practice** • Trust-wide training and development programme • Learning events, safety huddles and debriefs	**First and second line (internal) assurances** • Monthly Divisional Board and Transformation meetings • Monthly programme reports • Digital programme boards • Key performance metric reporting to Board/Committees • Board and Committee transformation update reports **Third line (external) assurances** • External /internal audit review of key programmes i.e., transformation portfolio, efficiency and productivity, strategic projects • Annual and Pulse staff surveys • National benchmarking reports • NHS Model Hospital Portal • GIRFT programme
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps • Market movement from Perpetual licensing to Software as a Service (SaaS) is preventing the capitalisation of Software licenses and deployment	**Control treatments** • Review Vendor licensing models 1/8/23 • Identify NHS E revenue funding models (not capital) 1/8/23 • Identify Blended Capital/revenue models 1/8/23
• Consistency with engagement across all staff groups to support improvement projects	• Roll-out strategic objectives aligned with Grow Together conversations and new Trust values and behaviours 1/12/23
• Ongoing number of Trust projects require cultural change and formal organisational redesign approaches	• Formalisation of an organisational development change model & engagement programme to commence Dec 22/23 as part of Quality Management System preparation.
• Variation in business-as-usual systems and processes	• Adoption of lean thinking in pathway redesign model as part of the new Quality Management System 3/4/24
• Improvement training compliance is variable across staff groups and levels of seniority	• Review of the current dosing model for improvement skills and training following confirmation of Improvement Partner in Q1 23/24.1/12/23

• Digital Solutions and Delivery team has been historically funded through Capital using contract resource, but new Capitalisation rules mean a move towards revenue, this could significantly reduce the size of the team for Road map deliveries	• Move towards a substantive team to reduce spend • Seek NHS E revenue funding streams
Assurance gaps • Performance data indicates issues with sustaining changes & embedding culture of improvement & learning	**Assurance treatments** • Review of current processes for aggregated Trust learning and gap analysis plan to be developed by end Q4 22/23.
• Programme milestones and KPIs reflect compliance issues with Trust project management principles	• New strategic project management governance framework established. Ext audit scheduled Q4 22/23.
• Engagement in the design and adoption of digital systems	• Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. • Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions
• Alignment of new transformation portfolio digital requirements with overarching Digital Roadmap	• Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions

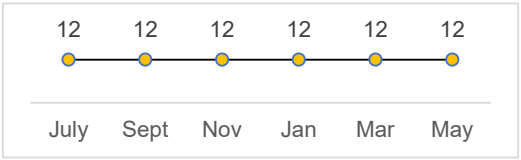
Current Performance - Highlights

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 12
Strategic Risk No.11: **Enabling innovation**		
If we do not foster a learning culture where experimentation and questions are encouraged and staff are supported to innovate and do the right thing when mistakes happen	***Then*** there is the risk staff will become disempowered, will not identify solutions, not challenge without fear, not learn from mistakes and managers will hide issues and the culture will be psychologically unsafe.	***Resulting in*** avoidable harm to patients, missed opportunities for improvement and potential regulatory intervention and a culture of uncivil behaviour and lack of trust amongst staff

	Impact	Likelihood	Score
Inherent	5	4	20
Current	4	3	12
Target	3	3	9

Risk Trend



Risk Lead	Director of Transformation	Assurance committee	People

Controls	Assurances reported to Board and committees
Strategies and Plans • Quality / Patient Safety Strategy • EDI strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance' • Change Toolkit and Policy **Governance and Performance Management Structures** • Patient Safety Forum(s) • Collaborative(s) (harm free care/ deteriorating patient) • A just culture guide for evaluating patient safety incidents • Freedom to speak up guardian / network • Mortality review process • Clinical audit programme **Learning from Incidents** • Clinical and serious incident review panels • Schwartz rounds/ quality huddles/ Here for You sessions • After Action Review debriefs **Quality Management Processes** • CQC and compliance preparedness framework • Incident management KPIs • Patient safety specialist role (s) **Training and sharing best practice** • RCN Clinical Leadership Programme • QI Bite size, masterclass & coaching sessions • PDSA / quality improvement in action • Leadership rhythm / bite-size sessions • Human factors simulation training	**First and second line (internal) assurances** • Divisional quality meetings/ structures • Accountability Review Meetings • Key performance metric reporting to Board/Committees • External/ internal audit review programme i.e., BAF & Risk Management, MHPS • CQC peer/ ICB review assessments • Risk Management Group **Third line (external) assurances** • Annual and Pulse staff survey results • Care Quality Commission assessment process • ICB / Place Quality Surveillance Group • NHS patient survey results • NHS clinical incident reporting benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps • Single improvement methodology not established across the organisation	**Control treatments** Develop and roll-out a Quality Management System with Improvement Partnership support due to commence in Quarter 2 23/24.

• Freedom to Speak up Strategy not launched or imbedded	• Develop leadership and management framework to support freedom to speak up processes as part of BAU in Q4 22/23 Update: Freedom to Speak Up Strategy in draft format and under consultation with stakeholders with planned submission by FTSU Guardian for Committee sign-off now scheduled for early Q1 23/24.
• Variation in ward to Board quality governance structures and operational procedures	• Good Governance Institute review. • National Safety Incident Framework launch in Q1 23/24 in a phased approach.
Assurance gaps • Efficacy of current learning systems from incidents, complaints, audit and wider performance issues where there are reoccurrences of similar themes and outcomes.	**Assurance treatments** • Review of systems to capture and share learning • Develop and launch a refreshed vision for learning and improvement, closely linked to strategic objectives and Trust values to commence Q3 22/23. Update: Review and improvement in learning processes across the organisation has involved the a) development of the new national Patient Safety Incident Response framework b) establishment of learning capture behind every complaint response letter and commencement of complainant satisfaction questionnaires c) a new robust learning evaluation for all EPB strategic programmes, and d) a new place-based Learning Network led by ENHT with a series of learning events between ENHT and PAH already occurring throughout the year.
• Level of staff absence, survey feedback themes and grievances reported by staff through FTSU Guardian.	• Review of ward/specialty MDT governance processes - develop MDT ward leadership model • Development of ICB / Place learning network Update: Specialty and Ward MDT leadership model and structure to be incorporated into the next Divisional redesign phase, scheduled for consultation in Q1 23/24.

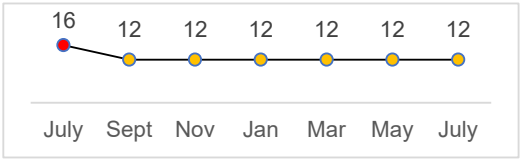
Current Performance - Highlights
•
• ITT procurement exercise for Improvement Partnership concluded 17th March with top two suppliers invited to an on-site presentation 5th April. Tender specification conforms soft landing during Q2 before wider launch in Q3 23/24. • Learning sessions also now established as routine following all major operational and/or emergency planning incidents with most recent example covering junior doctor industrial action. • Place-based learning network now established with wider ICB learning events underway involving ENHT and PAH; discussions for an ICB-wide learning network are ongoing.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
6092	There is a risk our staff do not feel fully engaged which prevents the organisation maximising efforts to deliver quality care.	16

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		Risk score 12
Strategic Risk No.12: **Clinical engagement**		
If the conditions for clinical engagement with best practice and change are not created and fostered	***Then*** we will be unable to make the transformation changes needed at the pace needed	***Resulting in*** not delivering our recovery targets or improved clinical outcomes; not building a financially sustainable business model; and being unable to contribute fully to system-wide transformation

	Impact	Likelihood	Score
Inherent	4	4	16
Current	4	3	12
Target	4	2	8

Risk Trend



Risk Lead	Medical Director; (Chief Nurse)	Assurance committee	QSC

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy • Quality Strategy **Information systems and resources** • QlikView Quality dashboards • Life QI • Datix / 'ENHance' • GIRFT • KOPs programme **Governance and Performance Management Structures** • Operational committees e.g. Patient Safety Forum, Mortality surveillance committee **Learning from Incidents** Key performance SOPs e.g. Incident learning responses: serious incident reports, round tables, restorative culture framework – new Patient Safety Incident Response Framework (PSIRF) to be introduced to respond to patient safety incidents to learn and improve patient safety **Quality Management Processes** • CQC and compliance preparedness framework • Safety Incident management framework • Quality Improvement service • Transformation service • Reward and recognition **Training and sharing best practice** • Royal College of Nursing Clinical Leadership Programme • Clinical Directors development Programme • Clinical Directors' Away Days • New Consultants development programme • Improvement and transformation capability sessions • Quality Improvement coaching • Leadership and human factors development programmes • Research programmes	**Internal Committee-level assurances** **Sub Board Committees** • Quality and safety Committee report • Education committee escalation report • Clinical Audit and Effectiveness Committee escalation report Safety Culture survey **Third line (external) assurances** • Annual and Pulse staff survey results • Care Quality Commission assessment process • ICB / Place Quality Surveillance Group escalation report • NHS patient survey results • Peer assessment review report and action plan • External/ internal audit programme reports and action trackers • Getting it Right First Time national programme • GMC Survey • HEE National Education & Training Survey

Staff engagement and well being • Here for you health at Work • Values and behaviour programmes • Freedom to speak up guardian / network • Medical Director quarterly update presentations & Q&A session - All consultant & SAS doctors invited • Medical Director's weekly ~~quarterly~~ newsletter • MD introductory meeting with specialties • MAC, LNC & JDF • Trainees in Leadership Support Group • Healthy teams Programme • Kindness and Civility Programme • Weekly Positive Leadership Walk Arounds	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
Control gaps Skills and knowledge within clinical workforce to learn how to drive change	• Combined efforts to drive skills and knowledge by people team, transformation team, quality improvement team and business information's analysts in progress • Engage with an improvement partner *end of Q3 2023/24 – likely to be in place earlier*
Capacity within clinical roles to apply change methodology	• Agreed job planning and rostered time demonstrated through Roster on PA allocation. To be reviewed as part of job planning criteria for 2023, full rollout by Q4 23-24 • Proposal to provide selection of trainees time to be involved in KOPs/QI and transformational projects
Unwarranted variation in quality assurance framework	Redesign quality assurance framework *by end of Q3 22/23* [OVERDUE]
Current national safety Incident framework	New safety incident response framework implements *by end of Q4 23-24*
No allocated Medical lead Quality Improvement	In short term lead identified is Associate Medical Director for Quality and Safety. Appointment of Deputy Medical Director for Quality Improvement scheduled for Q1, 2023-4
Operational pressures, especially throughout Q3 and Q4	Risk based approach to quality improvement and prioritising
Assurance gaps Improving evidence of imbedded sustainable changes following learning from incidents, complaints, audit, and wider performance issues	New national safety incident response framework (PSIRF) to be implement by Q4 23-24 will improve evidence

Current Performance - Highlights
The following are highlighted from the most recent Integrated Performance Report: • Sustained improvement in recognition and management of sepsis • Sustained improvement in incident reporting • Sustained improvements in learning form deaths and mortality outcomes

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	10
Report title	ENHT UH Partnership Annual Report			**Meeting Date**	5 July 2023
Presenter	Justin Daniels, Medical Director				
Author	Jennifer Godwin, University Partnership Manager				
Responsible Director	Justin Daniels, Medical Director			**Approval Date**	1 May 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

The Trust entered into a formal partnership with the University of Hertfordshire (UH) in March 2017 to promote a closer working relationship for the benefit of patients, students and staff.

The partnership is governed by the Joint Management Committee and reports via the annual report to relevant committees in each organisation.

This report demonstrates the depth and breadth of the partnership between ENHT and UH; and shows how our staff and patients are directly benefitting from our partnership.

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):

QSC June 2023
ENHT UH Partnership Joint Management Committee
UH Senior Executive Group for School of Life and Medical Sciences

Recommendation	For approval

To be trusted to provide consistently outstanding care and exemplary service

University Partnership - Joint Management Committee

Annual Report 2022-2023

Report prepared by Jennifer Godwin

Partnership Manager

May 2023

1. Executive Summary

KPI	Metrics	Progress at 31st March 2023
KPI-1. Innovative Workforce Development and Transformation	Embed newly developed workforce roles into Trust workforce including Physician Associate, Nursing Associate, expansion of Non-Medical Prescribing and Advanced Clinical Practitioners. - Collaborative workforce planning to inform requirements for future training demands. - Increase uptake of other transformational workforce roles such as Advanced Clinical Practitioners. Increase collaboration between Trust Faculty of Leadership and the Business School to support staff development and talent management. - Career Conversations underpinned by coaching and talent management. - IT solutions for recording of continuous feedback. - Explore further the support for a joint leadership lab.	First students have graduated on the career pathway from Clinical Support worker to Registered Nurse via apprenticeships. Planning and business case is underway for how to embed Physician Associate Role. Trust appraisal system has been redeveloped to include career conversations. The viability of a Joint leadership lab will become clearer as ICS strategies and priorities emerge.
KPI-2. Enhanced Student Experience	Evidence of enhanced student experience will be assessed through the University's Annual Monitoring and Evaluation Report and reviewed by Joint Management Committee. Development of Clinical Educators including Ward Managers and Ward Leaders in line with the requirements from the NMC and other relevant professional bodies. Work towards a more integrated and collaborative approach to location of training and sharing of physical, clinical and teaching resources. This may include UH endorsement of Trust in-house courses. Recognition of clinical experts and trainers including honorary contracts and time-in-job plan. Increase the numbers of clinical subject matter experts and percentage of courses delivered by them. Renewal and revision of the Practice Placement Agreement between the Trust and UH which expires in March 2020. Sustainable access to Non-Medical Prescribing (NMP) course for Pharmacists and other staff groups to support Trust objectives. Increase the range of students on placement within the Trust for example: - Ensure Trust placement opportunities reflect the full range of fields of study on offer at UH. - Placement of 'sandwich' students e.g. Biosciences students currently employed as Clinical Trials Assistants at Mount Vernon. - Joint PhD students.	Placements and Student Experience workstream is in set-up, first meeting will take place outside this reporting period. Continued demand for NMP for pharmacists with direct benefits on Trust capacity for ward based TTOs and time to discharge, a key element of the Trust response to unprecedented demands on services. Changes to undergraduate and post grad diploma curriculum will help to resolve this in future. Work is ongoing as to how to reflect academic work on Trust systems including electronic staff record. Supporting ambitions through career conversations and building a leadership and coaching faculty. Looking to expand the intern / sandwich placements beyond the research and strategy teams and into less obvious areas such as I.T./business intelligence as funding allows.
KPI-3. Research, Innovation and Service Improvement	Increase the number of collaborative research projects, joint publications and an assessment of their contribution to UH and ENHT objectives and strategic drivers. Including an assessment of the impact of joint research on patients and patient care. - Monitor breadth of projects across disease areas and academic schools. - Optimisation of Trust IM&T services and further digitisation of Trust systems will give rise to additional opportunities for collaboration. - Develop and strengthen Patient Public Involvement (PPI) activities between UH (national experts in PPI)/ENHT.	Number of joint publications has increased year on year. We recognise the lag period involved between establishment of research and the publication of results and the partnership is now beginning to see real results for patient benefit. 5 established joint research groups in renal, urology, cardiology, critical care and gastroenterology which make up the vast majority of joint research and publications.
KPI-4 Strategic Planning	A strategic plan will be in place covering the first six years of the partnership until the planned revalidation in 2023. This will encompass establishing project themes, facilitation of wider engagement between the Trust and Schools across the whole University, risk management and the sustainability of the partnership.	Revalidation is no longer possible as we do not meet the DH criteria for University Trust status. We have agreed new wording for the memorandum of understanding, and this is in the process of being signed.

2. Partnership Management

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

The purpose of the Joint Management Committee (JMC) is to support the delivery of the commitments made by both the Trust and University under the Memorandum of Understanding (MoU). It ensures effective inter-professional collaboration in the areas of research, education and practice across both organisations.

Details of the structure of the JMC can be found in appendix A.

2.1. Memorandum of Understanding

After working together for many years, ENHT and UH formalised our partnership by signing a MoU in March 2017 valid for 6 years. The MoU included 'Recognition of University Trust Status' and an expectation for the Trust to seek the necessary approval from Department for Health and Social Care (DH) to change the Trust name to include the word 'University'. We have since discovered that we do not meet the requirements for membership of the University Hospitals Association which is an integral part of becoming a University Trust.

In December 2022, the JMC agreed revised wording for a new MoU to confirm our commitment to a close working relationship without the Trust becoming a University Trust, this has been redrafted and signed by UH and is in the process of being signed at the Trust.

Trust board confirmed, in January 2023, the desire to become a Teaching Trust with a commitment to reconsider University status at such time our partnership meets the criteria laid out by DH.

2.2. Teaching Status

Our partnership will form the cornerstone to the Trust application for teaching status as we demonstrate our commitment to teaching.

Three key requirements for Teaching status:

- The Trust must demonstrate to DH that it has a 'significant teaching commitment'.
- The Trust must appoint a non-executive director from the university.
    - Schedule 4 of the 2006 NHS Act provides at paragraph 5(1)(d) that *"where the NHS trust has a significant teaching commitment, a provision to secure the inclusion in the non-executive directors referred to in paragraph I of a person appointed from a university with a medical or dental school specified in the order"* – We have asked DH to confirm if the university must have an undergraduate medical school in order to meet the requirements of the Act however our research suggests that other Teaching Trusts have similar partnerships to ours with universities with a post graduate medical school.
- The Trust must check with NHS stakeholders, patients and the public to ensure that the new name is clear and understandable.

3. Performance Measures

Progress towards our KPI's can be seen in the executive summary on page 2 of this document.

3.1. Workstream Updates

3.1.1. Medical

During the past year, UH have completed the first steps towards adding an undergraduate medicine programme to their portfolio. It will be a number of years before students require placements in the Trust however the strength of our partnership is such that the Trust will play a significant role in the development of this course.

3.1.2. Nursing

Partnership working is key to the sustainability and development of the nursing workforce. The Trust has a long history of hosting UH students on undergraduate nursing and midwifery courses and now also hosts students on the MSc Nursing courses. This allows graduates from other disciplines to convert to nursing.

Opportunities are also available for current Trust staff to further their careers by studying at UH; Clinical Support Workers can train to become Registered Nursing Associates and Registered Nurses with the first cohort completing this pathway during 2022-23. During the year Nurses have also had the opportunity to train to be Midwifes and Advanced Clinical Practitioners as well as attending continuing professional development (CPD) short courses.

Jerome Alagao, Pre-registration Lead Practice Facilitator within the Trust non-medical education team, was the proud recipient of the 2022 Dean's Award for Excellent Practice Placement.

The student-nominated award recognises the contribution of staff in practice placements.

Jerome was nominated for his holistic student support for being a wonderful role model and providing consistent access for students and his team. Jerome's team were also credited in the nomination.

In addition, the non-medical education team at the Trust were also shortlisted for 2022 Student Times Award in 3 categories - Practice Supervisor, Placement Area and SNA of the Year and in 2023 have been shortlisted for same award in 1 category - Practice Assessor of the Year

3.1.3. Apprenticeships

As at March 2023, the Trust had 300 members of staff undertaking 33 different apprenticeships across the organisation from accountancy to pharmacy technician, health and safety to human resources and chef to engineering. For the first time this year the Trust has a member of occupational health enrolled on the level 6 apprenticeship at UH.

Our partnership with UH provides higher level apprenticeships in nursing associate, nursing degree (top-up) and senior leadership master's degrees (including MBOS and MBA). During this reporting period we have had two intakes for the 20-month top up nursing degree course

and 10 staff complete the course and graduate as Registered Nurses with the next cohort due to graduate in October 2023. One graduate from 2022 was Alexi Pateman, see appendix B to read her story:

Hello my name is… Alexi Pateman

During National Apprenticeship Week 2023, the Trust held several events both virtual and face-to-face designed to increase awareness of apprenticeships as well as promoting stories of current apprentices to inspire others to follow in their footsteps. The Trust held drop-in sessions in the staff Hub, with the University Partnership Manager promoting UH apprenticeship opportunities.

3.1.4. Continued Professional Development

Annually, CPD is commissioned at UH by the Trust. For the financial year 2022/2023, the Trust invested £199k in education at the university, through the new Salisbury Procurement Framework, as the historical HEE contracts with the university no longer exist.

The 4-day bespoke mental health programme developed in the last financial year has continued, alongside specialist clinical maternity, assessment and prescribing courses. The cancellation of the Emergency care module has led to an increase in Minor Injuries and minor Illnesses modules being procured. There has been increased interest in the Post graduate Certificate in Education modules, reflective of the focus on clinical education delivery across the Trust. Leadership module commissioning continues, in line with Trust strategy and service requirement.

3.1.5. Pharmacy

Over the past year the Trust and UH have worked closely together to pilot the new ‘Royal College of Pharmacist’ standard for undergraduates. As part of these changes, all newly qualified Pharmacists will be prescribers at the point of qualification by the 25/26 cohort which we very much welcome. This does however mean a significant increase in clinical time for students during their training from 8 to 65 days, the Trust is working with UH and the ICB to ensure these extra demands are introduced in sustainable manner.

The Trust currently has 7 junior pharmacists enrolled on the Post Graduate Diploma in Pharmacy Practice (PGDipPP). Most will complete their non-medical prescribing course as part of the diploma which has been a welcome addition to their course.

Non-medical prescribing (NMP) remains a key issue for the Trust, utilising prescribing pharmacists in the medicines reconciliation and discharge processes results in faster discharges, fewer prescribing errors and improved medicines optimisation. Timely access to NMP courses also contributes to recruitment and retention of staff, staff progression and enhanced job satisfaction. We will continue to work in partnership to ensure continued and sustainable access to the NMP course for pharmacists.

3.1.6. Research

The research workstream meets quarterly with the chair alternating between UH and ENHT every 2 years.

The number of joint publications, as an indicator of joint research, has been identified as a measure of partnership success. The number of joint publications prior to the partnership was 9 in 2016 assessed using an electronic search methodology. In 2021 the number had increased to 35 and 48 in 2022. This metric provides a useful indicator for collaboration,

acknowledging that there can be a long gap between initiating joint research and a joint research paper being published. References can be found in this report compiled by ENHT library services.

The joint publications arise from 5 established research groups:

- Urology, Cancer and Robotics led by Mr Vasdev
- Cardiology led by Prof Gorog
- Renal, led by Prof Farrington
- Nursing and Critical Care, led by Prof Pattison
- Gastroenterology led by Johanne Brookes

ENHT is fully supportive of UH's commitment to expand the Clinical Trials Support Network (CTSN) into a full Clinical Trials Unit (CTU). Although the initial application was unsuccessful, the bid was well received and this remains a realistic aim, a CTU will be of great benefit to joint research.

Professor Natalie Patterson was successful in gaining funding for her SEISMIC-R study at the January 2023 meeting of the National Institute for Health Research (NIHR) Health and Social Care Delivery Research (HSDR) committee. SEISMIC-R is a Study to Evaluate the Introduction of new Staffing Models in Intensive Care: a realistic evaluation.

Consultant urologist promoted to Professor of Robotic Surgery at UH

Consultant urological surgeon and Trust Associate Medical Director for Cancer Mr Nikhil Vasdev was promoted to Professor of Robotic Surgery at UH School of Life and Medical Sciences in August 2022. The appointment followed an academic interview, where the panel highlighted his "pioneering low pressure robotic prostate cancer research and surgery expertise developed over the last 10 years", as well as his collaboration with research groups at the university and his range of publications on the subject.

Professor Vasdev said: "We have continued to offer robotic cancer surgery throughout the pandemic using new, internationally-recognised protocols which were developed by the Trust in partnership with the University of Hertfordshire."

"My new role will aim to further develop these academic collaborations to enable more patients to benefit from robotic surgery and research. I'm delighted to receive this promotion and very grateful to my colleagues and the senior executive team for their constant support."

REND Project

Research Engagement Network Development (REND) Programme: Phase 1: Evaluation took place during 2022-23. This is a joint project across Hertfordshire and West Essex (HWE) Integrated Care System (ICS) with the goal ***of "enabling all individuals and communities to be offered the opportunity, and be supported, to be involved in research"***. We acknowledge that research is not fully inclusive and therefore the evidence base for developing new treatments and services may not fully take into account all those we serve.

This was a challenging and difficult problem to address but the patient stories gathered during the process are incredibly valuable and inspirational. Phase 1 has developed a repository of information to support the development of the HWE ICS research strategy.

Impact on patients

Led by Professor Diana Gorog, Validate-R is a good example of the partnership working to deliver a complex cardiology Clinical Trial of an Investigational Product (CTIMP). The trial is sponsored by ENHT with monitoring and statistics support from UH. This study has recently concluded, and we look forward to the publication of results.

Cardiologist co-authors world's first international guidelines on cardio-oncology

Professor Diana Gorog, Consultant Cardiologist & Associate Medical Director for Research at the Trust and Professor of Cardiovascular Medicine & Joint Head of the Centre for Clinical and Health Services Research at the UH; is co-author of the world's first international guidelines on cardio-oncology, which will affect almost all medical and surgical specialties who treat cancer patients.

Professor Gorog was among 30 expert authors from across the world involved in developing the guidelines over 2 years. Reflecting on the achievement, she said: "I am honoured to be a member of the author task force for this first international guideline on cardio-oncology."

"It provides guidance on best practice for healthcare professionals to improve the care of patients with cancer before, during and after their cancer treatment, to minimise and treat cardiovascular complications."

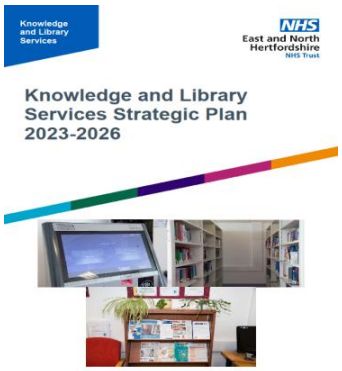
3.1.7. Leadership & Management

A verbal agreement was reached before the pandemic for facilitators from the ENHT and UH to jointly deliver programmes in a joint leadership development faculty. ENHT is keen to use the experts within the organisation as a faculty of leadership. Linking to the UH appears appropriate but discussions are required during 2023.

The ENHT leadership model has evolved through the pandemic and a blended approach to the work now exists. We would wish to secure this approach within an academic partnership and will look to explore possibilities. Coaching is becoming more important and the ENHT faculty contains some high-level coaches who already teach on coaching programmes.

The Joint Leadership Lab is an idea in name and consideration only at present. It does seem to catch the imagination, but practical next steps require hard resources. The idea of a joint ENHT/UH facility on site is appealing – this might also support the ICS position as we create a consistent approach to leadership development.

In the spring of 2023, a review will take place of the leadership and management development requirements within ENHT and it is hoped a new relationship with UH business school will emerge to facilitate senior leadership apprenticeship programmes.



3.1.8. Library Services

In January 2023, the library services at the Trust launched their Knowledge and Library Services (KLS) Strategic Plan 2023-2026 confirming their commitment to supporting learners and students. This strategy, developed with stakeholders, sets out a vision and direction for the KLS and aims to ensure Trust staff, learners, students and other stakeholders have access to Knowledge and Library Services that meet national, regional and local requirements and standards and contributes to the strategic objectives of the Trust by supporting:

- clinical effectiveness
- workforce training excellence
- consistently excellent seamless services
- continuous improvement and innovation

In addition, the library will contribute to national and regional KLS networks. Performance will be evaluated in line with national Health Education England, KLS, quality improvement outcomes measures.

4. Conclusion

This report demonstrates the depth and breadth of the partnership between ENHT and UH. We are now beginning to reap the rewards of years of work to build a strong foundation and a common approach. Our partnership helps us meet organisational goals and provides benefit for our staff students and patients we look forward to developing the relationship further particularly in light of the emerging plans.

5. APPENDIX A – Structure of the Joint Management Committee

5.1. Status and Authority

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

The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any officers of the Trust or University and all officers and staff are directed to co-operate with any request made by the Committee. The Committee may obtain professional advice as required, and may require directors or other officers to attend meetings.

5.2. Membership

The membership of the Joint Management Committee comprises:

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

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

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

In January 2021 our lay representative / service user resigned, we thank her for her contributions and are seeking a new member.

5.3. Quorum

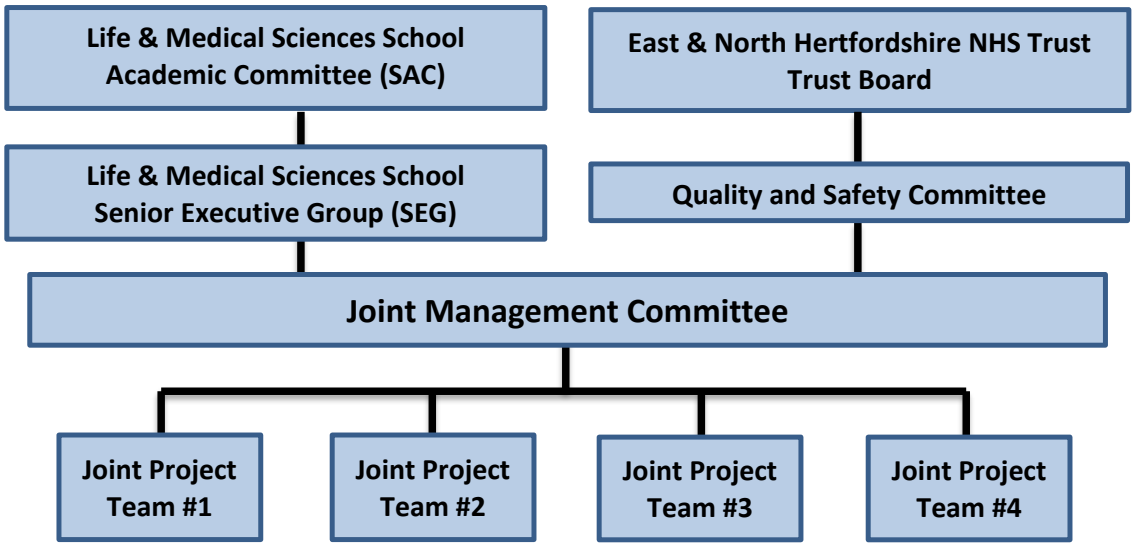
The Committee will be quorate if there are two members present from each of the Trust and University. See below for summary of attendees.

5.4. Frequency of Meetings

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

In 2021-22 the Joint Management Committee schedule met on 22nd April 2021, 15th October 2021 and 1st February 2022. Unfortunately, the meeting on 16th July 2022 was cancelled due to operational pressures in the Trust.

5.5. Governance Structure



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

- Annual report to the Trust Board and University Senior Executive Group.
- Re-approval of the University Status in 2023 (with planning to begin in next reporting period).

5.6. Resources to Support Partnership

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

5.6.1. Partnership Manager

Both the Trust and the University have committed to contribute equally to the post of Partnership Manager. This post has been occupied since 1st November 2017.

Attendance at Joint Management Committee	Attendance 28th Jan 21	Attendance 22nd April 21	Attendance 15th Oct 21	Attendance 1st Feb 22	Attendance 17th May 22	Attendance 12th July 22	Attendance 11th Oct 22	Attendance 19th Jan 23
ENHT - Medical Director (co-chair)	Attended	Attended	Attended	Attended	Apologies	Attended	Apologies	Attended
ENHT - Director of Nursing and Patient Experience	Attended	Attended	Apologies	Apologies	Apologies	Apologies	Attended	Apologies
ENHT - Director of HR	Deputy	Deputy	Deputy	Apologies	Deputy	Deputy	Deputy	Deputy
ENHT - Director of Medical Education	Attended	Apologies	Apologies	Apologies	Attended	Apologies	Apologies	Attended
ENHT - Associate Director of Research and Development	Attended	Attended	Attended	Attended	Attended	Apologies	Attended	Attended
UH - Dean of LMS (Co- chair)	Attended	Attended	Attended	Attended	Attended	Attended	Attended	Attended
UH - Dean of HSK	Deputy	Attended	Apologies	Apologies	Apologies	Attended	Apologies	Apologies
UH - Associate Dean Academic Quality from LMS	Attended	Attended	Attended	Apologies	Attended	Attended	Attended	Attended
UH - Head of Centre for Health Services and Clinical Research	Attended	Attended	Apologies	Apologies	Attended	Apologies	Attended	Attended
UH - Associate Dean Community, International and Partnership	Attended	Deputy	Attended	Attended	Apologies	Attended	Attended	Attended
External Advisor from HPFT UH partnership	Attended	Attended	Attended	Apologies	Attended	Attended	Apologies	Attended
Service User	Attended	Vacant	Vacant	Vacant	Vacant	Vacant	Vacant	Vacant
Partnership Manager	Attended	Attended	Attended	Attended	Attended	Attended	Attended	Apologies
Quorate?	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

APPENDIX B

Hello my name is… Alexi Pateman

Alexi Pateman is a staff nurse working in critical care.

How long have you worked for the Trust?

I joined the Trust as a Clinical Support Worker (CSW) in September 2014 after finishing sixth form although I had previous experience at the Trust through the midwifery student volunteer programme.

Why an apprenticeship?

Growing up I wanted to be a dancer but soon realised that was not going to be a viable career choice. I completed sixth form but didn't want to go to university; I wanted to start work and earning a wage. I applied for the job as apprentice CSW as I remained keen to learn but I didn't know I wanted to be a nurse until I started!

Describe your apprenticeship journey?

I completed the level 2 and then level 3 CSW apprenticeships whilst working in the renal department. At that time the Nursing Associate apprenticeship was not yet available, so I worked as a CSW in renal dialysis for a year or so before the opportunity of a further apprenticeship became available.

I was on my last clinical placement of the Nursing Associate apprenticeship in AMU during March 2020 when the first wave of the Covid-19 pandemic hit. The University of Hertfordshire (UH) quickly ensured that our registrations were complete so we could get back to work as planned. Working in renal dialysis during the first wave of covid was very challenging; patients with covid were brought to Lister from satellite units and we ran dialysis overnight too to cope with demand.

In January 2021 I started the top-up to registered nurse degree apprenticeship just as the country was closing down for the second time. All lectures moved online which I enjoyed, especially the time not spent travelling to uni. UH did what they could to make online learning possible including sending home wound care kits etc. but practicing catheterisation with fruit doesn't really compare to real life and I was glad when practicals resumed in person.

What support have you had for your apprenticeship?

Lots! I feel lucky to have worked for some great managers in the Trust who have supported me through my studies as well as the fantastic nurse education team. All apprentices in the Trust on the top-up to registered nursing degree apprenticeship were assigned the same personal tutor from UH who was lovely to work with, we were quite a close group and able to message each other for support about assignments and placements etc.

What has been the impact of apprenticeships on your career?

It was not possible for me to go to university the traditional route and you can't be a nurse without a degree. Not sure what I would be doing now without apprenticeships, but I wouldn't have the career and opportunities I have now.

What would your colleagues be surprised to discover about you?

I enjoy motorsport, especially drifting and have been involved in events at Rockingham and Santa Pod in the past.

What's next for you?

Since I graduated, I've been working in critical care and am still learning so much. Nursing is very broad, there are so many different jobs that all require different skill sets. I enjoy working in a fast-paced environment and no two days are the same in critical care which is exciting!

Report

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	11
Report title	Strategic Delivery Report: 2022 / 23 Objectives			**Meeting Date**	5 July 2023
Presenter	Kevin O'Hart, Director of Improvement				
Author	Kevin O'Hart, Director of Improvement				
Responsible Director	Kevin O'Hart, Director of Improvement			**Approval Date**	8 June 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

This report provides an end of year position regarding progress and achievement towards the Trust's 2022/23 strategic objectives. The portfolio is managed using evidence-based, project management tools and techniques. Each programme is reviewed monthly via the Executive Programme Board, the governance platform responsible for the development, oversight, and delivery of strategic transformational priorities and objectives. This new model incorporates an executive SRO allocated to each programme who is accountable for 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

The report reflects material progress against all eight strategic objectives during 2022/ 23 with Trust performance benchmarking positively across a range of areas. All objectives were deliberately ambitious, pushing the organisation to strive to do better for our patients and staff.
Where targets have not yet been fully met there is a clear path and trajectory to achievement in the year ahead, whilst other elements have been refreshed and incorporated within new strategic objectives for 2023/24.
Where programmes have been completed and closed, ongoing monitoring and accountability will be managed via the Trusts' new divisional performance review meetings.

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

Risk 11 Innovation
Risk 10 Technology, systems and processes

Report previously considered by & date(s):

Executive Programme Board 8 June 2023

Recommendation	The Board is asked to note the contents of the report.

To be trusted to provide consistently outstanding care and exemplary service

2022/ 23 Strategy Delivery Report

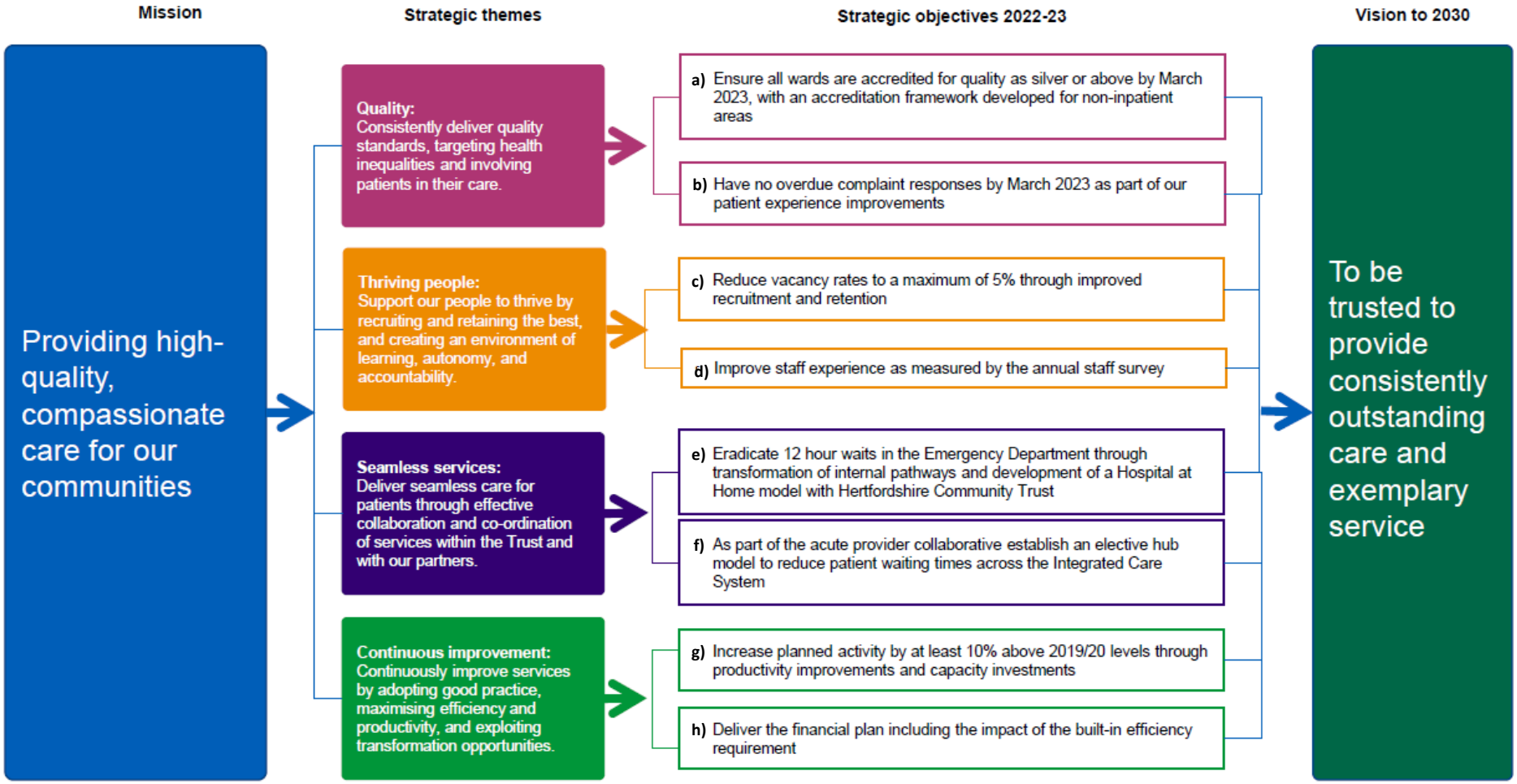
East and North Hertfordshire NHS Trust

Trust Board
Agenda Item 11
5 July 2023

Kevin O'Hart, Director of Improvement

Strategic Objectives 2022 - 23

East and North Hertfordshire NHS Trust



2022/23 Strategic Portfolio Delivery Report

East and North Hertfordshire NHS Trust

Strategic Theme Quality / Objective A - Ward Accreditation
SRO – Theresa Murphy , Chief Nurse
In July 2022 the Trust achieved the prestigious Pathway to Excellence® designation from the American Nurses Credentialing Centre. The Trust was the first within the national cohort of fourteen NHS providers selected by the Chief Nursing Officer for England, to become designated with this internationally recognised programme. Pathways to Excellence embeds three pathways: Nursing and midwifery excellence (pathway standards of: shared decision making, leadership, safety, quality, wellbeing, professional development); local accreditation and shared decision making. The Trust's strategic objective aimed to ensure all wards were accredited for quality as silver or above by March 2023. During 2022/23 we were able to celebrate seven ward accreditations at Silver and Gold level, with all other inpatient wards continuing to work towards achieving accreditation and focusing on improving compliance with fundamental standards. Building on these foundations a comprehensive review of the Clinical Excellence Accreditation Framework was undertaken. A revised model for 2023/24 and associated strategic objective will ensure future assessment processes align more closely with the Trust's current objectives and priorities and are in line with CQC compliance standards. The new accreditation framework will launch from April 2023. Accreditation will be split into two parts, the first part being sustainable achievement of all fundamental standards. To enable wards to monitor their progress with the fundamental standards, a new accreditation dashboard is being developed on the ENHance platform. Individual wards will not progress to the second 'excellence' part of the accreditation process until all fundamental standards are consistently achieved. Following completion of both parts of the assessment process, an accreditation award level will be agreed. The priority moving forward will be for wards to focus on improving compliance with fundamental standards rather than achieving an accreditation award.

Strategic Theme Quality / Objective B – PALS & Complaints
SRO – Kevin O'Hart, Director of Improvement
In response to the pandemic NHS providers prioritised efforts to support direct clinical care and front-line duties and responsiveness to COVID. For a brief period, extended timeframes for complaint responses were agreed in line with many other NHS organisations, which led to a general deterioration in overall response performance.

2022/23 Strategic Portfolio Delivery Report

East and North Hertfordshire NHS Trust

Strategic Theme Quality / Objective B – PALS & Complaints
SRO – Kevin O'Hart, Director of Improvement
As part of a wider PALS and Complaints Improvement Programme the Trust therefore aimed to increase both the timeliness and quality of responses to complainants, in addition to focusing on earlier PALS resolution. A refreshed training and awareness education programme was launched and is ongoing, with an emphasis on early local intervention and resolution of issues as they arise in local wards and department areas. Simultaneously we applied a lean thinking (process improvement) approach to our current way of working. This involved streamlining and standardising complaints pathways and processes making them simpler, by helping staff involved in complaints handling, eliminate all kinds of waste and allowing resources to be used more efficiently. Whilst the Trust has not yet fully met our target for overdue responses, performance has improved by 52% during 2022/23. This work will therefore continue into 2023/24 where we will also introduce routine sharing of our learning with complainants in our response letters and undertake regular complainant satisfaction surveys to monitor our ongoing progress.

Strategic Theme Thriving People / Objective (C) – Vacancy Rates
SRO – Thomas Pounds, Chief People Officer
The Trust benchmarked favourably with national vacancy levels with a baseline 2022/23 position reported as 6.5%. This strategic objective aspired to drive towards a 5% vacancy factor, which would have placed the Trust in upper quartile performance. The Trust programme targeted improvements in both recruitment and retention of staff and focused across three main areas involving the onboarding of new staff, the ongoing socialisation of staff in their career journey and development of a new continuous feedback and review model. Improvements using a lean-based approach have streamlined and simplified processes enabling a seamless journey to support new joiners, with a refreshed offer of specialist support for international staff to smooth their transition to a new country. An improved digital solution allows new recruits to access more easily and rapidly a range of resources to support their recruitment and onboarding process. A range of surveys (joiner, pulse and the annual staff survey) then provide a wealth of material which the People team will use to monitor and demonstrate the impact of the programme. During 2022/23 the Trust made significant progress and recruited 1270 whole time equivalent (WTE), increasing our substantive workforce by 166 WTE including 154 WTE more registered nurses and midwives. The ability to meet the target was complicated by

2022/23 Strategic Portfolio Delivery Report

East and North Hertfordshire NHS Trust

Strategic Theme Thriving People / Objective (C) – Vacancy Rates
SRO – Thomas Pounds, Chief People Officer
additional staffing requirements as part of wider NHS initiatives that increased service demand i.e. Elective Recovery Programme and an internal in-year change in the headroom allowance for rota based staff. Due to these changes the Trust vacancy position at the end of March 2022/23 moved to 9%. The programme itself will run through to July 2023/24 at which stage all milestones should be delivered, this includes a trajectory for how we will meet our overall ambition by quarter three 2023/24.

Strategic Theme Thriving People / Objective (D) – Staff Survey
SRO – Thomas Pounds, Chief People Officer
The Trust's objective was to improve overall experience as measured by the staff survey. To achieve this the Trust focused heavily on staff engagement and morale. In response to the previous year's survey results a 'team talk' framework was designed for teams to explore themes from within their department and jointly design plans for improvement which were presented to the Trust's People Committee with actions taken forward within the divisional accountability structure. An organisation wide engagement exercise was carried out to develop and design the Trust's new values which were launched in quarter one. This was followed up by the development of team charters for each team aligned to the values and associated behaviours to ensure the values became embedded within all that we do. With a key part of our values being respect, a civility and respect tool kit and development material was shared widely across the organisation. Emphasis was on creating increased psychological safety and encouraging people to speak out about their experiences. To support achieving this, the Trust has expanded its Freedom to Speak Up resources as well as utilising the staff networks, created the 'ask Adam' (Chief Executive) inbox, set up coffee roulette and launched the healthy leadership walk arounds. Positively the engagement in the staff survey increased by 5%, from 42% to 47% against a national average of 44%. The results overall did not improve but remained broadly in line with national average for most domains except for 'We are always learning' which dropped due to lower uptake of appraisals at the time. There was a positive shift in staff reporting concerns and indicators from the workforce race equality standards did improve for black, Asian and minority ethic staff although more needs to be done to close the relative gap in experience.

2022/23 Strategic Portfolio Delivery Report

East and North Hertfordshire NHS Trust

Strategic Theme Seamless Services / Objective (E) – Urgent & Emergency Care
SRO – Lucy Davies , Chief Operating Officer
To reduce 12 hour waits in the Emergency Department (ED) the Trust worked to improve the internal flow through the department; ensuring patients could be seen in good time with more efficient processes to discharge patients from hospital earlier and safely ensuring access to quality care at home. This objective was supported by several transformation programmes and partnership working with system partners. The local 'Hospital at Home' (HAH) service which is run by Hertfordshire Community NHS Trust provides high quality care for patients in the comfort of their own home, allowing patients to recover better and leave hospital earlier, or even avoid being admitted to hospital in the first instance. HAH colleagues now have access to clinical information about patients who are receiving a response from the ambulance service, but who could be supported at home with rapid in-person medical care and remote monitoring – instead of coming into ED. An initial pilot showed that 66% of contacts were not brought into hospital, with 71 fewer patients needing to come into ED. Remote monitoring and early intervention is also being trialled for patients living with heart failure, as part of a developing integrated heart failure service. If patients do need to come into the ED, we want to ensure that they receive the care they need in good time, and this year the Trust focused on ambulance handover times. These times reduced by 40% - from an average of 72 minutes in Nov-Dec 2022, to 43 minutes in Jan-Mar 2023. The Trust's Urgent and Emergency Care improvement programme tested and implemented new ways of working to improve these times, with a new 'pull model' helping to move patients through the department more rapidly. Finally, the Trust made strides in our discharge programme, aimed at improving the discharge process so that patients can go home earlier in the day, allowing those who require admitting get into a bed more quickly. Significant improvements were made in holding early board and ward rounds, and we are rolling out 'criteria-led' discharge to make further strides in increasing weekend discharges. A pilot in Cardiology showed an improvement from 1.26% to 41% of discharges taking place before 12pm noon. It is anticipated improvement work will continue in this key area with a revised strategic objective for 2023/24 which will focus on NHSE priorities and operational planning guidance involving ED waiting times and a new target for 76% or more patients seen within 4 hours.

2022/23 Strategic Portfolio Delivery Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective (F) – Elective Hub
SRO – Martin Armstrong , Director of Finance and Deputy Chief Executive
In 2022/23 the Hertfordshire and West Essex ICS successfully bid for national capital funding to support the development of a system-wide elective surgical hub. Based at St Alban's City Hospital and operated by West Herts Teaching Hospitals, the hub will provide vital surgical capacity for the ICS to recover elective services and keep pace with future demand. Focused on high volume low complexity surgery the hub will deliver ring-fenced elective capacity accessible to the whole system. ICS partners, including the Trust have established a programme board to support the rapid development of the business case and joint operating model. Approval of the business case is anticipated in early 2023/24 with building work planned to enable the hub to be operational during 2024/25.

Strategic Theme Continuous Improvement / Objective (G & H) – Elective Productivity & Efficiency
SRO(s)– Martin Armstrong , Director of Finance and Deputy Chief Executive & Mark Stanton , Chief Information Officer
To meet increased planned activity targets by at least 10% we implemented a range of productivity improvements to support new ways of working and release capacity. This has included the roll-out of patient-initiated follow-up (PIFU) pathways as part of a wider transformation programme. PIFU empowers patients to take control of their care, providing pre-agreed self-management support and resources, with triggers ensuring patients can still see a specialist sooner than planned if they need to, as well as avoid unnecessary trips to hospital if they have no need to be seen. For patients, this means more choice and flexibility around when they access care. For clinicians, it means fewer appointments of low clinical value, freeing up time to support the patients most in need. The implementation of PIFU has required new operational and digital processes, with intense operational and clinical engagement, and targeted communication activities to help introduce a new way of working. A total of 6,327 patients have already moved onto these new pathways over the year, representing 1.6% of all outpatient activity. Whilst we have not met the national target of 5%, we benchmark with average national performance of 2%. Issues with clinical adoption is therefore recognised at a national level with initiatives planned later in 2023/24 to target increases, the programme will therefore continue to support teams during this period to further increase uptake.

2022/23 Strategic Portfolio Delivery Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective (G & H) – Elective Productivity & Efficiency
SRO(s)– Martin Armstrong , Director of Finance and Deputy Chief Executive & Mark Stanton , Chief Information Officer

As part of Trust work to increase diagnostic capacity and reduce patient waiting times, we were successful in our bid to become part of the first wave of new Community Diagnostic Centres (CDC). Since the launch of new services within the New QEII Hospital in Welwyn Garden City we have delivered 14,000 additional diagnostic examinations. Elective diagnostic waiting lists have been reduced for MRI, ultrasound and ECHO, and new clinical pathways have been developed including non-acute fatty liver disease (Gastro) and Direct Access cardiology pathways (ECHO and Holter).

One of the major challenges we have faced in the first phase of the programme is recruitment of appropriately qualified staff. This has been significantly supported by a very successful international recruitment campaign, and we are delighted to welcome and support our international colleagues to the Trust and this exciting new service. Patient feedback regarding the new CDC has been extremely positive with patients favouring increased availability of evening and weekend appointments to help balance busy family and work commitments.

Improvements within theatres to support our elective recovery focused on the surgical pathway experience for our patients, facilitating safe, efficient care to as many people as possible within the theatre capacity we have available. COVID had a significant impact on our ability to deliver this aim, and 2022/23 has been a year of recovery.

National data covering the first six months of 2022/23 identified the Trust as seventh best performance for elective recovery, and the Trust continued to report upper quartile performance that exceeds national averages for ‘overall’ and ‘in session’ theatre efficiency at 84% and 78% respectively. However, we recognise we have not yet returned to pre-pandemic activity levels, and still have an opportunity to improve our performance to meet the 85% national target for both. Our Surgical Care Programme has worked on all the areas that impact this efficiency (late starts, turnaround times, cancellations, and early finishes) to identify ways of reducing the time wasted and create time for additional patients to be treated. Our average case per list (ACPL) metric is also upper quartile and exceeds peer and national averages and will continue to be our primary focus as part of our elective recovery plan.

The trust has benefited from the provision of two new procedure rooms this year, built on site at the Lister with another planned in 2023/24 at the New QEII Hospital. These facilities provide the opportunity to treat less-complex cases in greater numbers, releasing space in our operating theatres for more complex operations.

2022/23 Strategic Portfolio Delivery Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective (G & H) – Elective Productivity & Efficiency
SRO(s)– Martin Armstrong , Director of Finance and Deputy Chief Executive & Mark Stanton , Chief Information Officer
The Trust was also fortunate to receive national funding and install a new digital theatre management system which enables teams to input, access and analyse information more easily across the patient pathway. This tool will provide teams with real-time information and improved data accuracy regarding both previous performance and future planning. The workforce in theatres is crucial for our success, with recruitment and retention a nationwide challenge. This year we have reviewed and redesigned our team structure enabling a greater emphasis on continual professional development and training, so we can grow our own future leaders. This new model has also significantly increased the number of senior clinical leadership roles in the department. Whilst both ongoing material investment and improvements in performance have continued through 2022/23 with the Trust benchmarking as upper quartile, there remains further opportunity to be explored and delivered through a revised strategic objective in 2023/ 24.

Report

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	12
Report title	Strategic Transformation Update			**Meeting Date**	5 July 2023
Presenter	Kevin O'Hart, Director of Improvement				
Author	Kevin O'Hart, Director of Improvement				
Responsible Director	Kevin O'Hart, Director of Improvement			**Approval Date**	8 June 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

This report provides the first quarterly summary update from Executive Programme Board detailing improvement plans behind the Trust's core 2023/ 24 strategic objectives. The objectives have been disseminated across the organisation with the expectation during quarter one each division, department and team will have developed their own aligned objectives as part of Grow Together conversations which reflect everyone's individual and collective role in organisational delivery of this portfolio.

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

The 2023/ 24 portfolio seeks to build on the progress and learning from last year and continue the Trust's continuous improvement journey with significant emphasis focused on both the key challenges and opportunities the organisation and wider system is currently facing.
The underlying programmes will support the management of increasing demands within our UEC pathways, reflect the wider improvements we need to make across our wards areas in response to our learning from CQC, as well as building on last year's elective recovery successes to ensure we manage our waiting list and waiting times as effectively as possible, which in turn will support the delivery of our financial plan.

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

Risk 11 Innovation
Risk 10 Technology, systems and processes

Report previously considered by & date(s):

Executive Programme Board 8 June 2023

Recommendation	The Board is asked to note the contents of the report.

To be trusted to provide consistently outstanding care and exemplary service

2023/ 24 Strategic Transformation Report

Part 1: Strategic Objectives

Trust Board

Agenda Item 12

5 July 2023

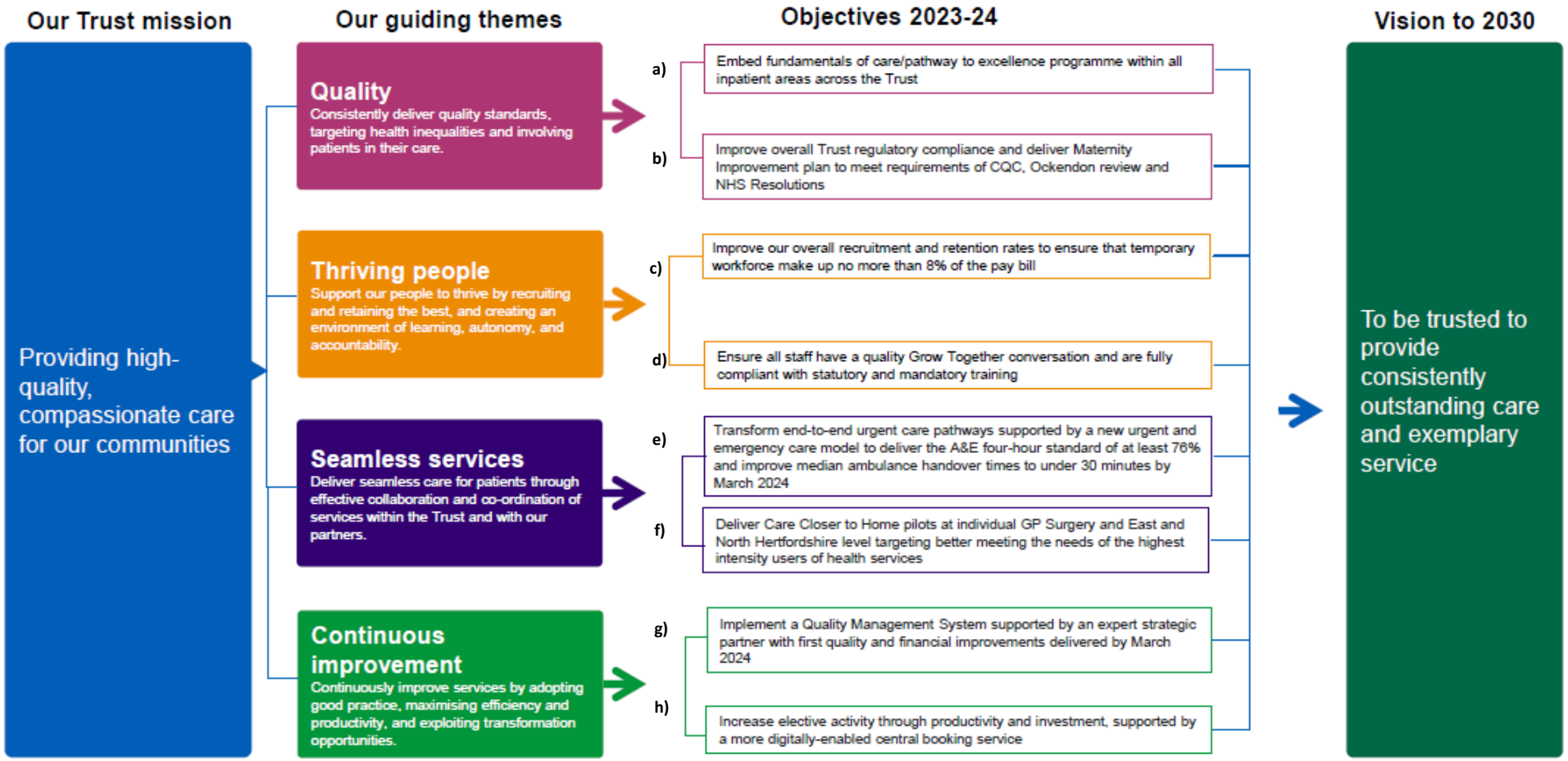
Kevin O'Hart, Director of Improvement

East and North Hertfordshire NHS Trust

ProudToBeENHT

Strategic Objectives 2023 - 24

East and North Hertfordshire NHS Trust



Strategic Objectives 2023 - 24

East and North Hertfordshire NHS Trust

Strategic Theme Quality / Objective A – Fundamentals of Care
SRO – Theresa Murphy , Chief Nurse
In response to the review at the end of 2022/ 23 the anticipated revision of the clinical excellence accreditation framework (CEAF) has now been completed. Part one includes seventy-one standards of care, each with a defined minimum criteria to achieve. These fundamentals relate to staffing, staff training, patient safety, infection prevention and control, tissue viability, falls, medicine administration, patient observations, nutrition assessment and patient and staff experience. CEAF standards will be assessed by observation of practice by specialist teams, review of patient documentation, discussions with staff and patients , review of audit and performance data, as well as staff survey responses. Part two of the CEAF include the 'excellence standards' including research, shared decision-making and staff recognition. Weekly drop-in sessions are held for ward leaders to meet with the nursing and midwifery excellence team to review their progress and discuss any issues , including any additional support requirements. All seventy-one fundamental standards must be achieved, and the excellence part of accreditation completed, before a ward can become accredited at either bronze, silver or gold level. Once accredited, wards will need to continue to demonstrate sustained improvement to maintain their status. The first cohort of twelve wards commenced their CEAF programme in April, with the remaining inpatient wards to join in July. This phased approach allows for more intense support at the beginning,with improvement plans agreed to monitor progress throughout 2023/ 24.

Strategic Theme Thriving People / Objective C – Temporary Workforce
SRO – Thomas Pounds , Chief People Officer
The Trust has set a goal to reduce its expenditure on bank and agency workforce so that it makes up no more than 8% of the overall pay bill. This is in order to reduce the premium element of pay and therefore deliver the workforce and financial plan. It also supports driving quality by having a larger substantive workforce base. Part of the success relies upon a range of schemes to reduce the level of whole time equivalents utilised including exploration of service transformation opportunities. However, fundamental to the achievement is the development of the control environment and the accountability framework that needs to be in place. The plan sets out four workstreams including targeted vacancy reduction, a secure bank and agency control environment, improved use

Executive Programme Board Updates

East and North Hertfordshire NHS Trust

Strategic Theme Thriving People / Objective C – Temporary Workforce
SRO – Thomas Pounds , Chief People Officer
of staff deployment systems and enhanced absence management. A key area of focus over quarter one has been on medical recruitment. A resourcing plan has been developed targeting the top twenty high bank and agency areas using a range of solutions including expansion of international recruitment, enhanced attraction offers, establishment control principles, shortened time to hire and specialty led oversight and reviews. With the recruitment pipeline and anticipated appointments the annual temporary staffing reduction is expected to be £2.1m. A monitoring and oversight structure has been put in place for nursing and midwifery in June. Principles include increased accountability with ward managers on the management of their budgets, identification of areas requiring more intensive support, reinstatement of principles and rules for good rostering practice. To support this work, two new applications in QlikView have been developed as a key management and planning tool.

Strategic Theme Seamless Services / Objective E – Urgent & Emergency Care
SRO – Lucy Davies, Chief Operating Officer
There is a national target to return to, by March 2024, an overall performance level of 76% of patients to be seen and a decision made about either their onward care or discharge within 4 hours. For ENHT, the main opportunity to drive delivery against this national requirement is at Lister, in both adults and paediatric Emergency Departments. This is because the Urgent Treatment Centre (UTC) at the QEII consistently delivers high performance against the 4 hour standard (circa. 99%). Work has therefore been focused on how, at the Lister site, UEC performance can be improved, in the face of challenging levels of demand. A series of workshops earlier in the year brought together key clinical and operational leaders to define what changes need to be made to support the improvement that is required. Following these, a single Trust UEC programme has been co-developed with all key stakeholders and it aligns to an ICB funding opportunity to enhance our existing services and support in meeting the target. There are six key areas of work: Project 1: Co-located UTC - a co-located UTC separate to the ED with its own leadership and staffing model, on the Lister Site. This will enable around 80 patients per day to be seen in an urgent care environment separate to ED, releasing true emergency capacity for patients who need it the most, and ensuring that those who have a same-day need for urgent care are treated more rapidly. The clinical

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Seamless Services / Objective E – Urgent & Emergency Care
SRO – Lucy Davies, Chief Operating Officer

model for the UTC has been developed and is under review, whilst estates options are explored to agree the most suitable location.
Project 2: Paediatric ED – this project will review current demand and capacity requirements for Paediatric ED, ensuring that both the workforce and clinical models match growing demand.
Project 3: Adult ED Pathways and Skill Mix – the team will review opportunities to stream patients to other suitable hospital pathways outside the ED (e.g. SDEC, UTC, hot clinics), releasing ED capacity. Alongside this they will review and assess the ED workforce model to match staffing to patient demand profiles.
Project 4: Diagnostics –funding has been agreed to mobilise an additional CT scanner located next to ED, dedicated to emergency diagnostics. The team will also scope the potential for a diagnostic hot clinic model for urgent but not emergency patients.
Project 5: SDEC & Assessment – the team are working to increase SDEC and Assessment capacity to support patient flow and reduce emergency admissions. Alongside creating new pathways that support patients, we will also increase SDEC opening times.
Project 6: Inpatient Capacity – to support onward flow out of the ED for those patients who need to be admitted, the team will review ward processes and increased medical presence to support more discharges across seven days.

It is expected that these key areas of work (along with local improvements within each department) will contribute towards the two key objectives of 4-hour performance, and improved ambulance handover performance (working to achieve 30 minutes as our median handover time).

Having rolled out a new standardised approach to Board and Ward Rounds, ward-based improvement is now focusing on criteria-led discharge (CLD) and how we can roll out this approach across the Trust. CLD is the use of agreed clinical criteria to guide clinical decisions regarding patient discharge from hospital. It enables a range of registered healthcare practitioners (such as junior doctors, nurses, or therapists) to lead a patient's discharge from hospital (rather than needing to wait for the consultant) and makes the discharge plan and progress of discharge planning transparent to the entire team caring for the patient, as well as the patient and family, and/or carers.

This model also enables higher rates of discharges at the weekends or out of hours. Consultants set the criteria for discharge and an estimated date for discharge when the patient is first admitted, which gives the patient and their family or carers a good understanding of what happens next. Two pilots are ongoing – one in ENT (a surgical speciality) and one in our Acute Cardiac Unit (a medical speciality). These have both been shown to be successful in improving rates of discharges at the weekends, increased nursing staff confidence and empowerment to make discharge decisions and has had no negative impact on patient experience.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Seamless Services / Objective E – Urgent & Emergency Care
SRO – Lucy Davies, Chief Operating Officer
The next step is to take the learning from these pilots and roll out CLD across all speciality areas and wards throughout the rest of 2023/ 24. A roll-out plan has been agreed which will ensure that the relevant ward-based nurses and other supporting healthcare practitioners have been formally trained and are assessed ahead of go-live. Each speciality will be supported to choose particular conditions or pathways where CLD would make most impact for their patients and helped to develop new pathways to enable CLD in their area.

Strategic Theme Seamless Services / Objective F – Care Closer to Home
SRO – Kevin O'Hart, Director of Improvement
ENH HCP is working collaboratively to develop a 'care closer to home' model to provide services in our local area, where service provision is designed around people and tailored to their specific needs. This work will align with ICB proposals for a new primary care target operating model and an increasing ambition to drive change at local integrated neighbourhood team level. A range of desired outcomes were agreed as part of the model's development that specifically focus on improving health and care access, reducing delays, increasing integration between services and expanding utilisation of community and primary services. The proposed model places people at the centre, with wrap-around services to focus on key 'touch points' including local authority, primary care, and the voluntary and community sector. This will involve a core, integrated community and primary care team led by complex care coordinators, with specialist support from secondary care, public health, mental health, and voluntary sector co-opted in as required. A regular cross-organisational multi-disciplinary meeting within each locality area will allow teams to come together and respond more to individualised local needs, as well as bring in expertise from secondary care specialists (such as ENHT consultants) as and when needed. Working in this new model will require staff with a broad set of a skills to identify and respond to a wide range of needs for their patients, not just their primary presenting health condition. A proof-of-concept pilot using population health analysis is planned to test this new model before rolling out more widely. Population health datasets have identified the initial cohorts for this early development phase, which are areas with unmet needs, areas with a strong correlation between deprivation scores, mortality rates and disease prevalence, and areas where levels of disease detection are low. By working together in a collaborative team environment, with a very local tailored focus, health professionals will be empowered to use

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Seamless Services / Objective F – Care Closer to Home
SRO – Kevin O'Hart, Director of Improvement
their collective expertise and resources wisely, understand how patients use the whole health and care system, identify a wider range of support that can help patients holistically. Organisations are coming together during June to agree an outline model for a integrated neighbourhood team, which each locality area will then develop and test over the coming months, with support an input from all partner organisations.

Strategic Theme Continuous Improvement / Objective G – Quality Management System
SRO – Kevin O'Hart, Director of Improvement
During 2022/ 23 the Trust Board committed to the adoption of a new quality management system involving the whole organisation working together to enhance 'value' from the perspective of the patient, improve quality and safety of service delivery, and embed a sustainable culture of continuous improvement. This strategic approach provides the philosophy and capability for all staff to engage with improvement as part of their daily management routines. This evidence –based model has now been adopted as a national NHSE recommendation , with publication in April 2023 outlining ten key areas of focus. Following a robust procurement process earlier this year the Trust has now appointed Virginia Mason Institute (VMI) as our preferred partner as part of our 3-year continuous improvement journey. VMI are a global, not-for-profit healthcare organisation renowned for an exemplary record of high quality safe patient care following the development of its own unique Virginia Mason Production System. VMI will be supporting us alongside Surrey and Sussex Healthcare NHS Trust (SASH), an organisation with a longstanding relationship with VMI and correspondingly exemplary track record in quality care outcomes. VMI and SASH will use their experience and expertise to support us in the design, launch and embedding of our own quality management system based on their learning. There is a high-level 3 year work plan for how we will establish and embed this new way or working, this will commence with a organisational readiness assessment process that will run from July to September. We then anticipate VMI and SASH teams will be on site for a more formal launch in October 2023.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective H – Elective Recovery
SRO(s) – Martin Armstrong, Director of Finance, Deputy Chief Executive & Mark Stanton, Chief Information Officer
Our strategic objective regarding increasing elective activity in line with the national recovery programme incorporates improvement work within both outpatients (OPD) and theatres (Surgical Pathway Programme). The OPD programme aims to provide an improved patient centred service that delivers safe and efficient treatment by the right team at the right time. This work will include increasing opportunities for how patients can interact with the hospital in a more digitally-enhanced way, where this is safe and appropriate to do so. Following the disruption of the pandemic, we have an increasing number of patients on our waiting lists who need an appointment as early as possible. This programme will ensure our clinics are set up in such a way that we can see patients sooner in their pathway, organising more 'one-stop' style models , therefore making best use of resources, as well as both the patient and the clinician's time. The programme was developed following a series of multidisciplinary strategy development sessions earlier this year, with feedback from patients and multidisciplinary staff groups informing our key themes and priorities for improvement. The programme will focus on three key areas: efficiencies within our pathways through redesign, improved patient engagement and experience through a new digital patient portal as well as improved contact centre processes, and improvements to our waiting list digital infrastructure to streamline accuracy, tracking and real-time performance monitoring. The new patient portal will allow clinic letters to be sent to patients electronically – reducing the waste and cost associated with paper letters, and making processes quicker and more patient-friendly (with paper letters remaining an option for those who are digitally excluded). Whilst the Trust benchmarks favourably across a range of metrics there remains additional opportunity for improvement and we will therefore target further reductions in the number of patients who do not attend their appointment, increasing the number of new patient appointments by reducing follow-up appointments where clinically safe and appropriate to do so through the use of alternative models including patient-initiated follow-ups. Patients are already engaged in this programme, with representatives being recruited specifically to assist our work on process redesign. The surgical pathway programme has continued to evolve with a key focus since this year on increasing elective recovery, reducing elective waiting times, and driving activity performance through improvement of the average case per list (ACPL).Speciality specific targets and improvements have been agreed in conjunction with annual demand and capacity planning and will be monitored through the divisional performance review meetings.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective H – Elective Recovery
SRO(s) – Martin Armstrong, Director of Finance, Deputy Chief Executive & Mark Stanton, Chief Information Officer
The Trust's theatre performance continues to be upper decile (24th in the country) with 2023/ 24 benchmarking reflecting an ACPL of 2.6 against a peer median of 2.2, with productivity performance of 86% (23rd in country) against an NHSE target of 85% and a peer median of 81%. The programme team also contribute to wider work within the Integrated Cared Board , where we benefit from the insight and learning from the National GIRFT team with our internal work showcased amongst other local providers. The focus in quarter two will continue the ongoing improved delivery of the ACPL targets, whilst also focussing on under-utilised session time by individual speciality and consultant. This will be achieved through a multi disciplinary rapid improvement approach to reduce late starts , cancellations on the day, and effective booking processes . A rolling assessment approach will enable improvement to be supported, monitored and sustained with agreement and engagement from the clinical leadership. A pre-operative assessment workstream will support the reduction of cancellations on the day, and the use of real time consultant procedure times which will enable more accurate booking. A perfect Theatres week is planned for the 10th July , with the preparatory work beginning w/c 26th June to enable appropriate booking, pre admission calls , and agreement in advance of list orders. Clinical, Operational, Improvement and Executive team members will participate in the week and the learning shared to inform the focus for quarter three. Following the successful completion of phase one of our community diagnostic centre programme in 2022/ 23 , we will continue to expand the number of new services to support wider elective recovery requirements in the year ahead. This will involve establishing three new clinical pathways at our New QEII Hospital site, based on local clinical need and population health management analysis. The direct access ECG ECHO and Holter pathways will provide a one-stop shop and straight to test model whereby GPs will refer patients who meet select criteria for specific diagnostic tests prior to a virtual consultant review. Similarly a new lung function and FeNo clinic will provide expertise in earlier diagnosis and treatment of chronic disorders of airways like asthma. Each of these clinics will mobilise at various stages during quarter one.

2023/ 24 Strategic Transformation Report

Part 2: ENH HCP Updates

Trust Board

Agenda Item 12

5 July 2023

East and North Hertfordshire NHS Trust

Kevin O'Hart, Director of Improvement

ProudToBeENHT

ENH HCP

NHS
East and North Hertfordshire
NHS Trust

Our Area

East and North Hertfordshire Health and Care Partnership is one of four partnerships in the Hertfordshire and West Essex Integrated Care System (HWE ICS). The HWE ICS integrated care strategy has identified six key priorities":

- Give every child the best start in life
- Support our communities and places to be healthy and sustainable
- Support our residents to maintain healthy lifestyles
- Enable our residents to age well and support people living with dementia
- Improve support for people living with life-long conditions, long-term health conditions, physical disabilities, and their families
- Improve our residents' mental health and outcomes for those with learning disabilities and autism

North Hertfordshire
Main acute trust: E&N Herts NHS Trust

2 PCNs | 10 practices | 111,384 patients

Upper Lea Valley
Main acute trust: E&N Herts NHS Trust, PAH, Addenbrookes

3 PCNs | 11 practices | 124,635 patients

Stevenage
Main acute trust: E&N Herts NHS Trust

2 PCNs | 6 practices | 90,281 patients

Stort Valley and Villages
Main acute trust: PAH

1 PCN | 5 practices | 51,835 patients

Welwyn & Hatfield
Main acute trust: E&N Herts NHS Trust

2 PCNs | 8 practices | 111,067 patients

Lower Lea Valley
Main acute trust: Barnet & Chase Farm, PAH

2 PCNs | 8 practices | 73,152 patients

ENH HCP Quarterly Summary

East and North Hertfordshire NHS Trust

ENH HCP Developments

The East and North Hertfordshire Health and Care Partnership (ENH HCP) has evolved significantly since formal formation in August 2021, developing into an effective and inclusive 'place-based' partnership that is beginning to deliver tangible improvements in health and care for our population. ENH HCP has already delivered a range of flagship programmes (e.g. Hospital at Home, Community Diagnostic Centre) that are already demonstrating a positive impact on health and care services in our area. There are an additional number of programmes currently piloting new ways of working (e.g. Managing Heart Failure at Home, Integrated Heart Failure Services) that will demonstrate further impact in the year ahead.

A HCP development group involving senior leaders from ENH HCP organisations have co-produced a new target operating model that reflects the vision for how the partnership will work collaboratively in the future on our joint, strategic priorities. This work forms part of wider discussions with the ICB involving a new framework for how governance and financial considerations , population health management support and leadership arrangements are managed between system and place. Once finalised this model will be strengthened and incorporated as part of a planned review of the underlying ENH HCP memorandum of understanding later this year. A proposed new HCP Commissioning Board would allow increased local autonomy and decision making to inform how developmental and growth funds are used to prioritise new joint initiatives.

Ongoing six-monthly cultural surveys to measure perceived organisational development progress amongst HCP partners continues to demonstrate significant improvement across all domains with qualitative feedback reinforcing this position. A series of three workshops established in early 2023 concluded in June with the aim of defining the current 'as is' culture of the partnership, articulation of the future target culture vision and identification of any improvement actions required to secure achievement. The outcomes from this work will be presented to the HCP Partnership Board for formal ratification by chief executives.

A review of the 2022/ 23 HCP transformation portfolio is also now complete; a number of programmes that have been successfully rolled-out during the last twelve – eighteen months will transition to business as usual (e.g. Hospital at Home, Community Diagnostic Hub, vCKD) . In their place a range of new adult and children's and young people's priorities have been developed following population health analysis , ensuring new programmes of work are focused on those areas where there remain significant disparities in the health of our population in comparison to our peers. Using this data the HCP will target interventions and finite resources prioritising conditions and services where there are the largest opportunities to affect the wider determinates of health. This work will be mobilised via the Care Closer to Home Steering Group which using existing Integrated Neighbourhood Teams, will redesign how multidisciplinary services are better organised to respond and manage residents who present with greatest need.

ENH HCP Quarterly Summary

East and North Hertfordshire NHS Trust

Hospital at Home

Several key areas of work within the Hospital at Home (HAH) programme were completed during Spring 2023, and as such the programme is now transitioning to 'business as usual', with HCP operational and clinical teams taking overall responsibility for the continuing use of HAH and achievement of KPIs. Prior to transition a new digital referral system, built into NerveCentre, will make the referral process much quicker and easier for clinicians to complete, and provides HCT teams the opportunity to see more clinical information about the patient to assist in decision making about referrals. Over the last year, new clinical capabilities have been added into the service expanding the types of patients suitable for referral.

A number of new pathways have also been launched (such as a pathway for patient with a level 1 or 2 acute kidney injury) and a 'new pathway set-up guide' is in place to support the development of any future pathways as more specialities begin to make use of HAH. A new KPI dashboard has also been developed which shows live information about how many referrals are being made, how many patients are on the service, what kind of support they are receiving, and how long they stay on the service.

To support spread and sustainability within ENHT clinicians from multiple speciality areas have been given dedicated time within their job plans to dedicate to HAH by: working with HCT to add new pathways as needed, promote the service amongst their clinical colleagues, regularly review their own patients to find those who could be best supported at home, and by providing expertise to HCT colleagues at regular multi-disciplinary team meetings to help review current HAH patients.

HAH is already a case study published in the NHS Digital peri-operative playbook, creating significant interest from international audiences including teams visiting from Singapore and Germany. The HAH service has also won the regional "Excellence in Primary Care and Community Care Award" at the 2023 Parliamentary Awards, after being nominated by Oliver Heald MP and Stephen McPartland MP. Winners have been chosen across ten regional categories, with each now going forward to the national awards in London on 5 July – the NHS's 75th birthday

Managing Heart Failure at Home/ Integrated Heart Failure Services

Joint work between organisations in the East and North Herts HCP culminated in a co-designed new model for an integrated heart failure service (IHFS) which was prioritised as an area of opportunity due to unmet clinical need. ENH HCP was subsequently selected as an accelerator site for a new approach to managing heart failure (HF) at home, this award was accompanied with pilot funding. This NHSE pilot has now started and focuses on three key aspects; personalised care, remote support and monitoring and integrated care. Over six months commencing April 2023/ 24 up to fifty patients will be boarded onto this new service. Eighteen patients have already been

ENH HCP Quarterly Summary

East and North Hertfordshire NHS Trust

Managing Heart Failure at Home/ Integrated Heart Failure Services
boarded as at 21st June 2023, with ENHT HF specialist nurses helping identify appropriate patients who may benefit from longer-term remote monitoring by HCT and Doccla, with the aim of intervening earlier in the case of deterioration and therefore the pilot is already preventing hospital admissions. The approach is not for acutely unwell patients who would be treated in hospital or a virtual ward as an alternative to admission or to enable early supported discharge. It is focused on providing proactive support for HF patients and those with complex comorbidity needs to identify early signs of deterioration. The pilot will test the pathway, identifying if patients (utilising remote support and technology) can effectively and safely self-manage their condition and reduce pressure on services. Specialist HF training using a competency based approach for the HCT and Doccla nurses providing care is ensuring a safe and responsive service, and has also helped to lay the groundwork for future HF pathways including through Hospital at Home, as part of a wider Integrated Heart Failure Service. This model has been viewed as a proof of concept to support IHFS model which has now been funded through system growth funding allocations for mobilisation later in 2023/ 24.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	13
Report title	Maternity Services CQC Update			**Meeting Date**	5 July 2023
Presenter	Amanda Rowley, Director of Midwifery				
Author	Amanda Rowley, Director of Midwifery				
Responsible Director	Theresa Murphy, Chief Nurse			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

- An announced inspection of Maternity Services at ENHT was undertaken by the CQC on 4 and 5 October 2022 which focused on the key lines of enquiry of safe and well-led. Following the inspection, the Trust was issued with a Section 29A warning notice with significant improvements needed to ensure patient safety.
- An improvement plan was formulated in immediate response to the concerns raised with clear timelines and trajectories for completion.
- The final inadequate rating for maternity was published on 20 January 2023 and six key work streams were identified.
- The service was able to meet the compliance trajectories specified within the improvement notice and made a final evidence submission in response to the 29A notice on 17 April 2023.
- An unannounced inspection of all core services, including Maternity was undertaken at ENHT between 20 and 22 June 2023.
- Significant improvements in maternity since the last inspection were acknowledged in the high level feedback received, along with positive changes to the environment, availability of equipment and improved facilities.
- The service are currently responding to the CQC data request.

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: Safe; Caring; Well-led; Effective; Responsive.
Quality
People
Patients
Staff

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

ID 3069 – Reputational risk in relation to CQC Improvement notice
ID 3070 - Staffing resource within governance team needed for Materntiy Incentive Scheme
ID 70 – Midwifery staffing levels
ID 1136 - Insufficient numbers of obstetric medical staff
ID1127 – Risk to babies from insufficient neonatal Doctors to meet BAPM requirements.

Report previously considered by & date(s):

N/A	
Recommendation	The Board is asked to note the improvements made in line with the 29A notice. The board are asked to note the ongoing challenges outlines within the report.

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Maternity CQC Update

Amanda Rowley, Director of Midwifery
Douglas Salvesen, Divisional Medical Director

East and North Hertfordshire NHS Trust

Date 5th July 2023

Background

East and North Hertfordshire NHS Trust

- An announced inspection of Maternity Services at ENHT was undertaken by the CQC on 4th and 5th of October 2022 which focused on the Key lines of enquiry of safe and well-led. Following the inspection the Trust was issued with a Section 29a. warning notice with significant improvements needed to ensure patient safety.
- An Improvement Plan was formulated in immediate response to the concerns raised with clear timelines and trajectories for completion.
- The final CQC report and inadequate rating for maternity was published on Friday 20th January. Six key workstreams were identified.
  - 1. Maintenance, Equipment and facilities
  - 2. Infection Control
  - 3. Risk Assessment, Reporting and Mitigation
  - 4. Training – Monitoring and compliance
  - 5. Safe staffing
- The service was able to meet the compliance trajectories specified within the improvement notice and made a final evidence submission in response to the 29A notice on 17th April 2023.

CQC 29A Update: GAP Analysis Actions: June 2023

East and North Hertfordshire NHS Trust

Workforce and Training

- An establishment review has commenced using the Birthrate plus methodology.
- Current activity and acuity will be used to support an establishment recommendation for midwifery staffing
- A review of the staffing model for maternity theatres and recovery is in progress to reduce reliance of Midwives in theatre.
- The business case to support 1 additional Neonatal Consultant working towards BAPM standards has been approved.
- Appraisal rates in 2022-23 were below the expected standard. The service has developed a local tool to track appraisal compliance and to evidence progress towards appraisal trajectories during the current appraisal window.
- Training remains on trajectory to achieve full training compliance.
- Current Midwifery vacancy rate 10%. Our pipeline position is strong with many of our 3rd year students choosing to stay with us at ENHT. The recent maternity open day resulted in 5 conditional offers being made to external applicants.

Estates and Equipment

- All equipment orders have now been fulfilled
- Estates work in Triage and the consultant led unit have been completed, Work to improve the facilities and environment In Gloucester / Dacre are ongoing with an expected completion date of June 2023.

Ongoing challenges:

- Ensuring consistency of high standards of cleaning undertaken by the contractor. Ongoing audits, walkarounds and timely escalation of concerns are helping to achieve sustained cleaning standards.
- Digital transformation – We continue to work towards the introduction of electronic patient records to in line with the Trust Digital Strategy.
- Alignment of Trust and locally held training data– can lead to disparity of data reporting.
- A workforce strategy is needed that recognises current and future working environments and service requirements.

Key successes:

- Recruitment into the newly developed post of Equipment Coordinator for maternity services
- Sustained Improvement in electrical and biomedical engineering (EBME) equipment servicing / testing compliance.
- Launch of the Birmingham Specific Obstetric Triaging system (BSOTS) and increased footprint of the Triage area
- Increase in available space on the Consultant Led Unit for the Obstetric and Anaesthetic teams to undertake their administrative and training tasks
- A high standard of guideline compliance of 93% continues across the Women's and Children's Division
- The MVP undertook a very positive 'Walk the Patch' and the key improvements were noted - particularly the antenatal and postnatal ward environments

Unannounced CQC Inspection: June 2023

East and North Hertfordshire NHS Trust

- The unannounced inspection of all core services including Maternity was undertaken at ENHT between the 20th and 22nd June 2023.
- One of the Inspectors had been part of the inspection team who visited the Trust last October and recognised the significant improvements since the last inspection.
- The service are currently responding to a CQC data request related to the inspection with well led interviews planned for July 2023 following which a final report will be issued.
- High level feedback received following the inspection reflected that staff were being kind, caring and patient focused.
- The significant improvements in maternity since the last inspection were acknowledged and received high praise.
- Positive changes to the environment, availability of equipment and improved facilities were seen.
- Staff were welcoming to the inspectors and keen to share positive changes and improvements since the last inspection.

Meeting agenda

East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	14
Report title	Patient Safety Incident Response Framework (PSIRF) Plan			**Meeting Date**	5 July 2023
Presenter	Theresa Murphy Chief Nurse				
Authors	Margaret Mary Devaney, Director of Quality Jon Bramall Consultant Anaesthetist and Intensivist Michelle Anstiss Associate Director of Governance				
Responsible Directors	Theresa Murphy Margaret Mary Devaney			**Approval Date**	23 June 2023
Purpose	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

The NHS Patient Safety Strategy was published in 2019 with some key objectives to transform how patient safety is manged in healthcare. One key objective was to establish a new improvement focused Patient Safety Incident Response Framework (PSIRF) with the purpose of learning and improving patient safety.

This patient safety incident response plan sets out how East and North Hertfordshire NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months.

We will also be developing our patient safety incident response **policy** for patient safety management in our organisation. It will include detail for relevant aspects of incident management in our organisation, including patient safety incident reporting and safety improvement monitoring.

Future oversight and monitoring will include:

- Numbers, themes and trends of incident responses
- Compliance with Duty of Candour
- KPIs related to patient and staff experience
- Learning and improvement

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

It is a framework that supports development and maintenance of an effective patient safety incident response system across the Trust.

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between ‘patient safety incidents’ and ‘Serious Incidents’. As such it removes the ‘Serious Incidents’ classification and the threshold for it.
Risk: *Please specify any links to the BAF or Risk Register*
The plan has identified key ‘local’ patient safety risks which have been identified from a review of incidents, claims, complaints and risks on the risk register (as well as other key data sources).
Report previously considered by & date(s):
Trust Management Group June 2023 Quality and Safety Committee 28 June 2023

Recommendation	The Board is asked to approve the PSIRF plan prior to sharing with the ICB for their approval.

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East and North Hertfordshire NHS Trust

Patient safety incident response plan

Effective date: September 2023

Estimated refresh date: September 2024

	NAME	TITLE	SIGNATURE	DATE
Authors	Margaret Mary Devaney	Director of Quality & Patient Safety Specialist		June 23
	Jon Bramall	Consultant Anaesthetist and Intensivist Associate Medical Director for Quality and Patient Safety		June 23
	Tracey Van Wyk	Head of Quality Improvement		June 23
Reviewer	Michelle Anstiss	Associate Director of Governance		June 23
	Chris Curtis	Patient Safety Partner		June 23
Authoriser	Quality and Safety Committee			28 June 23
	Trust Board			5 July 23 (TBC)

Contents

Foreword from our Director of Quality

For anyone who has been exposed to the systems, processes and cultural challenges of improving patient safety, then like me, they will welcome the proposed changes within the new Patient Safety Incident Response Framework (PSIRF).

The current approaches to patient safety can be top down, target driven and bureaucratic. They have, for a long time been focussed on collecting data and often fail to support sustainable improvements.

Changes within the new PSIRF plan will embrace the opportunity to produce a learning framework that builds on the ethos that humans are fallible and improvements can only be achieved through systematic changes that are co-designed. Sustainable improvements will only be possible through a multidisciplinary approach and a true value placed on understanding what matters to patients and families.

The Trust values support the approach to include, respect and improve as the basis for how we work. Staff will be supported when they are involved in an error and be encouraged to speak up about any concerns they have around the safety of the service they deliver.

This plan will aim to close the gap on the theory of delivering safe care 'and the reality' of delivering safe care.

When an error occurs we can often over simplify a solution to prevent it happening again, where we have missed the opportunity to explore complicated and complex problems that require a different approach for learning to take place, and in tandem a different approach to improve.

Improving safety may require a combination of actions that affect clinical practice, organisational processes, information management, tools and equipment, communication methods, external factors, and individual person human factors. Therefore, how we respond and learn when an incident occurs requires a more holistic approach to drive sustained improvements.

Relationships are at the heart of the PSIRF plan. Providing 'psychological safety' when we are at work enables people to feel safe when they make a mistake, confident to ask for help and helps produce a more effective, high performing team.

> '*What we do know is that there is an observed correlation between psychological safety and learning and performance'*
>
> Edmondson 2019

Margaret Mary Devaney

RGN, Director of Quality

Introduction

The NHS Patient Safety Strategy was published in 2019 with some key objectives to transform how patient safety is manged in healthcare. One key objective was to establish a new improvement focused Patient Safety Incident Response Framework (PSIRF) with the purpose of learning and improving patient safety.

This patient safety incident response plan sets out how East and North Hertfordshire NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months.

The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

It is a framework that supports development and maintenance of an effective patient safety incident response system with four key aims:

1. compassionate engagement and involvement of those affected by patient safety

2. application of a range of system-based approaches to learning from patient safety incidents

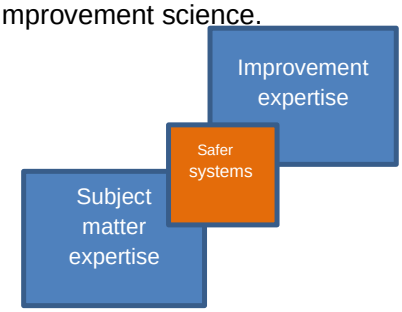
3. considered and proportionate responses to patient safety incidents

4. supportive oversight focused on strengthening response system functioning and improvement.

Preparation for this change has been occurring nationally through some early adopter sites, but some local changes have also been happening here that lend us to transition to this new way of working.

Through the current serious incident framework management, we have started to 'cluster' similar incidents together to support more collaborative learning and changes. We have adopted multidisciplinary 'round table' learning forums where staff can share their knowledge and experiences of the incident that has occurred.

We have been following a structured approach to improving safety through improvement collaboratives such as 'harm free care', 'sepsis' and 'deteriorating patient collaborative', combining the expertise of patent safety and improvement science.



This PSIRF plan has been produced following interrogation of information across ENHT services, collating patients' and family experience and asking staff what response they need when an error occurs. Our Patient Safety Partner has been involved in the production of our plan. We intend to continue wider stakeholder engagement with ICB and system colleagues, HM Coroner and social care colleagues.

Our services

About the Trust

East and North Hertfordshire NHS Trust was created in April 2000, following the merger of two former NHS Trusts serving the east and north Hertfordshire areas. Today, the Trust provides a wide range of acute and tertiary care services from four hospitals, namely: the Lister in Stevenage; the New Queen Elizabeth Hospital II (QEII) in Welwyn Garden City; Hertford County in Hertford; and the Mount Vernon Cancer Centre in Northwood, within the London Borough of Hillingdon.

Since October 2014, the Lister has been the Trust's main hospital for specialist inpatient and emergency care. The New QEII hospital, which was commissioned by the East and North Hertfordshire Clinical Commissioning Group, opened fully from June 2015 and provides outpatient, diagnostic and antenatal services, along with an urgent care centre. Hertford County also provides outpatient and diagnostic services. The Mount Vernon cancer centre provides tertiary cancer services including radiotherapy, chemotherapy and immunology services.

The Trust owns the freehold for each of the Lister and Hertford County; the New QEII is operated on behalf of the NHS by Community Health Partnerships and the Mount Vernon Cancer centre operates out of facilities owned by the Hillingdon Hospitals NHS Foundation Trust.

The area served by the Trust for acute hospital care covers a population of just over 600,000 people and includes south, east and north Hertfordshire, as well as parts of Bedfordshire. The Mount Vernon Cancer Centre provides specialist cancer services to some three million people from across Hertfordshire, Bedfordshire, Luton, north-west London and parts of the Thames Valley. The Trust's main catchment is a mixture of urban and rural areas that are in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in parts of Cheshunt, Hatfield, Letchworth, Stevenage and Welwyn Garden City. From 2018 to mid-2021, the Trust saw a consistent reduction in mortality, with rates that were consistently lower than our national peers. While the last eighteen months have seen an upward trend, this has been mirrored nationally, the Trust remains well positioned compared to national peers.

The birth rate is slightly lower than the England average, with the Trust's core catchment population forecast to rise by approximately 6% in the years to 2030; the most significant growth is expected in people aged 65 and over (25%) with this age group also more likely to have the greatest impact in terms of health needs. Black and minority ethnic groups (i.e. non-white British) make up approximately 10% of the population in east and north Hertfordshire. In addition, it is expected that just under 17,000 new houses are planned to be built in the Trust's core catchment area by 2030.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic, ambulatory and urgent care services – including an emergency department and maternity care – as well as regional and sub-regional

services in renal medicine, urology and plastic surgery. Approximately 6,750 staff are employed by the Trust. The Trust's annual turnover is approximately £610.6 million.

Organisational Structure

During the year, the Trust moved to a clinical operational structure of four Divisions consisting of Planned Care; Unplanned Care; Women's and Children; and Cancer. Prior to this the Trust had two operational Divisions: Planned Care, and Unplanned Care.

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.

Strategy overview and objectives

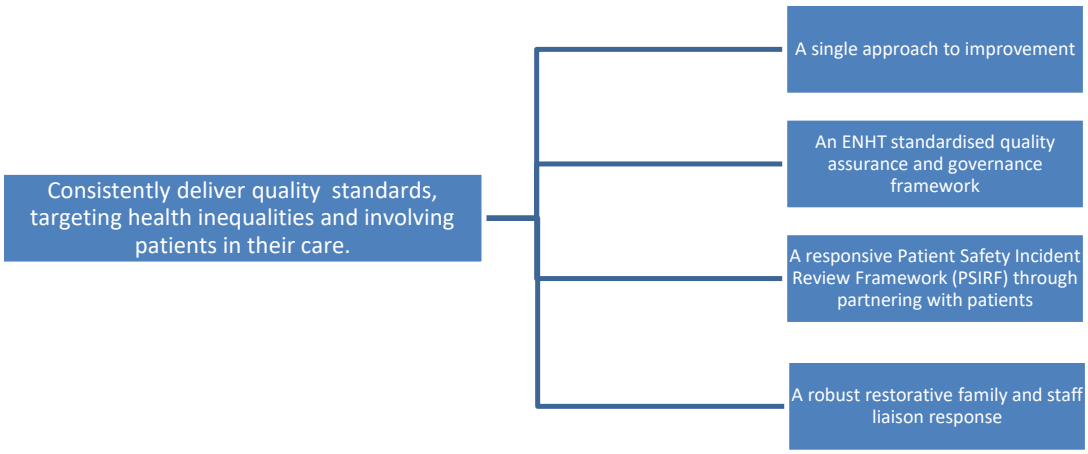
The Trust's Vision is "To be trusted to provide consistently outstanding care and exemplary service".

The Trust has four guiding themes that shape its annual objectives:

- Quality – Consistently deliver quality standards, targeting health inequalities and involving patients in their care
- Thriving People – Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy and accountability
- Seamless Services – Deliver seamless care for patients through effective collaboration and coordination of services within the Trust and with our partners
- Continuous Improvement – Continuously improve services by adopting good practice, maximising efficiency and productivity and exploiting transformation opportunities.

These themes and objectives are underpinned by our Trust Values: Include, Respect and Improve.

The Trust launched its five year Quality Strategy in 2019. Key quality strategy drivers for 2023/24 include:



Safety Culture

We are in the process of defining our safety culture and work is underway, involving a wide range of multi-disciplinary staff (including HR & OD colleagues, clinical leaders, and Freedom to Speak Up Guardian) to:

- Interview staff involved in various incident and HR investigations to understand their experiences to inform improvements and culture change where required
- Review and revise HR policies to ensure they do not undermine just culture through sanctions or suspensions and that they reflect a restorative and just culture approach

Involvement and support for staff following incidents

We are on a journey at ENHT to ensure it is a safe and fair place, where everyone's voice is encouraged, valued and listened to, helping us to continually learn, inspire change and improve.

We recognise that many staff will be involved with a patient safety incident at some point in their careers and this can be a traumatic experience. We have a range of wellbeing support for staff which will be explicit in our new policy framework.

We will be formalising our policy framework throughout the summer 2023, which will provide detailed guidance for staff involved in safety incidents, to support this plan.

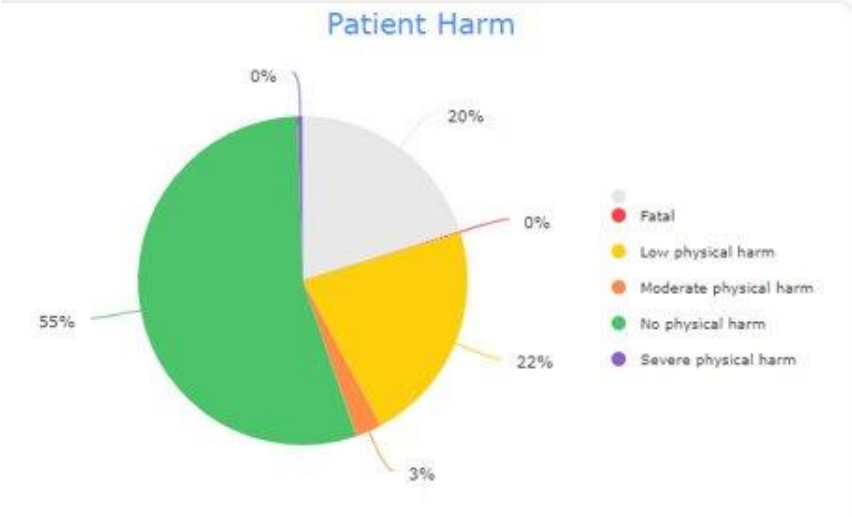
Involvement of patients, families and carers following incidents

We recognise the significant impact patient safety incidents can have on patients, their families and carers. Getting involvement right with patients and families in how we respond to incidents, is crucial, particularly to support improvements to the services we provide. The patient voice is very much an integral part of our work at ENHT and as part of our new policy framework, with involvement from our Patient Safety Partner, we will be

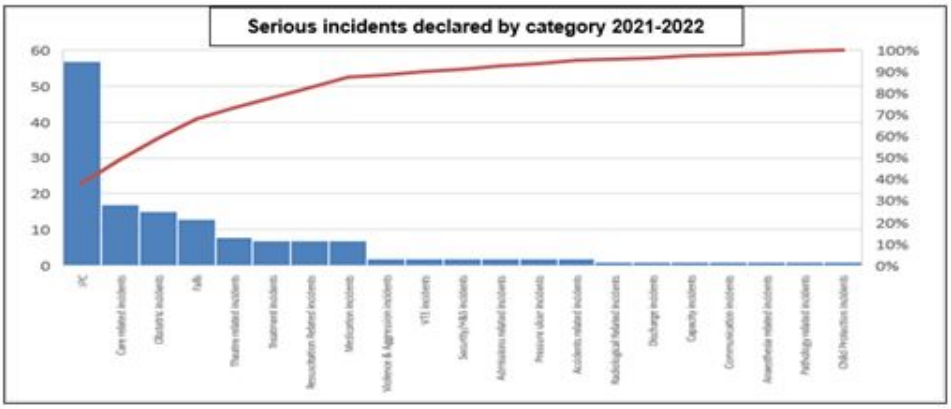
developing procedures and guidance to support staff in how to discuss incidents and involve patients and families.

Defining our patient safety incident profile

Just under 5000 patient safety incidents were reported between 2019 and 2022. 98% of these were Low or No Harm incidents. The chart shows a breakdown of the incidents by harm.[1]



Of the Serious Incidents declared from 2021-22, the largest category was infection control incidents relating to hospital onset COVID. Of the remaining incidents the key themes were “care related”, obstetric, falls, treatment incident and medication incidents.



Top themes:

- Care related incidents
- Obstetric incidents
- Falls
- Treatment incidents
- Medicines incidents

[1] 20% of the incidents were reported under the new Learning From Patient Safety Events (LFPSE) framework

Data was also examined from claims where the key themes were related to failures and delays in diagnosis and treatment, as well as recognised complications of surgical procedures.

Complaints and concerns were also analysed and the top themes were communication, medical care, diagnosis, discharges, and delayed treatment and care.

In analysing the data it was important to bear in mind that neither the crude number of incidents nor the level of harm is the best predictor of what should be the Trust's patient safety priorities. For example, 'falls' features in the list of incidents and is also associated with harm, and yet the benchmarking data shows that the harm associated with falls is similar to other trusts. Of course, work minimising the risk of falls will continue, but other areas should form the main priorities for the Trust.

A wide variety of stakeholders were engaged in analysing the data and developing the patient safety priorities. This group included teams involved in incident investigation, claims, complaints, and risk. There was engagement with mortality surveillance, pharmacy and the Quality Improvement team. The team also included a patient representative.

A significant theme that emerged was around the culture surrounding patient safety incidents, as well as the broader culture in the organisation. Learning has highlighted that some current responses to incidents can appear punitive, uncivil and unappreciative of the impact on staff. For this reason, "improving safety communication through building a culture of safety and co-production" was included as a priority.

Five general themes were identified which allows scope for more specific investigations within these areas. The themes span across all divisions in the Trust. These initial investigations and improvement work may be then transferrable to other areas within that domain.

Patient Safety Priority	Rationale	Suggested initial focus for PSII / Improvement
Improving safety communication through building a culture of safety & co- production	Communication failures was a common theme throughout incidents, complaints and claims. This priority will impact on the improvement work for all other priorities	Civility and culture
Early recognition, reliability & managing acutely unwell/deteriorating patient	Serious incidents reports and claims have shown that this is a significant problem and current performance data shows that it remains a current issue	Early recognition, and prompt response to deterioration
Reducing avoidable harm for pressure ulcers, critical	The Harm Free Care programme has been running some	Reducing medication

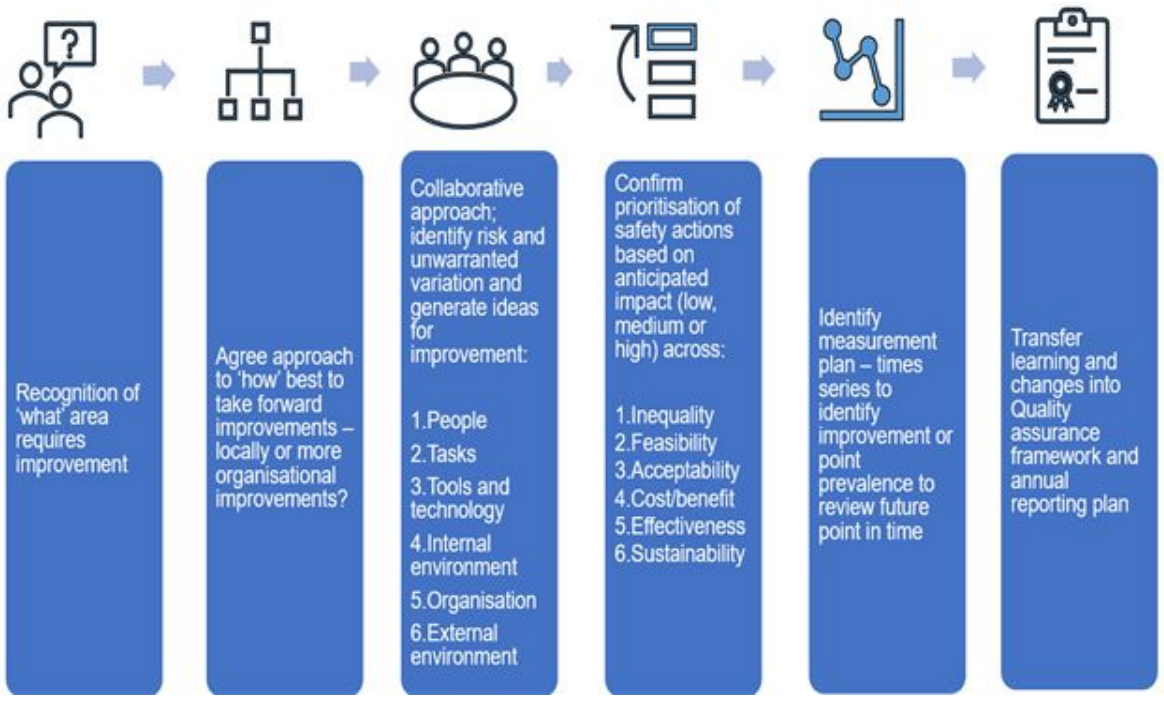
medications, falls, medication errors & Venous thromboembolism (VTE)	improvement work in these areas. Data shows that it continues to be an issue that matters.	incidents
Recognition & management of challenging behaviours/ Violence & aggression	There has been an increasing number of incidents relating to the management of challenging behaviour.	Mental health crises in acute hospital
Reducing patient safety risks from long waiting times from admission to discharge	There have been incidents related to patients on waiting lists as well as process delays during inpatient stay. This priority has some significant risk register entries associated with it	Delays in care in Ophthalmology, Paediatric audiology and Breast services

Defining our patient safety improvement profile

The following principles will apply to our patient safety improvement programme:

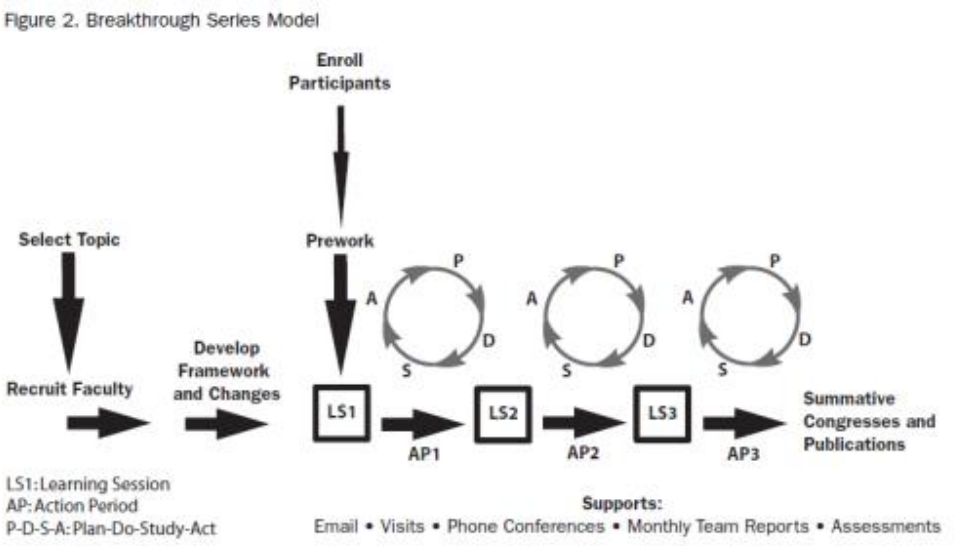
- Improvement will be co-design and co-delivery with staff, patients, carers and the public
- The Trust will support being courageous and providing the leadership necessary to make change happen
- We will continue to deliver good quality health and social care services whilst we make changes
- Changing to a true partnership approach with a culture of shared innovation and learning with our patients
- Building upon best practice and utilising work already undertaken such as harm free care collaborative and transformation programmes
- Working collaboratively with others where services operate across boundaries

Learning from incidents shall inform our patient safety improvement programmes. The safety learning pathway shall follow key point below:



On occasions, an incident type may already be well understood. For example, a previous similar incident may already have been investigated with improvement plans to address the causes implemented along with effective monitoring. In this scenario, resources may be better directed at improvement rather than repeating an investigation that will yield the same outcome.

Opportunities exist across ENHT internal and external systems to learn through a structured and collaborative 'Series Collaborative Model' (2003), detailed in the diagram below:



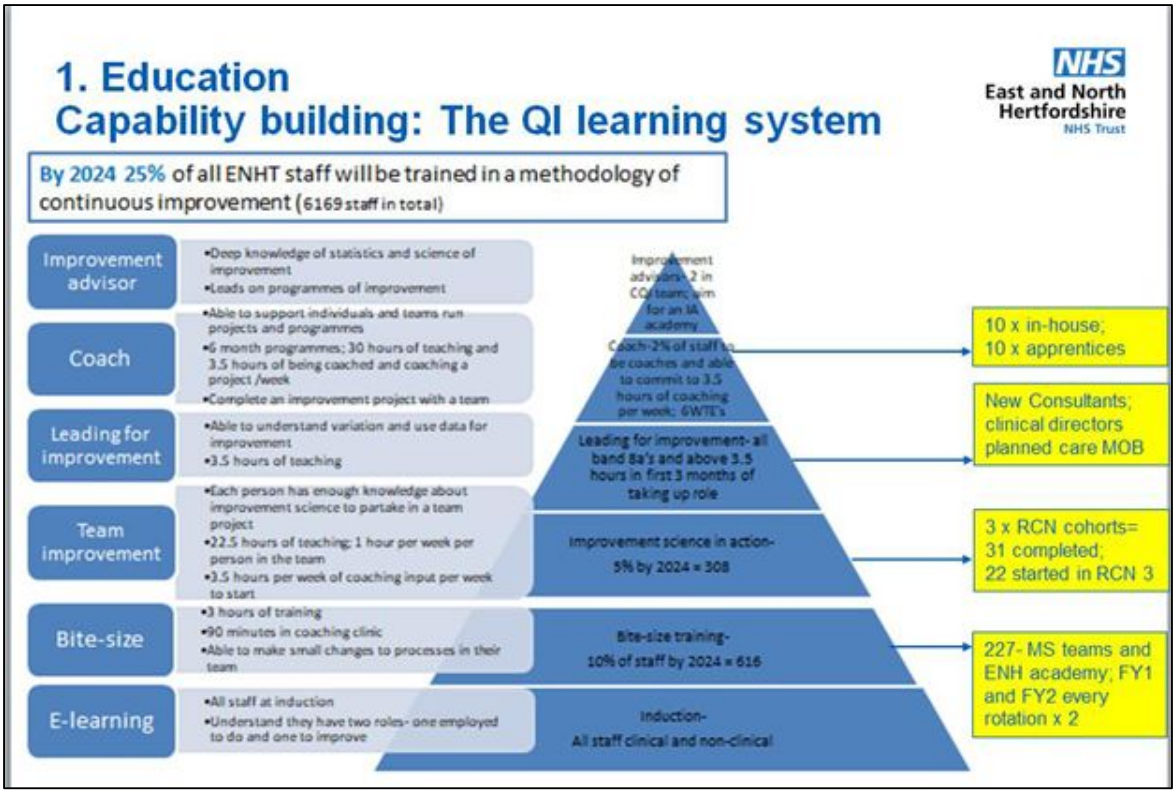
At ENHT we want to engage with our patients in new ways that enhance the quality of care and improve the patient experience. We have successfully involved patients with our Continuous Quality Improvement co-design programmes, and we have recruited our first Patient Safety Partner (PSP). The PSP is committed to co-designing how we continue to work with patients, their families and carers, and staff to identify what patients need and want. This will help us to understand the role that patients can play in their own safety, and the different mechanisms that could work to help them be informed and safe.

Alongside work on safety and prevention, we will be actively promoting and encouraging the Duty of Candour. At the same time, we will be working to create a more informed process for patients and families around incidents and future learning reviews.

Training and development for safety improvement

The Trust has delivered a programme of building improvement skills through:

- Programmes: harm free care and deteriorating patients.
- Projects: 57
- Coaching: 178 people have attended running programmes, projects and training and coaching.
- Training: Over 300 trained at varying levels of depth of knowledge.



The Trust plans to increase the understanding of improvement skills, patient safety and develop a safety culture together with human factors by completing the following:

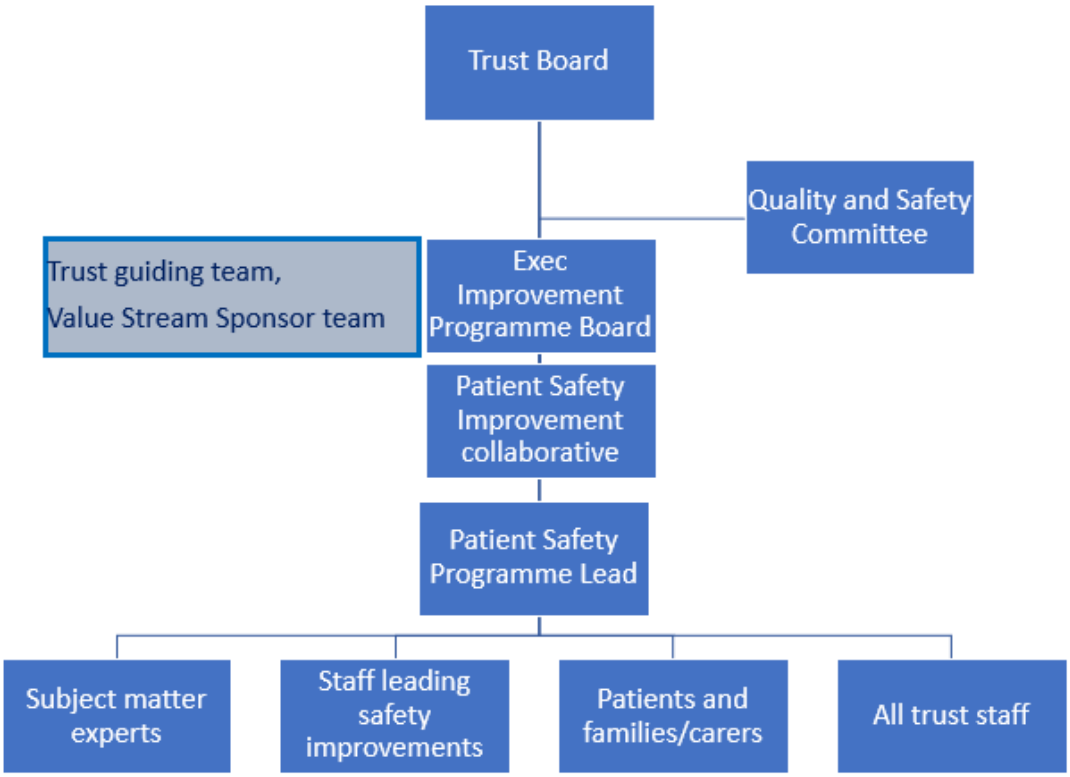
- develop Continuous Quality Improvement (CQI) training strategy in partnership with Virginia Mason Institute
- develop Board skills and understanding in CQI
- set up a Quality Improvement faculty and steering group
- identify human factors training opportunities
- provide opportunities for undergraduate and postgraduate multi-disciplinary CQI development
- implement suite of learning responses that will inform improvement efforts e.g. facilitated debriefs (after action reviews), SWARMs, walk through, talk through, and other response skills
- provide expanded online CQI and safety science (SEIPS) resources
- support staff to become patient safety improvement leaders
- support the development and deployment of Patient Safety Partners

PSIRF training requirements at ENHT

Training	Summary and audience	Duration	Provider & Expected Staff Numbers
Essentials of patient safety for all staff	Level 1: All staff (priority those in engagement, learning response and oversight roles)	30-60mins	eLearning for health (ENH Academy) 6000+
Essentials of patient safety	Level 1: Essentials of patient safety for boards and senior leadership team (oversight roles)	30-60mins	eLearning for health (ENH Academy)
Essentials of patient safety L2	Level 2: Access to Practice (Learning Response Leads) There are two sessions. The first introduces *systems thinking,* the second session looks at *human factors* (the science of work and of working together in safely designed systems) and *safety culture* (the significance of a true learning culture, free of inappropriate blame)	30-60mins	eLearning for health (ENH Academy) All medical staff and AfC staff band 5 and above
Systems approach to learning from patient safety incidents	*(Required for learning response leads and those in oversight roles)*	2 days	Initially external provider & review in-house capacity and capability to deliver going forward
Oversight of learning from patient safety incidents oversight	*(Required for those in oversight roles)*	1 day	Initially external provider & review in-house capacity and capability to deliver going forward
Patient and staff involvement in learning from patient safety incidents	*(Required for engagement leads and those in oversight roles)*	1 day	Initially external provider & review in-house capacity and capability to deliver going forward

Additional Training available according to Training Needs Analysis (TNA)
Multidisciplinary team (MDT) review/round tables
Swarm huddle/Hot debrief/safety huddle
After action review (AAR)
Facilitation skills and confidence building to run MDTs, roundtables, SWARMs, hot debriefs, group facilitation, facilitating improvement planning
Schwartz rounds – conversation alongside the Trust approach
Additional training – adhoc short external courses as required

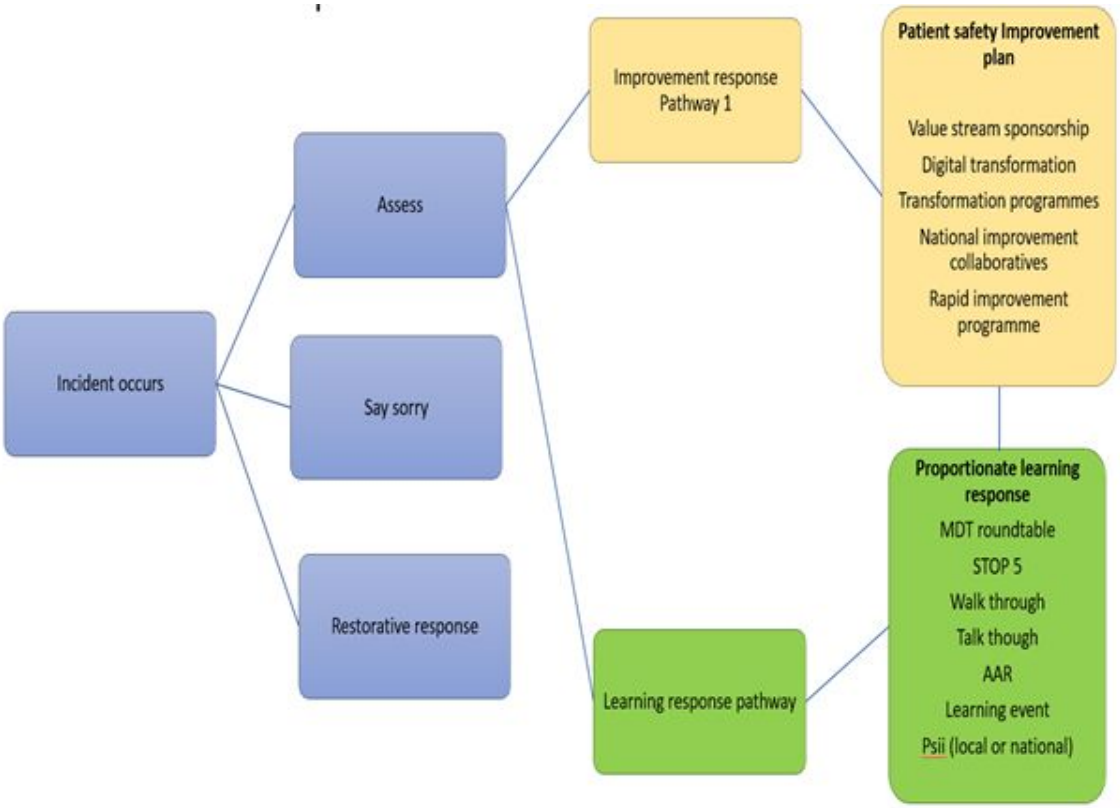
Patient safety improvement programme



Our patient safety incident response plan: national requirements

The aim is to achieve a systematic learning and improvement approach and less of a 'cause and effect' approach, through recognising that multiple interactions and contributory factors exist across a 'whole system'.

Learning shall be achieved through adoption of tools that explore interacting contributory factors rather than a single factor. Research has demonstrated that the learning should scope Systems Engineering Initiative for Patient Safety (SEIPS) 6 key factors i.e. person (s), tasks, tools and technology, internal environment, organisation and external environment. When these areas are considered together they will support insight to all elements of our 'systems'.



Some events in healthcare require a specific type of response as set out in policies or regulations. These responses may include mandatory Patient Safety Incident Investigation (PSII), review by or referral to another body or team, depending on the nature of the event.

From our incident and resource analysis we estimate, due to the services we provide, we will complete approximately 10 PSII reviews per annum where national requirements have been met.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the safety improvement plan
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)	PSII	Create local organisational actions and feed these into the safety improvement plan
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII	Create local organisational actions and feed these into the safety improvement plan
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	Respond to recommendations as required and feed actions into the safety improvement plan

Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Respond to recommendations as required and feed actions into the safety improvement plan
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place	Referred to Healthcare Safety Investigation Branch (HSIB) for independent patient safety incident investigation	Respond to recommendations as required and feed actions into the safety improvement plan
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Respond to recommendations as required and feed actions into the safety improvement plan
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Respond to recommendations as required and feed actions into the safety improvement plan

Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	Respond to recommendations as required and feed actions into the safety improvement plan
Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS	Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations Healthcare organisations must fully support these investigations where required to do so	Respond to recommendations as required and feed actions into the safety improvement plan
Domestic homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of	Respond to recommendations as required and feed actions into the safety improvement plan

	organisations and commissioners of health services in relation to DHRs	

Our patient safety incident response plan: local focus

ENHT shall continue explore patient safety incidents relevant to the population we serve rather than exploring only those that meet a certain nationally defined threshold.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Improving safety communication through building a culture of safety & co- production	Learning response pathway	Create local safety actions and feed these into the safety improvement plan
Early recognition, reliability & managing acutely unwell/deteriorating patient	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts
Reducing avoidable harm for pressure ulcers, critical medications, falls, medication errors & VTE	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts
Recognition & management of challenging behaviours/ Violence & aggression	Learning response pathway	Create local safety actions and feed these into the safety improvement plan
Reducing patient safety risks from long waiting times from admission to discharge	Learning response pathway	Create local safety actions and feed these into the safety improvement plan

We have provided a list of current improvement work underway at ENHT (Appendix A). We plan to focus our efforts going forward on development of safety improvement plans across our most significant incident types, either those within national priorities, or those we have identified locally. We will remain flexible and consider improvement planning as required, where a risk or patient safety issue emerges from our own ongoing internal or external insights.

Appendix A ENHT Improvement programmes 2023/2024

Existing work stream/project	PSIRF Plan local theme
Deteriorating patients including reliability of observations, escalations and human factors SIM training after events.	Early recognition, reliability & managing acutely unwell/deteriorating patient
Harm free care programme including the prevention of VTE, falls, medication errors, CAUTI, poor nutrition and hydration and pressure ulcers.	Reducing avoidable harm for pressure ulcers, critical medications, falls, medication errors & VTE
RCN clinical leadership programme- 20 leaders in each cohort lead a project that aligns to a safety and or an experience priority for their team.	Could cover any one of the themes if focusing on safety
Keeping our patients safe digital transformation project.	Early recognition, reliability & managing acutely unwell/deteriorating patient Reducing avoidable harm for pressure ulcers, critical medications, falls, medication errors & VTE Recognition & management of challenging behaviours/ Violence & aggression
Maternity improvement programme.	Maternity safety priorities including national patient safety initiatives
Mount Vernon cancer centre re-provision programme board.	Re-provisioning of pathways
Transformation programmes: a. Care closer to home b. Temporary workforce c. Fundamentals of care and pathways to excellence d. Urgent and emergency care e. Surgical pathways f. Community diagnostic centre programme g. Outpatient department programme including patient initiated follow-up h. Criteria lead discharge programmes i. Complaints j. Hospital at home	Different programme streams touch on each of the five different local safety themes

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	15
Report title	Quality Account 2023			**Meeting Date**	5 July 2023
Presenter	Theresa Murphy- Chief Nurse Margaret Okojie- Associate Director of Quality Governance				
Author	Margaret Okojie- Associate Director of Quality Governance				
Responsible Director	Margaret Mary Devaney, Director of Quality			**Approval Date**	29/06/2023
Purpose (*tick one box only*) [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

The attached Quality Account for 2022-2023 is presented for approval and sign off in line with legislative requirements for NHS organisations to produce a document detailing information in relation to the quality of services provided to local communities, any achievements and/or improvements made and any areas where further improvements may be required for each financial year.

Highlighted within the quality account are achievements and progress so far made by the Trust against its five year Clinical and Quality Strategy (2019-2024). In addition, identified areas for further improvements are also noted.

Our quality priorities for improvement for 2023-2024 supports the Trust's five-year strategy and continued focus will be given to our identified strategic themes i.e., good governance, valuing the basics- keeping patients safe, and developing staff capability

A draft of this account was shared with our system partners and Integrated Care Board (ICB). Feedback has been incorporated into the account to further strengthen our reporting.

Impact: where significant implication(s) need highlighting

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 **APPROVE** the quality account.

To be trusted to provide consistently outstanding care and exemplary service

June
2023

East and North Hertfordshire
NHS Trust

Quality Account 2022-23

Quality Report Contents

About the Quality Report

PART 1

1.1 Chief Executive's Foreword

The last 12 months has seen a period of challenge and change for the Trust as we continue to live with the effects of Covid and recover our services. In 2022/23, we saw new members join the Trust's executive board, including our new Chief Operating Officer Lucy Davies and new Chief Nurse, Theresa Murphy.

To reflect this change, in July 2022 we launched our new vision, mission and values which set out how we will consistently provide outstanding care and exemplary service to our patients and the community we serve. And this 2022/23 Quality Account outlines our achievements, identifies where improvements could be made and sets out our future continuous improvement plans.

I am proud of the work colleagues across the Trust have done over the past 12 months. This has included being the second Trust in the UK to receive Pathway to Excellence designation across all our hospitals, demonstrating our genuine commitment to creating an environment where staff can excel and our commitment to continuous improvement. Departments across the Trust also launched our new electronic Prescribing Medicines Administration (ePMA) system and have now embedded this into clinical practice – helping to ensure our patients receive the medication they need more quickly.

The commitment that all our staff continue to show is also demonstrated through the results of the Friends and Family Test, where we have seen a sustained improvement in most categories. This has been achieved by reflecting on the feedback received and making practical changes to the way we do things. Even with the ongoing challenges, I am particularly pleased to see that our emergency department has seen patient satisfaction increase by 3% from last year.

Despite the successes we have experienced, it's important to recognise those areas where we need to improve – including working with our system partners to improve our emergency department pathways and reduce ambulance handover delays. As an organisation we are committed to making these improvements, working closely with service users and our new improvement partner the Virginia Mason Institute.
I'd like to thank all our staff who have worked hard to ensure we can continue to provide high-quality care to our patients and the local community.

Adam Sewell-Jones
Chief Executive

Performance Overview

1.2 Accountability for Quality: how we hold ourselves accountable

NHS organisations are required under the Health Act 2009 and the subsequent Health and Social Care Act 2012 to produce a document detailing information in relation to the quality of services provided to local communities, any achievements and/or improvements made and any areas where further improvements may be required for each financial year. The annual Quality Accounts are produced by the Trust as mandated under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010. The Quality Account is therefore a key mechanism which provides demonstrable evidence of measures undertaken in improving the quality of the Trust's services.

The aim of the Quality Account is to enhance the Trust's accountability to the public and its commissioners on both the achievements made to improve the quality of services for our local communities as well as being very clear about where further improvement is required. Quality Accounts are both retrospective and forward looking.

As part of the development of the Quality Account all NHS Trusts are required to identify measurable priorities mapped against Darzi headings of Safe, Effective and Patient Experience.
The purpose of the account is to:

- promote quality improvement across the NHS
- increase public accountability
- allow the Trust to review the quality of care provided through its services
- demonstrate what improvements are planned
- respond and involve external stakeholders to gain their feedback including patients and the public.

The Trust's overall vision is to be trusted to provide consistently outstanding care and exemplary service. We will deliver our vision by focusing on our strategic themes- Quality, Thriving People, Seamless services, and continuous improvement which will in turn support operational performance.

Our strategic priorities are underpinned by our values and a series of enabling strategies including the people, quality, finance, and estates strategies.

Refreshed Trust Values

Our values underpin everything we do and describes what matters to us at the Trust. They are a promise of how we will carry out our work – how we will treat our patients, our staff, and our partners.
Following an extensive review and refresh of our strategy in 2021/22 (including a bottom-up review of service ambitions, our vision and strategic objectives, we are agreed we will

Include: We value the diversity and experience of our community colleagues and partners, creating relationships and climates that provide an opportunity to share, collaborate and grow together.

Respect: We create a safe environment where we are curious of the lived experience of others, seek out best practice and are open to listening and hearing new ideas.

Improve: We are committed to consistently delivering excellent services and continuously looking to improve through a creative workforce that feels empowered to act in service of our shared purpose.

Clinical and Quality Strategy (2019-2024)

Our 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.
Strong evidence describes how 'managing quality' well requires us to approach quality as a whole system i.e., through quality planning, quality assurance and quality improvement.

Key objectives of the Quality Strategy include:

Understand where variation exists and use data to proactively drive improvement by reducing the 'unwarranted variation'. Aiming to enable staff 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 within which our efforts of continuous improvement will be focused. These are:

Each component represents key priorities identified through the 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 a compelling vision for all staff working at East and North Hertfordshire Trust. The people strategy details plans based on four key pillars- 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-developed to encompass key focus to 2030- highlights what, where and how we as an organisation would determine key focus areas to enable change in delivery models, workforce composition and the types of roles needed in the future to meet the demands of the community we serve.

Organisational Structure

Following a review in 2022, the Trust now has four main operational divisions. These are Women & Children, Planned Care, Unplanned Care and Cancer services.
Each division has a Divisional Medical Director, who is a senior clinician, a Divisional Nursing & Quality Director, and an Operations' Director. This triumvirate structure is replicated at specialty level.

Supporting our 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.

PART 2: Priorities for Improvement and Statements of Assurance from the Board

2.1. Progress with 2022/2023 priorities

Highlighted below are our priorities which are aligned with the Trust's quality strategy priorities. These priorities were developed following appropriate consultations with relevant parties.

Quality Priorities 2022 to 2023		
Domain	**Description**	**Key Focus Areas**
Effective	Build ENHT Quality Improvement Capability & Capacity	Delivery quality improvement (theory & Practioner) for all staff
Safe	Keeping our patients safe	Medication management Sepsis pathway compliance Safer invasive procedure standards Deteriorating patients Safeguarding Adults and Children VTE risk assessments
Patient Experience	Respect patients time through improving the flow through inpatient and outpatient services.	Improving discharge processes Improving patient access

In 2022/2023, delivery against identified quality priorities focused mainly on ensuring continued focus is given to the creation of opportunities for clinical and non-clinical staff to gain knowledge on Quality Improvement methodologies aimed primarily at maintaining and ensuring sustained continuous improvements from any gains made in the delivery of safe care.

In addition, the Trust strengthened its position in ensuring users of our service/patients received safe care with a dedicated focus on quality care for the deteriorating patient (i.e. reduction of cardiac arrests, safeguarding adults and children, compliance with required observations & associated audits, medication management, sepsis pathway compliance, as well as monitoring all escalation modules), improvements around safer invasive procedure standards, and Venous thromboembolism (VTE) risk assessments.

Furthermore, we have made progress in our priority to respect our patients time by improving flow through our inpatient and outpatient services with specific focus given to improving our discharge processes and improving access to our services.

2.2. Achievements made with the 2022/2023 quality priorities

Key achievements made include:

- **SAFE:** There have been steady progress made in the quality targets in identified areas set for 2022/2023.

- **EFFECTIVE**: The Trust, in July 2022, achieved the prestigious Pathway to Excellence® designation from the American Nurses Credentialing Centre (ANCC). We were the first Trust, within the national cohort of 14 Trusts selected by the Chief Nursing Officer for England, to become designated with this internationally recognised programme for nursing and midwifery standards. Achieving Pathway to Excellence® designation demonstrates the Trust's genuine commitment to creating an environment where our staff can excel (utilising the key six pathway standards of shared decision making, leadership, safety, quality, wellbeing and professional development) and our commitment to continuous quality improvement (working in conjunction utilising our Clinical Excellence Accreditation Framework (CEAF). The CEAF is a comprehensive assessment that measures key standards of nursing and clinical care aligned to six pillars within our Nursing, Midwifery and AHP Strategy. These pillars are
    - Developing and strengthening leadership
    - Optimising pathways
    - Valuing people
    - Inspiring and innovating through research and quality improvement
    - Ensuring quality and safety
    - Partnership working

  Our work in quality improvement across all service areas has progressed significantly and its impact observed in the close collaborative working with the digital and pathways to excellence teams aimed at embedding the fundamentals of care improvement work with focus on delivering harm free care and the reliability of observations.

2.2.1

Quality Domain: EFFECTIVE

Priority 1: Build ENHT Quality Improvement (QI) Capability & Capacity: Partly Achieved

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

Quality improvement methodologies drive the transformation of existing services, the development of new services and the collaborative working of partnerships.

The quality improvement team works alongside the 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

Our Priority for 2022/23 has been to work towards achieving:

- Deliver on QI bite size training for 200 staff
- Provide QI induction training for all staff
- Improvement apprenticeship for 15 starters
- Establish safety related projects across all divisions in clinical areas
- Establish and adopt sustained divisional led patient safety breakthrough series collaboratives on safety & patient experience issues.
- Establish sustained quarterly QI masterclasses
- Establish 'quality clinics' by offering coaching/learning coordination in clinical areas
- Design and imbed ENHT Exemplar ward programme with the digital and pathways to excellence teams to embed the fundamentals of care
- Establish a patient co-designed faculty aimed at shared decision making
- Ensure all wards are accredited for quality as silver or above by March 2023

Achievements to date:

We have achieved much of the target we set ourselves and delays to achievement can be attributed to current pressures on service delivery overall. We have temporarily paused the commencement of establishing quarterly masterclasses and holding a multidisciplinary collaborative on safety and patient experience issues.

In 2022, we achieved gold ward accreditation for four ward areas (i.e., Pirton Ward, Ward 11A, Swift Ward and the Critical Care Unit). Silver accreditation level was achieved by 3 wards (i.e. Ashwell Ward and Wards 10/11 at Mount Vernon Cancer Centre. However, following regular assessment of the fundamental standards, many wards have been unable to ensure compliance with the fundamental standards of care in a consistent way and have therefore not been able to progress to an accreditation award.

ENHT has however continued to improve its performance in delivery on improvements with 19 quality improvement safety related projects ongoing across all divisions with the added advantage of the deteriorating patient collaborative now instituting education roadshows, testing learning coordinators and recording doctors' escalations onto NerveCentre- a system that supports electronic prescribing & medicines administration.

We have also delivered against our targets for launching QI academy bitesize modules with overall impact seen in **227** staff completing these modules, a 3rd cohort completing organisational quality improvement learning programme events and 13 staff uptake apprenticeship. **178** staff have attended coaching clinics and are supported to take the next step in their QI projects. Further strengthening has been achieved at local level through the identification of QI improvement leads and QI discussions becoming an integral part of clinical governance meetings.

The establishment of our coaching clinics has solidified QI learning and supported staff to adopt the recording of quality improvement projects and programmes on the live Life QI platform. There are currently 57 active and 33 completed projects. These projects span quality improvement pillars around equality and diversity, person-centred care, efficiency, timely response and safe care.

In 2022/23, we began the process of adopting a framework that reflects and values patient co-design and successfully collaborated with the ICS engagement team that allowed us to extend our reach, standardise and reduce waste. We recruited patient safety partners, and more roles are being advertised.

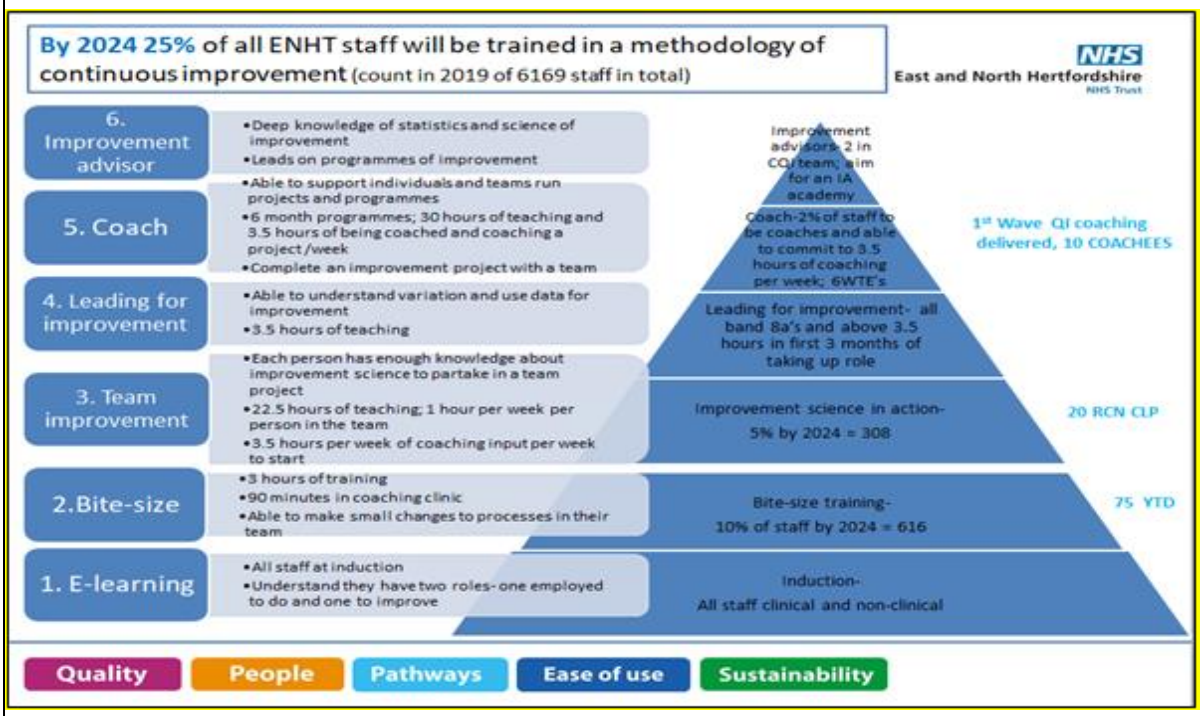
Unfortunately, the 'What Matters To You' project was not funded and as such, we have been unable to move forward with this. However, we plan to run a What Matters To You day in 2023/24 and build a group of What Matters To You champions to lead improvement on themes identified

Plans for 2023/24

Quality Improvement

- We will continue to work in partnership with our single improvement partners and corporate services to scale our QI work to include coaching, leadership development, patient co-production & design.
- We will incorporate our methodology as part of the national requirements for co-designing the ENHT approach implementing the Patient Safety Incident Response Framework (PSIRF)
- We will work to increase the number of patient and carer experience related projects through a PACE improvement group
- Establish and adopt sustained divisional led patient safety breakthrough series collaboratives on safety & patient experience issues.
- Establish sustained quarterly QI masterclasses

- Commence a contract with a single improvement partner in 2023 to enable a single standardised methodology and training for a quality management system. Training will be embedded at all levels of the organisation from induction.



Plans for 2023/24

Nursing Excellence

- Launch new ward accreditation framework to support ongoing improved care quality with the development of unique metrics for paediatrics, neonatal and outpatients.
- Develop and establish nursing and midwifery audits on the Trust's electronic monitoring platform
- Agree an executive sponsor for the work being done around the set up and delivery of a shared decision-making council aimed at co-production and partnership working
- Pathway to Excellence mid-year monitoring report to maintain Pathway designation and annual review of organisational cultural survey gap analysis to sustain excellence.
- Continue with DAISY Foundation recognition scheme for nurses and midwives with support from ENHT Charity.

2.2.2

Quality Domain: SAFE **Priority 2: Keeping our patients safe**	**Partially Achieved**
Reason: Part of our quality goals within the Trust's Quality strategy- valuing the basics & keeping our patients safe (2019-2024) Sepsis can be triggered by any infection, but commonly occurs in response to bacterial infections of the lungs, urinary tract, abdominal organs or skin and soft tissues. If caught early, patient outcomes are excellent. Left unchecked, patients are likely to spiral to multi-organ failure, septic shock and die. It is estimated that, every year, sepsis costs the NHS £2 billion and claims the lives of at least 52,000 people. Medicines Management is a system of processes and behaviours that support, determine and guide how medicines are used within an acute setting and by patients. Safer invasive procedures standards are designed to reduce misunderstandings or errors and to improve team cohesion. The standards, written by clinicians from multiple professions and specialties, re-launches the WHO checklist. It mandates key stop moments when the standard pathway is confirmed, and patient-specific details clarified. The Deteriorating patient is a patient that moves from one clinical state to a worse clinical state, increasing their risk of disease, organ failure, prolonged hospital stay or death. Safeguarding adults and children remains an integral priority of patient care within the Trust, the Trust continues to undertake its 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). 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 (as the executive lead for safeguarding) are key members of the Hertfordshire safeguarding boards and partnerships. 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,	**Our Priority for 2022/23 has been to work towards achieving:** Sepsis • Achieve >95% in sepsis pathway compliance Medication management • Achieving <4% in omissions of critical medications • Achieving >90% in antimicrobial stewardship • Implement & launch an electronic prescribing/administration system with the functionality of generating digital reports Safer invasive procedures standards • Establish LocSSIPS for 80% of invasive procedures Deteriorating patients • Achieve <0.8% in rate of cardiac arrests • >90% compliance with timely observations through audits • Launch & measure escalation module and develop a means of monitoring the escalations Safeguarding Adults & Children • Achieve 25% reduction in the number of incidents of harm to individuals with a Learning Disability VTE risk assessments • Achieve >95% improved compliance with VTE risk assessment part 1 and part 2

personal or familial history of VTE, cancer, or obesity. 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	

Achievements to date

1. **Sepsis pathway Compliance**

	Aim	Achieved
Antibiotics in ED within an hour	> 95%	87%
Antibiotics on the ward within an hour	> 95%	90%
Neutropenic sepsis antibiotic within an hour	> 95%	80%
ED Sepsis six bundle	>95%	78%
IP Sepsis six bundle	>95%	64%

Overall Sepsis pathway compliance performance of 79.8% achieved despite high operational pressures on services and staffing challenges (high turnover). Our key focus in 2022 was optimising sepsis education (formal, informal & simulation sessions) throughout the trust for our clinical, pharmacist and CSW teams, as well being clinically visible in the emergency department, critical care and inpatient areas.

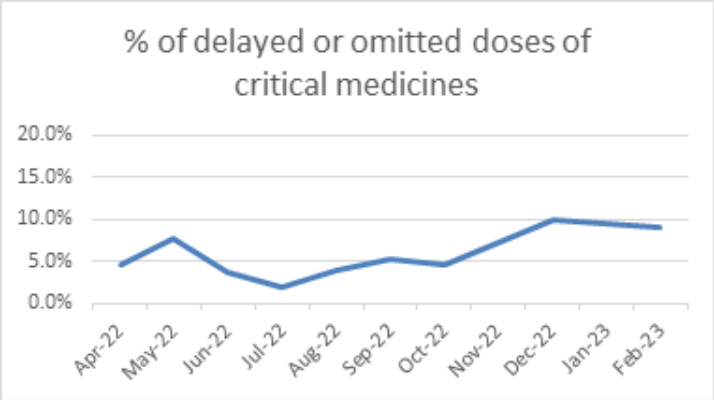
The highest recorded compliance in 2022/23 is seen between August- November 2022 at >80%- an improved position compared to same period last year. However, looking at the year, trends in sustained improvements is noted towards the second half of the year compared to compliance from April-September 2022. Sustained compliance in IV antibiotic compliance of above 80% was achieved from September 2022 to March 2023.

2. **Medication Management**

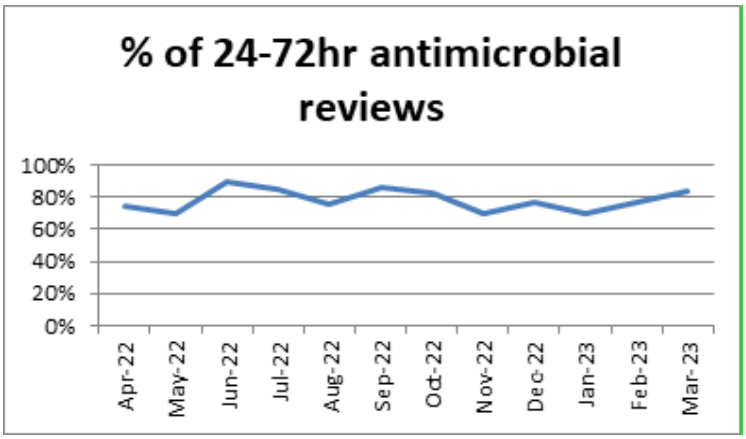
Over the last year the pharmacy department has focused on embedding electronic Prescribing Medicines Administration (ePMA) system into clinical practice. As an outcome of this, we have revamped our medicinal products policy with a new Medicines Management policy in place that details how medicines will be managed safely and effectively across the Trust. In addition, we have also reviewed our standard operating procedures for controlled drugs focusing on fundamental standards such as reducing the number of delayed and omitted doses of critical medicines, venous thromboembolism (VTE) prevention and antimicrobial stewardship (AMS).
Achievements to date:

	Target	Achieved 2022/23
Omitted and delayed doses of critical medicines	<3.5%	5.6%
Antimicrobial stewardship, 24–72-hour review	>90%	78%
Trusts medicines optimisation strategy	Stakeholder management in progress	Draft written
ePMA	Embed into all clinical processes	Achieved
Trust's Medicines Management training	Launch	Achieved - 55% compliance/ March 2023

Critical Medicines: The aim for the Trust is to achieve <3.5% omissions of critical medications that should not be missed or given late. A critical medicines audit is conducted across the Trust on a bimonthly basis. During 2022/2023 the Trust achieved an average of 5.6%. In July 2022 the Trust achieved 2.0% but this has increased since July due to unintentional impact relating to operational pressures.



Antimicrobial stewardship (AMS): This a co-ordinated 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.
We achieved our 90% target in June 2022, following which there was a slight fall in performance, which picked up again in March. We will continue to aim to achieve sustained >90% compliance with good governance and antibiotic stewardship focusing on targeted education and training towards AMS.



Medicines Optimisation: The current medicines optimisation strategy was developed using the NHS improvement, hospital pharmacy and medicines optimisation assessment framework.
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).
Areas of progress this year have included:

- The Medicines Management Policy is regularly audited across the Trust; quarterly controlled drugs audits are performed by pharmacy; unlicensed drugs audits and safe and secure medicines 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 reports and action plans on Medication Safety and Security from the Pharmacy walk arounds.
- Therapeutics Policy Committee and New Drugs and Formulary Group biannual report was presented to the Clinical Effectiveness Committee in January 2023
- Trust wide medicines management training was launched and to date 55% of all doctors, nurses and pharmacists have completed the online training.

A new medicines optimisation strategy is in development and a draft has been written.

3. Deteriorating patients

A key priority within the Trust remains the timeliness of patient observations and improving escalation of the deteriorating patient.
The Trust had sustained a below national average cardiac arrest rate of 0.9 per 1000 admissions (national average= 1.0 per 1000 admissions).
We have also achieved our aim of launching an escalation module with allows for appropriate monitoring. As part of our CQUIN focused project, we achieved a 98% compliance in the timeliness of responses to the deteriorating patients. However, targeted continuous improvement work is required to ensure the reliability and timeliness of observations. To support this, we have relaunched NEWS2 training as an e-learning module. This training is considered as role-essential for relevant clinicians including our pharmacy staff and AHPs and allows us to monitor compliance very quickly through our Academy e-learning system. In addition, a review of our procurement and repair processes, standardised training around the BEACH The Bedside Emergency Assessment Course for Healthcare Staff (BEACH) and targeted improvement work in using digital equipment are ongoing projects to improve compliance.

A pilot of targeted improvement work has been started within our Renal wards, supporting our medical staff in the use of digital equipment to respond to escalations concerning their cohort of patients. This work is being led by the doctors using quality improvement methodology and involves Junior doctors creating and delivering training to support the promote the benefits of our digital EPR system. This work is being run alongside nursing staff who are responsible for escalations and improving training on when it is appropriate to escalate patients

4. Safeguarding Adults and Children

Significant progress has been made in the redesign of our maternity safeguarding processes in Q3 & Q4 which was supported by the development and launch of enhancements to the Trust's electronic patient records systems (EPR). Improvements made are seen in more efficient systems for logging and alerting staff teams to safeguarding risks relating to specific vulnerable service users and real time communication case management instructions to patient facing multidisciplinary teams whose impact is seen in staff in learning and debriefing exercises relating to safeguarding incidents.
Safeguarding caseload activity in the Trust remained above pre-covid levels during 2022/23 however there has been a slight decrease in activity when compared to 2021/22 which is in keeping with reported activity nationally.

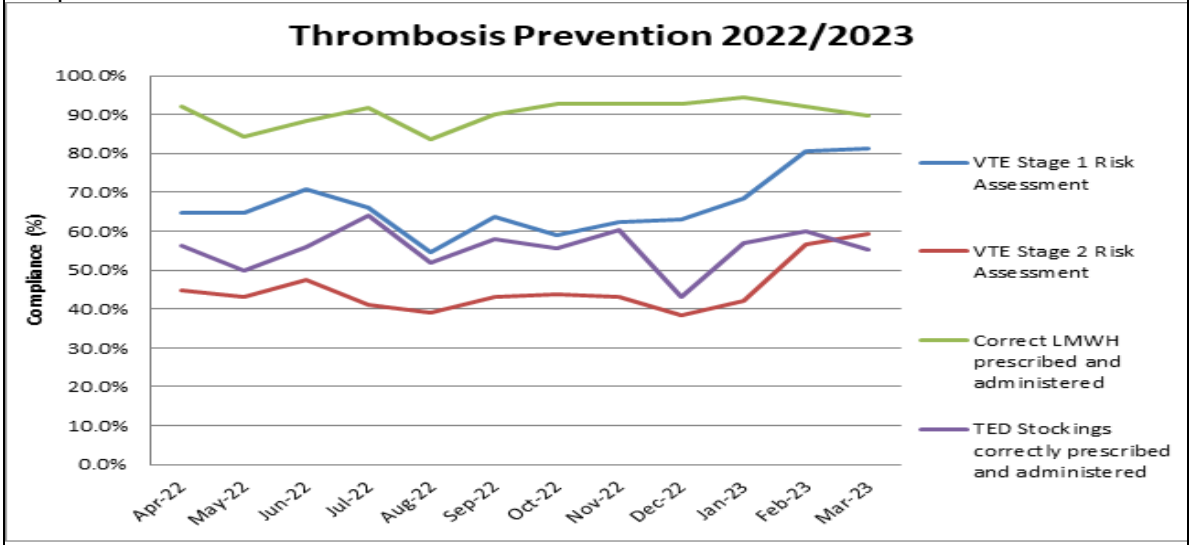
In January 2023, we successfully recruited a children's independent sexual violence advisor to support and align our work with patients under the age of 18.

The Trust continues to demonstrate on-going commitment to safeguarding training ensuring all staff receive the required levels of training under the guidance set out in the intercollegiate documents for children and adults.

5. Venous Thromboembolism (VTE) risk assessments

In January 2023, the Trust successfully transitioned to a digital reporting system- NerveCentre- that allows for better and robust data capture, better oversight and real time feedback at ward, speciality, and consultant level. This however led to a decline in risk assessment completion.

The Trust continues to audit its VTE risk assessments at biweekly intervals to capture compliance.



We have achieved a sustained 85% compliance in prescribing and administering the correct low molecular weight heparin (LMWH). In comparism to the same period in 2021/22, stage 1 VTE risk assessment compliance improved from 68.4% in January to 81.4% in March, stage 2 VTE compliance increased from 42.0% to 59.4% respectively.

The Trust utilises learning themes from Root Cause Analysis (RCA) investigations of potential hospital associated thrombosis (HAT) cases identified to ensure quality areas around accurate documentation, management of bridging therapy, inaccurate doses of anticoagulation is captured and used in training/learning sessions to embed understanding, establish any potential harm and identify subsequent learning. This has led to a reduction in the number of outstanding HAT RCAs across the Trust.
We have successfully appointed a VTE lead practitioner, reviewed, updated and relaunched our VTE policy as well as incorporated VTE training as an essential training programme for all relevant staff teams. 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%

Plan for 2023/24

Sepsis pathway compliance

- Digitalisation of the sepsis six proforma. To be used throughout the trust for ED and inpatient care episodes.
- Work alongside the paediatric team to optimise sepsis education and compliance in both paediatric inpatients and ED patients.

- Regular sepsis and Joint Modelling of Clinical and Biomarker Data in Acute Kidney Injury (AKI) joint simulation to further educate and collaborate with all MDT members, to include clinical nurses, doctors, pharmacists, Care Support Worker (CSW's) and more.
- Digital fluid balance to be used in the emergency department.
- Collaborate with oncology CNS to educate and improve performance surrounding neutropenic sepsis.
- Continuous improvement of all aspects of sepsis recognition and compliance in the ED and inpatient areas.
- Continued sepsis sessions in both CSW's and nurse trust introductions alongside BEACH sessions for CSW's.

Medication Management

- Finalise and launch the new Medicines Optimisation Strategy inline with the national Patient safety Strategy and the local implementation of Patient Safety Incident Response Framework (PSIRF).
- Review the pharmacy and medicines management KPI dashboard in terms of reporting, targets and presentation
- Work towards ePMA benefits realisation
- 90% of relevant staff to complete essential medicines management training
- 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 2023/24.
- 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.
- Review discharge medicines incidents and support the Trusts work on improving discharge processes.
- Roll out and embed a nationally recognised tool for deprescribing across all frailty/elderly care and orthogeriatric wards, plus update Trust pharmacist enabling policy to empower pharmacist non-prescribers to de-prescribe using an approved set of criteria.
- Work with system-partners to deliver an ICS-wide covid medicines delivery unit (CMDU) that provides covid medicines to vulnerable patients in a way that promotes equality across our population of patients.
- Implement a 'green' approach to the implementation and switching of inhalers within respiratory inpatients/outpatients that reduces the Trust's carbon footprint for inhaler prescribing and supplements the Trust's sustainability agenda.

Deteriorating patients

- Continued focus on ensuring we meet our targets of compliance with 50% reliability of all observations
- Align improvement work aimed at supporting Physiological Observation Assessment Competencies with our Nursing staff (registered and non-registered) to NEWS2 training
- Establish our work in the review of reliability of escalation data to ensure the data collected and reported is reliable. This is to include the roll out of improved patient status at a glance (PSAAG) dashboards on all our wards

Safeguarding Adults and Children

- Increased focus on Trust wide safeguarding education with the development of an electronic validation system for level 3 safeguarding adults training aimed at ensuring

compliance data is accurately recorded.

- Recruitment of a lead nurse for learning disabilities in Q1 to support training programmes to achieve learning disability care standards & learning from LeDeR reviews are incorporated into practice. This will work to address unwarranted variation and address Equality diversity and inclusion issues that cohorts with multiple disadvantage face.
- Establish & launch appropriate infrastructure to support transition into the role of a responsible body in line with liberty protection safeguard code of practice.
- We would give focus to developing effective methods in 'sharing the learning' gleaned from incidents/outcomes.

VTE assessments

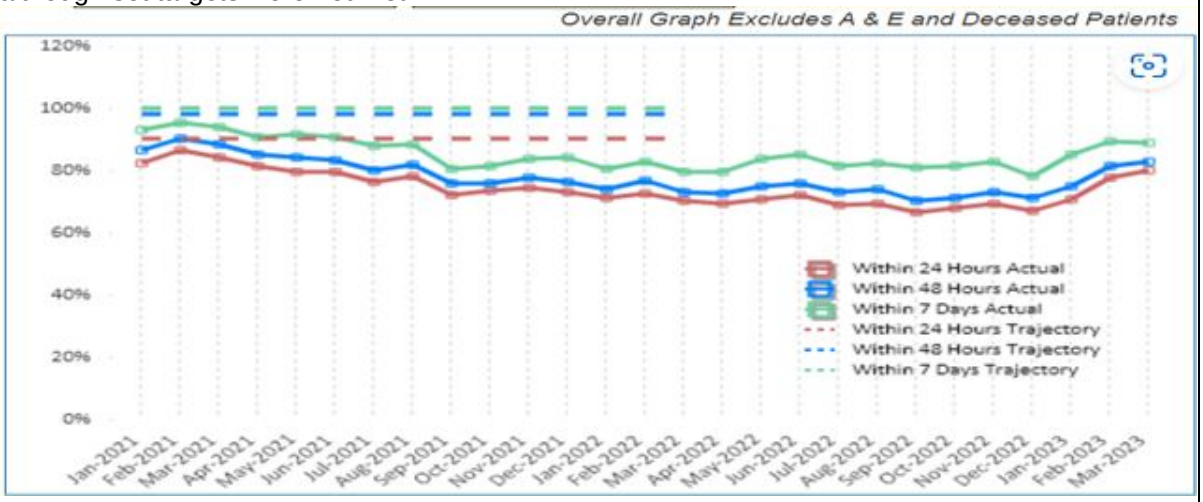
- >95% of patients requiring a stage 1 and 2 VTE assessments by March 2024
- Embed digital risk assessment platform into clinical practice. For instance, utilisation of VTE status on NerveCentre dashboard as a prompt for assessment completion.
- Continue to review, assess and improve VTE digital assessment for ease of service-user. Continue to improve patient engagement and review VTE patient information.
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.

2.2.3

Quality Domain: PATIENT EXPERIENCE	**Partially Achieved**
Priority 3: Respect our patient's time through improving flow through inpatient and outpatient services	
Reason: Further improvements required to embed and sustain progress made**.**	**Our Priority for 2022/23 has been to work towards achieving:** • Stabilising, improving & reducing the number of discharge summaries not sent to the GP within 24hours of discharge • Improve midday patient discharge by >15% • Reduce by <19% the proportion of beds occupied with length of stay >14 days • Improve delivery of 7-day services • Reduce delays by >90% for ED 4 hour waiting times.

Achievements to date

Discharge summaries:
The Trust established a series of interventions (electronically assessed training modules for staff involved in hospital discharge, standardising discharge templates & removing barriers within the discharge pathway) aimed at improving its performance. Some improvements have been noted although set targets were not met.



Mid-day discharges:
On average, the Trust achieved 15.8% of midday discharges-a slight increase in comparable position from the last two years, and back to pre-pandemic levels.

Month	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
% of discharge before midday	15.0%	13.8%	15.8%	17.0%	15.5%	16.0%	16.2%	15.9%	15.8%	16.6%	15.5%	16.3%

Reduce proportion of beds occupied with length of stay >14 days
Length of stay reviews occur weekly within divisions for every patient with a LOS of over 14 days.

The Trust continues to work with community partners to safely expedite patient discharge in a timely way, as well as plans and actions developed to manage at ward level.
On average 24.12 % of beds were occupied by patients where the length of stay was more than 14 days: an increase of 3.6% from last year.

Month	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Proportion of beds occupied by patients with length of stay over **14 days**	25.03 %	25.67 %	25.82 %	21.85 %	22.99 %	24.42 %	23.37 %	23.24 %	23.75 %	24.39 %	23.96 %	24.88 %
Proportion of beds occupied by patients with length of stay over **21 days**	14.52 %	15.51 %	15.11 %	11.57 %	12.14 %	14.31 %	13.20 %	13.40 %	13.93 %	12.94 %	13.83 %	14.51 %

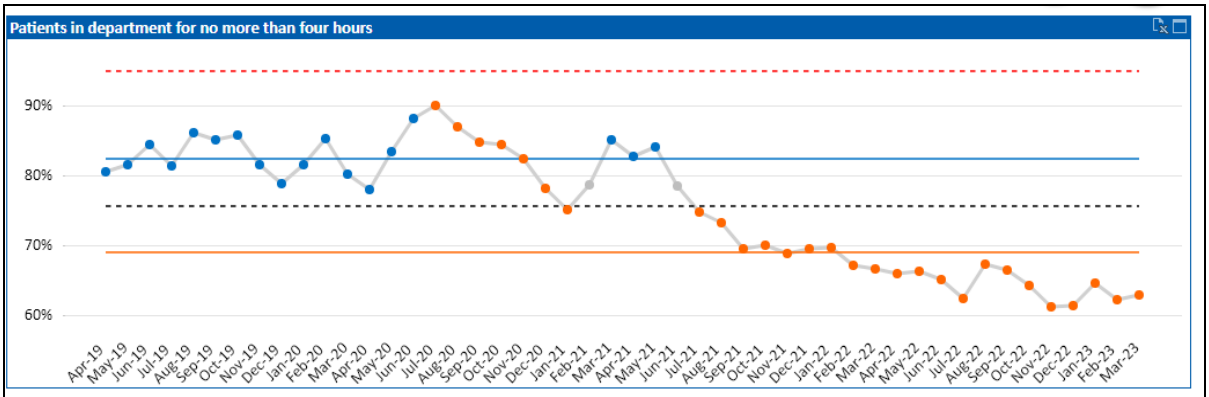
ENHT has also successfully established a new board and ward round standard operating procedure aimed at supporting timely discharges as well as developing a criteria led discharge competency framework (CLD).

Reduce delays by >90% for ED 4 hour waiting times
In 2022/2023 we welcomed 180,583 patient attendances to our emergency departments; we cared for 50,412 inpatients and saw 590,794 patients in our outpatient settings. The target is for 95% of patients seen, treated and either admitted or discharged within four hours of arrival.

The focus in 2022 / 2023 has been to return to business as usual following the covid pandemic and work towards the achievement of elective and non-elective target performance.
This includes the development of and delivery against the elective recovery plan, including eradication of patient waits over 104 weeks from referral to treatment. The Trust delivered on time against this metric. There was also a target of eradicating patient waits over 78 weeks by March 2023; this was achieved in all bar three specialties: trauma and orthopaedics, gastroenterology and community paediatrics.

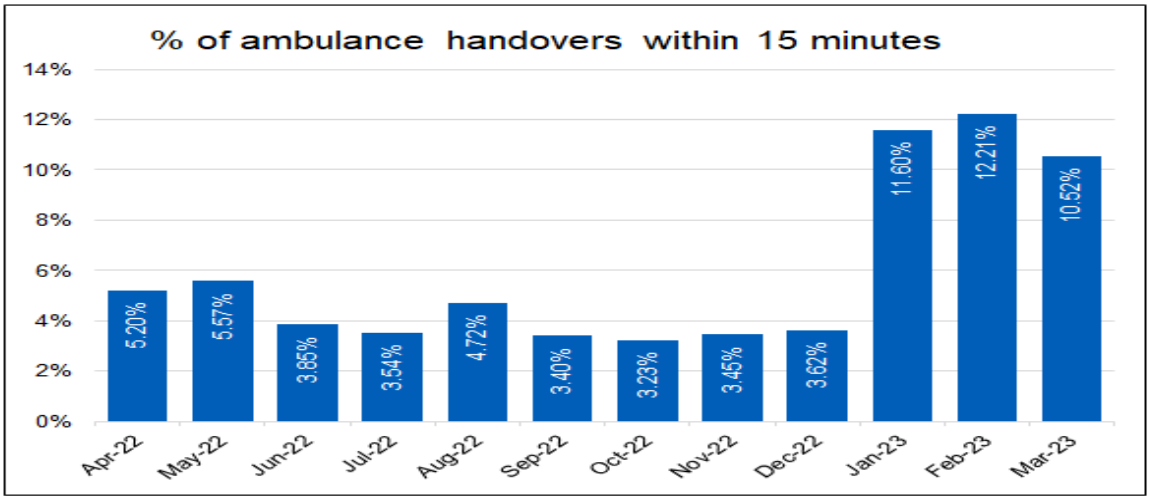
The Trust has made progress with implementing its Patient initiated follow up (PIFU) programme and this continues to be rolled out throughout the Trust. 12 specialities are now using PIFU, and 8 additional specialities went live in April 2023. The Trust continues to work towards its target for all specialities roll out.

The Trust has continued to underperform against the four-hour wait time target from arrival to the Emergency Department to being admitted, discharged, or transferred. The end of year position saw the Trust achieving 64.2%. The target for 2023/2024 is set at 76% so the Trust has already started a series of actions to work towards achieving and exceeding this to get back towards performance of 95%.
During 2022 the Trust undertook major capital work within its emergency department, both adult and paediatric and the Same Day Emergency Care (SDEC) department. This work while underway prevented expansion of alternative pathways, direct access by GP and ambulances to assessment space and adequate flow of patients to meet their needs and achieve the targets. Better space is now open and will support improved performance
This is a key Trust objective in 2023/2024 and will remain a focus for the board.



The Trust through comprehensive planning ensured that the department was safely managed during the March 2023 non consultant medical staff industrial action.
However, there has been a real and sustained improvement in ambulance handover times due to focus of executives, the emergency department, inpatient wards and improved system working.

With the completion of the capital build of the ambulance handover area and the focus on patient offloads and turnaround of ambulances, there was a marked improvement in the performance in the last quarter of the year. This was also supported with the 'pull for safety' model which sees Assessment pulling suitable patients from the emergency department to enable both self-presenting patients as well as ambulance arrivals to be seen more promptly. This work will continue to ensure improvements are sustained. The work with system partners is essential to improve the emergency department pathways including prevention of admission, call before convey which enables ambulance crews to call for advice before transporting the patient to the emergency department, direct referrals to SDEC and emergency clinics.



Plan for 2023/24

Discharge summaries:

- Continued focus on recent and historical 24hr/7 days discharge summary compliance.

ED 4 hour waiting times

- Continued focus on improving ED 4 hour waiting times
- Establishment of a surgical assessment unit and new patient pathways will be a focus for 2023/2024.

2.2.4.

Quality Domain: PATIENT EXPERIENCE	**Partially Achieved**
Priority 3: Respect our patient's time through improving the flow through inpatient and outpatient services	
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	**Our Priority for 2022/23 has been to work towards achieving:** • Maintain Friends and Family test scores (average) for inpatients by >95%, out-patients by >95%, maternity (birth) by >93% and emergency department by >90% • Increase PALS responsiveness by 80% (closed within 5 days) • Design and support patient co-design within planning, design and testing phases of quality improvement initiatives. • Measuring the themes of the What Matters To You (WMTY) conversations

Achievements to date

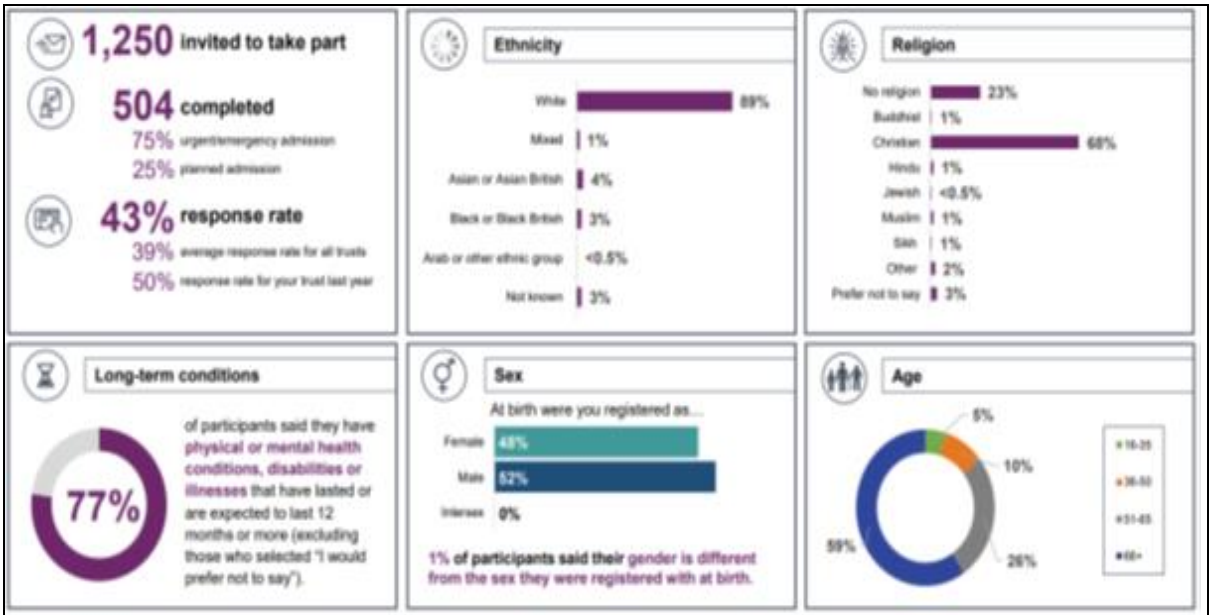
Friends and Family Test Scores:
We have continued to have sustained performance in all categories of our Friends and Family test scores with positive feedback received. Through developing and implementing specific initiatives based on themes from the previous year's FFT survey, utilising feedback data and reviewing other sources of patient feedback we have been able to determine where key focus can be given to improve our position.

Theme	20/21	21/22	22/23
Patient feedback	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 96.37 OP 96.09 Mat 96.25 ED 88.10

The Trust considers that this data is as described, as it is based on data submitted directly by patients to the national surveys programme.

We have successfully relaunched our carer forums aimed at providing support to carers. Two carer forums were held one face to face during the day and one virtually in an evening, ensuring that all who wanted to have their voices heard had the opportunity to do so. Since these meetings we have been working hard towards revising our Trust Wide Carers Policy and are currently setting up a quarterly forum to ensure that the objectives are being met and challenged where needs be. A dedicated carer email address and voicemail has been established.

The Trust had an overall 43% response rate, which is better than the average response rate for all Trusts at 39%. However, this is a decline on last year's response rate, which was 50%.
Overall, the Trust scored about the same, reporting a similar performance to most other Trusts that took part in the survey. Out of the 47 questions, 45 were scored about the same (96%), 1 was scored better than expected (2%), and 1 was scored worse than expected (2%).



Increase PALS responsiveness by 80% (closed within 5 days)
Overall response timeframe within 5 days for PALS in 2022/23 was 56%. There is a 21 day turn around on PALS concerns and this has been in place since the start of 2022. We have established a Trust wide complaints and PALs transformation workstream who continue to work towards reducing the timeframe of responses where possible.

Plan for 2023/24

- Develop and implement an electronic system for the capture of identified carers
- Set up a quarterly carers forum to ensure that the objectives are being met and challenged

2.2 Quality Priorities for Improvement 2023- 2024

Introduction to 2023/24 quality priorities

East and North Hertfordshire NHS Trust Board recognises that the foundation to excellent care delivery lies in the skill, enthusiasm and innovation our staff teams bring to their individual roles. This means that we will now actively seek to build on this and achieve an organisational culture that empowers our staff to take the initiative, deliver high quality care guided by the care fundamentals and therefore make lasting changes that benefit patients accessing our services and the community at large.

Our five-year quality strategy (2019-2024) defines our quality statement, which is Safe, timely, effective and personable and is aimed at leading a long-term approach to transforming the way we deliver our services for the better.
We will continue to focus on our strategic themes of Quality (by consistently delivering quality standards, targeting health inequalities and involving patients in their care), Thriving people(support our staff to thrive by recruiting & retaining the best), seamless service delivery (through effective collaboration and coordination of services within the Trust and with our partners) and Continuous improvement(through continuously improving services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities).

Quality Priorities 2023 to 2024			
Domain	**Description**	**Key Focus Areas**	**How we measure Success**
Effective	Good Governance • Excellent responsiveness to incidents • Learning from incidents • CCQ • Informatics & Reporting • GIRFT/NICE • Compliance Framework • Efficient, simple reporting structures.	Reduce unwarranted variation	Launch Quality Assurance Framework ENHT by May 2023 Newly created divisions to be supported to develop effective governance structures. The basic governance structures should be broadly similar from one division to the next by May 2023 Mapping organisational reporting – supported by standardised templates and information (score cards, IPR, fundamentals, NQI) by May 2023 In partnership with X4 established business units (and learning externally) review and standardise structures to manage quality by April 2023, publish ENHT proposed structure by June 2023. Review and rationalise structure of management meetings below trust management group, and sub board structures
		CQC Fundamentals	Map service level regulatory requirements work plans Measure & monitor service level reliability across CQC fundamentals from April 2023, across all services by March 2024

		Oversight of Quality	Scale and Spread ENHance quality oversight platform by Sept 2023 Improve systematic approach to quality oversight
		Good Governance	Build capability Implement PSIRF by September 2023 Improve Risk management processes
Safe	Valuing the Basics: Keeping our patients safe	Harm Free Care Programme Medicines Management Medical Devices Infection Prevention Control (IPC) Safeguarding Documentation	Continue to scale and improve oversight of clinical risk in system Quality Fundamental improvement programme Medical devices management Safe medication management – at discharge Safeguarding processes and training Increase co-design patient partners

Safe	Keeping our patients safe	Adult & paediatric deteriorating patients (including sepsis) End of Life Care Invasive procedures LocSSIP compliance Discharge transformation programme.	Re-design systems and processes around escalation of the deteriorating patient (including current repose team structures and hospital at night) Scale and spread the recognition and management of sepsis Refresh digital capture of reliability of 1hrly/4hrly observations and escalation policy, process and human factors Scale in-situ simulation across learning form incidents, started April 2023 Scale EOL improvements through spread of Gold Standard framework – data scale and spread plans in progress Improve quality assurance oversight of LocSSIP compliance at speciality level Design and imbed ENHT PSIRF plan, co-designed with patients
Patient Experience		PACE Programme What Matters to You programme Responsiveness to Complaints Patient Safety Partners	Reduce barriers to timely responses of complaints and PALS concerns Design methods and processes to have routine oversight of 'WMTY' for patients at local Establish and support the imbedding of patient safety partners Imbed and improve the trust carer's framework Ensure robust triangulation across

			patient experience data through PSIRF family liaison function (especially following a death) Patient centred approach through improvement partnership design
Well Led	Develop Staff Capability	Digital Strategy Staff Survey Pathways to Excellence Clinical Leadership programmes Here to Improve Freedom to Speak up People Strategy Patient Safety curriculum (NHSE/I)	Deploy robust trust wide support and end user skills through transition to Quality Oversight platform 'ENHance' Support the delivery of key 'quality management skills' Risk management Good Governance principles Quality Improvement Clinical Leadership (cohort 3 RCN) PSIRF Design ENHT restorative approach to errors Deploy ENHT Freedom to speak up Strategy Improvement partnership plan

2.3 Statements of Assurance from the Board

Review of services

During 2022/23, the East and North Hertfordshire NHS Trust (ENHT) provided and/or subcontracted 27 relevant health services. ENHT has reviewed all the data available 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 2022/2023 65 national clinical audits and 8 national confidential enquiries covered NHS services that East and North Hertfordshire NHS Trust provides.

During that period East and North Hertfordshire NHS Trust participated in 100% national clinical audits and 95% national confidential enquiries of the clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows National Clinical Audits and National Confidential Enquiries that East and North Hertfordshire NHS Trust was eligible to participate in during 2022/2023

National Clinical Audits	**Participated**	**Numbers submitted** (by % or total number)
Breast and Cosmetic Implant Registry	Yes	Continuous data collection
Case Mix Programme (CMP)	Yes	Continuous data collection
Elective Surgery (National PROMs Programme)	No	
Emergency Medicine QIPs – Assessing for cognitive impairment in older people (changed to care of older people (COP)	No	Audit provider delayed start date until April 23
Emergency Medicine QIPs – Pain in children	Yes	16
Emergency Medicine QIPs - Mental Health self-harm	Yes	In progress
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Yes	Continuous data collection
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	Yes	Continuous data collection
Inflammatory Bowel Disease Audit	Yes	Continuous data collection
LeDeR - learning from lives & deaths of people with a learning disability and autistic people	Yes	Continuous data collection

Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE) (Previously listed under Urology Audits)	Yes	3
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 Safety Audit (NDISA) Previously 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 Secondary Care	Yes	Continuous data collection
National Asthma and COPD Audit Programme (NACAP) - Paediatric Asthma Secondary Care	Yes	Continuous data collection
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Continuous data collection
National Audit of Cardiac Rehabilitation	Yes	Continuous data collection
National Audit of Care at the End of Life (NACEL)	Yes	50 Case note reviews 2 Staff Surveys, 15 Quality Surveys
National Audit of Dementia - Care in general hospitals	Yes	100%
National Cardiac Arrest Audit (NCAP)	Yes	Continuous data collection
National Cardiac Arrest Audit (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	Yes	Continuous data collection
National Cardiac Arrest Audit (NCAP) - National Audit of Cardiac Rhythm Management (CRM)	Yes	Continuous data collection
National Cardiac Arrest Audit (NCAP)- National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Yes	Continuous data collection
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	Yes	Continuous data collection
National Child Mortality Database (NCMD)	Yes	Continuous data collection
National Early Inflammatory Arthritis Audit	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 - Primary Hip Replacement	Yes	Continuous data collection
National Joint Registry - Primary Knee Replacement	Yes	Continuous data collection
National Joint Registry - Primary Shoulder Replacement	Yes	Continuous data collection
National Joint Registry - Revision Ankle Replacement	Yes	Continuous data collection
National Joint Registry - Revision Elbow Replacement	Yes	Continuous data collection
National Joint Registry - Revision Hip Replacement	Yes	Continuous data collection
National Joint Registry - Revision Knee Replacement	Yes	Continuous data collection
National Joint Registry - Revision Shoulder Replacement	Yes	Continuous data collection
National Joint Registry -Primary Ankle Replacement	Yes	Continuous data collection
National Joint Registry- Primary Elbow Replacement	Yes	Continuous data collection
National Lung Cancer Audit	Yes	Continuous data collection
National Maternity and Perinatal Audit (NMPA)	Yes	Continuous data collection
National Neonatal Audit Programme (NNAP) -	Yes	Automatic data collection
National Obesity Audit	Yes	100%
National Ophthalmology Database Audit (NOD) - Adult Cataract Surgery Audit	No	
National Paediatric Diabetes Audit	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
Perioperative Quality Improvement Programme (PQIP)	Yes	Continuous data collection
Renal Audits - National Acute Kidney Injury Audit	Yes	Continuous data collection
Renal Audits - UK Renal Registry Chronic Kidney Disease Audit	Yes	Continuous data collection
Respiratory Audits - Adult Respiratory Support Audit	Yes	TBC
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 (SAMBA)	Yes	TBC
Trauma Audit & Research Network (TARN)	Yes	Continuous data collection
UK Parkinson's Audit	Yes	100%

The table below shows the National Clinical Audits and National Confidential Enquiries that East and North Hertfordshire NHS Trust participated in, and for which data collection was completed during 2022/2023, 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 Confidential Enquiries	Participated	% Cases submitted
Child Health Clinical Outcome Review Programme - Testicular torsion	Yes	100%
Child Health Clinical Outcome Review Programme - Transition from child to adult health services (NCEPOD)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance and confidential enquiry - Continuous data collection	Yes	TBC
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal confidential enquiries - Continuous data collection	Yes	TBC
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality surveillance - Continuous data collection	Yes	TBC
Medical and Surgical Clinical Outcome Review Programme - Community acquired pneumonia (NCEPOD)	Yes	100%
Medical and Surgical Clinical Outcome Review Programme - Crohns disease (NCEPOD)	Yes	100%
Medical and Surgical Clinical Outcome Review Programme - Endometriosis (NCEPOD)	Yes	TBC

National Audits

The reports of 19 national clinical audits were reviewed by the provider in 2022/2023 and East and North Hertfordshire Trust intends to take the following actions (Appendix A) to improve the quality of healthcare provided.

National audits
Each Baby Counts 2020 Final Progress Report for 2018 data (16389)
IBD Registry 2018/19 Annual Report - Annual Report on the Use of Biologics for Inflammatory Bowel Disease (Published October 2019) (15805)
MBRRACE: Saving lives, improving mothers' care report. Maternal, Newborn and Infant Clinical Outcome Review Programme, (MNI-CORP) (16392)
NACAP Adult Asthma Clinical Audit Report 2019/20 (16172 Clin) (Audit period April 2019 to March 2020)
National Audit of Care at the End of Life (NACEL): Third round of the audit (2021/22) report (also includes Mental health spotlight audit summary report 2021/22) 17397
National Audit of Inpatients Falls (NAIF) Annual Report 2022 (2021 clinical & 2022 facilities data) (17307)
National Diabetes Footcare Audit NDFA Interval Review: July 2014-March 2021 (17384)
National Emergency Laparotomy Audit (December 2019 to November 2020) (published in November, 2021)- Seventh Patient Report (16790)
National Hip Fracture Database Report 2022. Improving understanding. Based on data between 2020 and 2021 (17308)
National Maternity and Perinatal Audit Clinical Audit Report 2022, Based on births in NHS Maternity services in England and Wales between 1 April 2018 and 31 March 2019 (17430Clin)
National Paediatric Diabetes Audit (NPDA) Report (16806) 2020/2021 data.
National Pregnancy in Diabetes (NPID) Audit Report 2020, England & Wales 16807) (Published 14th October 2021)
National Prostate Cancer Audit (NPCA) Annual report 2022 (17455)
NCEPOD - Inspiring Change: A review of the quality of care provided to patients receiving acute non-invasive ventilation (9341)
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)
NNAP - National Neonatal Audit Programme 2022 - For 2020 data (16804)
Sentinel Stroke National Audit Programme Annual Report Report 2020/21 (16890)
Sentinel Stroke National Audit Programme Post-acute Organisational Audit Report Sentinel Stroke National Audit Programme (SSNAP) (16890(org))
Serious Hazards of Transfusions Annual SHOT Report 2018 (16893)

Below are the 19 national clinical audit reports reviewed by East and North Hertfordshire Trust in 2022/2023 with details of the actions identified to improve the quality of the healthcare provided.

National audit	Results and Key improvement actions agreed
Each Baby Counts 2020 Final Progress Report for 2018 data (16389)	The 1 recommendation included was identified as not relevant to East & North Hertfordshire Trust as it does not relate to individual Trusts and relates to the Royal College of Obstetricians and Gynaecologists. In addition, the recommendation has been superceded by the Ockenden

	22 report.
IBD Registry 2018/19 Annual Report - Annual Report on the Use of Biologics for Inflammatory Bowel Disease (Published October 2019) (15805)	4 of the 11 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these no concerns or actions were identified or required.
MBRRACE: Saving lives, improving mothers' care report. Maternal, Newborn and Infant Clinical Outcome Review Programme, (MNI-CORP) (16392)	18 of the 23 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these the following actions were identified to improve compliance with 7 of the recommendations. • Patients attending general antenatal clinics to be referred back to GP for early review to determine If discontinued psychotropic medication should recommence • Obstetric lead to review 5 recommendations and identify any updates to current guidelines required • Review the current preconception counselling available with a view to broaden the range of medical specialist available for patients with pre-existing medical conditions
NACAP Adult Asthma Clinical Audit Report 2019/20 (16172 Clin) (Audit period April 2019 to March 2020)	All 3 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these the following actions were identified to improve compliance with these recommendations. • Education and training of staff to improve the % of patients assessed for asthma severity and administration of systemic steroids • Designing an electronic proforma to act as a checklist.
National Audit of Inpatients Falls (NAIF) Annual Report 2022 (2021 clinical & 2022 facilities data) (17307)	All 7 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. On review no concerns or actions were identified or required.
National Diabetes Footcare Audit NDFA Interval Review: July 2014-March 2021 (17384)	The 2 recommendations for healthcare providers and healthcare professionals included within the report were identified as being relevant to the East & North Hertfordshire service. On review no concerns or actions were identified or required.
National Emergency Laparotomy Audit (December 2019 to November 2020) (published in November, 2021)- Seventh Patient Report (16790)	All 9 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these the following actions were identified to improve compliance with 3 of the recommendations. • To appoint a replacement Radiology NELA lead • To promote the limited number of negative laparotomies identified from the negative laparotomies audit • Design and implement plan to incorporate Emergency Department teams in the emergency laparotomy pathway

National Hip Fracture Database Report 2022. Improving understanding. Based on data between 2020 and 2021 (17308)	All 11 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. On review no concerns or actions were identified or required.
National Maternity and Perinatal Audit Clinical Audit Report 2022, Based on births in NHS Maternity services in England and Wales between 1 April 2018 and 31 March 2019 (17430Clin)	All 7 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these the following actions were identified to improve compliance with 3 recommendations. • To discuss the implementation of IDECIDE tool to improve the availability and quality of individualised evidence-based information shared
National Paediatric Diabetes Audit (NPDA) Report (16806) 2020/2021 data.	8 of the 9 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these the following actions were identified to improve compliance with 2 of the recommendations. • To seek funding to recruit an additional 0.5 WTE psychologist to improve access to psychological support • Continue discussions with ICS re-funding to enable availability of continuous glucose monitoring and education for patients
National Pregnancy in Diabetes (NPID) Audit Report 2020, England & Wales 16807) (Published 14th October 2021)	All 3 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these the following action was identified to improve compliance with 1 recommendation. • Need to make referrals into National Diabetes Prevention Programme.
National Prostate Cancer Audit (NPCA) Annual report 2022 (17455)	All 22 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these the following action was identified to improve compliance with 1 recommendation. • Consider and seek funding to increase establishment eg a data manager for RALPs to get this information and run continuing PROMS as part of post treatment follow-up.
NCEPOD - Inspiring Change: A review of the quality of care provided to patients receiving acute non-invasive ventilation (9341)	All 21 recommendations included within the report reviewed by were identified as being relevant to the East & North Hertfordshire Respiratory service. On review no concerns or actions were identified or required.
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)	3 of the 13 recommendations included within the report were identified as being relevant to the East & North Hertfordshire Radiology service. Of these the following action was identified to improve compliance with 1 of the recommendations. • Decision to implement standardised CT pulmonary angiography to be made by cardiorespiratory radiologist.
NNAP - National Neonatal Audit Programme 2022 - For 2020 data (16804)	5 of the 12 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these no concerns or actions were identified or required.

Sentinel Stroke National Audit Programme Annual Report Report 2020/21 (16890Clin)	All 11 recommendations included within the report were identified as being relevant to the East & North Hertfordshire service. Of these the following actions were identified to improve compliance with 8 recommendations. • Consider innovative strategies like video triage, in hour stroke telemedicine consultation with paramedics • Ambulance staff to work with ISDN/CCGs • ISDN to work with the Trust to implement linked ambulance records and pre-hospital communication between paramedics and clinicians in the Trust • Regular review and improve on thrombolysis pathways- both pre- hospital and in-hospital pathways and involving other relevant teams including ED and Radiology • Start using AI and rapid brain imaging, CT perfusion scan • consistent provision of 7-day therapy assessments- PT/OT/SALT
Sentinel Stroke National Audit Programme Post-Acute Organisational Audit Report Sentinel Stroke National Audit Programme (SSNAP) (16890(org))	12 of the 14 recommendations included within the report were identified as being relevant to East & North Hertfordshire. Of these the following actions were identified to improve compliance with 9 of the recommendations. • Nursing establishment reviews and shared role reviews in line with ISDN work to take place. • To discuss and agree the stroke specific education framework with nursing management/education team in line with ISDN recommendations • OT lead to discuss and implement standardised eligibility for vocational rehabilitation and detailed in service specifications • Skill-mix of staff delivering reviews to be discussed with managers • Research compliance with any stroke studies to be reviewed by Trust research team and restarted
Serious Hazards of Transfusions Annual SHOT Report 2018 (16893)	34 of the 35 recommendations included within the report were identified as being relevant to East & North Hertfordshire. Of these the following actions were identified to improve compliance with 7 of the recommendations. • Update to Octaplex guideline and SOP to allow rapid release of PCC complex by Consultant in ED without the need to access Consultant Haematologist. • Complete blood tracking implementation on the ward • Drills need to be implemented after new MH policy is ratified. • Complete roll out of EBT to wards. ICE

	requesting to be rolled out in 2023. • Have processes in place which will not be confused by the introduction on PLEDGE. • MH guideline for Paeds to be updated and appended to adult guideline

Local Audits

The reports of 101 local clinical audits were reviewed by the provider in 2022/2023.

Local clinical audits
A Clinical audit of atrial Fibrillation detection in patients with transient Ischemic attack (TIA) on non-invasive cardiac monitoring (baseline ECG and ≥ 24 hour Holter monitoring) in an NHS Trust
A closed loop audit of Antibiotic Prophylaxis for Trauma and Orthopaedics
A prospective audit on polio vaccination in children with note of oral vs inactivated considering vaccine poliomyelitis PHE outbreak guidance
A study of post-op Hip Hemiarthroplasty dislocations at Lister Hospital
An audit on the investigation of acute Renal colic with CT KUB
Antenatal Care
Antenatal Optimisation for babies born less than 34 weeks
Assess primary care Allergy referrals to secondary care
Audit of Anaphylaxis
Audit of Antibiotic prophylaxis for patients undergoing trauma and orthopaedic surgery
Audit of Communication and Documentation of Orthopaedic Critical Results
Audit of repair of episiotomies and perineal tears
Audit of Ultrasound Technique for the Evaluation of Soft Tissue Lumps
Audit on children presenting with headache/migraine to children's A&E and out-patient
Audit on Patch Testing
Audit on the Management of Hyperthyroidism in Pregnancy
Audit relating to radiology imaging referrals from the Emergency department
Both bone forearm fracture
Care in Labour
Compliance of elbow hemiarthroplasty for trauma with the BESS and GIRFT guidelines for Primary and Revision ELBOW Replacement
Diagnosis and management of uncomplicated pericarditis at ENH
Discrepancies in Clinical Details for CT requests form the Emergency Department
Documenting COVID-19 as a risk in consenting Process.
Documenting COVID-19 as a risk in consenting Process. (Re-Audit)
EP D.3 Clinical Audit (Re-audit of 17727)
EP H IR(ME)R Written Information for Sealed source radiotherapy
EP H IR(ME)R Written Information for Sealed source radiotherapy (Re-audit of 18189)
EP M IR(ME)R Non-Medical Exposures Audit (Re-audit of 17730)
EP N IR(ME)R Procedure Comforters and Carers (Re-audit of 17731)
Epilepsy in pregnancy
ERAS protocol compliance audit for catheter removal in Elective Colorectal Surgery

Evaluation of compliance of NJR policy and Trust policy of recording of data Reverse shoulder replacements performed for traumatic injuries
Evaluation of non-resolution of RUQ pain following Laparoscopic Cholecystectomy
Evaluation of time to discharge following RALP
Evaluation of time to discharge following RALP Audit Cycle #2
Exogen use for the management of delayed fracture union
Flexor Tendon Audit (Re-Audit)
GP23 – Carepath Tasks for Radiotherapy Patients
GROW / GAP audit Lister Hospital
Improving the efficacy and efficiency of Lumbar Puncture in the clinical setting
Infant Feeding Specialist clinic audit
Inpatient VTE Prophylaxis in Lister Hospital Surgical Patients. Round 1
Inpatient VTE Prophylaxis in Lister Hospital Surgical Patients. Round 2
low PAPPA AND SGA outcomes
Management of Distal Femur Fractures
Management of Gestational diabetes in pregnancy
Management of Polyhydramnios and Oligohydramnios
Management of radiological investigation reports within the Urology Department
Measuring serum calcium for adults with ureteric or renal stones. (NG118)
Metabolic profiling in newly diagnosed renal/ureteric stones: An audit based on NICE quality statement 2020
Microsatellite instability (MSI) immunohistochemistry (IHC), colorectal cancer and Lynch syndrome (LS) genetic testing – one year experience at UK District General Hospital
MOH review 2022
Multiple Birth Audit
Neonatal Resuscitation - The management of Neonatal Resuscitation and the Neonatal Team Attendance at delivery
Obstetric Enhanced Recovery Audit
Oxygen prescribing practices in Anaesthetic Department for post-surgical patients at Lister Hospital
Patient handover in the post anaesthetic care unit (PACU)
PC 6 - Review of patients having radiotherapy to Pelvis
PC 7 - Review of patients having radiotherapy to Breast
PC Patient Follow-up Procedures in the Radiotherapy Department
Phototherapy Audit on Patient Information & Consent.
Phototherapy Audit on Referral, Patient Assessment, Patient Information & Consent.
Presence of a Chaperone
Prophylactic antibiotic therapy for variceal bleed patients (QS38)
PT 11 - CT Scanning with IV contrast
PT 21 – VSIM Care Path
PT53 – Gynaecological CT Scanning
PT54 – Bladder CT Scanning
PT55 – Prostate CT Scanning
Quality of chest x-rays (Re-Audit of 17734)
Re-audit of GP 12 Hygiene in the Radiotherapy Department - Part 1 Patient Related

Re-audit of GP 12 Hygiene in the Radiotherapy Department - Part 3 Room Cleaning
Re-audit of GP 3 Uniform Policy in the Radiotherapy Department
Re-audit of GP 31 - scheduling of Treatment Task Carepaths
Re-audit of GP 33 - Use of Encounters for Radiotherapy Treatment Delivery
Re-audit of LA 8 - Activity Capture on Treatment Machines
Re-audit of PT 17 – VSIM Simple Treatments
Re-audit of PT 19 Activity Capture of Tasks - plan link tasks
Re-audit of RT 14 - Bladder Treatment Technique Audit
Re-audit of RT 2 Single Iso Breast
Re-audit of RT 3 Prostate Treatment Technique
Re-audit of RT 4 Head and Neck
Re-audit of RT11 Radiotherapy Non-adaptive Gynae Technique
Re-audit of VT 4 Vaginal Vault Treatment
Re-audit on the investigation of acute Renal colic with CT KUB
Response to Domestic Abuse Notifications in Maternity
RT 2 Single Iso Breast Audit
RT 23 External Beam Radiotherapy Delivery
RT 26 - Palliative radiotherapy Technique
RT 3 Prostate Treatment Technique
RT 4 Head and Neck Audit
Screening of CYPD aged 12-16 years for Macrovascular Cardiovascular Disease
Severe Endometriosis: An Audit on MRI and Surgical Findings
Stillbirth Audit July 2021 - June 2022
Stop before you block checklist compliance
The effect of the pandemic on T&O clinic appointments and looking to the future
The Number of MRI Scans Performed in TIA Patients as per NICE guidelines at Lister Hospital
The relationship between COVID 19 and newly diagnosed Diabetes Mellitus
Use of Gastrograffin for management of ASBO
VTE Assessment - Is VTE assessment veining recorded for urology inpatients?
Waiting time to do inpatient MRI brain in suspected stroke patient and its effect on Management and patient flow

East and North Hertfordshire NHS Trust intends to take the following actions to improve the quality of healthcare provided. Below is a sample of 10 of the 101 local clinical audit reports reviewed by East and North Hertfordshire Trust in 2022/2023 with details of the actions identified to improve the quality of the healthcare provided

Local audit	Results and Key improvement actions agreed
GP23 – Carepath Tasks for Radiotherapy Patients (18426)	**Audit aim** - To assess compliance with Mount Vernon Cancer Centre policy GP23 – Carepath Tasks for Radiotherapy Patients. **Outcome** – Audit showed partial compliance. **Actions** – Refresher training in the standards laid out in the GP23 – Carepath tasks for radiotherapy patients.
Re-audit of RT 3 Prostate	**Audit aim** - To reaudit compliance with the procedures

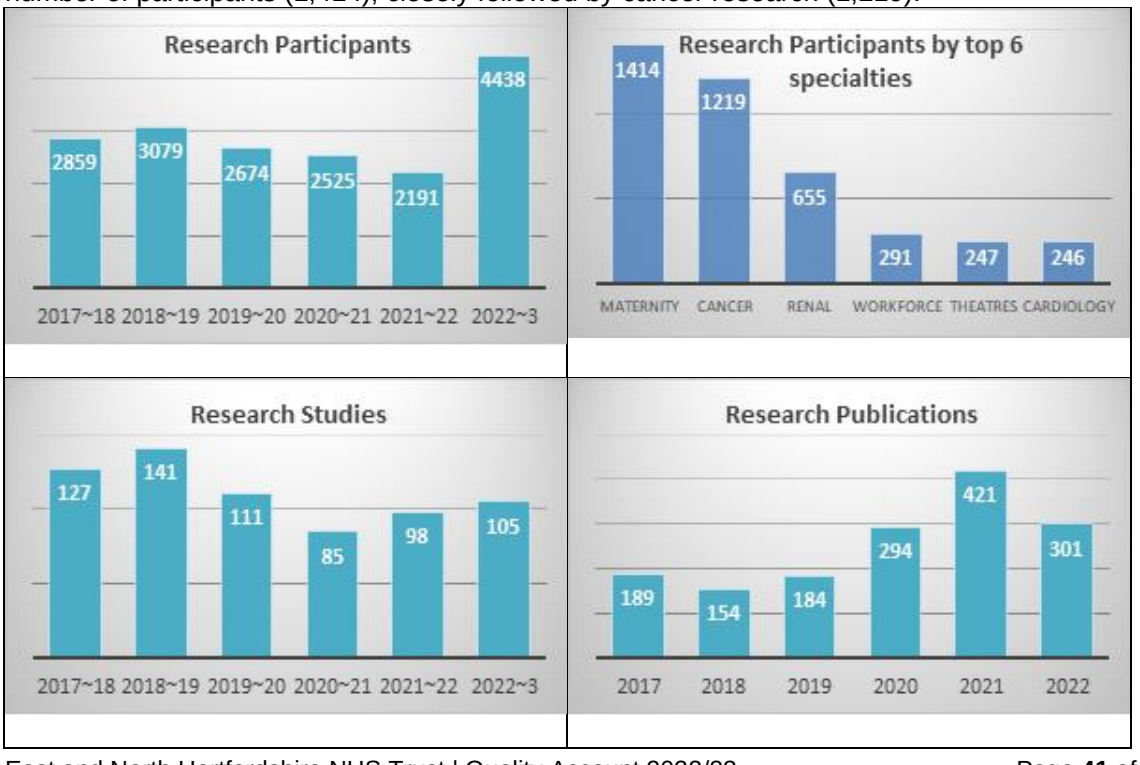
Treatment Technique (18200)	laid down in Radiotherapy Technique Documents for Prostate treatment. **Outcome** – Reaudit showed full compliance. **Actions** – None.
An audit on the investigation of acute Renal colic with CT KUB (18227)	**Audit aim** - Improve appropriate investigation of renal colic. **Outcome** – Audit showed partial compliance. **Actions** – Educational session with Emergency Department junior Drs re CT KUB should detect calculi in 44-64% of patients with suspected renal colic and pick up an alternative diagnosis in 6-18% of cases.
Documenting COVID-19 as a risk in consenting Process (18191)	**Audit aim** - To assess consent forms of patients who have undergone elective or emergency procedures during the covid pandemic to check adherence with the Royal College of Surgeons consenting process recommendations. **Outcome** – Audit showed partial compliance. **Actions** – To ensure that all doctors involved in consenting patients are made aware to document COVID-19 as a risk via posters and regular reminders during internal meetings.
Evaluation of time to discharge following RALP - Reaudit cycle 2 (18273)	**Audit aim** - To determine if RALP procedures could become day case procedures. **Outcome** – Audit showed partial compliance. **Actions** – To introduce dose reduction of clonidine with other anaesthetist in our #3 cycle, so that it could be implemented on other RALP lists, as reduces the absolute in-patient stay post operatively.
A Clinical audit of atrial Fibrillation detection in patients with transient Ischemic attack (TIA) on non-invasive cardiac monitoring (baseline ECG and ≥ 24 hour Holter monitoring)in an NHS Trust (18242)	**Audit aim** - To ascertain compliance with the RCP guidelines in detecting Atrial Fibrillation by non-invasive cardiac monitoring. **Outcome** – Audit showed full compliance. **Actions** – None.
Audit of Anaphylaxis (18216)	**Audit aim** - To assess if we are meeting the NICE guidelines for correctly identifying and managing patients presented with anaphylaxis. **Outcome** – Audit showed partial compliance. **Actions** – • Ensure clerking doctors are aware to include time of onset relevant symptoms as part of history • Create guideline highlighting importance of taking tryptase levels and including time taken on request form • Liaise with Emergency Department team re referring patients appropriately to medical take for monitoring • Create guideline for discharging safely including follow up at tertiary centre if necessary
Prophylactic antibiotic therapy for variceal bleed patients (QS38) (18272)	**Audit aim** - To assess compliance to NICE QS38 in terms of antibiotic prescription, and to provide means of improving clinical practice.

	Outcome – Audit showed partial compliance. **Actions** – • Variceal bleed and antibiotics poster, BASL bundle checklist to include antibiotic prescription • Suggestion to incorporate mandatory antibiotic prescription as care plan in Lorenzo, 12 month rolling audit of current practice in the trust
Assess primary care allergy referrals to secondary care (17717)	**Audit aim** - To determine whether the referral criteria from primary care to Allergy secondary care are appropriate or not and to look at the theme of inappropriate referrals. **Outcome** – Audit showed full compliance. **Actions** – None.
Epilepsy in pregnancy (reaudit round 3) (18308)	**Audit aim** - To assess adherence to nine audit measures, newly introduced in September 2017, for monitoring of women with epilepsy in pregnancy. **Outcome** – Audit showed partial compliance. **Actions** – To Improve documentation, to consider designing a pre-printed checklist to standardize the information collected.

Participation in Research and Development

The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 4,438. This has more than doubled over the last 12 months.

The research activity in 2022/23 relating to studies adopted to the NIHR Portfolio is summarised in the graphs below (please note that this is less than the total research activity as not all research studies are adopted). Research trends and the top six areas of highest research activity are shown below with research in maternity services having the greatest number of participants (1,414), closely followed by cancer research (1,219).



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". Our research supports our values of include, respect and improve.
We work in partnership with the University of Hertfordshire, the life science industry and non-commercial research funders to enhance patient and experience through research and innovation.

During 2022/23 the top six areas of highest research activity by participation were: maternity (1,414), cancer (1,219), renal (655), organisational research (291), theatres (247) and cardiology (246). We also have strengths in nursing research, robotic surgery, biomarker development and use of data and artificial intelligence.

The Trust contributes to publish its research. During 2022 there were 301 research articles published by East and North Hertfordshire NHS Trust staff of which 37 were jointly published with the University of Hertfordshire and this includes 20 systematic review/meta-analysis and seven randomised controlled trials.

The Trust is leading a programme across the Hertfordshire and West Essex Integrated Care System to develop a more inclusive participation with the goal of enabling all individuals and communities to be offered the opportunity, and be supported, to be involved in research.
Public involvement and research participation.

We continually ask research participants about their experience. During 2022/3 all of the 91 people who took part in our survey strongly agreed or agreed with the statement "Research staff have always treated me with courtesy and respect". We also collected qualitative feedback and some of this is given below.
Examples of qualitative feedback from research participants:

- *I felt that if I was involved in this research I would help in some small way, future generations*
- *The friendliness and welcoming attitude of the staff make the whole process a very pleasant experience*
- *Being able to make a difference as an individual and feel that in my small way have made a valuable contribution to society*
- *My research nurse explains everything to me, she is excellent, and it will be very helpful to other people in the future*
- *I was treated very courteously by staff and was able to fit appointments into my schedule*
- *Very happy with the research team, make you feel comfortable. They aim to please and very good with my appointments if I have to change day or time.*

Research examples - embedding research into practice for the benefit of patients

Study Name / Acronym	Description
Routine testing for Group B Streptococcus	(1,362 participants). Sometimes pregnant mothers with GBS can pass this infection to their babies with potentially harmful effects. This research is seeing if a bedside test to detect GBS infection is better than using a risk-based approach without the test.
Preventing hospitalizations due to viral infection in	(100 participants) This study is looking at how babies can be protected from serious illness due to respiratory syncytial virus by giving them antibodies.

infants	
Use of Artificial Intelligence to detect prostate cancer	(398 participants). This research is looking to use artificial intelligence to detect prostate cancer from routine scans, enabling faster and more accurate cancer detection
FibroScan assessment and outcomes in a renal dialysis population	(296 participants) The purpose of this study is to gain a better understanding of liver impairment and its relationship with inflammation in dialysis patients. This study involves analysis of some blood tests, a painless ultrasound scan of the liver called a FibroScan and an assessment of the amount of fluid in the body.
Magnet4Europe	(291 participants). The Magnet4Europe intervention transfers, changes, scales up, and evaluates an evidence-based model of organizational redesign of clinical work environments to enhance workers' wellbeing, retention and productivity. This is being run at the Lister hospital and supports our nursing workforce colleagues
Perioperative Quality Improvement Programme: Patient Study	(224 participants). This study gathers and analyses patient data to improving perioperative care. It measures complications after major planned surgery and looks to improve these outcomes through feedback of data to clinicians
Lung Cancer Detection using Blood Exosomes and HRCT	(201 participants). This project aims to decide whether a blood test can detect future lung cancer progression and treatment response
New blood thinner, with lower risk of bleeding, in patients with heart attack and atrial fibrillation	The cardiology team were the first to recruit and recruited the largest number of patients in the UK into two large trials assessing a new class of blood thinning medication (Factor XI inhibitor) against usual blood thinner (apixaban). The new blood thinner appears to have a lower risk of bleeding, than current medication, with the findings published in the Lancet.

Commissioning for Quality and Innovation (CQUIN)

In line with national guidance for 2022/23, The CQUIN financial incentive (1.25% as a proportion of the fixed element of payment) will only be earnable on the five most important indicators for each contract, as agreed by commissioners.
Regardless of this local decision on financial incentivisation, all providers in scope for CQUIN, as described within the API rules will be required (as mandated by NHS Digital through information standards notices and/or approved collections) to report their performance against all indicators to the relevant national bodies where they deliver the relevant services, irrespective of whether the indicator is included within their CQUIN scheme.

East and North Hertfordshire NHS Trust's income in 2022/2023 was conditional that CQUIN schemes were implemented and best endeavors on achieving quality improvement and innovation goals through the commissioning for quality and innovation payment framework.

A Fixed element within the contract arrangements and payments were made to the Trust during the COVID-19 pandemic at levels set nationally by NHSE/I. The CQUIN's were reported on through various platforms and were monitored for achievement by the Trusts Quality and contract's team

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'requires improvement'. 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

On 04 and 05 October 2022, the CQC carried out an inspection of our maternity services looking only at the safe and well-led key questions. This announced short notice focused inspection was carried out as part of the CQC's national review of maternity services.
The CQC rated our Maternity Service as 'Inadequate' and has served the Trust with a section 29A notice and recommendations on the immediate improvements that must be made within the service.
In its report, the CQC recognised that staff worked well with women in the community to plan services, there was a culture for improvement and innovation, and the team achieved good outcomes for women. However, there were concerns noted around insufficient staffing levels, mandatory training was below the Trust target, equipment needed more regular servicing, and cleanliness standards must improve.

The Trust has participated in other planned reviews by the CQC during 2022/23 relating to the following areas

- a system Inspection of Hertfordshire local authority children's services by CQC and Ofsted to review Special Educational Needs and Disabilities compliance (SEND), this review rated the services outstanding across the health and Social Care system.
  Areas for improvement included the timeliness and quality of some referrals, including the establishing of parental consent by partner agencies; supervision and management oversight of practice in care leavers services and support to enable care leavers to access and understand their health histories.
- Virtual CQC reviews were undertaken through 'direct monitoring approach' workshops, where ease of access, safety and well- led enquiries were undertaken across Medicine, Surgery and Pharmacy services.
  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.

During 2022/23 the trust has reviewed the quality assurance framework and accountability performance review framework. Actions to improve good governance standards include the review of reporting structures, a review of published analytical data and internal and external peer review for assurance.

Reporting to Secondary Uses Service (SUS)

The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
The Trust submitted records during 2022/2023 (i.e. up to 21st April 2023) to the Secondary Uses Service for inclusion in the Hospital Episode Statistics and these have been included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number, was:

- 99.9% (99.6%) for admitted patient care
- 99.9% (99.8%) for outpatient care
- 99.4% (95.3%) for accident and emergency care

The percentage of records in the published data, which included the patient's valid General Medical Practice code, was:

- 98.9% (99.7%) for admitted patient care
- 100.0% (99.5%) for outpatient care
- 100.0% (98.3%) for accident and emergency care

Data Quality

High quality information leads to improved decision making, which in turn results in better patient care, wellbeing and safety. We continued to focus on improving the quality of our performance data, the Trust is taking the following actions to improve data quality:

- Ensuring automated data flows become essential
- Raising awareness of poor data quality and focusing attention on areas which need support

Information Governance Toolkit (IGT)/ Data security

The Data Security and Protection Toolkit enables the Trust to measure its compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

The Trust provides information assurance by maintaining compliance against the Framework of NHS England's Data Security and Protection Toolkit (DSPT).
DSPT 2021/22 submission achieved "Approaching Standards" status. Preparation is underway working through an Improvement Plan to provide assurance for the 2022/23 DSPT cycle.

A baseline publication was made on February 24, 2023, and the outcome of an Internal Audit is pending but expected in advance of DSPT submission at the end of June 2023.
The Information Governance Steering Group continues to monitor progress ahead of DSPT submission 2022/23, due at the end of June 2023.

In the current DSPT year, three incidents have been reported on DSPT. Two of these incidents met the threshold for disclosure to the Information Commissioner's Office. The Information Governance Team assesses incidents in line with national guidance to determine whether they are reportable incidents or otherwise. As part of incident management, lessons learned are used to review relevant Trust processes.

Clinical coding

The Trust undertakes annual and regular clinical coding data quality audit to determine how accurately our coded clinical data reflects documented diagnoses and procedures in the patient record. This is part of the Data Security Standard 1, Personal and Confidential Data. Clinical coding also regularly undertakes clinical coding validation in both the admitted patient spell and outpatient attendances. The table below is the results for Admitted Patient Care [APC] audit.

	2022/23	Previous year (2021/22)	Standards Exceeded
Primary diagnosis	95.5%	97.0%	>=95%
Secondary diagnosis	98.0%	98.1%	>=90%
Primary procedure	96.1%	97.6%	>=95%
Secondary procedure	98.5%	99.1%	>=90%

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 maximise learning from our learning from deaths work.

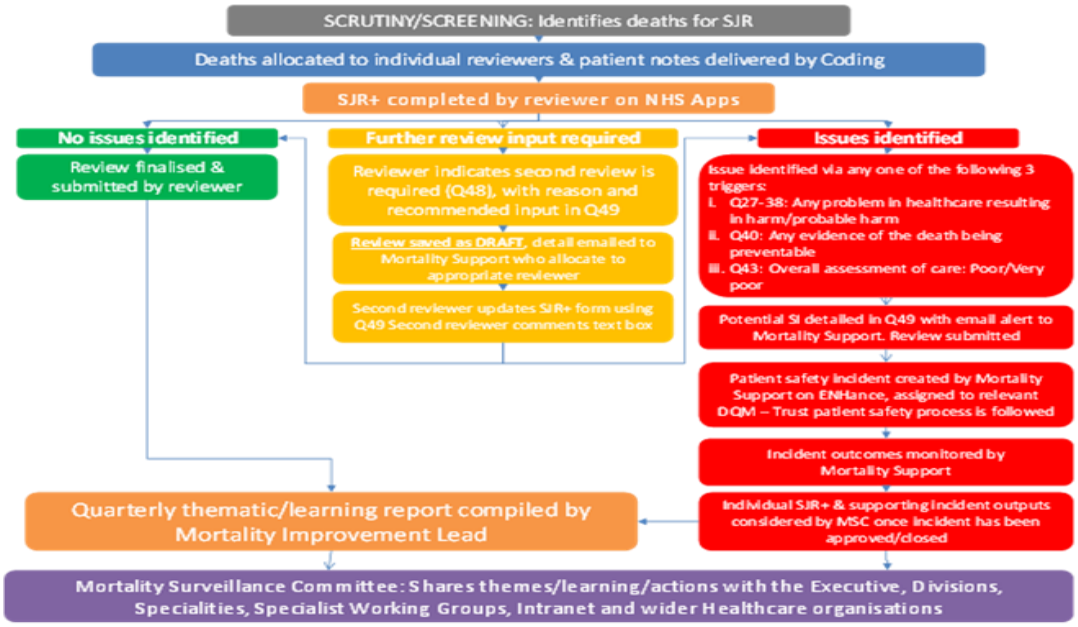
The Trust is committed to continuously seeking ways to strengthen our governance and quality improvement initiatives to support the learning from deaths framework.
While our mortality rates have remained strong, it is increasingly recognised that while monitoring these rates has a role to play in mortality governance, there is limited correlation between them, and the quality of care provided by organisations.

To learn from deaths and improve the quality of the care we provide; 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 reviewed our previous processes and have introduced several 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 was the adoption of the Structured Judgement Review Plus (SJR*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 new review process was adopted in July 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. Now that our new SJR*Plus* mortality review is in place, our focus is on developing our mortality reporting and communications framework to make best use of the review system outputs. 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

The below chart provides an overview of the mortality review process at East and North Hertfordshire NHS Trust using the SJR Plus review format on NHS Apps.



Key themes drawn from areas of concern in Q1-Q3 2021-22 are Communication, Clinical management & Review and Escalations.
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**	**2022-23 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 2022-23, 1375 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; 312 in the second quarter; 355 in the third quarter; 397 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 2023, 377 case record reviews and 5 investigations have been carried out in relation to 1375 of the deaths included in item 27.1. In 4 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: 126 in the first quarter; 102 in the second quarter; 101 in the third quarter; 49 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	8 representing 0.58% 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

	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.	1 representing 0.32% for the first quarter; 3 representing 0.96% for the second quarter; 3 representing 0.85% for the third quarter; 1 representing 0.25% for the fourth quarter. 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. Up to 30 June 2022: Stage 1 was undertaken by designated, trained mortality reviewers using the Trust's bespoke case record review methodology which was developed by a multi-professional team. It was 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 triggered 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 was 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 was considered and an avoidability of death score 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). Since 1 July 2023 the NHS Apps SJRPlus review format has been adopted. The preventability of death is now decided by the trained reviewer on completion of the review. Concerns raised trigger a patient safety incident, including where significant a Serious Incident, with subsequent investigation and action according to patient safety processes.
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.	Of the 8 deaths identified in 27.3, where either the SJR reviewer or Patient Safety team (or both) judged it more likely than not that the death was due to a problem in healthcare, 6 are still being processed meaning that final learning has not yet been confirmed. Brief detail of the remaining 2 cases: Case 1: Vital importance of appropriate review/medication prior to discharge of patient with a condition that put

		them at risk of stroke. Case 2: Vital importance not only of falls risk assessment and prevention planning but also of post-falls management.
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).	As stated in 27.4, 6 of the 8 deaths identified in 27.3, are still being going through the rigorous patient safety process so do not yet have finalised action plans agreed. Case 1: Review of national guidelines; consideration of need for local policy; inclusion of condition specific training for relevant staff including junior doctors and refreshed publicity regarding stroke pathways. Case 2: Comprehensive suite of actions developed to improve falls management including: Improve staff awareness of their responsibilities and of escalation protocols regarding falls management; promotion of electronic dashboard to be accessed/used to provide feedback at ward Huddles; implementation/monitoring of compliance for new falls training; increase awareness of the importance of reviewing patients within 30 minutes of a fall and taking a detailed history to assist in the creation of a robust plan to prevent future falls
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.	It has not yet been possible to assess the impact of the two cases where detailed action plans have been agreed.
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.	8 case record reviews and 41 ACON investigations completed after 1 April 2022 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.	2 *[of the 41 investigations reported in 27.7 above]* representing 0.15% of the patient deaths before the reporting period *[ie 2021-22]* 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.	2 representing 0.15% of the patient deaths during 2021-22 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

2.3.1. 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 2022 is **0.9059**, positioned within the 'as expected' Band 2 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 18th out of all acute non-specialist trusts (121).

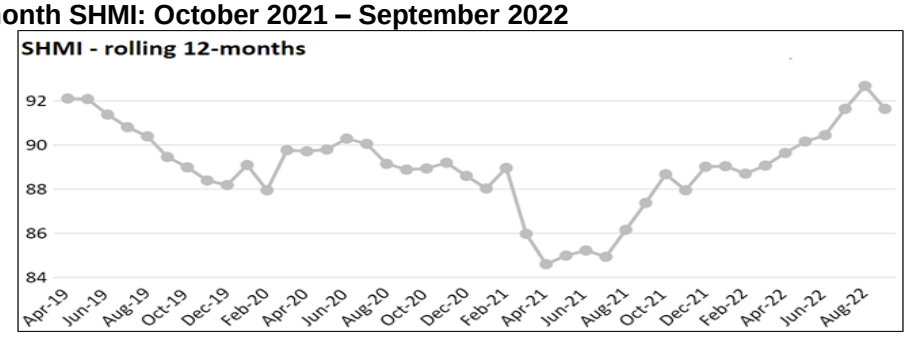
NHS Digital has excluded COVID-19 activity from the SHMI metric. Of note is that the fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, which provides some assurance that our response to COVID-19 has not generally 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	0.00		0.00	N/A	N/A	N/A
	Banding	0.00		0.00			
% deaths with palliative care coding	N/A	0.00		0.00			

NHS Digital, published [date] * At the time of this report, these values had not been published by NHS Digital

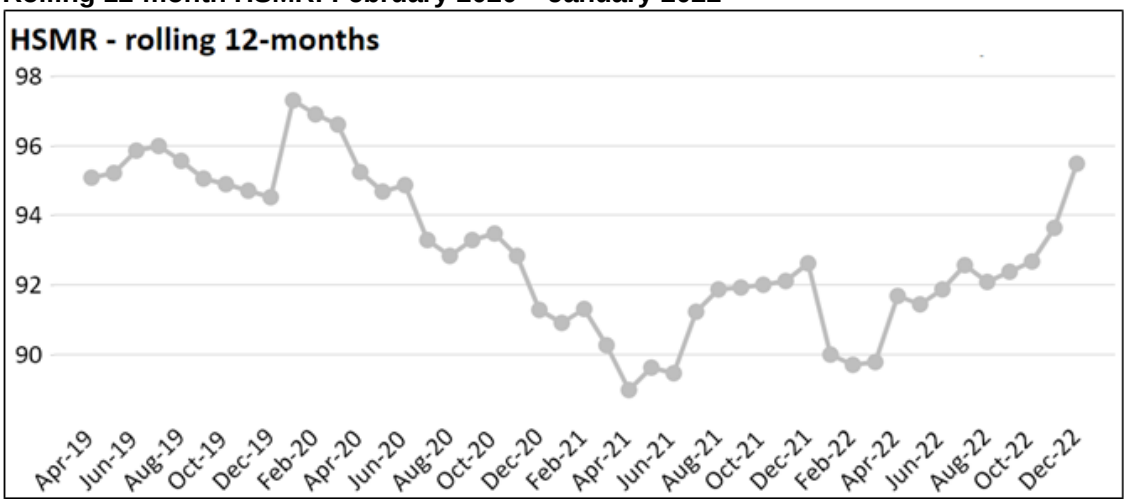
Rolling 12-month SHMI: October 2021 – September 2022



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 is currently within the second quartile of Acute Trusts. HSMR is generally available 3 months in arrears and the latest HSMR for the rolling 12 months to January 2023 is **97.08**.

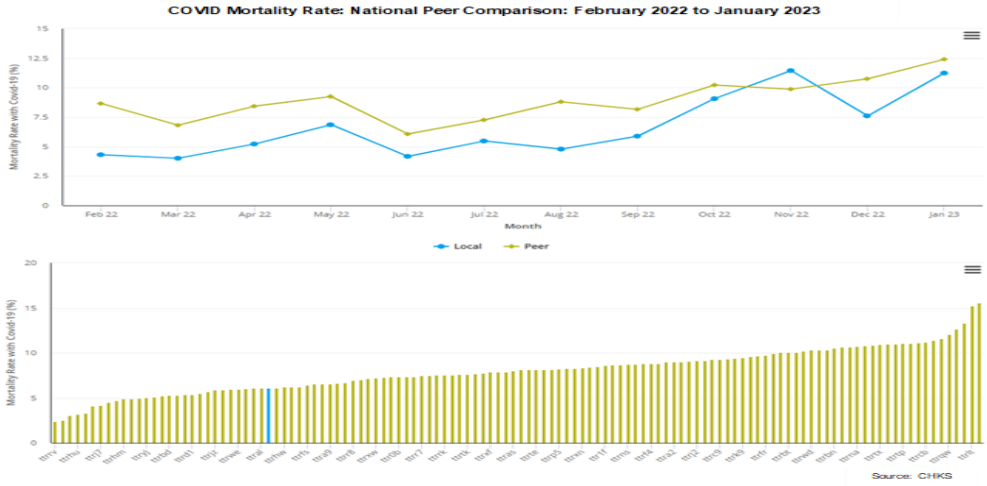
Rolling 12-month HSMR: February 2020 – January 2022



2.3.2 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 mortality rate for COVID has remained well positioned against our national peers as demonstrated by the following charts:

Our reported number of deaths for the year 2022-23 are as follows:

COVID Deaths 1 Apr-22 to 31 Mar-23	Definition
229	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.

183	Patients who had a laboratory confirmed positive COVID test and died within 28 days of the first positive specimen date. This is the Public Health England national reporting definition.

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.

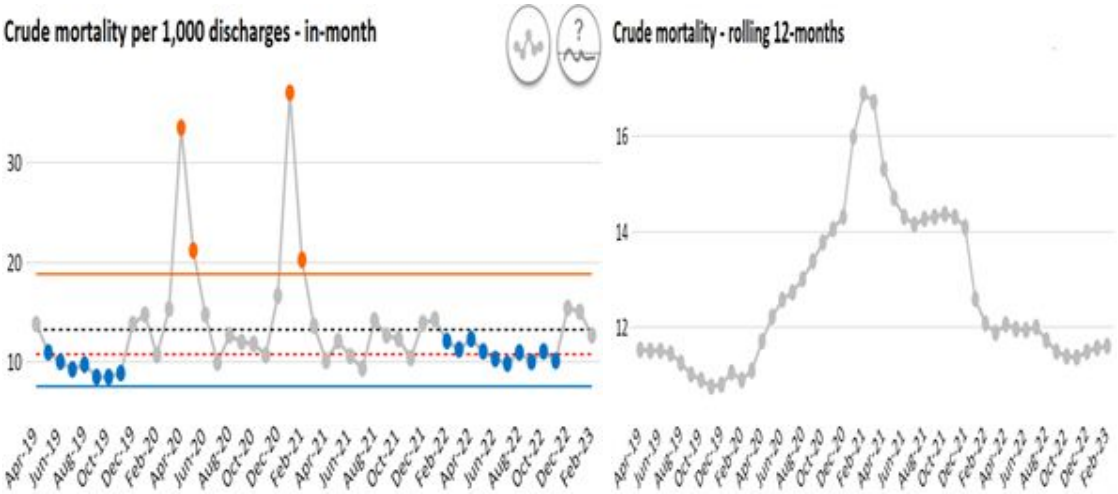
Crude mortality

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 rolling 12-month crude consistently tracking below national.



2.3.3 Patient Reported Outcome Measures PROMs (EQ-5D Index Score)

PROMs use a standardised tool as a measure of health outcomes. It is applicable to a wide range of health conditions and treatments and provides a simple descriptive profile and a single index value for health status; the health gain index is primarily designed for self-completion by respondents and is ideally suited for use in postal surveys, in clinics and face-to-face interviews. It is cognitively simple, taking only a few minutes to complete. Instructions to respondents are included in the questionnaire.

For the reporting year 2022/23, the Trust did not participate in PROM collections.

2.3.4. 28 Day/ Emergency readmissions

Readmissions data is only available till Jan-2023 and hence the data below is comparison of data from Apr - Jan period.

28 Day Readmissions	Apr 21 - Jan 22			Apr 22 - Jan 23		
	0-15	16 and over	Total	0-15	16 and over	Total

Discharge	9377	84370	93747	10533	86496	97029
30-day readmissions	1304	5326	6630	1317	4856	6173
30-day readmission rate	13.91%	6.31%	7.07%	12.50%	5.61%	6.36%

*Data up to January 2023

We consider the above data as described because it is extracted directly from Dr Foster, which is an established and recognised source of data nationally.

2.3.5. The Friends and Family Test (Responsiveness to patient needs)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This kind of feedback is vital in transforming NHS services and supporting patient choice.

Friends and Family Test	2021-22		2022-23*	
	A and E	**Inpatient**	**A and E**	**Inpatient**
Response rate	0.95%	23.21%	0.49%	21.75%
% would recommend	85.84%	96.69%	88.10%	96.37%

*data as at March 2023

The Trust considers that this data is as described for the following reason: the data has been extracted directly from the NHS England, which is an established and recognised source of data nationally.

2.3.6. Venous Thromboembolism (VTE)

The national bench making data collection continues to be paused and therefore is not currently available.

The Trust has taken the following actions since 2021 till date, to improve this indicator, and so the quality of its services,

- Reviewed and strengthened the VTE/HAT governance structure, this is in line with the Trust priority regarding VTE prevention.
- VTE training now an essential training for relevant clinical staff
- 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%
- Transformation of the HAT process 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.
- Established regular clinical engagement to share VTE data, improvement work and learning from HATs. Engaged in a patient information quality improvement project with patient partners to alert to signs and symptoms of VTE on Trust wide discharge letter given to patients on discharge.
- Semi-regular engagement sessions with junior doctors and clinical staff to obtain learning from the service user and then feedback to enable change
- Move risk assessments into a platform that allows for ease of assessment completion on hand-held devices in a timely manner.
- Reporting in real-time on the ‘patient safety at a glance’ (PSAAG) board to provide a ‘prompt’ as a visual reminder. Digital reporting at ward, speciality, and consultant level to support targeted improvement projects.

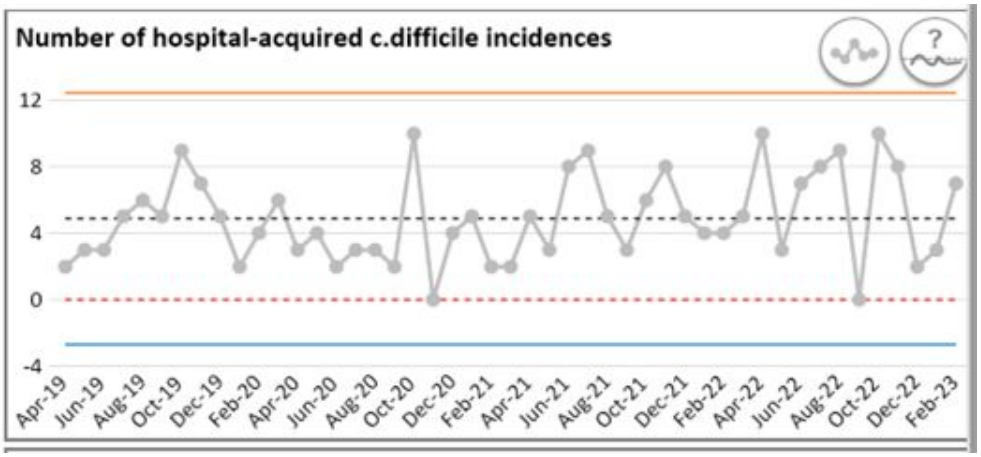
2.3.7. Clostridium difficile

This indicator measures the number of hospital acquired Clostridium difficile infections per 100,000 bed days.

ENHT IPC team continues to provide robust support (education, training, monitoring standards), promote 3C's (clean hands, clean equipment, clean environment) and regular audits are carried out by IPC to provide assurance that IPC safe practices are maintained.
For non-COVID related key infection control performance indicators for 2023/24

Month	C.difficile 22-23	MR SA 22-23	MSSA 22-23	Pseudomonas aeruginosa 22-23	E.coli 22-23	Klebsiella 22-23
April	10	0	5	2	4	0
May	3	0	2	1	6	1
June	7	0	4	0	9	2
July	8	1	1	1	6	3
August	9	0	2	0	1	1
September	0	0	4	1	7	2
October	10	0	3	1	3	2
November	7	0	1	2	5	4
December	2	0	2	1	4	1
January	3	0	0	1	3	2
February	7	0	3	2	4	0
March						
	Total	Total	Total	Total	Total	Total
	66	1	27	12	52	18
	Threshold number 2022 -2023	Threshold number 2022 -2023	Threshold number 2022 -2023	Threshold number 2022 -2023	Threshold number 2022 -2023	Threshold number 2022 -2023
	59	0	N/A	11	46	22

Trust-allocated cases of Clostridium Difficile infections – 66 against a threshold of 59 on 2022/23. All Clostridioides difficile cases have undergone review in real time to identify areas for learning and improvement locally.



*AW march ratified data

2.3.8. MRSA Bacteraemia (post 48 hours)

The Trust reported a total of 1 hospital onset MRSA bacteraemia (blood infections) which is above the threshold of zero. The Trust managed an MRSA colonisation outbreak within its neonatal patient group in September 2022. From 15th November 2022 - 22nd February 2023, no further cases of colonisation were identified following twice weekly screening. There continues to be targeted IPC support for our maternity services

The Trust reported one Influenza A case identified in Feb '23 which was community acquired. No Influenza B cases.

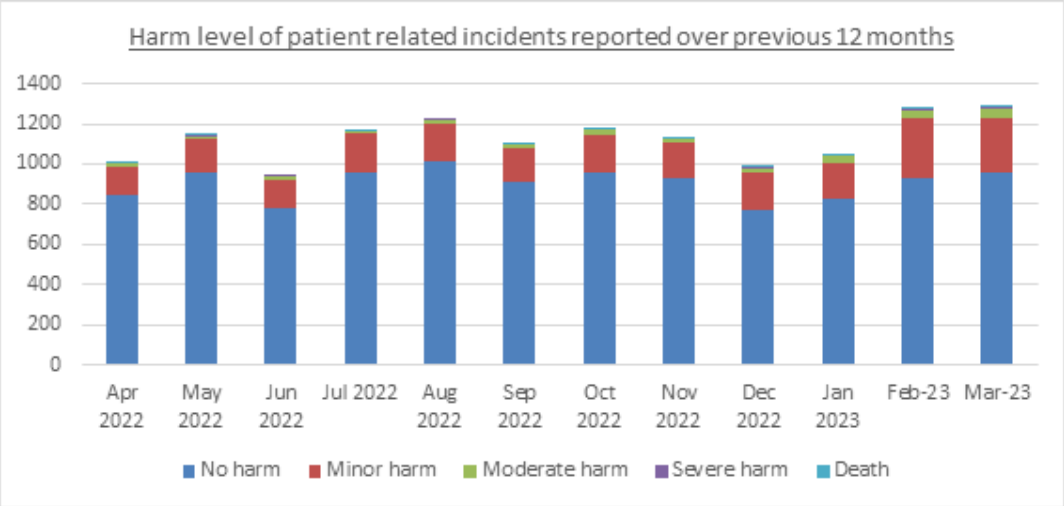
2.3.9. Patient safety incidents

The Trust encourages all healthcare professionals to report incidents on its electronic incident reporting system as soon as they occur and ensure timely investigations and outcomes, which are shared to support learning reflective of a positive safety culture.

In February 2023, the Trust transitioned to a newly implemented incident reporting system-Enhance- from Datix. Enhance, as a quality assurance platform incorporates a range of oversight modules (i.e., incidents, feedback, audits and surveys and the risk register).

The Trust adopted and implemented the new national NHS learning from patient safety events service (LFPSE) which replaces the National Reporting and Learning System (NRLS) to benchmark its reporting culture against other like performing NHS Trusts. This new way of reporting also allows for the central recording and analysis of patient safety events that occur in healthcare. This will contribute to a national NHS wide data source to support learning and improvement. Relevant incidents are reported to the national system via a direct upload from Enhance. It is envisaged that the LFPSE system will also replace the Strategic Executive Information System (StEIS).

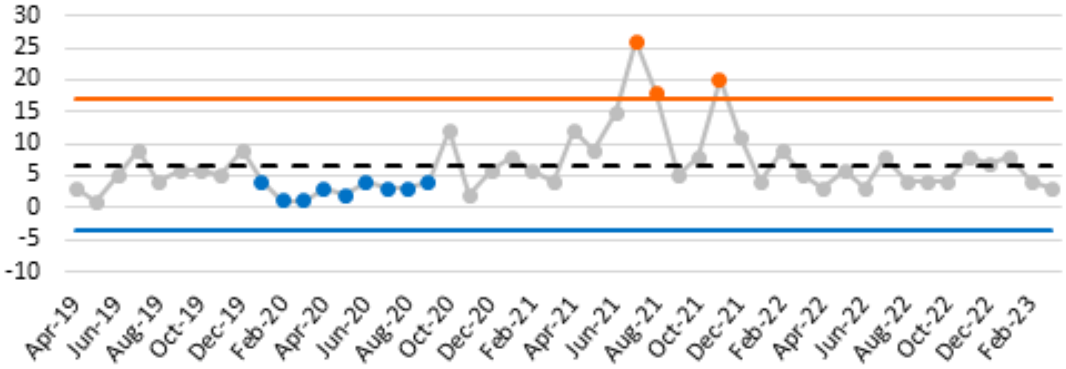
The data shows total number of all incidents reported by us for the period between 1 April 2022 – 31 March 2023 was 13,464 patient safety incidents. Of those, 98% reported resulted in no or minimum harm. Of the total incidents reported, 77% relate to patient safety incidents and 12% relate to staff. Within staffing incidents, the top 3 themes are violence and aggression, staffing and health & safety / security incidents.



East and North Hertfordshire NHS Trust considers that this data is as described in that

- The Trust uses an electronic reporting system which is used to report nationally and verified data to the NHS learning from patient safety events service (LFPSE)
- The serious incident data has been extracted directly from the Strategic Executive Information System (StEIS) which is an established and recognised source of data nationally
- The Trust continues to hold a weekly Serious Incident Review Panel, chaired by either the Chief Medical Officer, Director of Quality, Associate Director of Patient Safety and/or Chief Nursing Officer, which explore in detail those incidents that fall within the scope of the terms of reference of the panel.

Monthly reporting of serious incidents April 2019 - March 2023

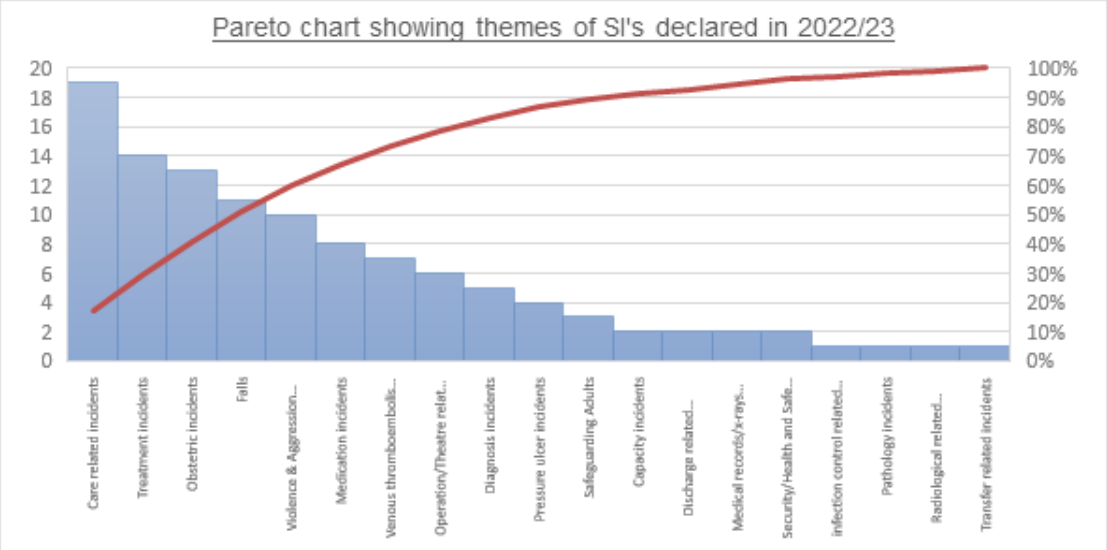


It is recognised that the biggest driver to improvement in reporting is feedback; the ways in which we can improve our feedback are being explored. Teams are being encouraged to ensure incidents are part of local discussions at quality huddles and team meetings. The Enhance system provides greater oversight of incident data and management and will facilitate easier triangulation moving forward.

Serious Incidents

The Trust investigates all identified patient safety incidents reported. During 2022-23, the Trust formally declared 63 Serious Incidents (SIs). This number reflects a reduction on 2021-22 when 147 were declared however 57 of these were attributable to the hospital onset hospital acquired COVID cases being declared as SIs, which was a new requirement from 2021.

The chart below (figure 2) shows the number of serious incidents reported each month and shows common cause variation.



It is noted that there has been an increase in serious incidents involving the management of violent and aggressive patients. It is worth noting that there have been collaborative learning reviews undertaken with Hertfordshire Partnership NHS Foundation Trust, the local mental health services provider in order to improve the pathway and experience of patients who present to the Trust with acute mental health needs.

Seven (7) investigations were undertaken into hospital acquired thromboses with 3 reports completed using an assurance document rather than a full investigation report due to the extensive Trust-wide work that is ongoing relating to hospital acquired thromboses. This includes moving the electronic risk assessment onto a new platform and ongoing QI improvement project lead by the Harm Free Care Lead and Clinical Pharmacist Thrombosis Lead.

Themes and learning gleaned from serious incidents are embedded within patient safety and patient experience improvement priority programmes such as the deteriorating patient collaborative and the harm free

care collaborative. In addition, the Trust has instituted round table discussions (senior and frontline staff attending) as a forum to support in-depth discussions on learning from incidents and review of pathways and human factors that may have contributed to the incident occurring. This has proven useful in ensuring early feedback is provided to staff directly involved and staff from wider teams.

In addition, the teams have been working slightly differently where several similar incidents have been noted to have taken place and have undertaken several thematic reviews, for example into incidents of patients having delayed follow up within certain specialties. As the Trust transitions into PSIRF (Patient Safety Incident Response Framework) templates and learning tools will continue to be reviewed and refreshed.

Never Events
The Trust reported three Never Events between April 2022 and March 2023.

	2020/21	2021/22	2022/23
Wrong site surgery	2	4	3
Total	2	4	3

Of the 63 SIs declared in 2022-23, three were 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. All the Never Events were classified as minimum or no harm. All three of the never events were cases of wrong site surgery; one in ENT and two in Plastic Surgery.
The Never Events were investigated by a dedicated team of Patient Safety Managers working in collaboration with clinical staff and the divisional quality teams to identify causes and learning. The findings have informed a range of learning and actions.

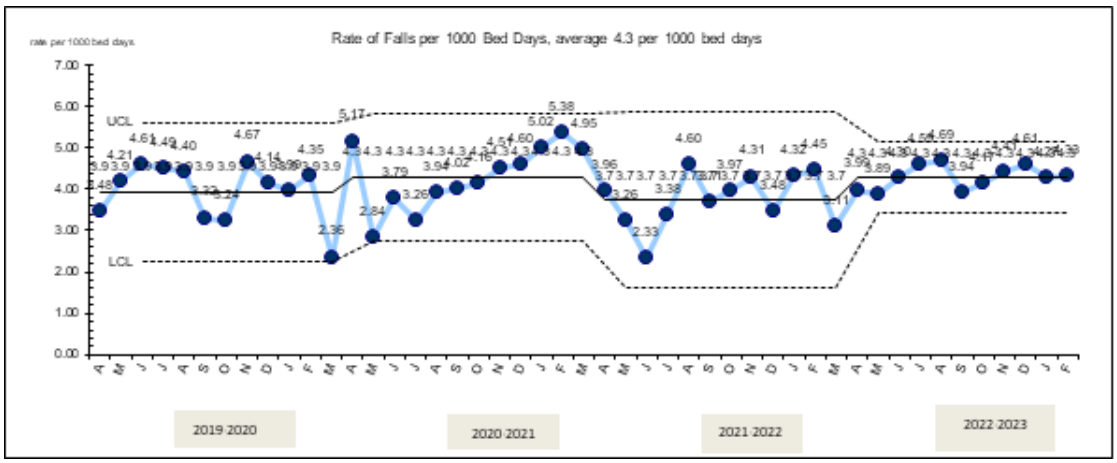
- Procurement of additional polaroid cameras for use in minor operations department
- Trust-wide communications reminding staff to ensure that WABA application must be used for clinical photographs
- Launch of new training video for all users of WABA application
- Reminder to staff that LAOPs checklist should be completed by two members of the clinical team.
- Within Planned Care, a programme of simulation training across theatres in recognition of the Human Factors elements influencing Never Events.

All three Never Events declared relate to Invasive Procedures—wrong site surgery. All incidents were classified as minimal or no harm. All areas have conducted a significant review and implemented changes to their procedures.

Duty of Candour (DoC)
The Trust is committed to being open and honest with our patients. The Duty of Candour is a legal requirement that for all safety incidents recorded as ‘moderate’ or ‘severe’ harm, a formal apology to the patient and/or family involved is carried out and an investigation into their care is undertaken; the responsible clinical team undertakes this. We feedback in writing the findings of our review and any actions we are taking to prevent a similar incident from reoccurring.

Inpatient falls

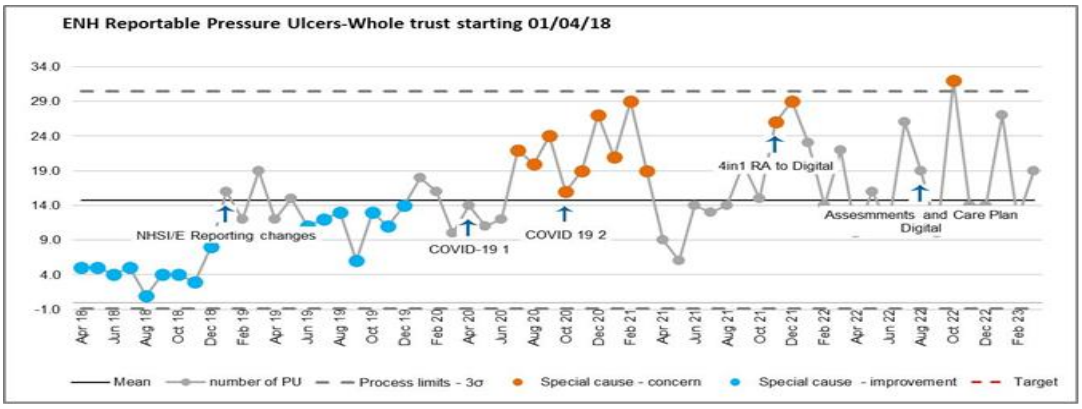
In 2022-2023, the Trust recorded an average falls rate of 4.3 per 1000 bed day (i.e. 797 inpatient falls) higher than the previous year (3.78). This represents an 18.6% increase compared with the previous year. However, the Trust’s occupied bed days also increased by 4% which has contributed to the increase of inpatient falls incidence.
Falls with serious harm is lower this year (16) compared to the previous year (19). Preventing falls with harm remains the trust’s priority.
Despite of the increase in falls rate, the Trust continues to record a lower falls rate compared to the national average of 6.6 (NHSE).



Inpatient pressure ulcers

The Trust is committed to the prevention of Hospital Acquired Pressure Ulcers (HAPU). All HAPU are investigated via Root Cause Analysis (RCA) to capture any learning. The Trust reported 210 Hospital Acquired Pressure Ulcers (HAPU) for 2022-23 which is a 2.4% increase on our previous year's data.

	2020-21	2021-22	2022-23
Number of reportable HAPU	235	205	210



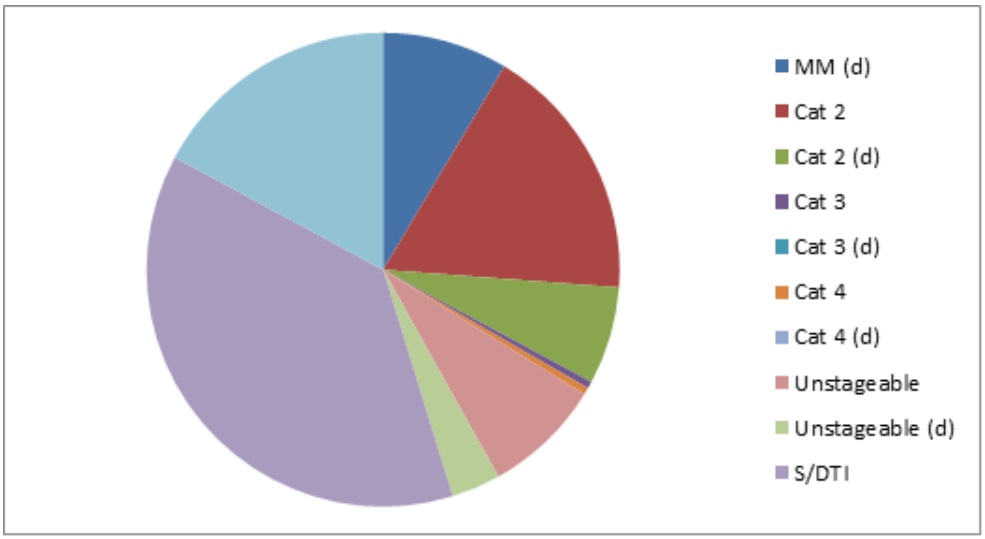
Due to the 2018 reporting changes 2019-20 has become our new baseline year because additional reporting categories of damage are now included compared to previous reporting periods.

Pressure Ulcer Categories

The most prevalent category for 2022-23 has been SDTI (suspected deep tissue injury) PU accounting for 54.76% of total reportable ulcers. 45.5% of these SDTI were directly related to the use of a medical device.

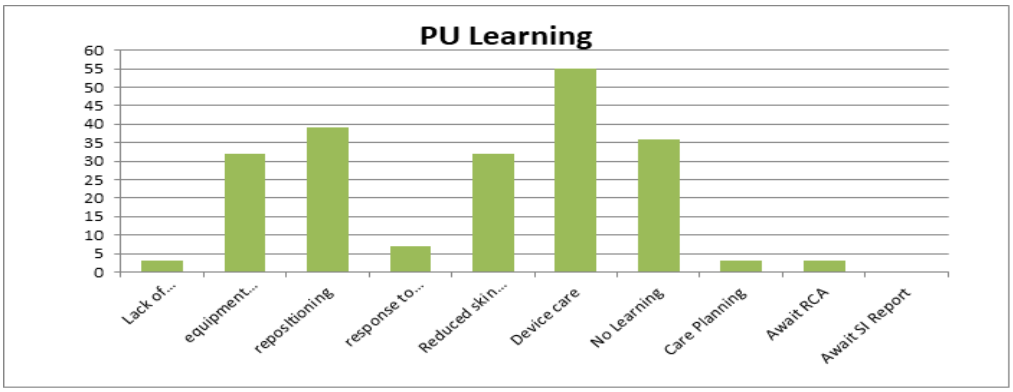
MM (D)	CAT 2	CAT 2 (D)	CAT 3	CAT 3 (D)	CAT 4	CAT 4 (D)	SDTI	SDTI (D)	US	US (D)
18	37	14	1	0	1	0	79	36	17	7

(D) Indicates a Medical Device Related HAPU



PU RCA Themes

The most prevalent themes identified from Hospital Acquired Pressure Ulcers are device care (26%) and repositioning (18.5%).



The Tissue Viability Team has identified 3 priorities for improvement work over the coming year.

1. Engage with and deliver improvement alongside the National CQUIN programme. 2023 sets a target for timely risk assessment and care planning to prevent HAPU in adult inpatients.
2. Implement the new PU clinical pathway and recommendations from The national Wound Care Strategy Programme as advised by NHSI/E. This will include changes to the categorisation of and reporting of some PU and the implementation of a new PU risk assessment tool.
3. Support 10b in their HAPU reduction Quality improvement project as subject matter experts.

We have set a target to reduce our mean reported pressure ulcers from 15 to 10. The above priorities should accomplish this aim.

Patient Experience

Complaints and Compliments

All complaints data is sourced from the Trust's internal logging system Enhance. The Complaints and PALS Department records and responds to complaints, concerns, comments and compliments received from all areas of the Trust, which are triaged to identify the most appropriate method of handling.

It is the Trust's ambition for complainants to have their concerns resolved as swiftly as possible, by offering a formal or informal method to resolution. The Trust captures and monitors any concerns raised by our patients and their families to introduce high impact actions and improvements across the organisation.

In 2022/23 746 formal complaints were received across all services (from 777 in 2020/21) within the Trust, and 3496 informal PALS concerns (from 3614 PALS 2020/21) were received. The Trust continues to work through a small backlog of complaints that were delayed due to the pressures during covid 19.

Indicator	20/21	21/22	22/23
Number of formal complaints	656	777	746
Number of PALS concerns	2935	3614	3496
Number of PALS concerns closed within 5 days/ % performance	2931 79.2%	2529 78%	1951 55%
Complaints – response within agreed timeframe	89%	72%	50%

*The Trust KPI is for 80% of formal complaints to be responded to within an agreed timeframe.

Complaint themes were mainly around communication and medical care.

Parliamentary and Health Service Ombudsman complaints

In the reporting year, 12 complaints were assessed by the Parliamentary and Health Service Ombudsman (PHSO). One complaint was closed with no further investigation and two complaints partially upheld.

The Trust embarked on a Complaints and PALS transformation project over the last year which will continue throughout 2023/24 and have improved our performance target for overdue responses by 27%. This work will therefore continue into 2023/24.

The Trust recognises that many compliments are received across the organisation but not registered for reporting purposes. The Trust is working to ensuring compliments are registered and shared across the organisation as examples of good practice and patient satisfaction.

2.4. Other Quality Information

2.4.1. Operational Performance Appraisal Summary:

In 2022/2023 we welcomed 180,583 patient attendances to our emergency departments; we cared for 50,412 inpatients and saw 590,794 patients in our outpatient settings.

Operational performance:

- The focus in 2022 / 2023 has been to return to business as usual following the covid pandemic and work towards the achievement of elective and non-elective target performance.

- This includes the development of and delivery against the elective recovery plan, including eradication of patient waits over 104 weeks from referral to treatment. The Trust delivered on time against this metric. There was also a target of eradicating patient waits over 78 weeks by March 2023; this was achieved in all bar three specialties: trauma and orthopedics, gastroenterology, and community paediatrics.

- Delivery against cancer targets has continued to remain a priority, with the end of year performance being 83.2% for the Trust against a target of 85% for the 62-day urgent referral to treatment. Further

work will be undertaken to ensure this is met in 2023/2024 alongside the other 7 standards. The Trust focussed well on and reduced the proportion of patients waiting over 62 days.

- Diagnostic waiting times remain a challenge due to increasing demand. Detailed analysis of capacity and demand has been completed. Additional pressure has been experienced due to an increase in cancer referrals and emergency attendances requiring scans.

- Stroke performance nationally is monitored on the calendar year rather than the financial year. The Trust remains at level D against the performance metrics in the national audit. There have been some improvements in the domains of occupational therapy and physiotherapy support, but more work is required and planned on access to a stroke bed within four hours of arrival and access to speech and language therapy.

2.4.2. Performance Analysis

In-depth performance review

This section of the annual report sets out in more detail the Trust's performance in 2022/23 in relation to key areas including clinical, operational, financial and workforce performance.

Operational Performance

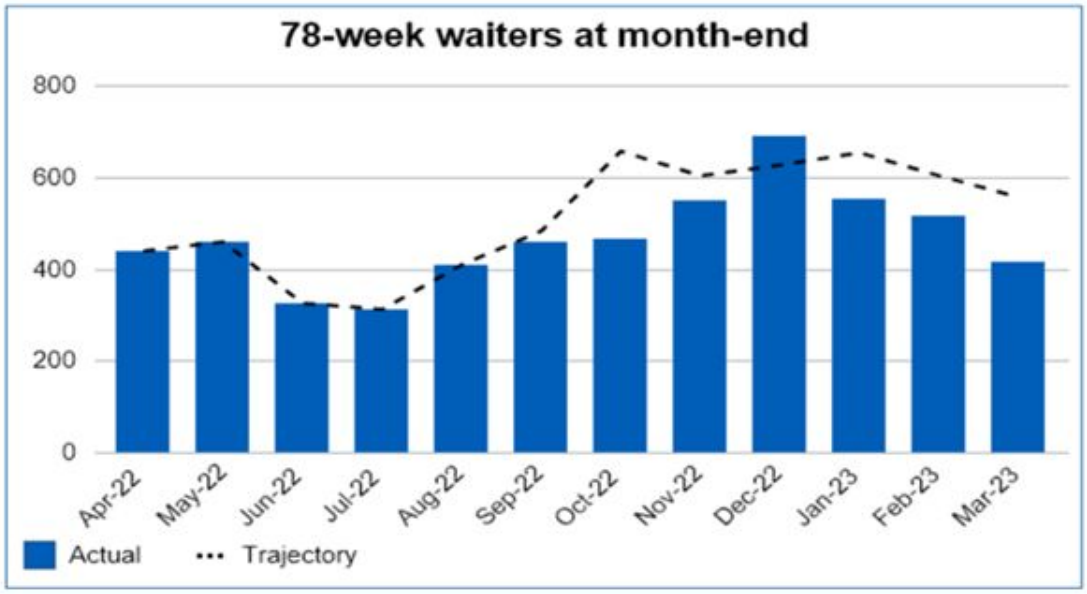
A summary of performance against the key metrics is provided below:

- **18 weeks referral to treatment (RTT)**

Despite the Trust performing well in the first half of 2022/2023, performance dropped in the second half due to medical workforce issues including substantive recruitment and extra contractual pay rate challenges. Progress has now been made on pay rates and the Trust is working on delivery against trajectory as well as substantive recruitment to reduce the need for waiting list initiatives.

The Trust met the target that no patient waits more than 104 weeks for their treatment by the end of June 2023.

The Trust ended the year with 405 patients waiting over 78 weeks vs the original trajectory of 554. The majority of these breaches were known capacity challenges in Community Paediatrics, Trauma and Orthopaedics and Gastroenterology. 24 patients were delayed due to patient choice and complexity of the patient pathway.
The number of patients waiting 78+ weeks for an appointment is 0.66% of the total RTT Patient Tracking List.



78 ww	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Plan	482	656	603	625	653	603	554
Actual	458	464	561	689	551	516	405
Variance	-24	-192	-42	64	-102	-87	-149

The three areas which did not meet the 78-week target continue to be monitored weekly, with a trajectory for gastroenterology to be achieved by the end of May 2023 and trauma and orthopaedics by the end of September 2023. Community paediatrics will not achieve the target due to a higher demand for this service than can be provided. Mutual aid has been requested via NHS England and work will continue with system partners and the independent sector to find solutions to meet these children's needs.

The Trust finished the year ahead of trajectory. The focus is now to achieve the 65-week target by March 2024 as well as meet the elective recovery target of 115% new outpatient and inpatient activity episodes against 2019/2020 activity; and a reduction of follow up patients to 75% of 2019/20 activity.

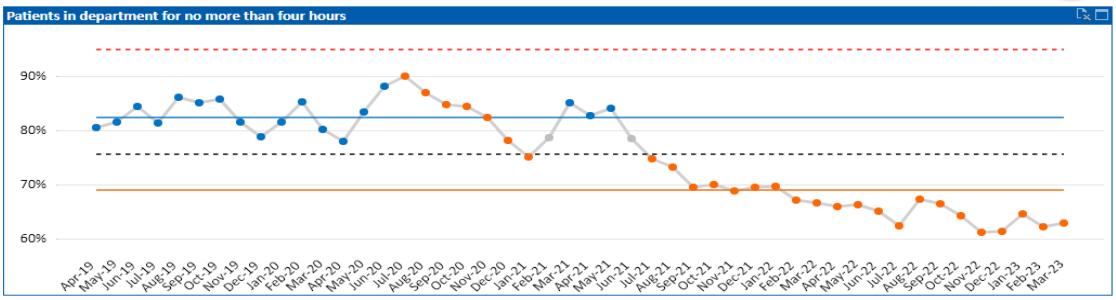
The Trust invited the Elective Intensive Support Team to review its processes and pathways to follow up on the work which was commenced prior to the pandemic. The demand and capacity work which the Trust undertakes was reviewed by the team and the feedback was that this was a very comprehensive piece of work and no actions required to change process.
Further work is scheduled to continue with the team in 2023/2024.

- **A&E (the target is for 95% of patients seen, treated and either admitted or discharged within four hours of arrival)**

The end of year position saw the Trust achieving 64.2%. The target for 2023/2024 is set at 76% so the Trust has already started a series of actions to work towards achieving and exceeding this to get back towards performance of 95%.

During 2022 the Trust undertook major capital work within its emergency department, both adult and paediatric and the Same Day Emergency Care (SDEC) department. This work while underway prevented expansion of alternative pathways, direct access by GP and ambulances to assessment space and adequate flow of patients to meet their needs and achieve the targets. Better space is now open and will support improved

performance. The establishment of the surgical assessment unit and new patient pathways will be a focus for 2023/2024.
The Trust through comprehensive planning ensured that the department was safely managed during the March 2023 non consultant medical staff industrial action.



Month	Lister Atts	QEII Atts	TOTAL Atts	TOTAL Breaches	Trust
Apr-22	9307	5419	**14726**	**5013**	**65.96%**
May-22	10288	6119	**16407**	**5519**	**66.36%**
Jun-22	9618	5841	**15459**	**5378**	**65.21%**
Jul-22	9874	5782	**15656**	**5884**	**62.42%**
Aug-22	9022	5610	**14632**	**4785**	**67.30%**
Sep-22	9076	5336	**14412**	**4840**	**66.42%**
Oct-22	9816	5847	**15663**	**5580**	**64.37%**
Nov-22	9771	5636	**15407**	**5974**	**61.23%**
Dec-22	10000	5977	**15977**	**6160**	**61.44%**
Jan-23	8605	5067	**13672**	**4840**	**64.60%**
Feb-23	8492	4793	**13285**	**5004**	**62.33%**
Mar-23	9719	5562	**15281**	**5674**	**62.87%**

- **Cancer performance**

Cancer performance was not sustained fully over the course of 2022/23. The 62-day cancer target was achieved for four months out of twelve months, and our performance against this standard remains one of the best regionally. Across all the cancer standards, the year-end position was compliant with 3 of the 8 standards and within 0.5% of achieving a further two standards. [please colour these 2 in amber rather than red – 2WW breast and 31 day subsequent – radiotherapy]

Report Pathway	Performance	Target
2WW GP Referral to First Outpatient	93.9%	93%
2WW Breast Symptoms - Cancer not initially suspected	92.8%	93%
31 Day Second or Subsequent Treatment - Anti-Cancer Drug	99.7%	98%
31 Day Second or Subsequent Treatment - Surgery	89.8%	94%
31 Day Second or Subsequent Treatment - Radiotherapy	93.6%	94%
31 Day DTT to First Definitive Treatment	96.7%	96%
62 Day Referral to Treatment from Screening	75.4%	90%
62 Day Urgent Referral to Treatment of All Cancers	83.2%	85%

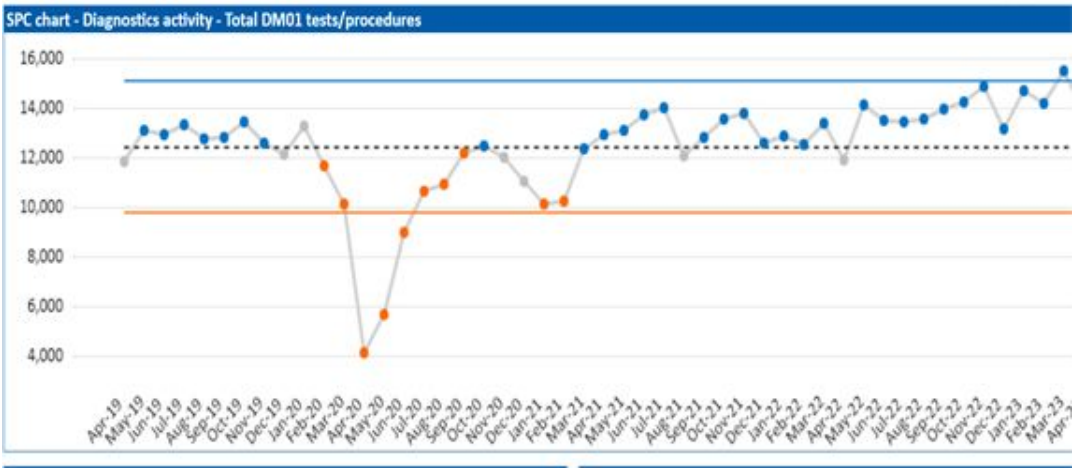
A factor for this underperformance was the high number of 2 week wait referrals putting substantial pressure on the Trust capacity in Endoscopy, Radiology and Histopathology.
Staffing issues in Anaesthetic, radiology and radiotherapy departments caused delays in the cancer pathways; these all have remedial plans in place to improve this in 2023/2024.

Demand and capacity exercises to confirm what resources and capacity we need to deliver the increased demand and sustain performance have been completed alongside a workforce plan which will include clarity on actual additional staff needed to meet the demand.
The medical extra contractual pay issue has been largely resolved which supports the additional capacity needed to meet demand.

The Elective Intensive Support Team is supporting pathway analysis for all Tumour Sites so we can clearly identify delays and make changes to improve the pathway. The 2 week wait pathway was flagged by this external team as being a show case for other Trusts due to its grip and control and achievement of the target.

- **Diagnostics (DM01) (less than 1% of patients should wait 6 weeks or more for a diagnostics test**)

As mentioned previously the demand on services has exceeded capacity. The Trust is working with system partners to manage this demand alongside the increase in activity through the community diagnostic hubs.



- **Stroke performance**

The Trust's performance continues at level D despite there being some improvements to some of the domains.

The four-hour performance continued to be a challenge initially due to the requirement for covid testing prior to bed placement, but in the latter part of the year this is generally due to stroke bed capacity. Further work will take place to protect bed capacity for stroke patients.
There have been improvements in the provision of both occupational therapists and physiotherapists; recruitment continues as well as reviewing their input and documentation.

Speech and language therapy input continues to be an area of concern and the Trust alongside its system partners are reviewing different models of care and delivery to mitigate staffing shortfalls.

The initial scanning of patients with suspected stroke remains at the highest score meaning that stroke can be diagnosed, and appropriate treatment commenced as early as possible.
Thrombolysis remains at level D due to the low number of eligible patients although there has been a change in the clinical guidelines which the Trust have implemented and will be reviewing the impact of. The Trust is also competing a missed opportunity audit and undertaking visits to other stroke units with better performance to develop our learning.

Seven Day Service

The Seven Day Hospital Services (7DS) Programme is a nationally driven quality improvement initiative and supports providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency and at the weekend across NHS Trusts in England. Guidance issued in 2022 requires NHS Trusts

to assess at least once a year whether their acute services are meeting four national priorities seven-day standards(of the 10 standards), using the board assurance framework. These four standards are: -

Standard 1 – all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission. A recent sample audit identified that approximately 60% of patients were reviewed within 14 hours of admission. The table below details the schedule for on-site consultant cover for our acute specialties: -

Speciality	**7-day Consultant on-site rota cover**
Acute Medicine/General Internal Medicine	0800-2100
Anaesthetics	0800-1800
Critical Care	0800-1800
Emergency Department	0800-2200
General Surgery	0800-1800
Obstetrics	0830-1715
Paediatrics	0830-2100
Respiratory	0830-1800
Trauma and Orthopaedics	0800-1800

Standard 5 – inpatients must have scheduled 7-day access to diagnostic services. The table below details our compliance with Standard 5 regarding access to these emergency diagnostic tests

Emergency diagnostic test	**Available on site at weekends**
USS	Yes
CT	Yes
MRI	Yes
Endoscopy	Yes
Echocardiography	Yes
Microbiology	Yes

Standard 6 – inpatients must have timely 24-hour access to key consultant -directed interventions. The table below shows the level of compliance with Standard 6 regarding 24/7 access to emergency consultant-led interventions:

Emergency intervention	**Available on site at weekends**	**Available via network at weekends**	**Not available**
Intensive care	Yes		
Interventional radiology	Yes		
Interventional endoscopy	Yes		
Surgery	Yes		
Renal replacement therapy	Yes		
Radiotherapy	No	Yes	
Stroke thrombolysis	Yes		

Stroke thrombectomy		Available 7 days per week	
PCI for MI	Yes		
Cardiac pacing	Yes		

At the time of this account being drawn up, complete data sets was unavailable

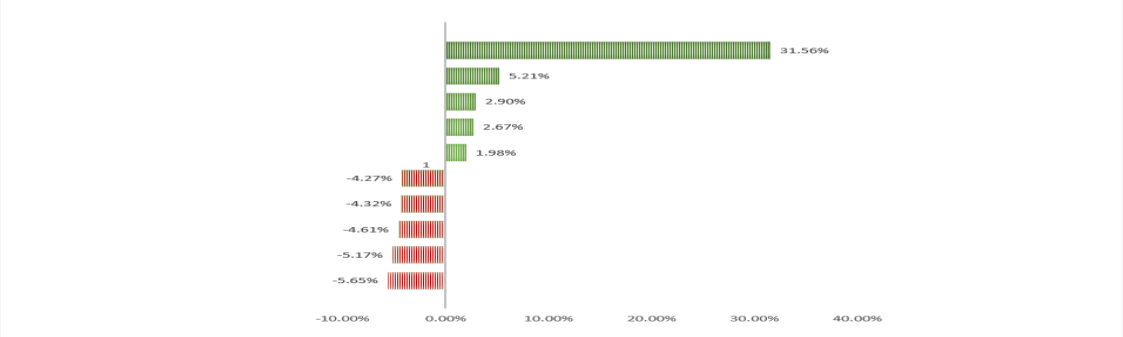
Standard 8 – patients with high dependency needs should be seen by a consultant twice daily; then daily once a clear plan of care is in place. A recent audit identified that approximately 60% of a sample of patients were reviewed within 14 hours of admission.

The Trust is currently undertaking an audit of its current provisions and the outcome would be discussed at board.

Staff/ National staff survey

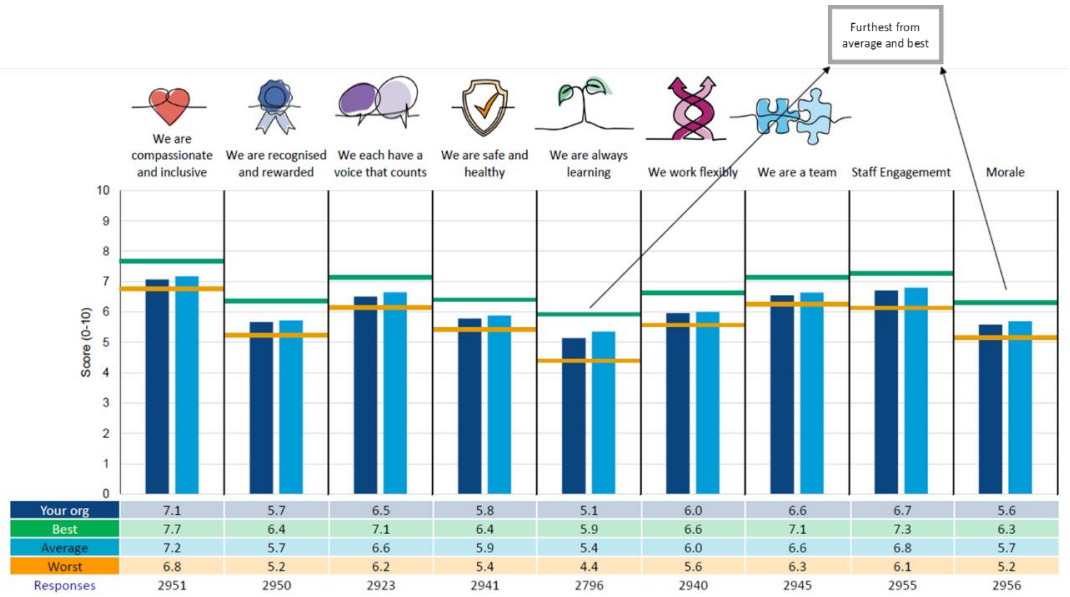
For 2022/23, we will focus primarily on themes around the following and continue work in other areas:

- We are Compassionate and Inclusive
- We are a team
- We are always learning



Key survey questions were around violence at work, reporting violence, opportunities for career development, accessing learning and development, prioritisation of patient care, raising concerns, friend and family referral by staff, levels of pay and work flexibility.

The survey results show improvement in people being clear about their objectives in work and this helping them improve doing their job and we can see more people reporting their experiences at work and progressing their career and an overall increase completion of staff survey within the Trust occurred.
We have completed the first part of cultural intelligence with the Board to support our EDI commitments and actions from last year's survey results and more work is to follow on our staff with disabilities and development of mentoring and coaching within the Trust during 2023.
The Trust continues with consistent approaches to improve culture including embedding our refreshed values and development of staff values charters, we use stay interviews and other interventions to support changing culture and encouraging safter and more inclusive environments for our staff.



Your org	7.1	5.7	6.5	5.8	5.1	6.0	6.6	6.7	5.6
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2951	2950	2923	2941	2796	2940	2945	2955	2956

Freedom to Speak Up / Raise Concerns

The National Guardian's Office (NGO) and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report which investigated failures in care at the Mid Staffordshire NHS Foundation Trust. These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. The NGO leads, trains and supports Speaking Up strategy within the NHS including monitoring the number and themes of concerns raised by NHS staff.

NHS Trusts are required to appoint a lead Non-Executive Director with the responsibility for providing oversight and guidance. We appointed to this role in February 2023. Governance is provided by the People Committee, providing assurance in relation to process and clear connectivity to the People Priorities and People Promise.
In March 2022, we appointed our first Freedom to Speak Up Guardian as an individual and targeted role providing an accessible 5-day service. This increased investment in supporting our colleagues to Speak Up demonstrates a positive shift within our Trust to building an open, transparent, and psychologically safe work environment.

The FTSU Guardian has ensured that:
1. Staff members who have approached her with concerns are supported in speaking up.
2. Any barriers to speaking up are addressed promptly
3. Helped influence a positive culture of speaking
4. Issues raised are used as opportunities for learning and improvement.

Assessment of issues
Total number of concerns raised this financial year (2022/23): **112**

	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	Total
Total Cases	40	31	81	39	191

Themes:
This is in line with the NGO's recommended themes. The breakdown is as follows:

Themes	**Number**	**Percentage**
1. Management Issues	94	49%
2. Systems and	25	13%

processes		
3. Bullying and Harassment	14	7%
4. Discrimination / Inequality	6	3.0%
5. Inappropriate attitudes or behaviours	37	20%
6. Patient Safety	15	8%
7. Other	0	0%
Total	191	100%

Learning and Improvement:

Ongoing improvements are being made to support staff to improve ‘speaking up’’. This is supported by an online skills training on the Trust’s training academy.

Part 3: Other information

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

Statement from Hertfordshire and West Essex NHS ICB

Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) response to the Quality Account of East and North Hertfordshire NHS Trust for 2022/2023.

NHS Hertfordshire and West Essex Integrated Care Board (HWE ICB) welcomes the opportunity to provide this statement on the East and North Hertfordshire NHS Trust Quality Account for 2022/23. The ICB would like to thank the Trust for preparing this Quality Account, developing future quality assurance priorities, and acknowledging the importance of quality at a time the provider continues to deliver services during ongoing challenging periods. We recognise the dedication, commitment and resilience of staff and we would like to thank them for this.

HWE ICB is responsible for the commissioning of health services from East and North Hertfordshire NHS Trust. During the year HWE ICB have worked closely with East and North Hertfordshire NHS Trust gaining assurance on the quality of care provided to ensure it is safe, effective and delivers a positive patient experience. In line with the NHS (Quality Accounts) Regulations 2011 and the Amended Regulations 2017, the information contained within the East and North Hertfordshire NHS Trust Quality Account has been reviewed and checked against data sources, where this is available, and confirm this to be accurate and fairly interpreted to the best of our knowledge.

During 2022/23 the Nursing and Quality Team have worked closely with the Trust, meeting routinely to review a range of areas related to both quality and safety. The ICB worked in partnership with the Trust to undertake Quality Assurance Visits obtaining assurances regarding the quality of care provided, and where identified improvements were highlighted, provided relevant support to embed the needed changes.

Following the Care Quality Commission's (CQC) inspection in 2019, the Trust's rating has remained as 'Requires Improvement'. In October 2022, the Trust received a CQC inspection within the Maternity department in which a Section 29A notice was issued, and we have noted that the elements of care identified as requiring action and improvements are described in the Quality Account. The Trust continue to focus on their CQC Improvement Plan and progress is regularly reported to the ICB as well as Trust Board and CQC.

During 2022/23 ENHT achieved mixed results in a range of areas regarding quality, patient safety and patient experience, and the ICB is pleased to see the progress so far in relation to Quality Improvements in these areas. This is particularly pertinent in relation to the recognition of deteriorating patients and the Harm Free Care programme. The ICB also welcomes the progress made by the Trust with the Clinical Excellence Accreditation Framework and achieving the Pathway to Excellence® designation.

The ICB notes the recent improvements achieved in relation to sepsis care and will continue to seek assurance that these alongside venous thromboembolism (VTE) risk assessments continue to move in the required direction and that related performance is sustained.

Recognising that there have sadly been a number of Covid-19 related deaths nationally and locally, it is positive that non-Covid-19 mortality rates have remained stable overall and Summary Hospital-level Mortality Indicator data reported throughout the year is positioned in the 'as expected' range. Where outliers are identified the Trust has

worked pro-actively to identify any improvements required. It is also encouraging to see the work undertaken to reduce mortality and ensure learning and robust processes are in place.

In relation to Infection Prevention Control, the Trust reported one MRSA bacteraemia case for 2022/23 within its neonatal patient group and there continues to be targeted IPC support to the maternity service. Cases of Clostridium difficile have been above the annual ceiling and all cases have undergone a review, towards learning and improvement. The ICB will continue to have oversight and seek assurance regarding Clostridium difficile cases for 2023/24.

During 2022/23 the Trust reported 3 Never Events; a decrease from the four reported the previous year. The ICB are pleased to note the ongoing actions and identified learning related to these incidents and would anticipate seeing a reduction in Never Events occurring in 2023/24.

The timeliness of complaint responses has seen a decrease in performance during 2022/23. The ICB acknowledges the added pressures that have impacted on this, and the work planned by the Trust in 2023/24. The ICB looks forward to seeing future improvements in this area and in ensuring that patients and families receive prompt responses to concerns raised.

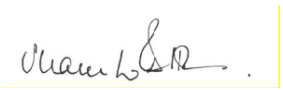
The Trust has undertaken a significant amount of work to improve the quality and timeliness of discharge summaries. Whilst the ICB recognises the strong focus in this area, it is aware that ongoing work is needed to achieve the Trust standard. The ICB expects this to be an ongoing focus for 2023/24 and looks forward to seeing a continued focus on the timeliness of both discharge summaries and clinic letters sent to primary care to support patient care.

Cancer performance was not fully sustained over the course of 2022/23. The 62-day cancer target was achieved for four months out of twelve months, and the year-end position showed compliance within three of the eight cancer standards. The ICB is pleased to see that improvements continue to be made in this area and would encourage the Trust to keep a strong commitment in this area, to support achieving and maintaining performance across related standards.

The 2022 annual staff survey results for the Trust showed areas of progress as well as those requiring action for improvements, including related to culture and the ICB recognises the ongoing work and commitment within the Trust in progressing these.

The ICB supports the Trust's 2023/24 quality priorities including the improving care of deteriorating patients and compliance with the sepsis pathway. Additionally, the ICB wishes to see improvements in compliance with VTE risk assessments, 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.

The ICB recognises the challenges experienced by the Trust in 2022/23 and we look forward to a continued collaborative working relationship as well as building on existing successes and collectively taking forward needed improvements to deliver high quality services for this year and thereafter.



Sharn Elton
Place Director, East and North Hertfordshire

Hertfordshire and West Essex ICB

Statement from Hertfordshire Healthwatch

Healthwatch Hertfordshire welcomes the openness of the Trust in hearing our patient experience feedback of it's services and more generally about our health inequalities research.

We have also appreciated the regular updates on quality improvements at the Trust in particular to maternity services and urgent and emergency care.

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.

Statement of adjustment following receipt of written statements required by section 5(1) (d) of the National Health Service (Quality Account) Regulations 2010

There are no major adjustments to be made following the receipt of written statements.

Annex 2: 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 2023 Date Chair

30 June 2023 Date Chief Executive

Appendix:

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum.
However, following updated guidelines published by NHSE, certain exceptions/changes have been made for 2022-23. These are

- NHS foundation trusts are no longer required to produce a Quality Report as part of their Annual Report. NHS foundation trusts will continue to produce a separate Quality Account for 2022-23.

- There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account and this is a matter for local discussion between the Trust (or governors for an NHS foundation trust) and its auditor. For quality accounts, approval from within the Trust's own governance procedures is sufficient.

- The publication process continues from last year's advice and Integrated Care Boards (ICBs) will assume Clinical Commissioning Group (CCG) responsibilities for the review and scrutiny of Quality Accounts (subject to the Health and Care Bill receiving Royal Assent). However, where this function has not transferred from CCGs to ICBs, CCGs must continue to undertake the review it for the 2022-23 reporting cycle.

Publishing requirements for the Trust's Quality account have also changes and all Trusts are no longer required to upload a copy of their quality accounts onto the NHS.uk website rather, Trusts are to ensure that their quality accounts are published on an appropriate page on its website (which is clearly visible and easily accessed by members of the public

Glossary

Acronym	Meaning
AKI	Acute Kidney Injury
AMS	Antimicrobial Stewardship
C-DIFF	Clostridium difficile
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSW	Care Support Worker
Enhance	Trust's Risk and Incident Management System
ENHT	East and North Hertfordshire NHS Trust
ED	Emergency Department
ePMA	Electronic Prescribing Medicines Management
EOLC	End of Life Care
FFT	Friends and Family Test
GP	General Practitioner
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
MRSA	Methicillin-Resistant Staphylococcus Aureus
NELA	National Emergency Laparotomy Audit
NHS	National Health Service
NIHR	National Institute for Health Research
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
PROM	Patient Reported Outcome Measures
PST	Patient Safety Team
PSIRF	Patient Safety Incident Response Framework
PSAAG	Patient Status At A Glance
QI/P	Quality Improvement/Project
RCA	Root Cause Analysis
PIFU	Patient initiated follow up
RTT	Referred to Treatment
SHMI	Summary Hospital Level Mortality Indicator
SJR	Structured Judgement Review
StEIS	Strategic Executive Information System
SUS	Secondary Uses service
VTE	Venous thromboembolism
WMTY	What Matters To You

East and North Hertfordshire NHS Trust

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	16
Report title	Committees Terms of Reference changes		**Meeting Date**	5 July 2023
Presenter	Stuart Dalton, Head of Corporate Governance			
Author	Stuart Dalton, Head of Corporate Governance			
Responsible Director	Martin Armstrong, Deputy Chief Executive		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

Following reviews by their respective committees, the following revised committee terms of reference are presented for approval for, which largely relate to updating membership:

- Finance, Performance & Planning Committee
- Quality & Safety Committee

The revisions are shown tracked changes for ease of reference.

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 **APPROVE** the changes the terms of reference.

To be trusted to provide consistently outstanding care and exemplary service

East and North Hertfordshire NHS Trust

FINANCE, PERFORMANCE AND PLANNING COMMITTEE

TERMS OF REFERENCE

1. Purpose

The purpose of the Finance, Performance and Planning Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and other short term planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee will play a key role in ensuring the sustainability of the Trust.

The Committee's work will include:

- maintaining an overview of the development and maintenance of the Trust's medium and long term financial strategy;
- providing scrutiny of operational performance;
- providing scrutiny of the implementation of the business plans to deliver the Trust's long-term strategy;
- overseeing risk management for the duties of the Committee.

The Committee shall be kept informed of any developments relating to the Hertfordshire and West Essex Integrated Care System that may impact on the work of the Committee.

2. Status & Authority

The Committee is constituted as a formal Committee of the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3. Membership

Three Non-Executive Directors, one of whom will be nominated as Chair

Core Attendees:

- Chief Executive
- Director of Finance
- Chief Operating Officer
- Chief People Officer (bi-monthly for workforce agenda items)
- ~~Director of Nursing~~
- ~~Medical Director~~

- Chief Information Officer
- Director of Improvement

Attendees:

- Chief Nurse
- Medical Director
- Director of ~~Improvement and Transformation~~Estates
- Deputy Director of Finance Financial Management
- Deputy Director of Finance Financial Planning
- Deputy Director of Workforce and OD
- Deputy Chief Operating Officer

All other Non-Executive Directors/Directors are welcome to attend.

Other staff will be invited to attend to present an item to the Committee or to support their personal development with the prior agreement of the Committee Chair.

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

4. Quorum

~~Two Non-Executive Directors~~The Committee will be quorate if two non-executive members are present, and two core attendees; one of ~~whom should~~which must be ~~either:~~

- the Director of Finance and the other must be the Chief Operating Officer or ~~in~~ their ~~absence~~respective nominated Representative.

- ~~Chief Executive and a designated Finance representative~~

5. Frequency of meetings

The Committee will meet every month (with the exception of August) and prior to Trust Board meetings. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

6. Duties

6.1 Financial Planning

Act as an Assurance Committee of the Trust's business and finance risks through the following activities:

To approve:

- Individual investment decisions including a review of Outline and Full Business Cases between £500k and £1 million.

To approve and recommend to the Board:

- The Trust's Business Plan, including the approved financial framework to support the delivery of the Trust's strategic objectives;
- The Medium Term Financial Strategy including the Long Term Financial Model;
- Proposals for the reinvestment of any surpluses generated by the Trust in undertaking its operational activities;
- Adoption of the annual plan and budgets for revenue and capital;
- For investment decisions or schemes in excess of £1 million, the Committee will make a recommendation to the Trust Board, who will ultimately make a decision on the proposal;
- The Cost Improvement Programme. Any potential concerns on quality are to be referred to the Quality and Safety Committee (QSC).

To monitor and review:

- Financial impacts relating to enabling strategies (specifically the digital, estates and capital strategies);
- The capital programme and work of the Capital Review Group;
- The development of the annual Cost Improvement Programme and oversee development of the rolling programme that is to be incorporated into the Long Term Financial Model and monitor in-year delivery;
- Value for money and efficiency issues as required to ensure problem areas are addressed and action taken as appropriate;
- Financial implications relating to the system collaboration framework;
- The development of financial forecasts and measures taken to promote financial sustainability.

6.3 Financial Performance

Regularly review the performance of the Trust against financial performance targets as described in the NHS Performance Management Framework (NHS Trust). This review should include:

To monitor and review:

- Financial performance in relation to both the capital and revenue budgets;
- Financial performance in relation to activity and Service Level Agreements;
- Financial performance in relation to sensitivity analysis and the risk environment;
- To commission and receive the results of in depth reviews of key financial issues affecting the Trust;
- To monitor the progress of the Trust's strategic projects;

- To monitor the benefits realisation of major projects.

6.4 Operational Performance

To monitor and review the Trust's operational performance, including consideration of issues such as winter preparedness and bed planning, significant operational service developments and compliance with national performance standards.

The Committee will receive regular updates regarding the national performance standards, currently:

- A&E,
- Cancer waiting times,
- Referral to treatment,
- Diagnostics,
- Stroke.

To work closely with the QSC to understand any quality and safety implications associated with operational performance.

To be kept appraised of operational performance matters relating to system collaboration.

To receive an agreed programme of deep dives relating to significant operational issues.

6.5 Workforce

To monitor and review risk areas that relate to Trust's workforce metrics impacting on our operational performance and financial planning including but not limited to: temporary staffing, recruitment and establishments.

6.6 Planning

To act as the lead assurance committee for the implementation of short-term business plans to deliver the Trust's long-term strategy.

To gain assurance on the design and delivery of transformation in support of the Trust's strategy.

To monitor and review at a strategic level:

- annual business plans to deliver the Trust's strategy, providing assurance and exception reporting to the Board on strategy delivery progress;
- delivery of the major strategic programmes within the business plans;
- oversee development of the integrated performance report measures for delivery of the strategy.

- financial planning to deliver the Trust's strategy and where relevant develop proposals for discussion/agreement by Trust Board;
- the Trust's strategic plans for IT/Digital, Estates and the Green Plan.

6.7 Other duties

To monitor and review:

- Procurement activities, progress against savings targets, ~~tender waivers~~ and key strategic tenders.
- Major change projects which may impact on the core areas of the Committee's work.
- Review elements of the Trust's workforce metrics impacting on our operational performance including but not limited to: temporary staffing, recruitment, establishments.

6.8 Risk Reporting

The Committee will regularly receive risk register reports for the areas relevant to its duties for review and consider with the appropriate escalation to the Trust Board and for incorporation within the Board Assurance Framework.

7. Reporting arrangements

The Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board, Executive Committee and Executive Directors for these groups/individuals to take appropriate action.

8. Process for review of Committee's work including compliance with terms of reference

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

- The Committee report to Trust Board;
- FPPC annual evaluation and review of its terms of reference.

9. Support

The Trust Secretary will ensure the Committee is supported administratively and advise the Committee on pertinent areas.

East and North Hertfordshire NHS Trust

QUALITY AND SAFETY COMMITTEE
TERMS OF REFERENCE

1. Purpose

The purpose of the Quality and Safety Committee (QSC) will be to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, health inequalities, research governance, information governance, health & safety, patient and public safety, compliance with CQC regulation and workforce issues ~~relating to the 'Grow Together' pillar of the People Strategy, or~~ where there is a clear and direct link to quality and safety issues. The Committee will be responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy and Quality Strategy.

Please note the Trust's Audit and Risk Committee will ensure the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk and the Finance, Performance and ~~People~~ Planning Committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances QSC will provide scrutiny.

2. Status and Authority

The Committee is constituted as a formal committee of the Trust Board.

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

The Committee challenges and provides assurance on all areas of risk within the remit of the Committee to the Audit Committee and the Trust Board. Please note: the Audit Committee provides an independent and objective review of the appropriateness and fitness for purpose of the Trust's systems of internal control and risk to the Trust Board.

3. Membership

Three Non-Executive Directors, one of whom will chair the committee.

Core Attendees

Chief Executive
Chief Nurse
Medical Director
Chief Operating Officer or nominated deputy
Chief ~~People~~ Finance Officer or nominated deputy

Other attendees:
Director of Quality
Associate Medical Directors
Deputy Chief Nurse
Chief Pharmacist
Patient Safety Leads
Head of Corporate Governance
Director of Midwifery
Director of Estates and Facilities
Director of Improvement

In addition to the above list of attendees the committee will co-opt attendance as required from the Chief Information Officer, Divisions, Infection Control, Health and Safety, Patient Safety, Clinical Governance, Information Team etc.

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

4. Quorum

The Committee will be quorate if two non-executive members are present, and two core attendees; one of which must be the Medical Director or ~~Director of Nursing~~Chief Nurse or their nominated representative.

5. Frequency of Meetings

The Committee will normally meet monthly with the exception of August (unless a meeting is required). The format of the meetings will be agreed with the Committee Chair and some meetings may include a focus on deep dive presentations if deemed appropriate and effective. The Chair of the Committee may convene additional meetings if required to consider business that requires urgent attention.

All attendees are expected to attend each meeting or to send a nominated deputy when they are unable to do so.

6. Duties

Managing Quality and Safety Risks

- To provide assurance to the Board that the services the Trust provides meet all national standards and are safe, effective, high quality and patient-focused
- To endorse and monitor the Trust's key governance strategies relating to quality and safety, such as the Quality Strategy.
- To review and monitor the Board Assurance Framework and the Corporate Risk Register risks assigned to the Committee, ensuring appropriate action is taken to mitigate risks where possible and advise the Board where acceptance of risk may need to be considered
- To monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. Care Quality Commission, NHS resolution, Health & Safety Executive (HSE), NHS Improvement (NHSI) and ensure action is taken for compliance.
- To improve and develop the effectiveness of the quality and safety assurance systems across the Trust by monitoring activity across the Trust through regular reports specified by the Committee in the Committee's Annual Cycle, and by exception

- To receive reports and monitor the progress in mitigating quality and safety risks arising from the Trust's major service developments
- To review the quality risk assessment of the CIP programme
- To work with the Audit and Risk Committee when appropriate, and specifically in agreeing the Annual Internal Audit plan and providing a review of effectiveness on the clinical audit.

Ensuring Compliance

- To monitor and advise the Board on progress against national and local quality and safety governance standards and compliance framework.
- To receive and review regular progress reports for achieving compliance against all aspects of the Quality of Services through the monitoring of the Fundamental Standards and CQC regulations.
- To monitor and advise the Board on compliance with the Hygiene Code and CQC Registration and Regulation
- To receive reports on the changes to Healthcare Regulation and assurance as to how the Trust will manage this process
- To review and approve the annual reports as stated in the annual cycle, with the exception of Health and Safety and Safeguarding which will be scrutinised prior to final approval by Trust Board
- ~~To approve the annual declaration of the Data Security and Protection toolkit~~
- Working with the Audit Committee to approve the Quality Account

Improving Quality

- To endorse and monitor the implementation of the Trust's key quality strategies.
- To receive regular reports from the Trust and Divisions on Patient Safety and Clinical Quality and Outcomes ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Patient Experience Indicators ensuring appropriate action is taken
- To receive regular reports from the Trust and Divisions on Nurse/Patient Indicators and safer staffing ensuring appropriate action is taken.
- To review the biannual nursing establishment review prior to consideration and decision by the Trust Board.
- To support the implementation of quality improvement programmes.
- To be advised of the progress of any major quality initiatives in the Trust.
- Deliver better health outcomes for our whole community, and actions to reduce health inequalities.
- Improve access and experience for our patients.
- Improve data collection, use and reporting in relation to equalities and inclusion.
- ~~Devise and monitor appropriate KPIs for equalities and inclusion to enable effective scrutiny of delivery against the equalities and inclusion priorities.~~
- ~~To receive regular reports on the 'Grow Together' pillar of the People Strategy, including regarding learning and education, statutory and mandatory training, talent management, clinical staffing establishment requirements and the report of the Guardian of Safe Working Hours.~~
- To consider reports regarding any ~~other~~ workforce issues where there is a clear and direct link to quality and safety issues~~, such as regarding the work of the Freedom to Speak Up Guardian~~.
- To monitor the quality and safety performance metrics.
- ~~To monitor the delivery of the annual plan and receive the annual report from the Joint Management Group in relation to the Trust's partnership with the University of Hertfordshire.~~

7. Reporting arrangements

The Committee will provide a report of each meeting to the Trust Board. It will make recommendations to the Board, Executive Team and Executive Directors for these groups/individuals to take appropriate action.

The Committee will provide reports to the Audit Committee as requested.

The core attendees and attendees will provide reports to the committee in relation to all areas of their portfolio and in line with the Annual Cycle and Action Log.

8. Process for review of the Committee's work including compliance with terms of reference

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

- The Committee report to Trust Board
- QSC annual evaluation and review of its terms of reference

9. Support

The Trust Secretariat will ensure the committee is supported administratively and advising the Committee on pertinent areas.

Approved at Board on 5 July 2023

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 02 | 2023-24

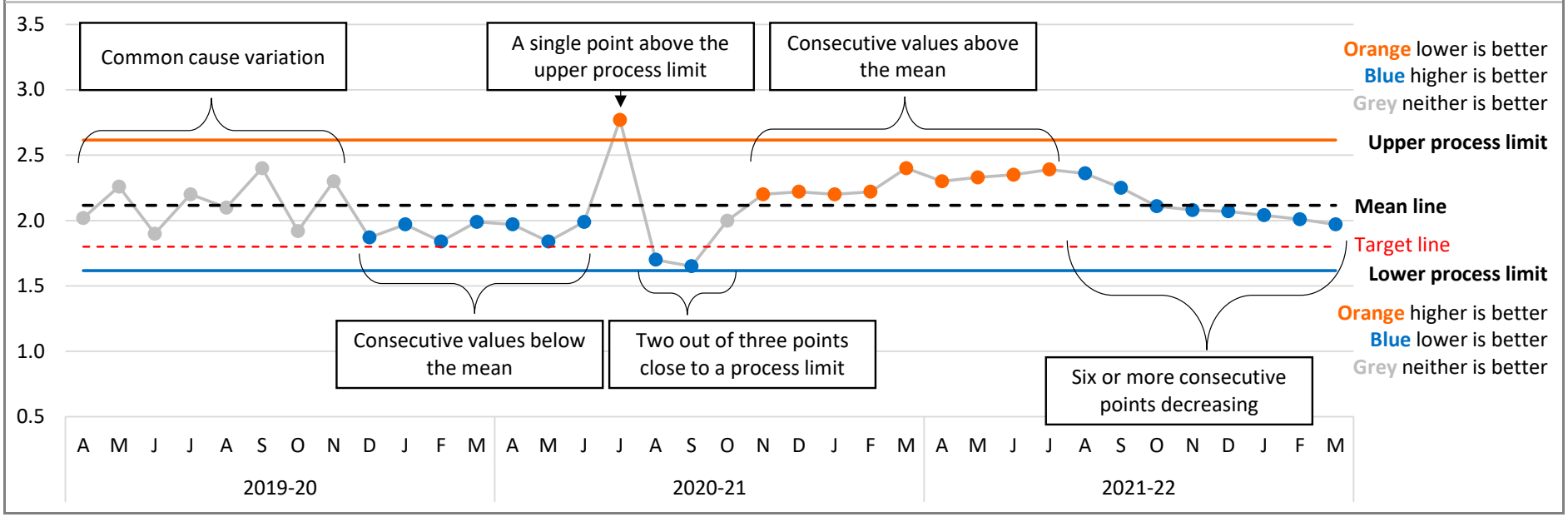
	P	?	F
H, L	0	4	4
	9	45	6
H, L	3	12	8

Data correct as at 23/06/2023

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



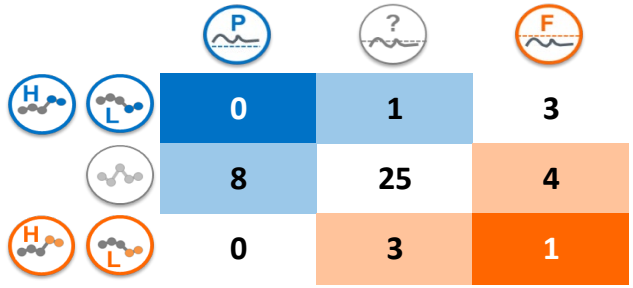
Variation	
H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

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

East and North Hertfordshire NHS Trust

Quality

Month 02 | 2023-24



Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	May-23	n/a	1,285			Common cause variation No target
	Serious incidents in-month	May-23	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-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	May-23	0	10		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	May-23	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	May-23	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	May-23	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	May-23	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	May-23	0	0	L	?	9 consecutive points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	May-23	80%	88.8%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	May-23	n/a	81.7%			Common cause variation No target
	Staff shortage incidents	May-23	n/a	11			Common cause variation No target

Month 02 | 2023-24

Quality

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-23	n/a	0.71			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	May-23	n/a	0.83			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	May-23	95%	0.0%	L	?	2 points below the lower process limit Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	May-23	95%	66.7%		F	Common cause variation Metric will consistently fail the target
	ED attendances receiving IVABs within 1-hour of red flag	May-23	95%	86.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	May-23	95%	68.9%	H	F	19 consecutive points above the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	May-23	85%	85.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	VTE risk assessment for stage 2, 3 and / or 4	May-23	85%	68.1%		F	One point above the upper process limit Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	May-23	n/a	96	H	?	Two points above the upper process limit No target
	Number of HAT RCAs completed	May-23	n/a	16			Common cause variation No target
	HATs confirmed potentially preventable	May-23	n/a	1			Common cause variation No target
PU	Pressure ulcers All category ≥2	May-23	0	19		F	Common cause variation Metric will consistently fail the target

Month 02 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	May-23	n/a	3.5			Common cause variation No target
	Proportion of patient falls resulting in serious harm	May-23	n/a	0.0%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Jan-23	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Feb-23	6.0%	5.8%			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	May-23	95%	96.3%		P	Common cause variation Metric will consistently pass the target
	A&E positive feedback	May-23	90%	95.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	May-23	93%	100.0%	H	F	5 points above the upper process limit Metric will consistently fail the target
	Maternity Birth positive feedback	May-23	93%	100.0%	H	F	3 points above the upper process limit Metric will consistently fail the target
	Maternity Postnatal positive feedback	May-23	93%	94.1%		?	Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	May-23	93%	0.0%	L	F	5 points below the lower process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	May-23	95.0%	98.2%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	May-23	n/a	252		-	Common cause variation No target

Month 02 | 2023-24

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	May-23	n/a	53		-	Common cause variation No target
	Number of complaints closed in-month	May-23	n/a	86		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	May-23	75%	98.1%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	May-23	80%	35.9%	L	?	1 point below the lower process limit Metric will inconsistently pass and fail the target
Maternity Safety Metrics	Caesarean section rate Total rate from Robson Groups 1, 2 and 5 combined	May-23	60 - 70%	63.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	May-23	3.3%	1.7%		P	Common cause variation Metric will consistenly pass the target
	Massive obstetric haemorrhage >1500ml LSCS	May-23	4.5%	1.0%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear vaginal	May-23	2.5%	2.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	3rd and 4th degree tear instrumental	May-23	6.3%	6.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	May-23	6.0%	5.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	May-23	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

Month 02 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	May-23	12.5%	6.7%		P	Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	May-23	2.3%	4.8%		F	Seven consecutive points above the mean Metric will consistently fail the target
	Bookings completed by 9+6 weeks gestation	May-23	50.5%	69.0%		P	Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	May-23	72.7%	78.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Number of serious incidents	May-23	0.5	0		?	Common cause variation Metric will inconsistently pass and fail the target
	SLA income against plan (£m)	May-23	2.7	2.6		?	Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	May-23	12.8	10.3		?	Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	May-23	12.8	11.5			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Mar-23	100	98.3		?	Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Mar-23	100	94.8			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Dec-22	100	99.0		?	Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Dec-22	100	89.3			Rolling 12-months - unsuitable for SPC

Month 02 | 2023-24

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Jan-23	n/a	501			Common cause variation No target
	Rate of emergency re-admissions within 30 days of discharge	Jan-23	9.0%	5.7%		P	Common cause variation Metric will consistently pass the target
Length of Stay	Average elective length of stay	May-23	2.8	2.4		?	Common cause variation Metric will inconsistently pass and fail the target
	Average non-elective length of stay	May-23	4.6	4.6		?	Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	May-23	n/a	95.4%	H		10 points rising No target
	Individualised care pathways	May-23	n/a	38			Common cause variation No target

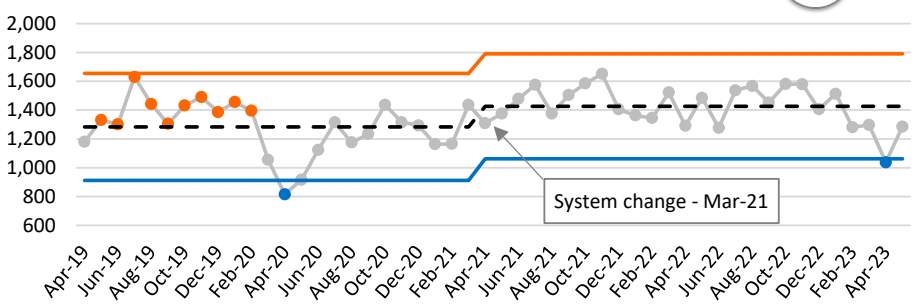
Month 02 | 2023-24

Quality

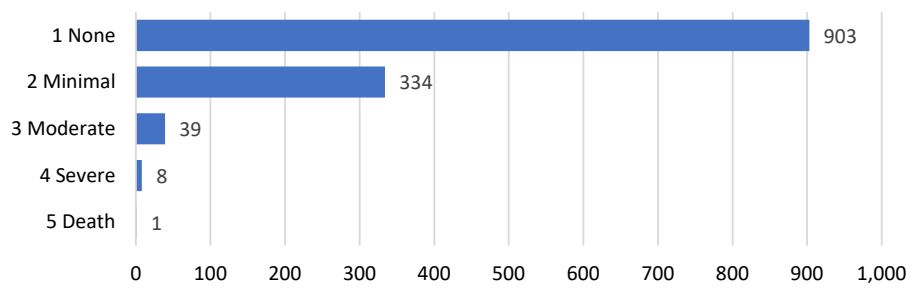
Patient Safety Incidents

East and North Hertfordshire NHS Trust

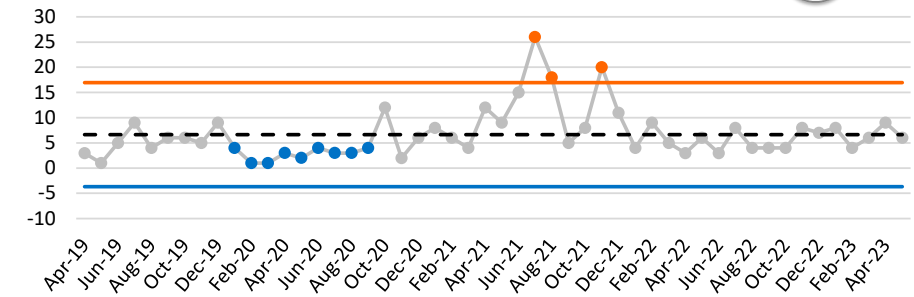
Total incidents reported



Number of incidents by level of harm - May-23



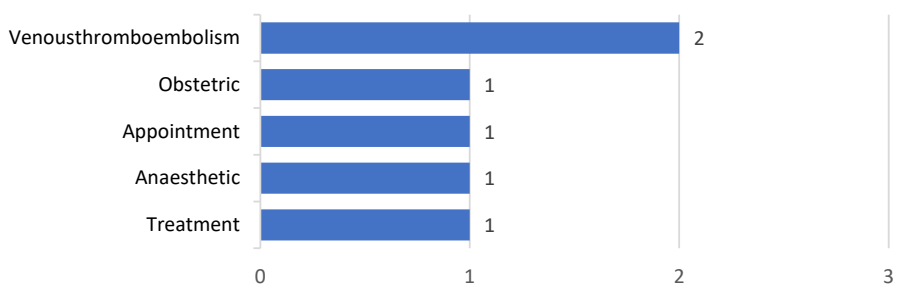
Number of Serious Incidents



Key Issues and Executive Response

- Incident reporting returned to normal expected levels
- Approximately 97% of incidents reported resulted in no or low harm, which is in-line with previous months.
- Ongoing development of reporting dashboards and functionality on the Trust incident reporting system.
- Normal variation in the number of new SIs declared in month (6).
- Two new SIs declared relating to hospital acquired thrombosis; learning is being reviewed in line with ongoing improvement work in Harm Free Care group.
- Ongoing preparation for the adoption of the new national patient safety investigation framework (PSIRF) including development of PSRIF plan to identify themes for PSII learning reviews for the next 12 months
- New SI sign off process to be trialled to widen sharing of learning and oversight and to mitigate the risk of transitioning into PSIRF with high number of open SIs.

Serious Incidents Themes - May-23



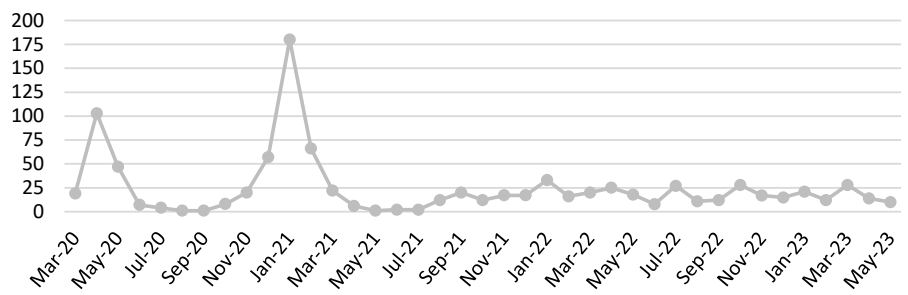
Month 02 | 2023-24

Quality

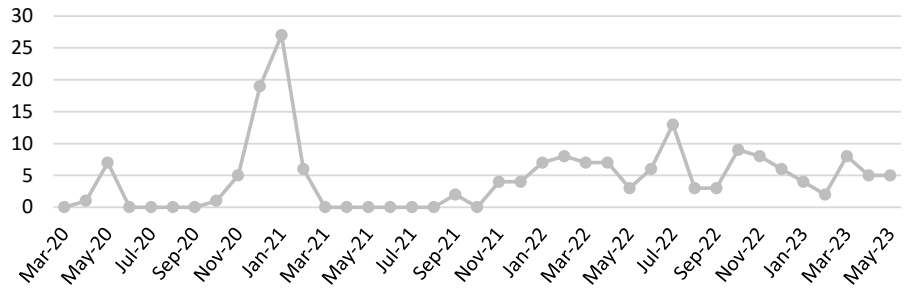
COVID-19

East and North Hertfordshire NHS Trust

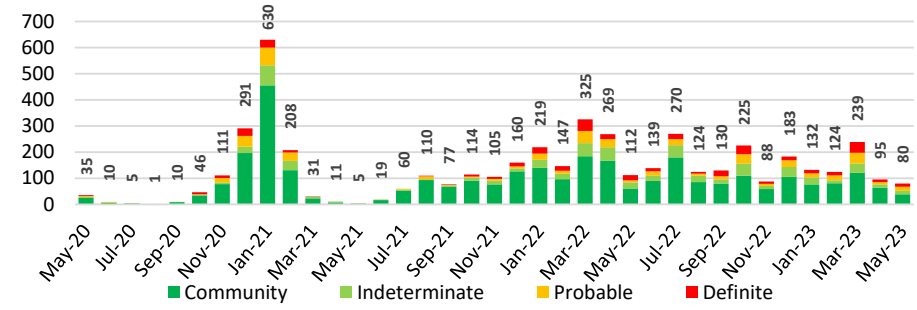
Number of deaths from COVID-19



Number of deaths from hospital-acquired COVID-19



COVID-19 cases by category



Key Issues and Executive Response

- The total number of inpatients with COVID in May dropped to 80. Of these cases 28 were contributed to probable or definite hospital-onset COVID.
- Of the total 10 patients who sadly died with a diagnosis of COVID in May, 5 of these cases were related to probable or definite hospital-onset COVID, and all of the 5 patients were appropriately receiving end of life care, and treated for significant underlying comorbidities.
- Structured reviews are undertaken locally to capture learning where a hospital acquired infection has been identified. Where any potential harms are identified, the individual cases shall be represented to serious incident review panel for executive oversight.
- Mobile Redi rooms have been in use throughout May to support patient isolation without having to move patients from ward to ward.

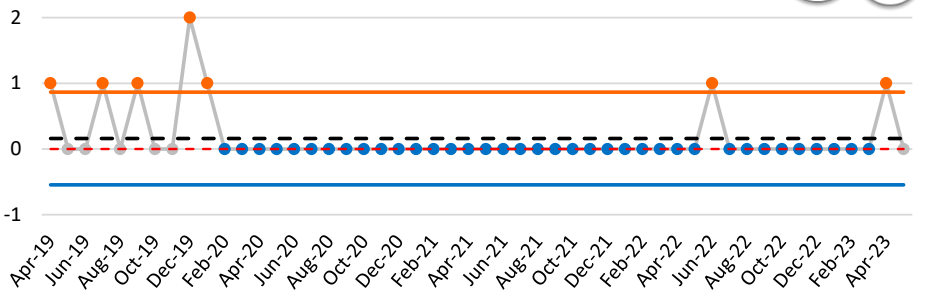
Month 02 | 2023-24

Quality

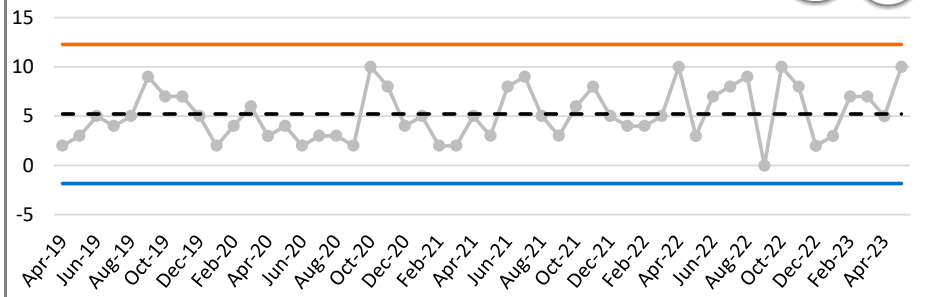
Infection Prevention and Control

East and North Hertfordshire NHS Trust

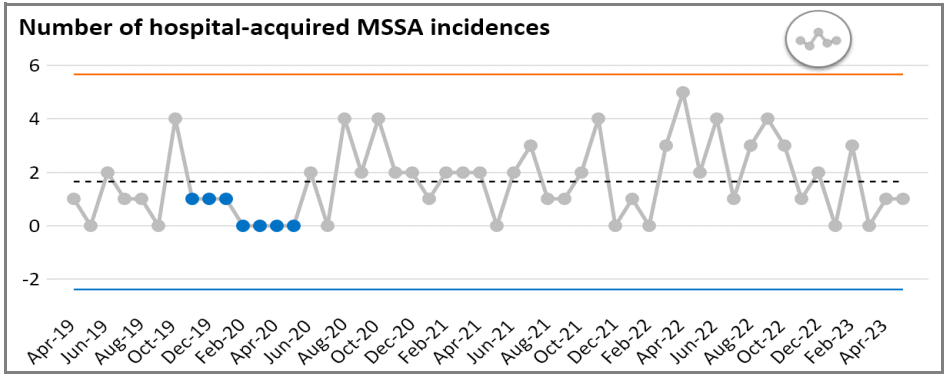
Number of hospital-acquired MRSA BSI incidences



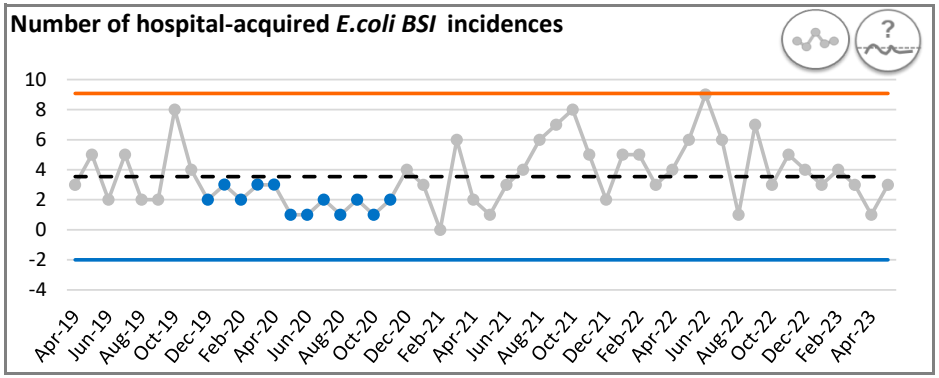
Number of hospital-acquired *C.difficile* incidences



Number of hospital-acquired MSSA incidences



Number of hospital-acquired *E.coli BSI* incidences



- *C difficile (C diff.)*- Year to date (YTD) cases remain above trajectory against the threshold of 58. This increase in cases is being seen regionally and nationally. However, a Trust wide *C diff*. action plan has been devised by the IPC team in conjunction with relevant stakeholders under the leadership of the DIPC. A focused drive on sending samples for patients with loose stools in the emergency department and acute admission areas is helping to eradicate delays in identifying cases and initiate early intervention. Focus is also on antimicrobial stewardship led by pharmacy and microbiology with IPC support.

(*C diff*. continuation) -This includes 1. Utilising QlikView to identify patients on antimicrobials for daily treatment review 2. Progressing system working, as C diff. cases are high throughout the East of England

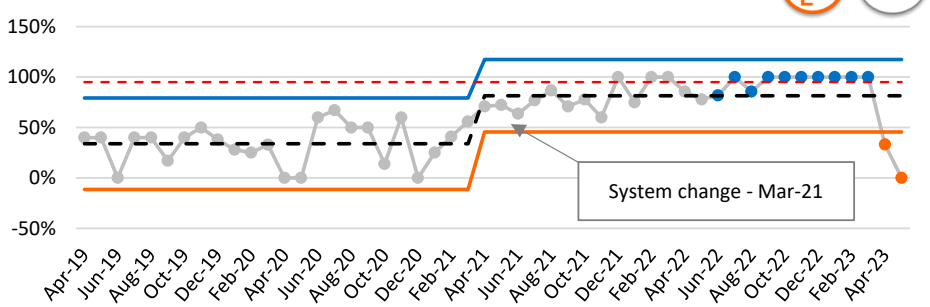
- MRSA BSI - further investigations with neighbouring Trust and ICBs will be held to investigate the case in April, when a patient with shared care was known to be colonised with MRSA
- MSSA BSI - the rate is currently below that of the same period in financial year 2022-2023. There is no threshold
- *E.coli BSI*- the Trust is currently on trajectory for the month of May 2023,against the threshold of 44

Quality

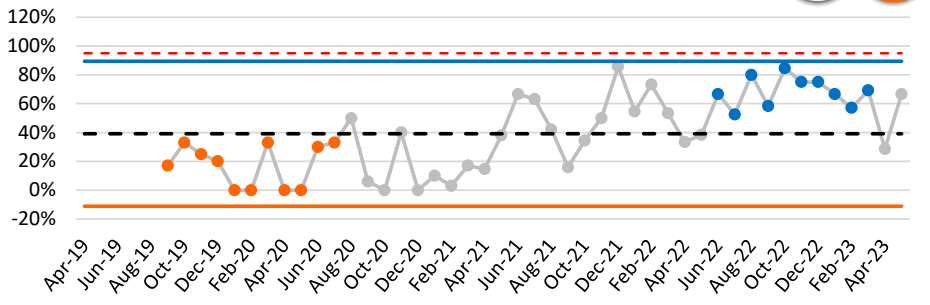
Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust

Inpatients receiving IVABs within 1-hour of red flag



Inpatients Sepsis Six bundle compliance



Themes

Sepsis IP	2022-23										2023-24	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%
Blood cultures	82%	89%	92%	86%	82%	83%	86%	88%	100%	100%	29%	100%
IV antibiotics	82%	92%	86%	92%	100%	100%	100%	100%	100%	100%	0%	0%
IV fluids	86%	50%	100%	75%	86%	100%	100%	100%	100%	67%	33%	100%
Lactate	76%	67%	89%	70%	83%	88%	80%	63%	62%	80%	43%	67%
Urine measure	74%	73%	87%	76%	100%	88%	88%	75%	86%	86%	71%	100%

Key Issues and Executive Response

Themes

- Once again the audit sample size was small due to lack of referrals, lack of staff completing the new digital proformas and short staffing within the sepsis team.
- One patient who required antibiotics within an hour of red flag sepsis did not receive this in time, resulting in an unfortunate 0% compliance for the second month in a row.
- The overall sepsis six compliance has significantly improved from a mere 29% compliance in April up to a 67% compliance in May.
- Blood culture collection in the IP setting has improved and exceeded targets, from 29% compliance in April up to 100% in May.
- IV fluid administration has significantly improved and exceeded targets by reaching 100% compliance in May, a great improvement from 33% in April.
- Urine output measurement has also exceeded targets and been at 100% in May, which is a notable improvement from the low 71% in April.

Response

- The main issue is the delay in antibiotic administration, this was a single case which needs to be looked into from ENHance (medication stock issue). The sepsis team will also discuss this issue at the Trust antimicrobial meeting (TAF).
- The sepsis team has organised regular teaching throughout June, including three extra teaching sessions for planned care, one for Barley ward, and awaiting more dates from Unplanned CPT.
- The sepsis team continue to be present on the wards to educate staff at the bedside on the new tool and promote its use as well as the sepsis 6.
- CSW, BEACH and Nurse Induction teachings on a regular basis includes recognition and management of sepsis.

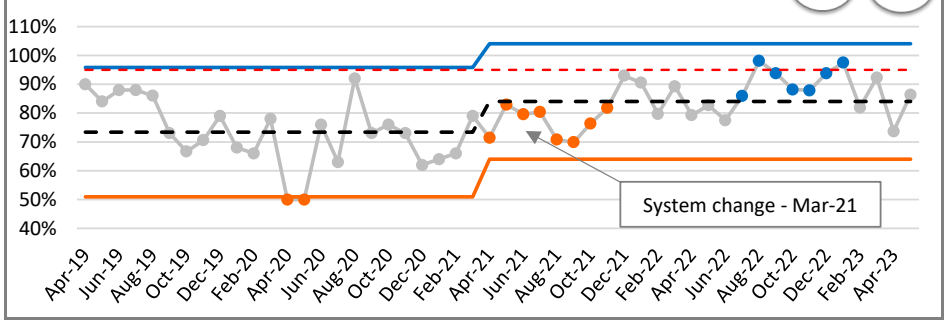
Month 02 | 2023-24

Quality

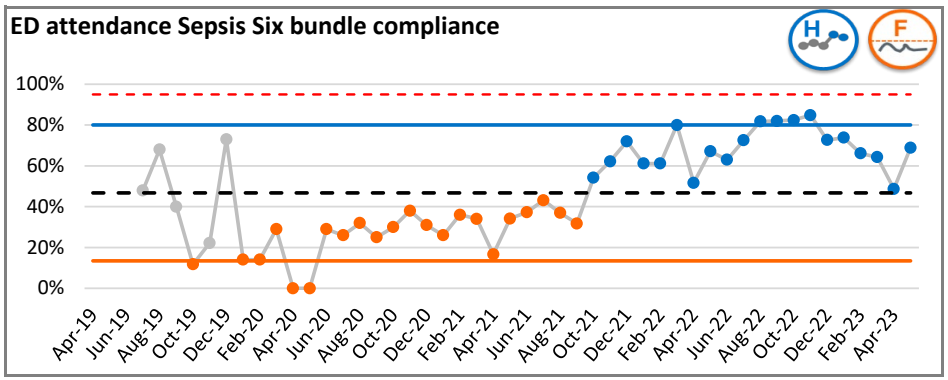
Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust

ED attendances receiving IVABs within 1-hour of red flag



ED attendance Sepsis Six bundle compliance



Themes

Sepsis ED	2022-23										2023-24	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	95%
Blood cultures	91%	87%	98%	93%	88%	94%	93%	90%	90%	93%	87%	93%
IV antibiotics	76%	86%	98%	92%	88%	88%	94%	98%	82%	93%	74%	86%
IV fluids	80%	93%	96%	96%	93%	90%	92%	97%	85%	100%	84%	81%
Lactate	95%	67%	98%	97%	100%	97%	100%	100%	95%	100%	92%	96%
Urine measure	77%	84%	81%	84%	88%	94%	78%	81%	74%	79%	67%	80%

Key Issues and Executive Response

Themes

- Within ED the average sepsis 6 compliance improved in May.
- Improvements can be seen within most elements of the sepsis six including blood culture collection, IV antibiotic administration, Lactate collection and urine output measurement.
- Lactate collection exceeded targets by reaching 96% compliance.
- Average time to antibiotics has decreased from 52 minutes to 27 minutes in May, suggesting that delivery time of antibiotics is improving.
- IV fluid compliance shows normal variation but remains slightly below targets.

Response

- The sepsis team continue to clinically provide bedside education to newer/junior staff. Bitesize teaching also continues, twice a week in the ED.
- To address low IV fluid compliance, the sepsis team is including teaching the importance of documentation where there is variation from the sepsis six e.g. 'a patient was not given IV fluids as per doctor's decision as they were fluid overloaded and had a stable blood pressure.' - as the official tool advises.
- Weekly sepsis team time sessions continue in ED until the end of July 2023 to educate staff on new Red Flag and sepsis 6.
- The Sepsis team have digitalised the proforma and have been praised for the numerous staff using it every day. Improvements are still needed but staff have shown a positive response to the new tool and throughout the coming months, an increase in sample size as well as compliance can be anticipated.
- The sepsis team are looking to repeat its AKI/Sepsis simulations in the coming months to help support with the care of septic patients.

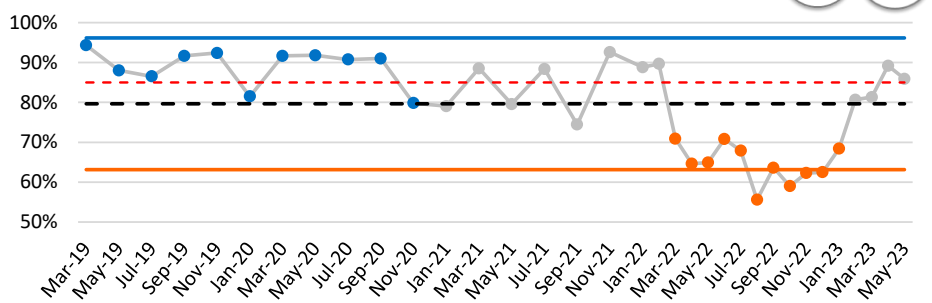
Month 02 | 2023-24

Quality

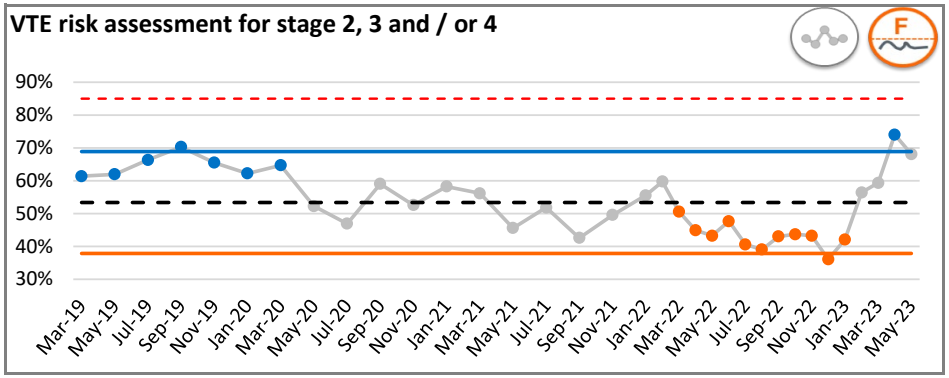
VTE Risk Assessment

East and North Hertfordshire NHS Trust

VTE risk assessment stage 1 completed



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



Key Issues and Executive Response

- Through the first quarter of 2023 several changes have been delivered to improve the reliability of VTE risk assessments at the point of clinical care during assessment and then documentation within our digital systems.
- These changes are incrementally improving the capture and visibility of the risk assessments, including visibility at local ward level through digital screens ('patient safety at a glance').
- In May further learning of current evidence-based guidance and collaboration with exemplar sites, has triggered an internal review of current protocols and procedures. This review will lead to a simplified clinical application of VTE risk assessment to be implemented beginning of June.
- Several clinical areas have QI projects in progress and show local improvements, through reviewing local data and understanding gaps.

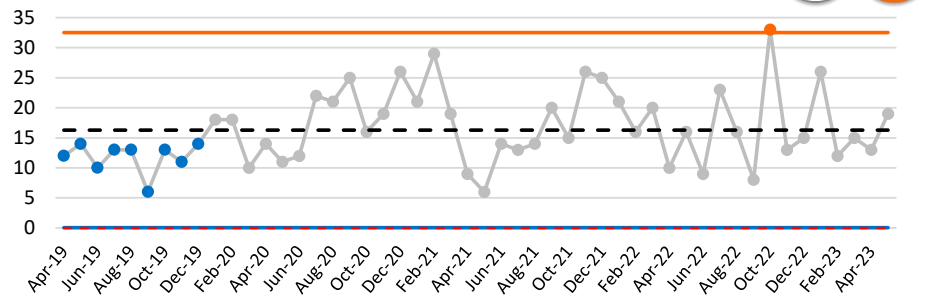
Month 02 | 2023-24

Quality

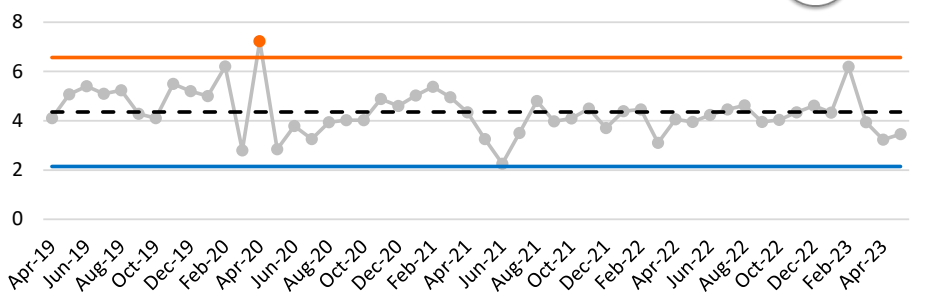
Pressure Ulcers | Patient Falls

East and North Hertfordshire NHS Trust

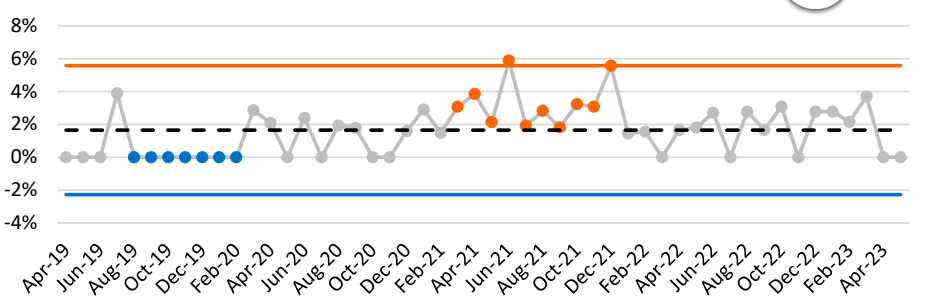
Number of hospital-acquired pressure ulcers



Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm



Key Issues and Executive Response

Pressure ulcers

- No serious harms were reported due to skin damage in May.
- Clinical engagement with clinical nurse now includes Pre-Reg Nurses to shadow TVN team to support learning on how to manage the risk of skin deterioration and promote PU prevention; and PU prevention bitesize training on a regular basis following dates arranged convenient to the clinical area.
- Improvements in progress include digital changes to support the upload of medical photos from NC, this will hopefully increase TVN validation of PU in real time.
- The TVN service have relaunched face - face Tissue Viability study day.
- Completion of digital waterlow assessment within 6 hours of admission is an improvement priority. Supporting 23/24 CQUIN.
- Current skin care risk assessment are reviewed in real time on nerve centre 'smart list' application allows escalation and review from the TVN service where gaps are identified daily.

Patient falls

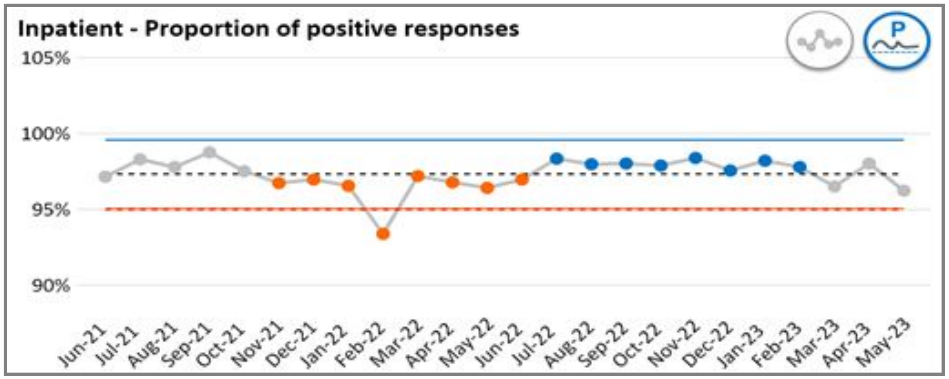
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- Falls Risk Assessment and Post Fall Assessment is now enabled in ED. Auditing to monitor compliance will commence and feed this back to the department/division.
- Baywatch to be re-promoted as part of falls prevention initiative from 2nd week of June. We will do quality rounds to monitor compliance and feed this back to the divisions.

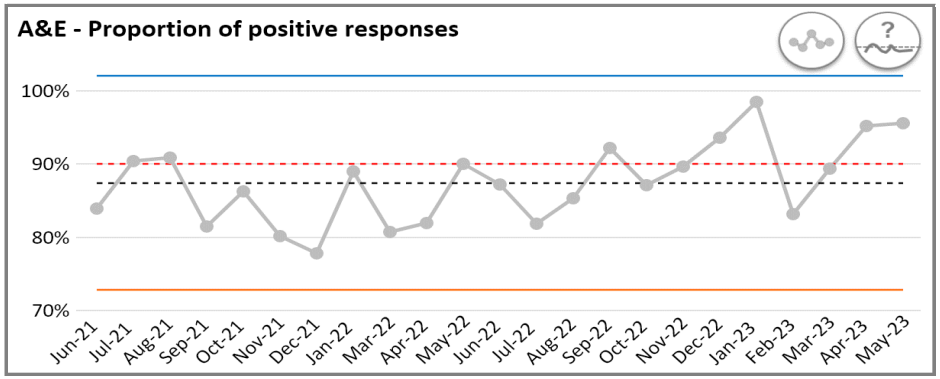
Month 02 | 2023-24

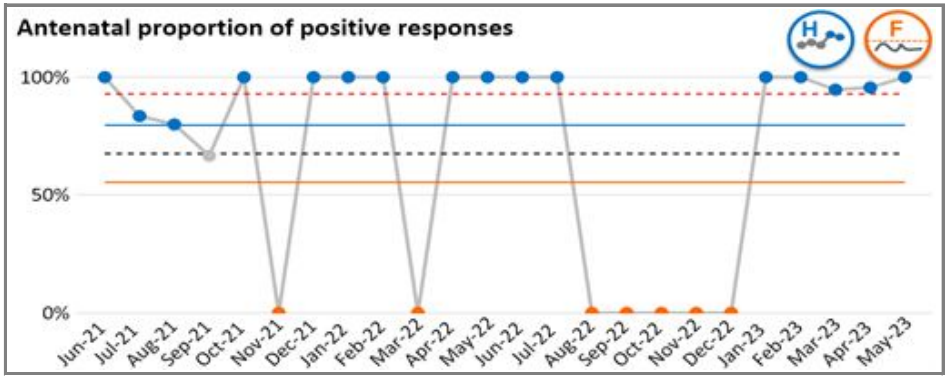
Quality

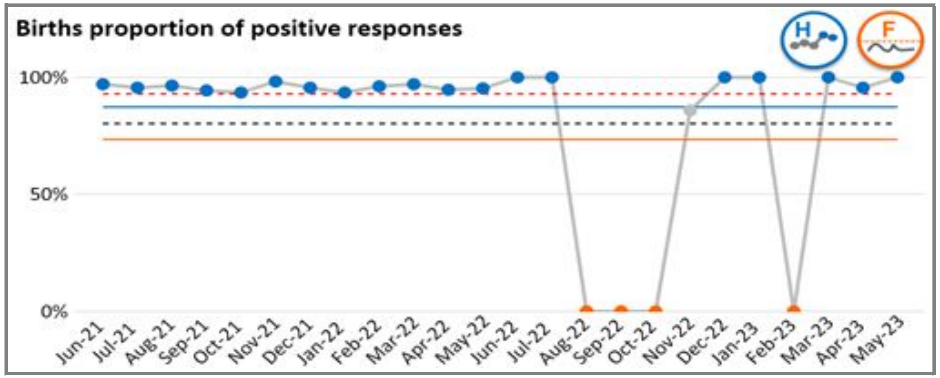
Friends and Family Test

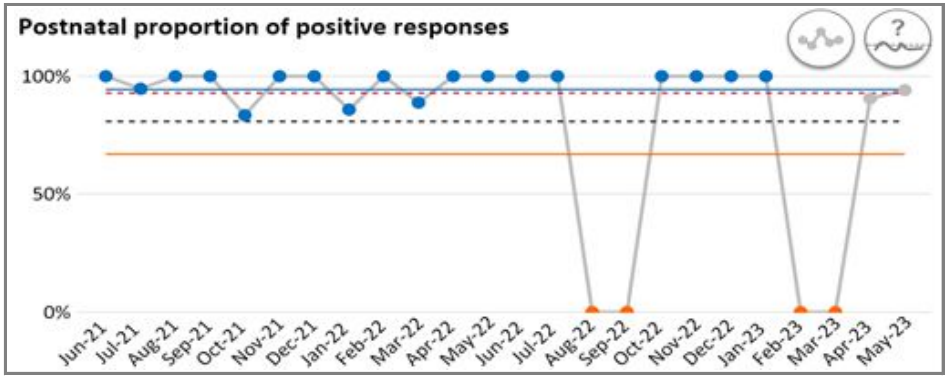
East and North Hertfordshire NHS Trust

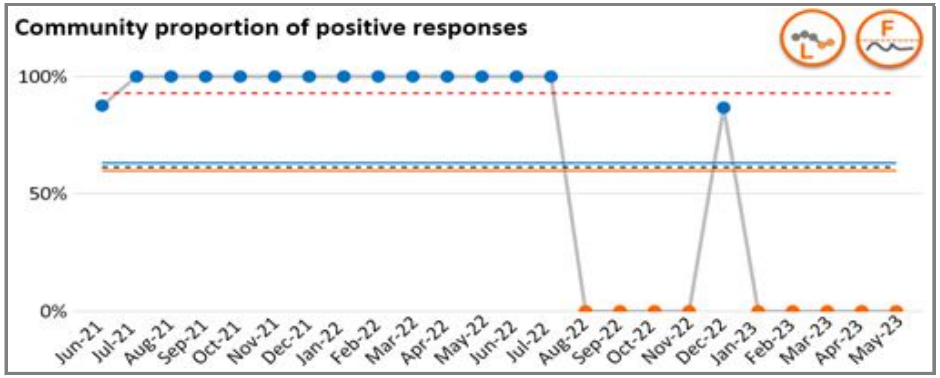










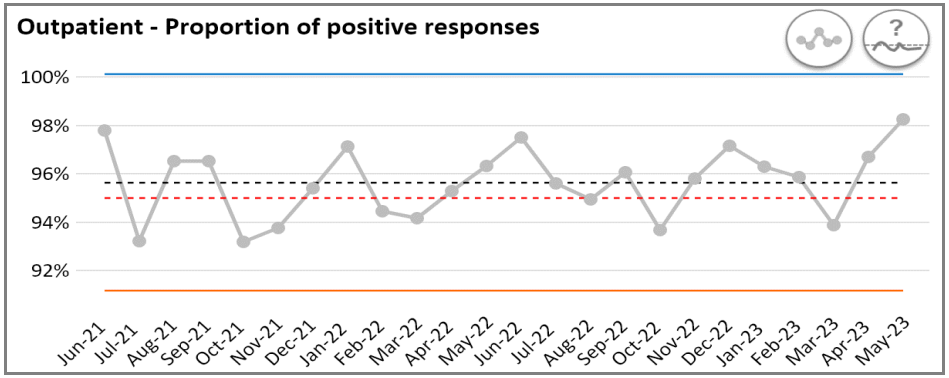


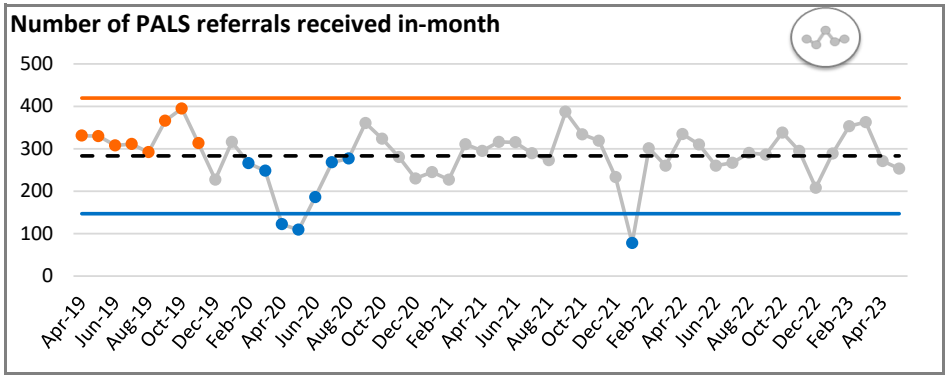
Month 02 | 2023-24

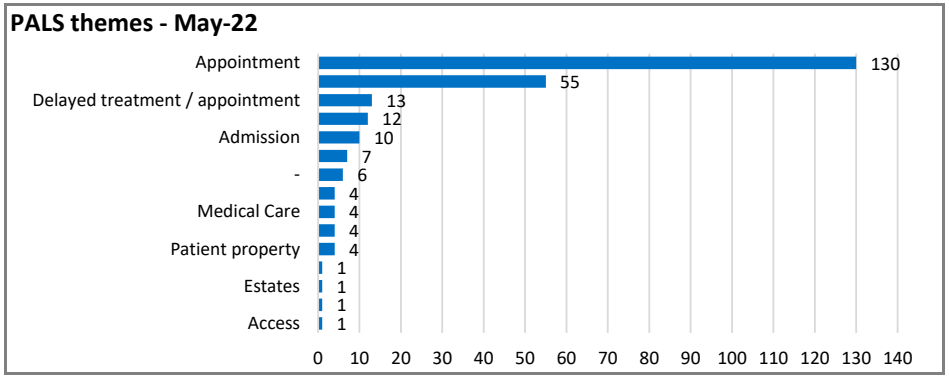
Quality

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

Excellence

- Responses in Maternity antenatal, birth and postnatal continue to increase.
- A&E satisfaction score continues to rise.

Challenges

- Community midwifery continue to receive zero responses to their FFT.
- Enhance QR code maker is currently broken - this has been reported and is currently being fixed.
- Maternity URL links on portable devices are currently not working - this has been reported and is currently being fixed. Paper copies and phone calls are currently being used.

Actions

- Continue to work with ENHance to ensure that all functions and reporting systems are in place.
- Patient Experience Team continue to support Maternity services in manually inputting survey forms.

Patient Advice Liaison Service

Challenges

- PALS response time currently sits at 6 weeks, related to volume of enquiries, team capacity and complexity of issues raised. All enquiries are screened on the day so that any urgent responses can be acted on.
- The PALS data is not currently correct, as the team are still actioning concerns raised in May (a month behind due to backlog).

Actions

- Additional support being provided from part time staff member in the Patient Experience Department.

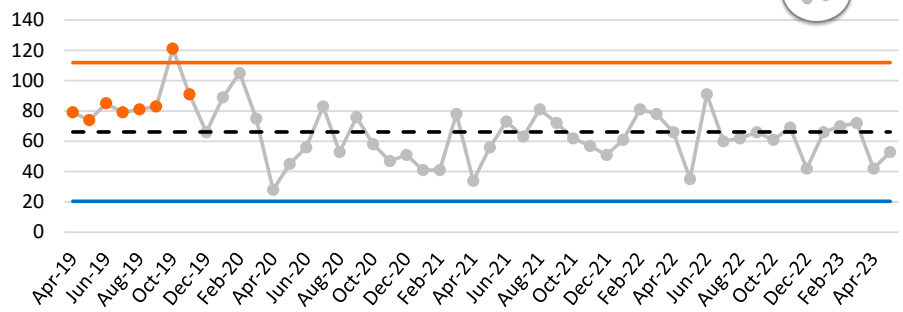
Month 02 | 2023-24

Quality

Complaints

East and North Hertfordshire NHS Trust

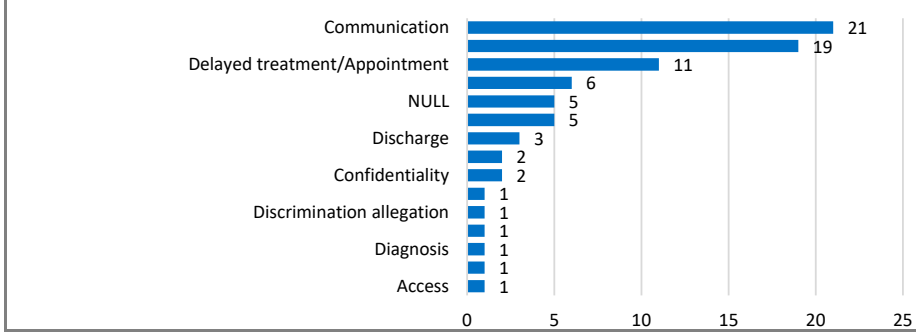
Number of written complaints received



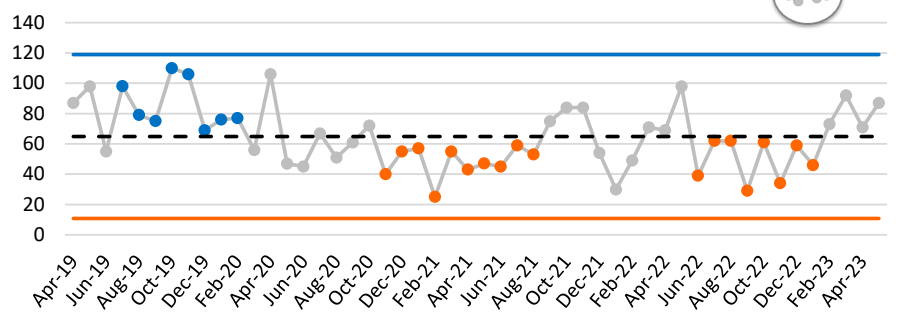
Key Issues and Executive Response

- Team continuing to work hard on the backlog on drafting
- Weekly improvement meetings with each division and divisional leads are underway- the 5 oldest complaints reviewed each week with expectation these are closed by the following week
- A new Trust wide action plan process will be rolled out in June to ensure that any complaint upheld or partially upheld has learning and improvements that can be monitored and evidenced via Enhance.

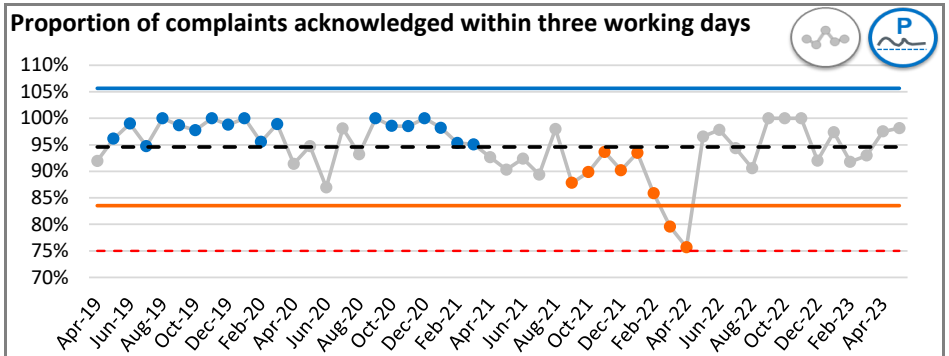
Complaints themes - May-23



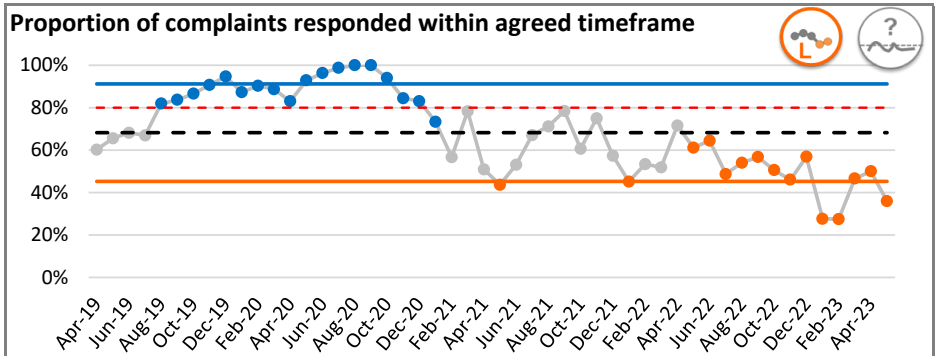
Number of complaints closed in-month



Proportion of complaints acknowledged within three working days



Proportion of complaints responded within agreed timeframe



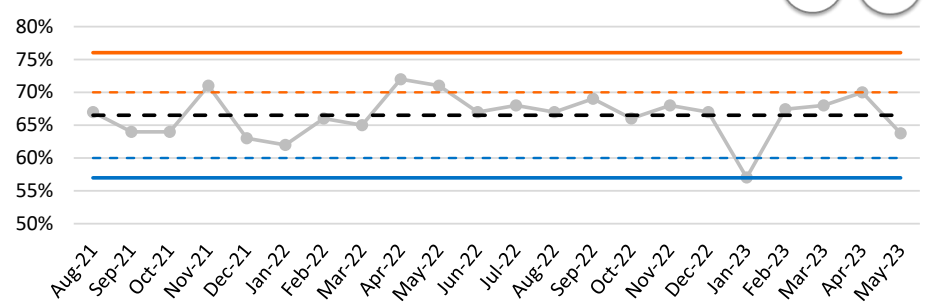
Month 02 | 2023-24

Quality

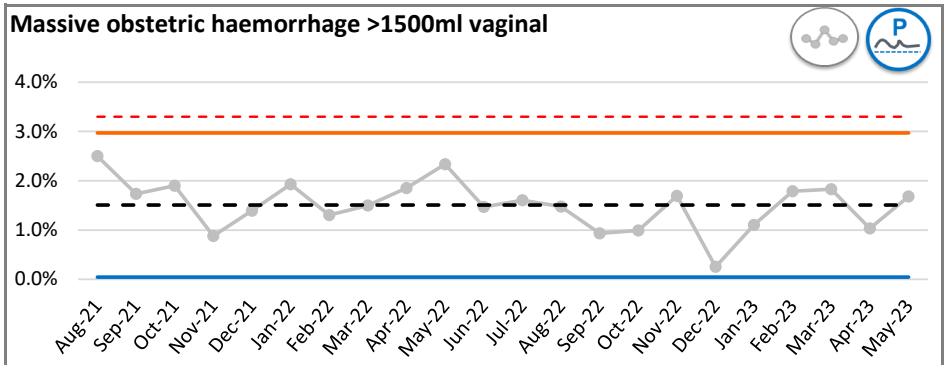
Maternity | Caesarean Section Rates

East and North Hertfordshire NHS Trust

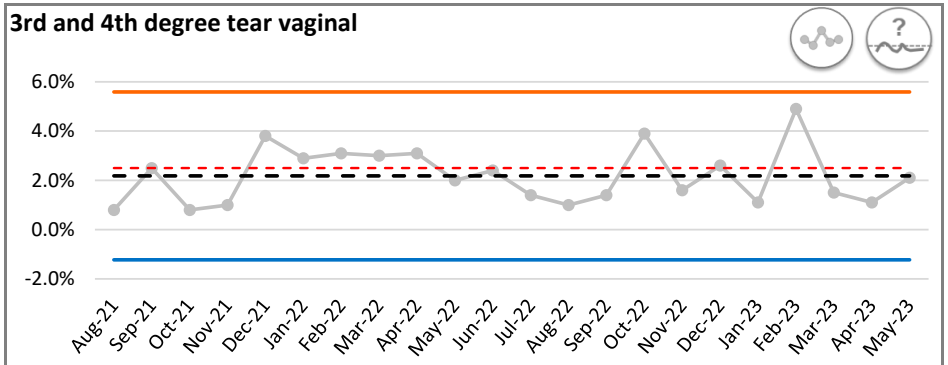
Total caesarean section rate from RG1, 2 and 5 combined



Massive obstetric haemorrhage >1500ml vaginal



3rd and 4th degree tear vaginal



Key issues and executive response

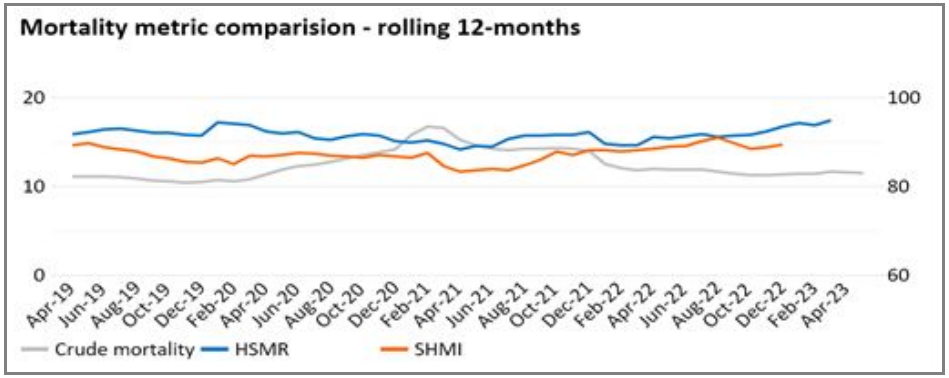
- There were 44 instrumental births , with 3 women experiencing a 3rd degree tear.
- All 3rd degree tears are reviewed by the Obstetric Risk Management Consultant and the Perinatal Pelvic Health team to identify themes.
- Learning is presented via the Risk Management Group

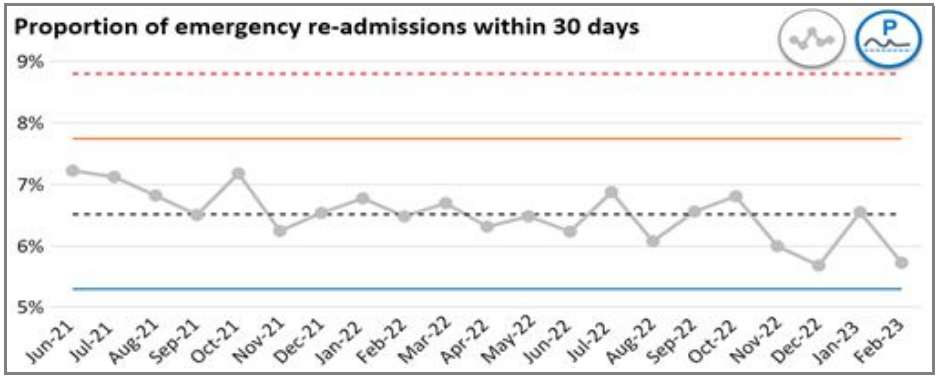
Month 02 | 2023-24

Quality

Mortality Summary | Emergency Re-admissions

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

Mortality Metrics

- Following the rise in crude mortality seen during the pandemic, levels are now broadly in line with pre-pandemic levels.
- Despite increases to both HSMR and SHMI we continue to be well placed vs national peers.

Learning from Deaths

- Reforms continue regarding the Trust's learning from deaths framework, including the adoption of a SJR Plus Review format, developed by NHSE which commenced on 1 July 2022. Reforms include the reduction in the number of reviews undertaken, with the focus being on gaining richer learning from the process.
- From 19 December the on-line SJR Plus tool migrated from the NHSE ORIS platform to NHS Apps.
- The SJR Plus review format, adopted by the Trust in July 2022 has provided an opportunity to revisit our broader 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.
- To provide additional clarity and focus, a Learning from Deaths Strategy (2022-24) has been developed which aligns with the Trust's overarching strategy and the Quality strategy. The strategy was approved by the Mortality Surveillance Committee in November 2022. An update on progress at year-end will be included in September Learning from Deaths report to Q&SC.

Re-admissions

- The Trust's re-admissions performance remains relatively stable and shows common cause variation for both the number of readmissions within 30 days and for the rate of readmissions within 30 days.
- The Trust's performance is well positioned in comparison to national and our Model Hospital peer group.

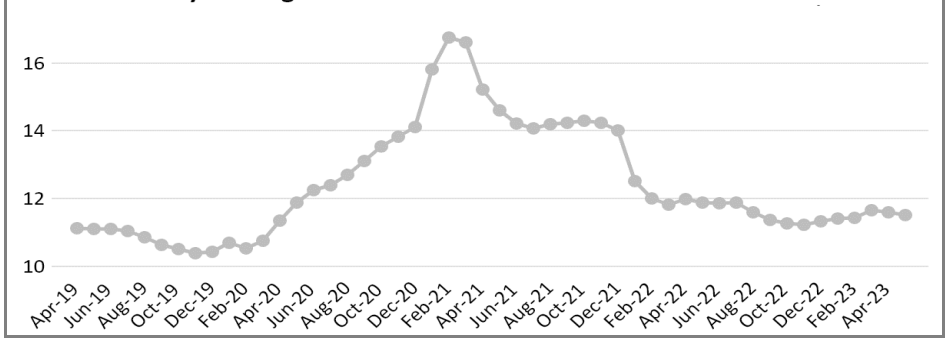
Month 02 | 2023-24

Quality

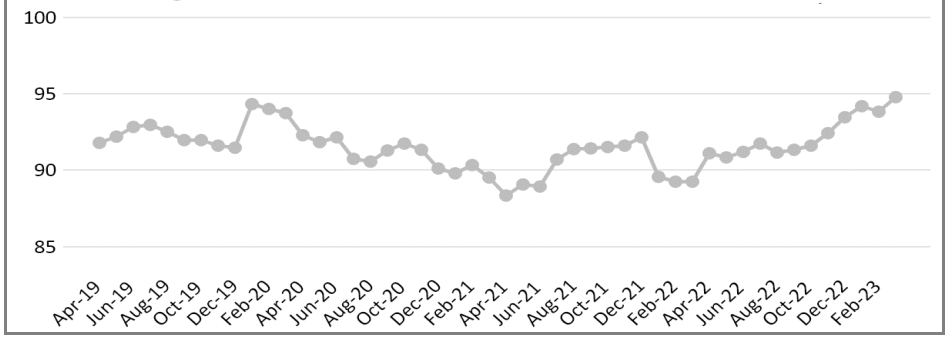
Mortality

East and North Hertfordshire NHS Trust

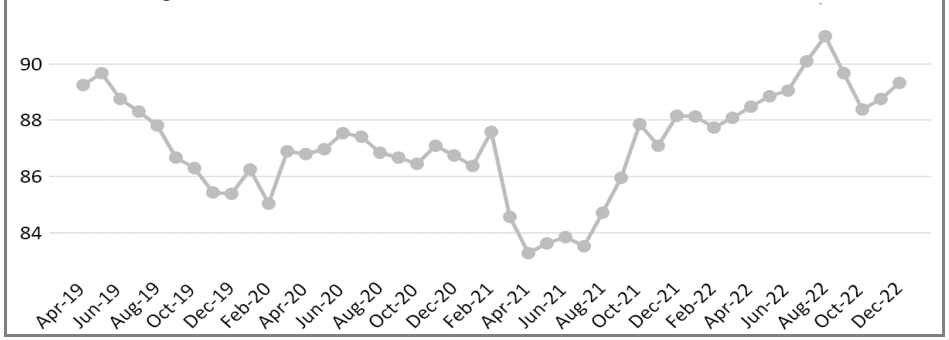
Crude mortality - rolling 12-months



HSMR - rolling 12-months



SHMI - rolling 12-months



Key Issues and Executive Response

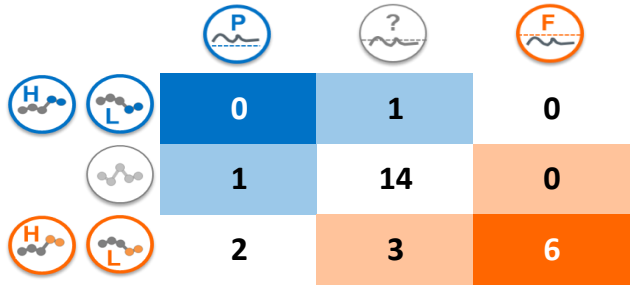
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception has been during the COVID pandemic, when the usual correlation has been weakened by the partial exclusion of COVID-19 patients from the HSMR metric.
- The general improvements in mortality prior to the 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.
- There has been an upward trend in in-month HSMR since December 2021. This contrasts with a downward trend in crude mortality for the same period, which is unusual as HSMR tends to follow the crude metric. The reason for this is not clear but is being monitored.
- Our rolling 12-month HSMR data to March 2023 (96.9) shows the Trust has remained well positioned compared to our Model Hospital Peer group. It has slipped into the mid-range of trusts nationally.
- The latest in-month SHMI position for November 2022 reported by CHKS shows common cause variation.
- Latest NHSD published rolling 12-month SHMI to January 2023 showed a slight increase from 90.74 to 91. 52.
- This positions the Trust in the 'as expected band 2, in the top quartile of trusts nationally.

Month 02 | 2023-24

East and North Hertfordshire NHS Trust

Operations

Month 02 | 2023-24



Operations

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-23	95%	65.0%	L	F	16 consecutive 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-23	2%	8.4%	H	F	19 consecutive points above the upper process limit Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	May-23	65%	9.3%	L	F	1 point below the lower process limit Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	May-23	80%	44.6%	L	F	1 point below the lower process limit Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	May-23	240	224.3	H	P	15 consecutive points above the upper process limit Metric will consistently pass the target
	Average (mean) time in department - admitted patients	May-23	tbc	642.0	H		1 point above the upper process limit No target
	Average minutes from clinically ready to proceed to departure	May-23	tbc	359			Common cause variation No target
	Critical time standards	May-23	tbc				Pending data
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	May-23	92%	49.9%	L	F	20 consecutive points below the lower process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	May-23	0%	41.8%	H	F	22 consecutive points above the mean Metric will consistently fail the target

Operations

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	Two week waits for suspected cancer	Apr-23	93%	92.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Apr-23	93%	91.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	28-day faster diagnosis	Apr-23	75%	69.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-days from diagnosis to first definitive treatment	Apr-23	96%	96.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-days for subsequent treatment - anti-cancer drugs	Apr-23	98%	100.0%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - radiotherapy	Apr-23	94%	65.6%	L	P	2 points below the lower process limit Metric will consistently pass the target
	31-days for subsequent treatment - surgery	Apr-23	94%	84.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from urgent GP referral to first definitive treatment	Apr-23	85%	83.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Apr-23	0	7.0		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from referral from an NHS screening service to first definitive treatment	Apr-23	90%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	62-days from consultant upgrade to first definitive treatment	Apr-23	n/a	83.8%			Common cause variation No target

Month 02 | 2023-24

Operations

Summary

East and North Hertfordshire NHS Trust

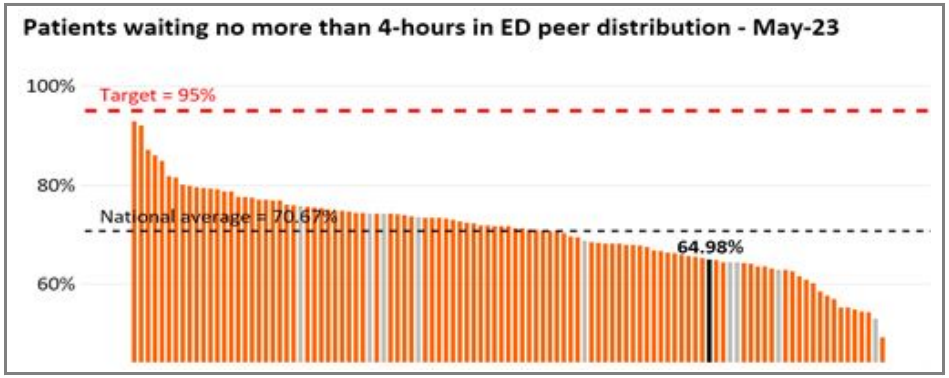
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q4 2022-23	A	D			
	4-hours direct to Stroke unit from ED	May-23	80%	23.6%	L	?	22 consecutive points below the meanMetric will inconsistently hit and miss the target
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	May-23	63%	100.0%		?	Common cause variation 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-23	63%	20.8%	L	?	22 points below the mean Metric will inconsistently hit and miss the target
	Number of confirmed Strokes in-month on SSNAP	May-23	n/a	57			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	May-23	80%	75.4%	L	?	1 point below the lower process limit Metric will inconsistently hit and miss the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	May-23	50%	55.2%		?	Common cause variation Metric will inconsistently hit and miss the target
	Scanned within 12-hours - all Strokes	May-23	100%	98.3%	H	?	10 consecutive points above the mean Metric will inconsistently hit and miss the target
	% of all stroke patients who receive thrombolysis	May-23	11%	7.0%		?	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-23	70%	0.0%		?	Common cause variation Metric will inconsistently hit and miss the target
	Discharged with JCP	May-23	80%	97.4%		?	Common cause variation Metric will inconsistently hit and miss the target
	Discharged with ESD	May-23	40%	55.3%		?	Common cause variation Metric will inconsistently hit and miss the target

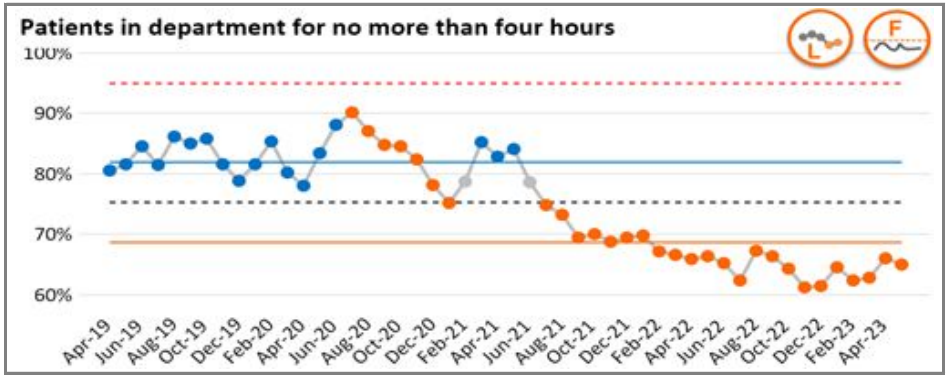
Month 02 | 2023-24

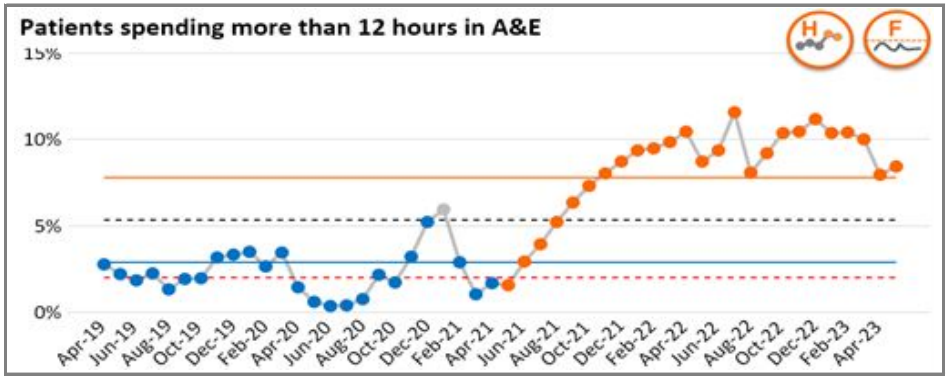
Operations

Emergency Department

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- Monthly attendances were at their highest since December 22 with increased activity across both Lister and QEII. QEII had their highest levels of activity since March 22. Ambulance arrivals increased for 3rd consecutive month, with the highest number conveyed since October 2021 and Mental Health attendances experienced their highest levels of activity since March 2022.
- Acuity remained high following last months increase, however admission conversion rates demonstrated a reduction compared to last month. The lower conversion rate although positively reflects in in the increased SDEC activity, also offers explanation for the deterioration in non-admitted performance with the average time in department for non-admitted patients increasing compared to last month i.e. patients with a recorded decision to admit are discharged from ED after prolonged LOS.
- Bed days for patients Not Meeting the Criteria to Reside increased with continued impact to UEC flow, e.g. percentage of patients spending more than 12 hours in ED.
- Compliance with emergency professional standards deteriorated compared to last month across all KPIs, largely due to the increased levels of activity, acuity and a reduced inpatient discharge flow. However, the most notable deterioration was seen in Time to Initial Assessment which was at its lowest since September 2021. Although partly explained by the activity and acuity, it is predominately linked to a pilot of a new triage process at QEII to support earlier senior decision making and data quality. This process is subject to formal review w/c 26th June.
- Following an ECIST peer review on 26th May 6 different UEC workstreams have commenced, These are; establishing a colocated UTC at Lister, ED workforce reviews (Paeds and Adults), Diagnostics Review, SDEC and Assessment, and Inpatient Capacity.

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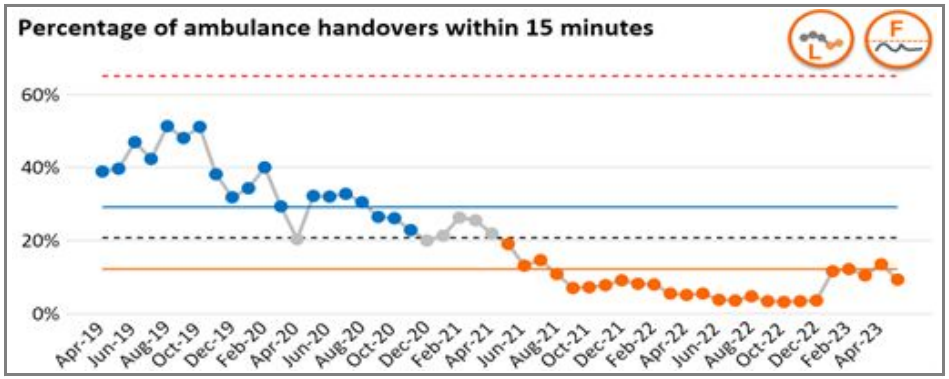
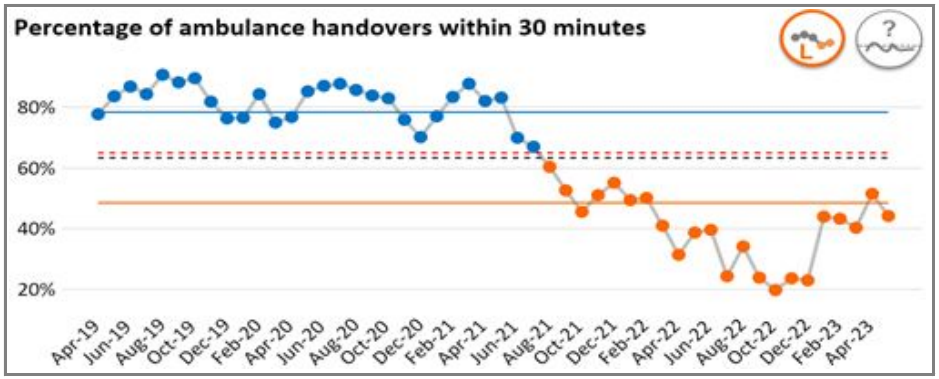
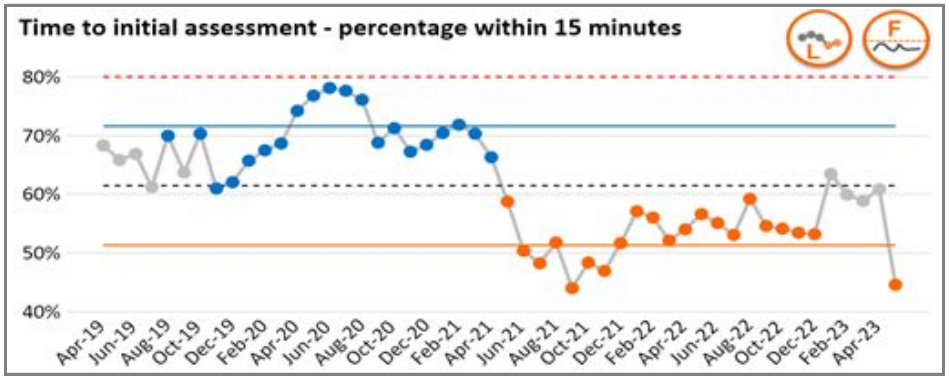
Operations

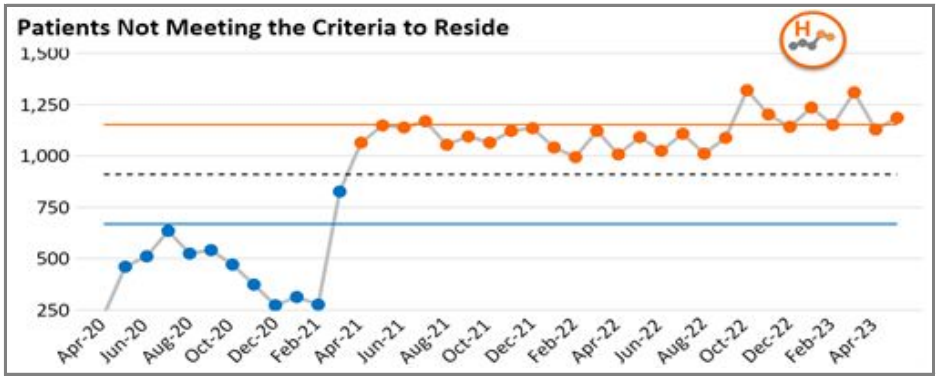
Emergency Department New Standards

East and North Hertfordshire NHS Trust









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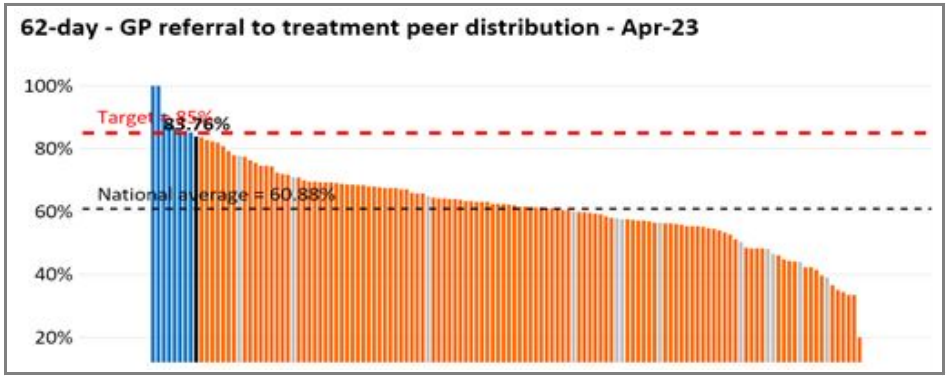
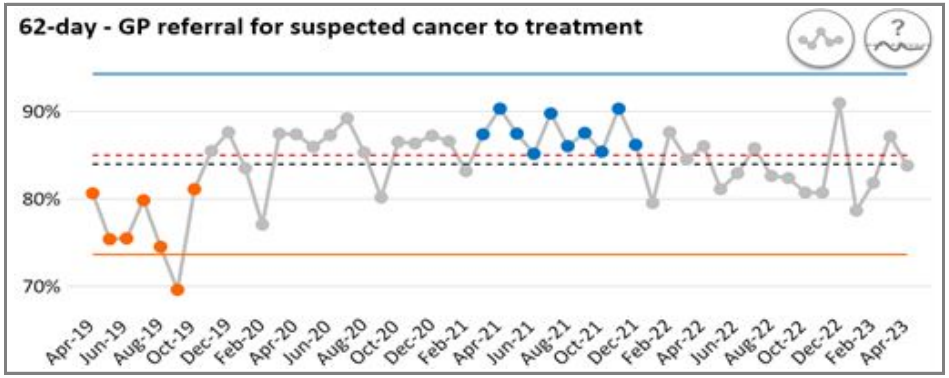
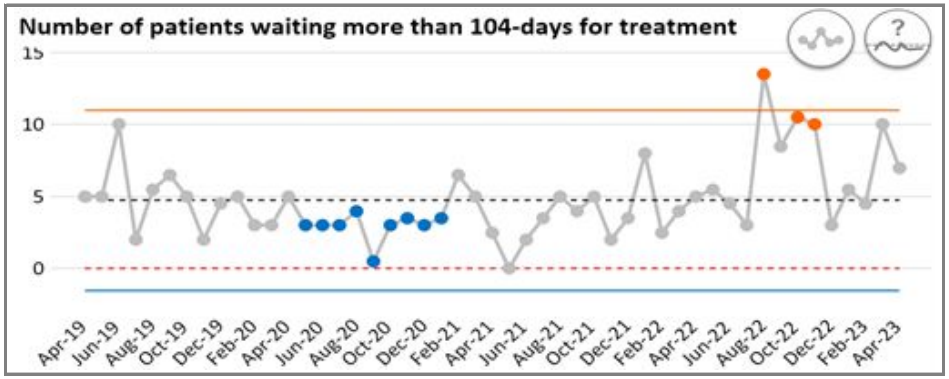
Operations

Cancer Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- The Trust remains in Tier 2 for cancer based on progress with reducing the 62-day pathway backlog. Weekly monitoring has moved to monthly oversight.
- Achieved 3 of the 9 national targets in April with compliance in 31-day first treatment, 31-day second or subsequent treatment for chemotherapy, 62-day referral to treatment for Screening.
- The Trust has not achieved the 2ww GP referral and 2ww Breast symptoms due to high number of referrals received in March and patient choice. This is forecast to return to compliance by May for 2ww performance. Patient choice and a small denominator still drives non compliance for breast symptoms.
- 31-day subsequent for Surgery is non compliant due to theatre capacity for Urology and Breast.
- 31-day subsequent treatment performance for radiotherapy has deteriorated due to high number of referrals, staff vacancies and delayed linac replacement. This has been escalated to regulators and performance compliance is due to recover by the beginning of September, attributed to Saturday lists, Recruitment and retention premia and strong recruitment pipeline.
- 28 FDS is non compliant but delivering against agreed recovery trajectory. Main drives include delayed additional Colonoscopy capacity, TP biopsy capacity and consultant TAT.
- 62-day referral to treatment performance remains non compliant but performance remains strong with the Trust significantly above national average. Non compliance is driven by delays in the diagnostic pathway by patients, endoscopy capacity (mainly colonoscopy) , and Junior doctor strike.
- Work continues with IMAS around pathway analysis, to identify constraints in tumour level pathways and whole Trust cancer training.

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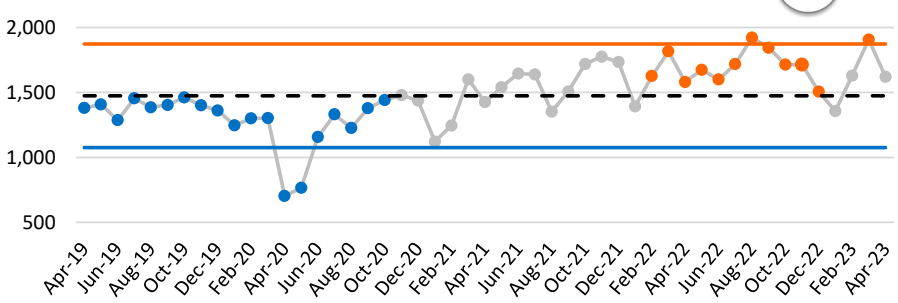
Operations

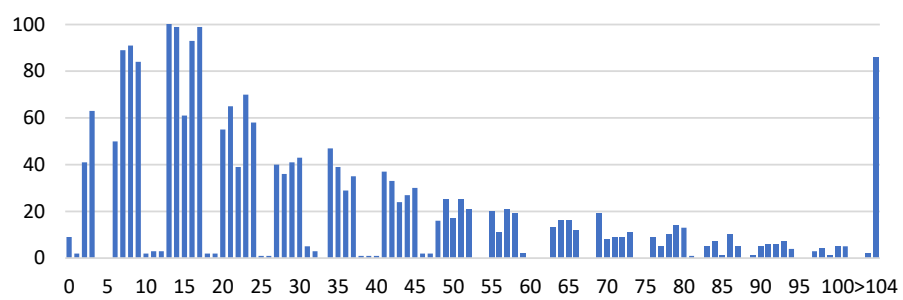
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

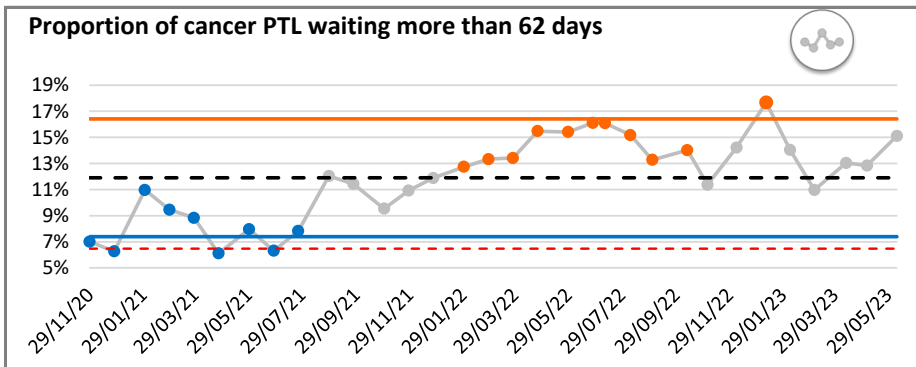
Suspected cancer referrals



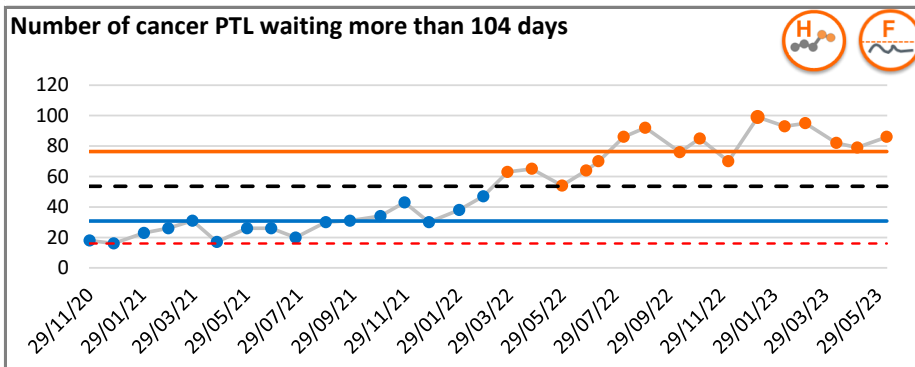
62-day PTL as at 08/06/2023



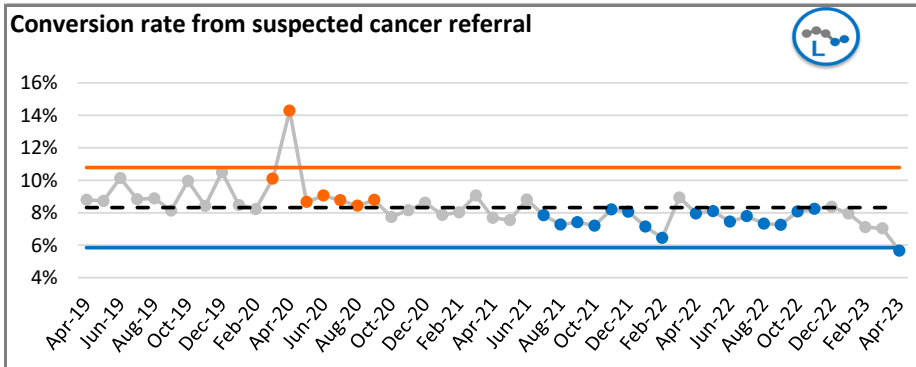
Proportion of cancer PTL waiting more than 62 days



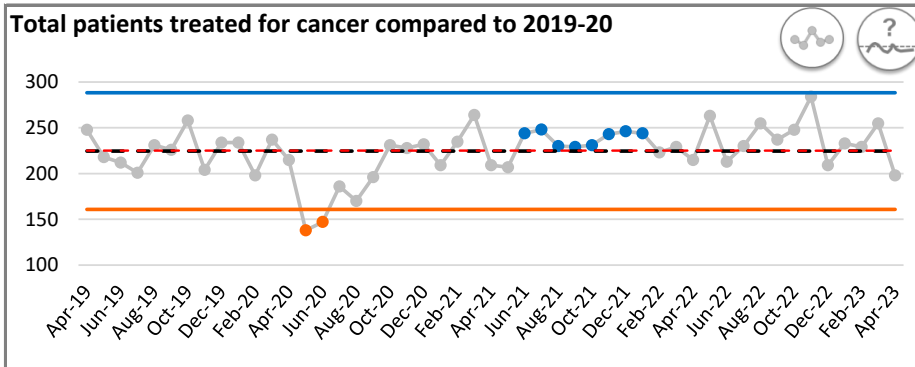
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



Total patients treated for cancer compared to 2019-20



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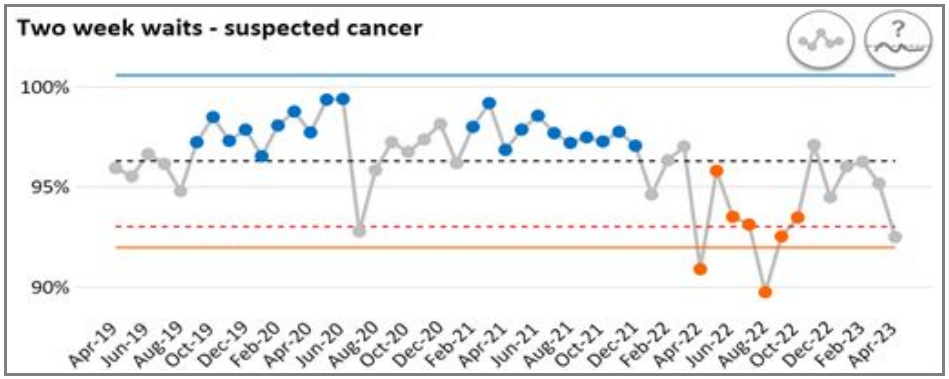
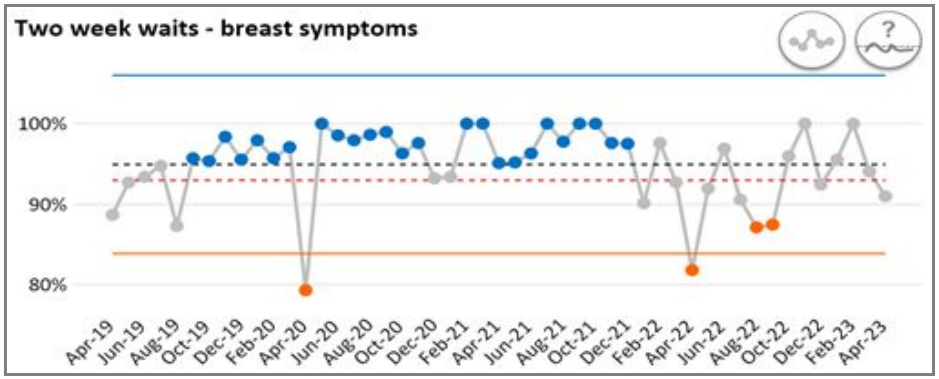
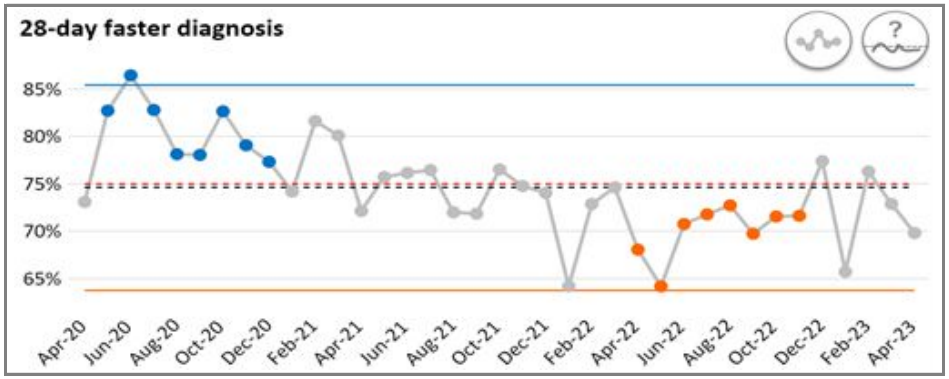
Operations

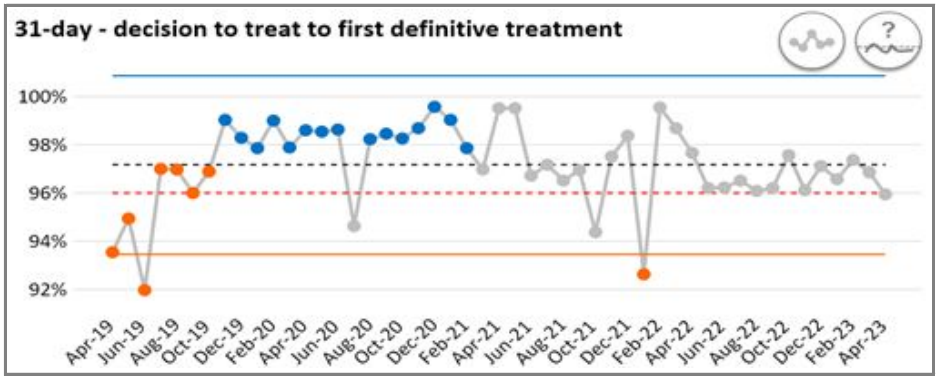
Cancer Waiting Times

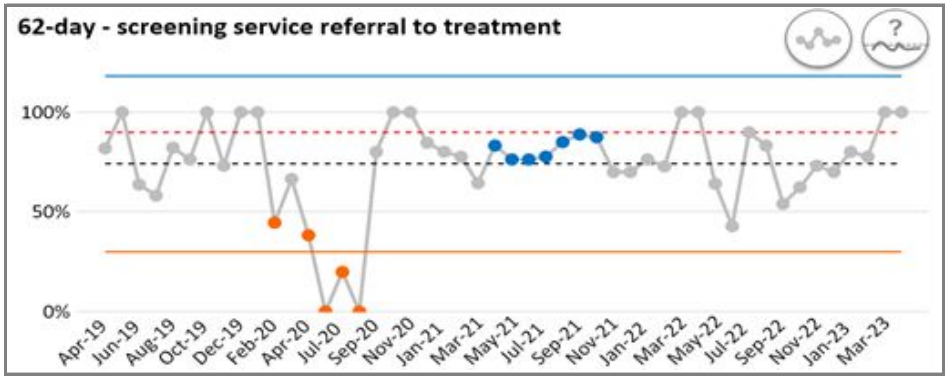
East and North Hertfordshire NHS Trust











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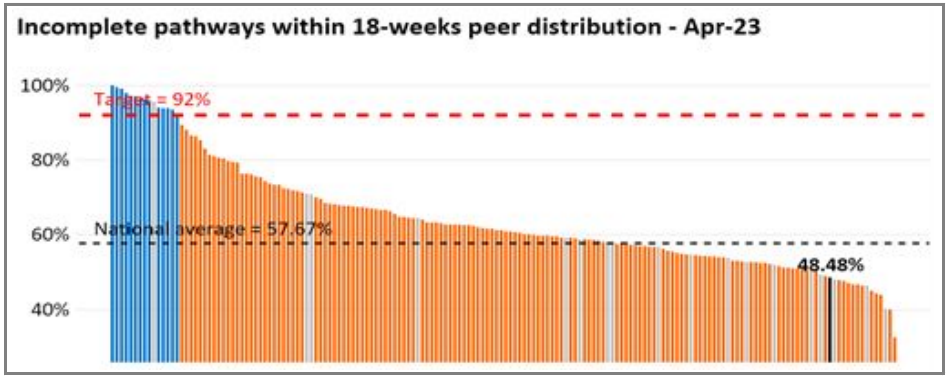
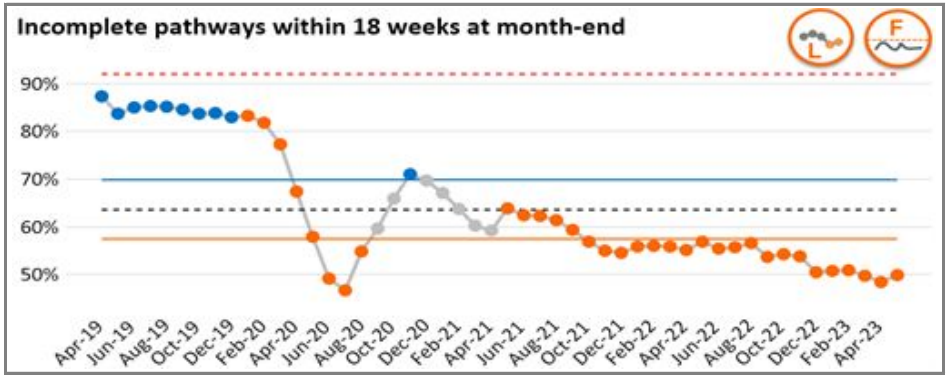
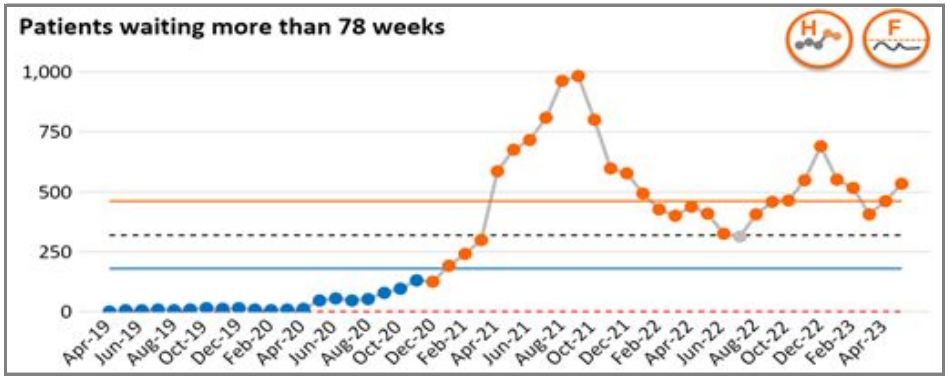
Operations

RTT 18 Weeks

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

RTT Performance

- 78+ week waiters: The Trust had 532 patients waiting over 78 weeks at the end of May, compared to 461 the previous months. This was due to an increase of 93 patients in Community Paediatrics.
- The majority of the breaches were known capacity issues in Community Paediatrics and Trauma and Orthopaedics, or patient choice and complexity delays.
- The number of patients waiting 78+ weeks for an appointment is 0.85% of total RTT PTL.
- 104+ week waiters: There were 0 patients waiting 104 weeks at the end of April.
- The Trust currently has 1,665 patients waiting over 65 weeks for first definitive treatment in May (961 are for Community Paediatrics).

Data Quality

- Patients waiting over 40 weeks are validated and all patients without an updated validation comment in the last 12 weeks are reviewed.
- All patients waiting 65 weeks+ are actively managed with the services.

Activity

- Admitted and non admitted clock stops have increased in month, with admitted clock stops back to October 2022 levels.
- Elective Inpatient and Daycase activity has increased.
- Advice and Guidance has remained stable on the upper control limit.
- New to follow-up ratio has remained stable below the lower control limit.

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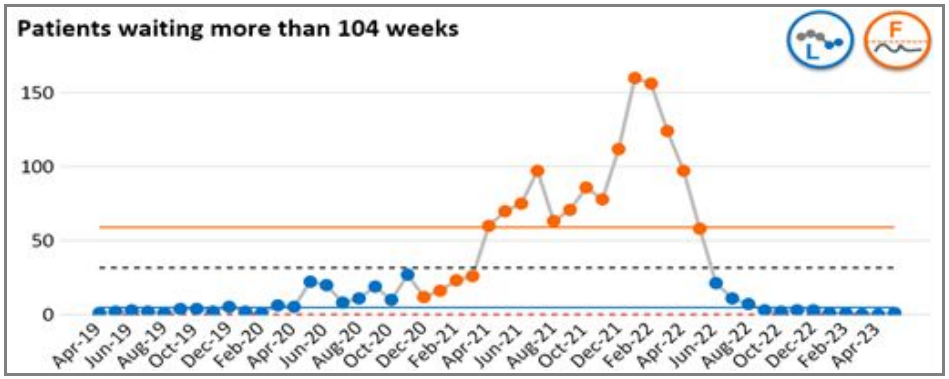
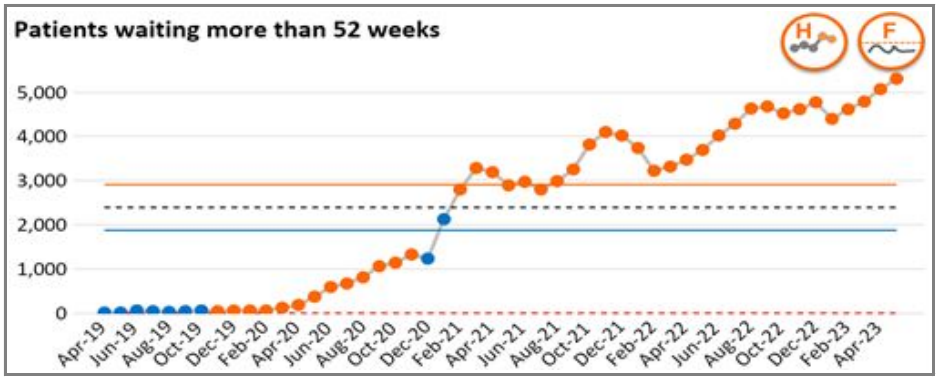
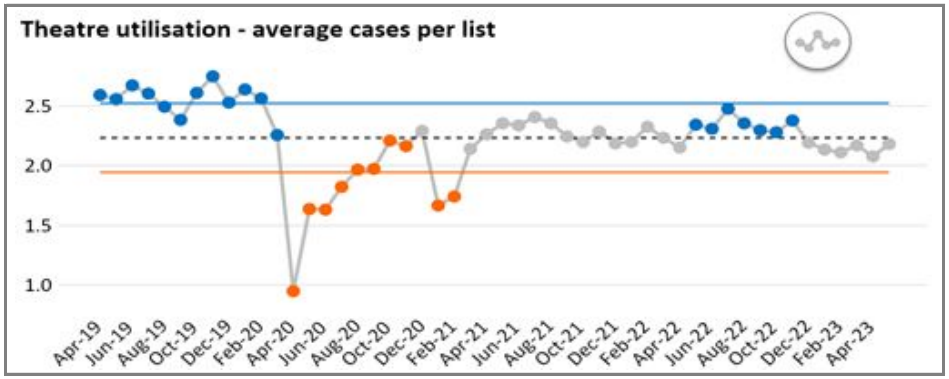
Operations

East and North Hertfordshire NHS Trust

RTT 18 Weeks Supporting Metrics







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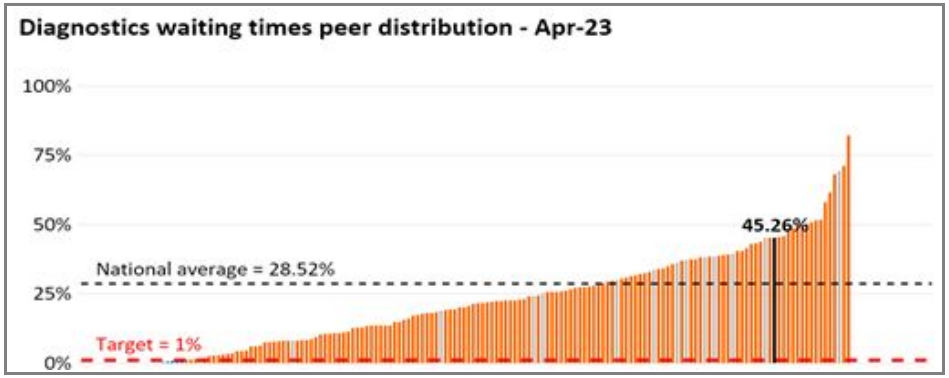
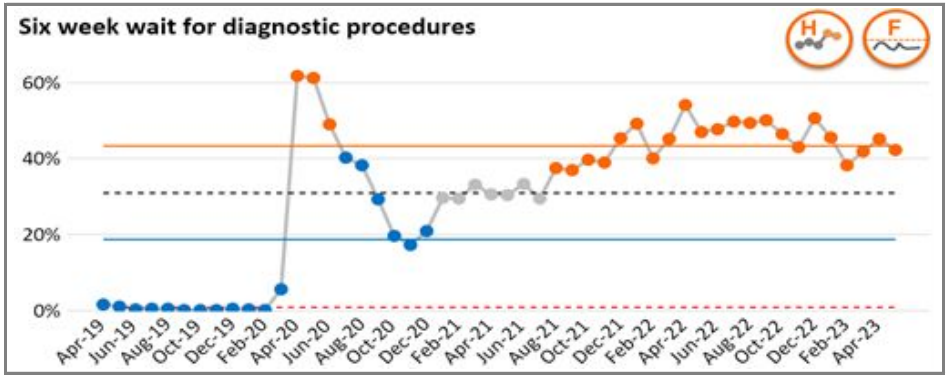
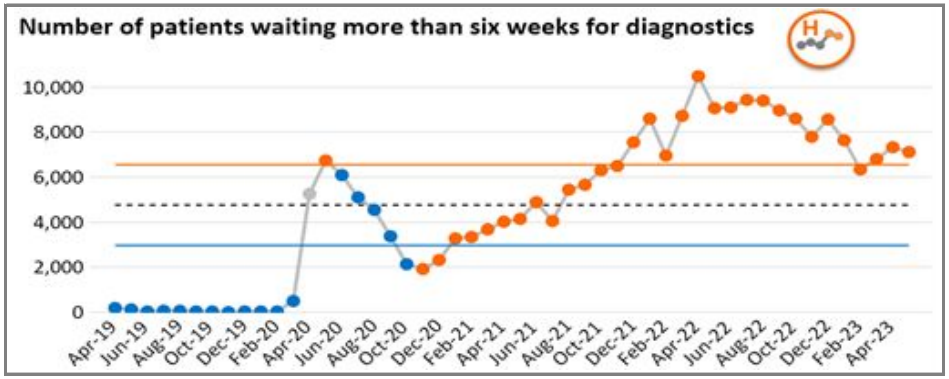
Operations

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Improvements

- Community Diagnostic Centre (CDC) activity continues to meet trajectory, except for DEXA with positive patient feedback.
- Robust vetting process within Gastroenterology.

Challenges

- CT1 is near end of life, and breakdown rate has increased. This is currently mitigated by CT4 although there are still safety equipment that need to be put in place (alarm).
- Continued sustained increase in cancer demand for CT, MRI & US, impacting ability to regain compliance with diagnostic waits within 6 weeks (DM01) at a faster pace.
- Endoscopy - Managing long waits for non-cancer following increases in 62-day pathway patients. Managing balance + risk.
- Ongoing increased demand with 2ww, routine and urgent referrals.
- Endoscopy paper referral process increasing inefficiencies. and risks.
- Waiting time for new ECHO referrals is approx. 12wks. Increase in urgent referral demand, which is taking up routine capacity.
- ECHO: Challenges management of demand within core capacity.

Actions

- Deep dive in the gap between actual activity and capacity is being undertaken on modality lead level and discussed in Radiology management meeting.
- ECHO: Recruitment plan in place, with aim to have appropriate staffing model from October, which will enable implementation of 7 day working and increased capacity.
- Gastro consultants working with GPs to support referral process and advice and guidance.
- 2nd Room open at QE on Thursday increasing in August to additional room following trajectory of full utilisation.

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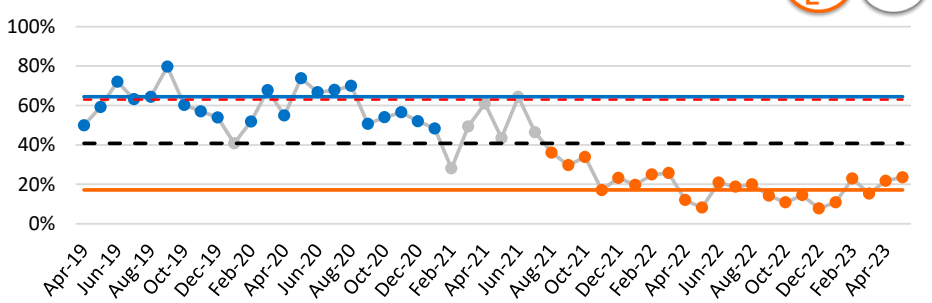
Operations

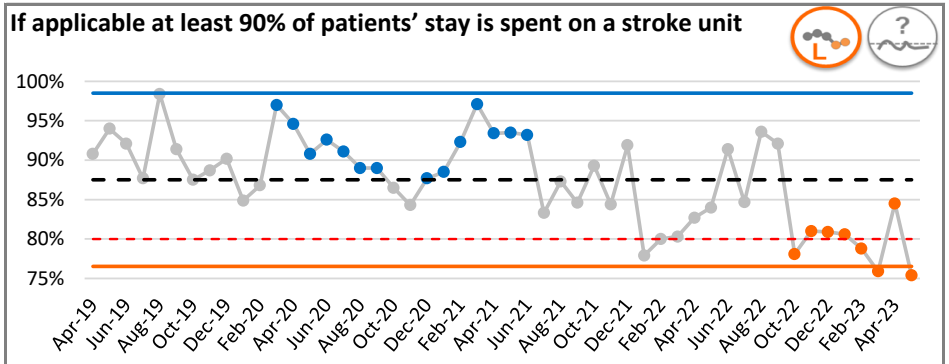
Stroke Services Supporting Metrics

East and North Hertfordshire NHS Trust

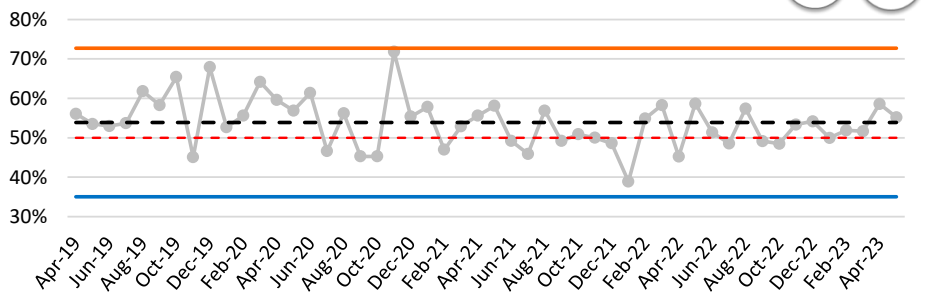
4-hours direct to Stroke unit from ED



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



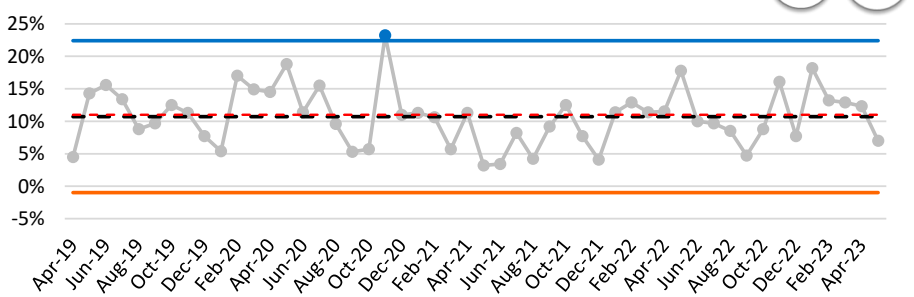
Urgent brain imaging within 60-mins for suspected acute stroke



Key Issues and Executive Response

- Ongoing improvements in the Median time for 4hrs going from 9hrs 20mins for March 23 to 6hrs 47mins. Implementation of support out of hours service provision to reduce delays in clerking, with allocated support from Medical oncall. In Hours direct from ED to the stroke unit and clerking on the ward area by Stroke oncall team- this is subject to Bed capacity.
- Thrombolysis Door to Needle within 1hr is based on 3pts of which due to complex clinical needs before thrombolysis, aligned to clinical pathways.
- Implementation of specific roles with the Thrombolysis pathway, across ED and Stroke.
- Physiotherapy and Occupational Therapy increased service provision and this reflects with the performance domains.
- There are concerns around the radiology pathway for reporting and implementation of the National Optimal Stroke Imaging pathway.
- In HCT's commissioned service for speech and language, there are capacity issues due to ongoing workforce shortages - however 100% compliance for May 23 for Swallow Assessments within 72hrs.

% of all stroke patients who receive thrombolysis

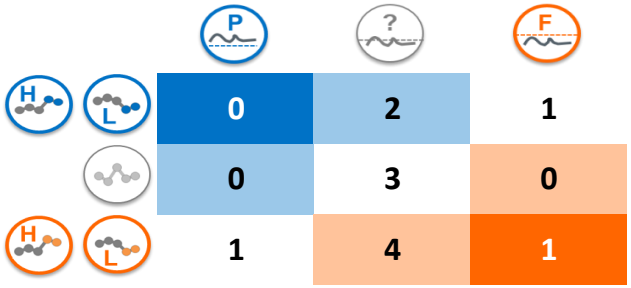


Month 02 | 2023-24

East and North Hertfordshire NHS Trust

Finance

Month 02 | 2023-24



Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	May-23	-2.4	-1.40		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	May-23	1,245	3,321	H		1 point above the upper process limit No target
	Cash balance	May-23	77.9	68.3	H	F	3 consecutive points above the upper process limit Metric will consistently fail the target
Key Financial Drivers	Income earned	May-23	45.3	51.2	H	?	13 consecutive points above the mean Metric will inconsistently pass and fail the target
	Pay costs	May-23	29.5	32.6	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	May-23	15.5	20.0	H	?	13 consecutive points above the mean Metric will inconsistently pass and fail the target

Month 02 | 2023-24

Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	May-23	24.9	28.7	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	May-23	0.9	4.9	H	F	14 consecutive points above the mean Metric will consistently fail the target
	Agency costs	May-23		1.0			Common cause variation No target
	Unit cost of agency staff	May-23		11.4			Common cause variation No target
	Bank costs	May-23	3.7	2.9	H	P	9 consecutive points above the mean Metric will consistently pass the target
	Overtime and WLI costs	May-23	0.5	0.6	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target
Other Financial Metrics	Elective Recovery Fund income earned	May-23	1.1	0.5		?	Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	May-23	2.8	3.5		?	Common cause variation Metric will inconsistently pass and fail the target
	Private patients income earned	May-23	0.4	0.6	H	?	1 point above the upper process limit Metric will inconsistently pass and fail the target

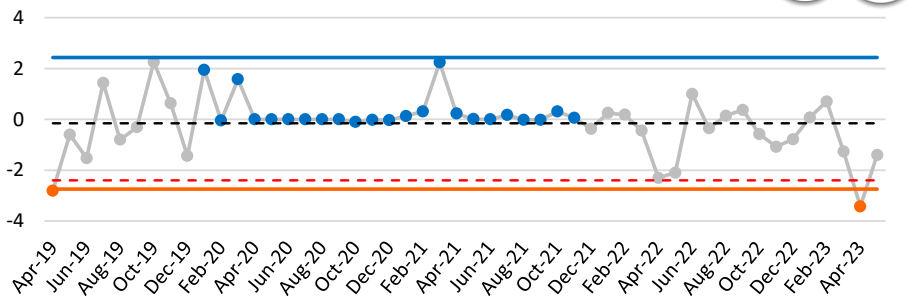
Month 02 | 2023-24

Finance

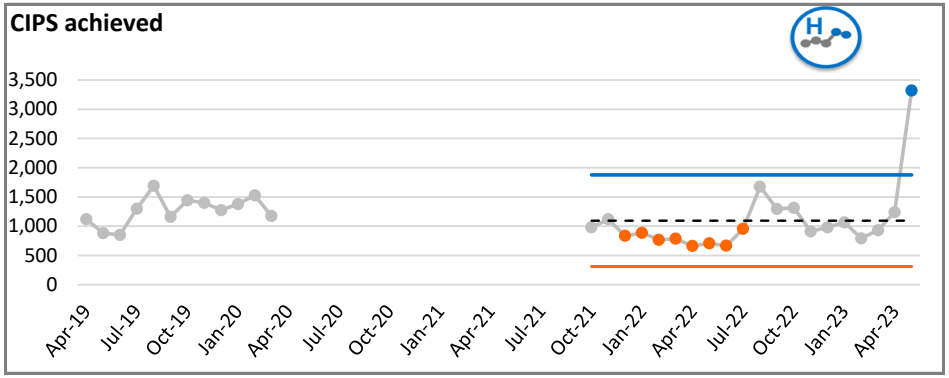
Summary Financial Position

East and North Hertfordshire NHS Trust

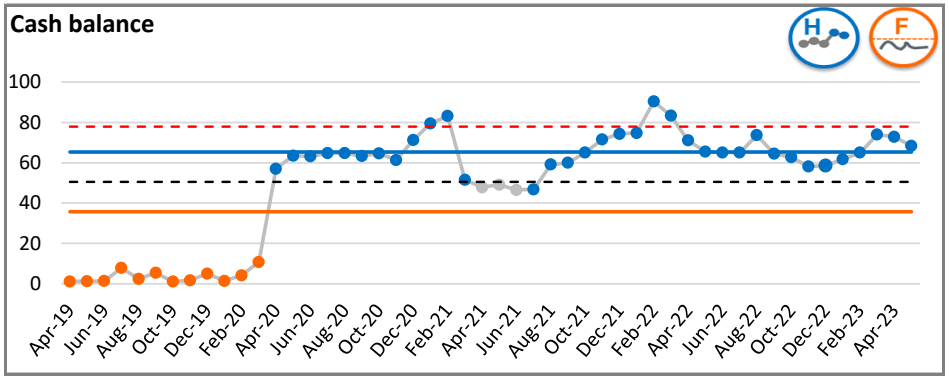
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust submitted a final 23/24 plan in May of £2.5m deficit. This plan assumes that a £33.1m cost improvement programme will be delivered.
- At Month 2, the Trust had planned for a YTD deficit of £4.9m and reported an actual YTD deficit of £4.8m.
- Month 2 has seen a significant improvement in the volume and value of elective activity undertaken by the Trust.
- Whilst pay budgets remain broadly in balance a number of hotspots of concern have emerged in respect of management of CSW budgets and elements of medical staffing spend.
- The CIP target for the YTD is £4.4m, against which savings of £4.5m have been recorded. Concern remains in respect of the level of unidentified savings plans within the Unplanned Division.

	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	607.1	97.5	97.1	-0.3
Pay	-375.7	-63.3	-63.4	-0.1
Non Pay	-199.7	-33.4	-33.5	-0.1
EBITDA	**31.7**	**0.8**	**0.3**	**-0.5**
Financing Costs	-34.2	-5.7	-5.1	0.6
Retained Deficit exc. PSF	**-2.5**	**-4.9**	**-4.8**	**0.1**
Adj Financial Performance	-0.3	-0.0	-0.0	-0.0
Deficit (Incl Fin Adj's)	**-2.8**	**-5.0**	**-4.9**	**0.1**

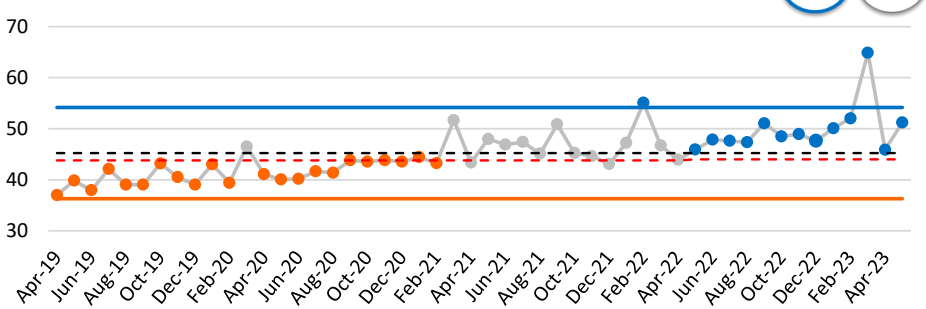
Month 02 | 2023-24

Finance

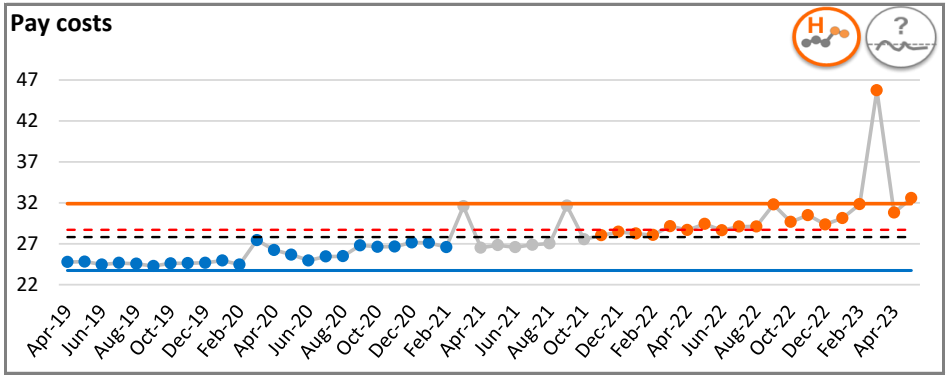
Key Financial Drivers

East and North Hertfordshire NHS Trust

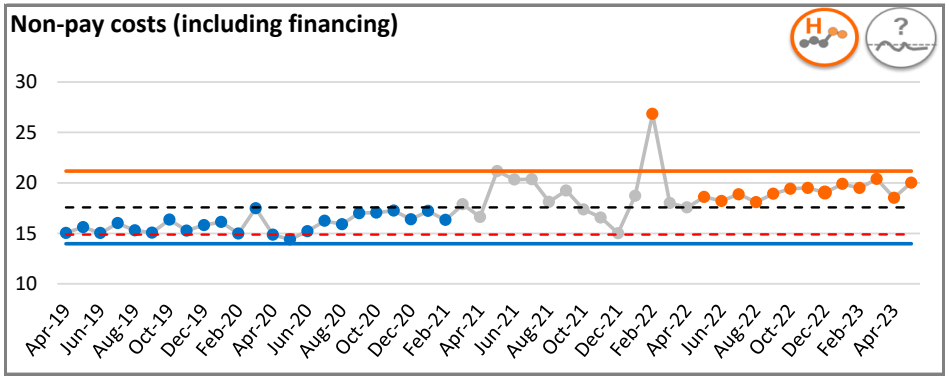
Income earned



Pay costs



Non-pay costs (including financing)



Key Issues and Executive Response

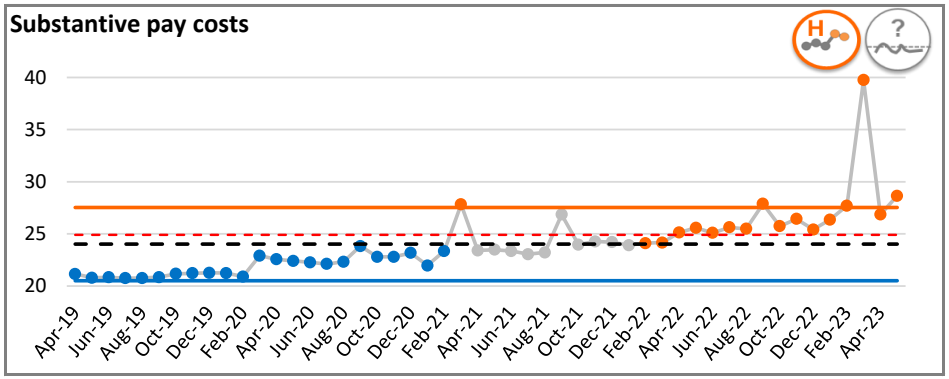
- The Trust submitted a final 23/24 plan in May of £2.5m deficit. This plan assumes that a £33.1m cost improvement programme will be delivered, supported by some release of non recurrent support.
- The plan phasing recognised a graduated start to the CIP programme, as well as a profile for stepping up of elective activity / ERF income. In the second half of the financial year the Trust is required to deliver monthly surpluses.
- At Month 2 YTD, the Trust planned for a deficit of £4.9m and the actual deficit was £4.8m.There was a £0.1m favourable variance in month against an in month deficit plan of £1.5m .
- Income was £1m favourable to plan in month (£0.3m adverse YTD), due to high cost drugs income and a significant improvement in elective recovery activity, which will be reflected in more detail in the Productivity and ERF report.
- The favourable income position was offset by £0.4m adverse on pay and £0.5m on non pay and financing costs. The non pay variance was mainly driven by high cost drugs, which is offset by income.
- Of the in month pay position, £0.2m relates to Clinical Support Workers where the Trust has used 33 WTE more than budget. Nursing staff was also £0.1m adverse to budget in month. The Director of Nursing, supported by workforce and finance colleagues, is introducing weekly prospective staff utilisation meetings to review all ward areas to ensure that staff are appropriately deployed within funded resources.
- Medical staff was £0.1m adverse in month. There are some significant 'hotspots' within Womens services, Childrens services and ED, which are collectively £0.2m adverse in month. Three task and finish groups, comprising medical, operational, workforce and finance colleagues, are being set up to undertake a deep dive into the drivers of the variances and to agree mitigations.
- The Trust has a challenging CIP target of £33.1m this year, which has been phased more significantly in the second half of the financial year. Year to date there is a £0.1m favourable variance on CIPs. A more detailed analysis of the CIP position will be presented in a specific CIP paper to FPPC.

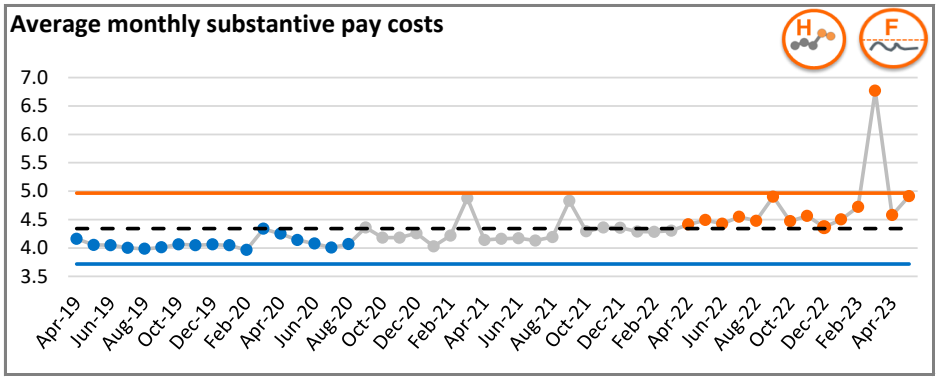
Month 02 | 2023-24

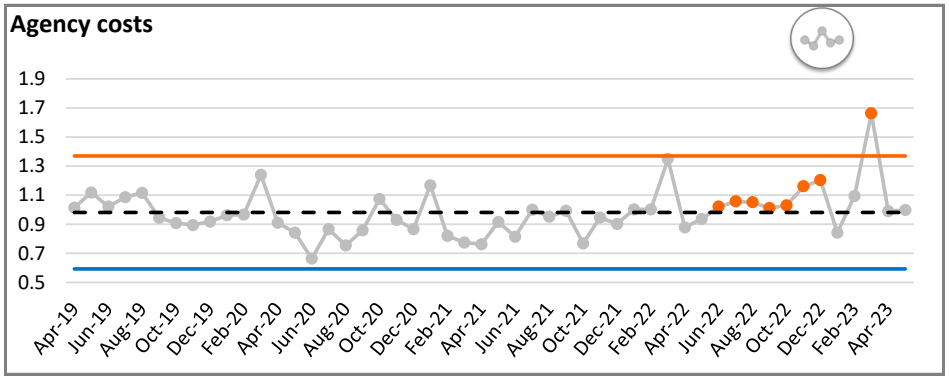
Finance

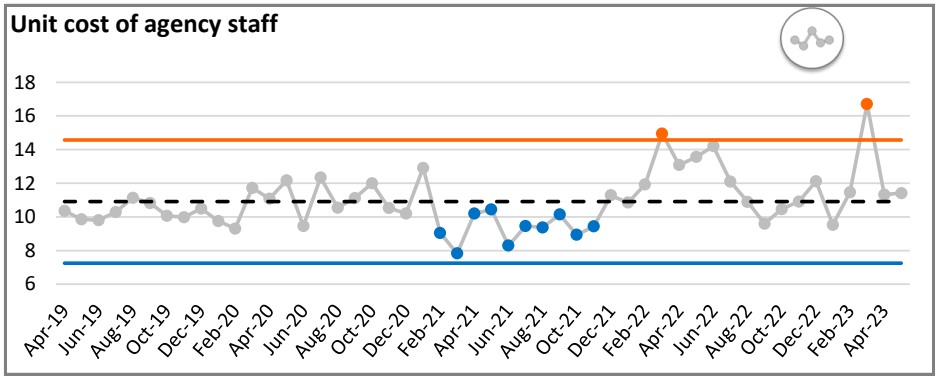
Other Financial Indicators

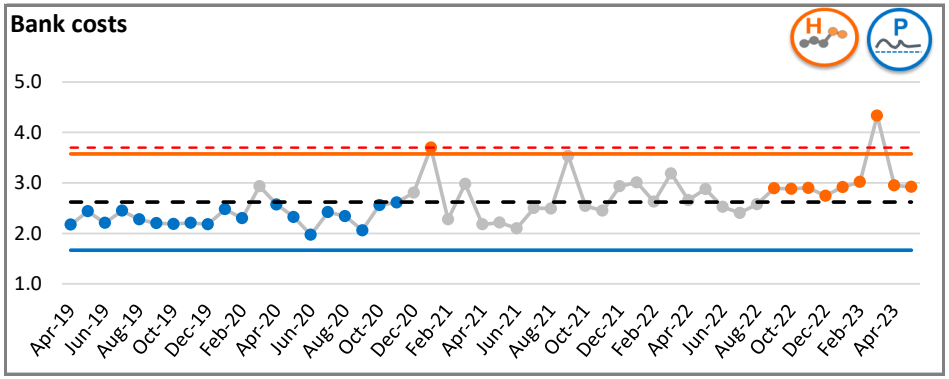
East and North Hertfordshire NHS Trust

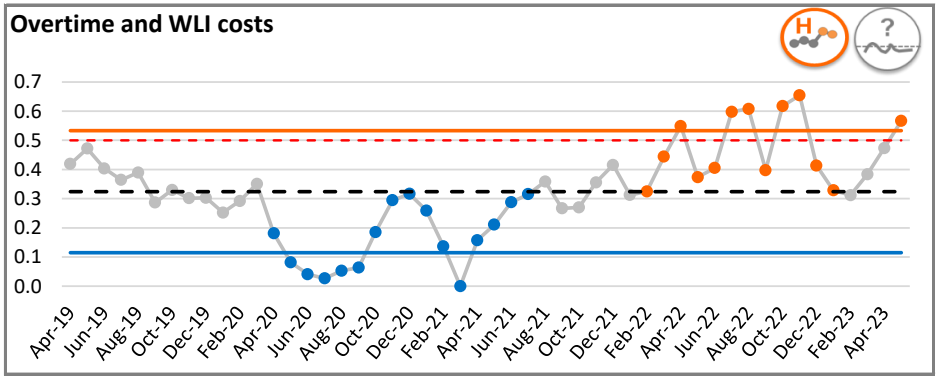










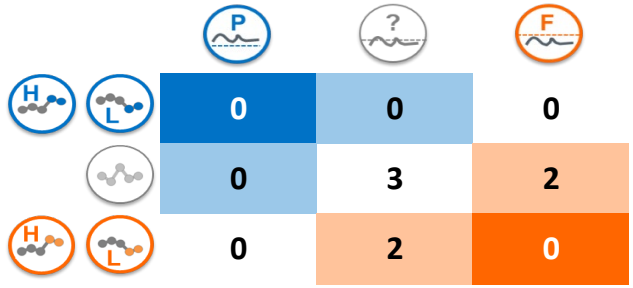


Month 02 | 2023-24

East and North Hertfordshire NHS Trust

People

Month 02 | 2023-24



People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	May-23	5%	7.8%	H	?	9 points above the mean Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	May-23	10%	9.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	May-23	4%	3.0%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	May-23	90%	86.8%		F	Common cause variation Metric will consistently fail the target
	Appraisal rate	May-23	90%	65.3%		F	Common cause variation Metric will consistently fail the target
Thrive	Turnover rate	May-23	12%	11.9%	H	?	19 consecutive points above the mean Metric will inconsistently pass and fail the target
Care	Sickness rate	May-23	3.8%	4.4%		?	Common cause variation Metric will inconsistently pass and fail the target

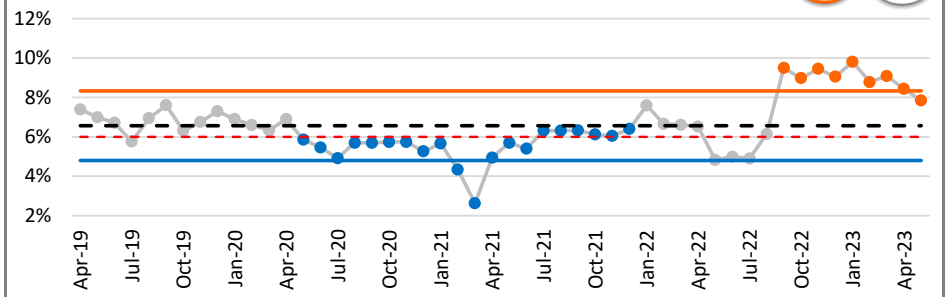
Month 02 | 2023-24

People

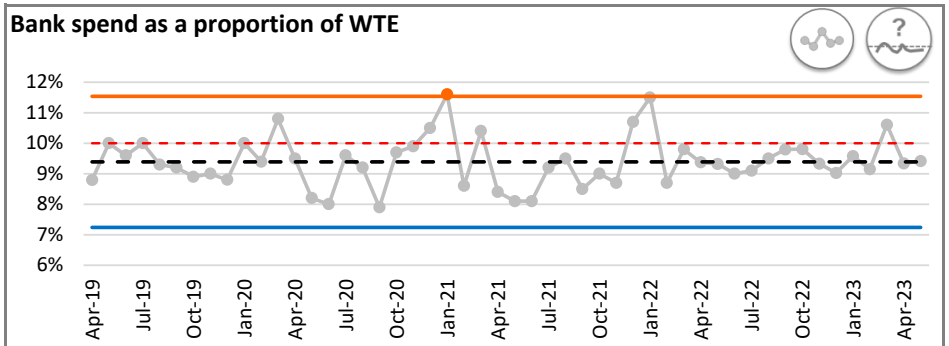
Work Together

East and North Hertfordshire NHS Trust

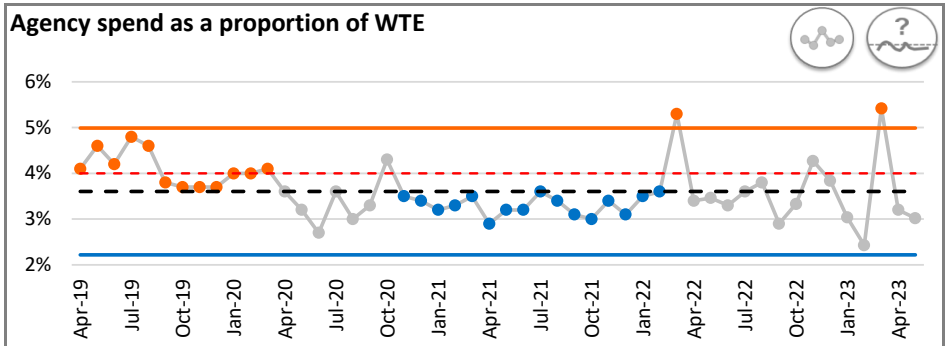
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- Continuous improvement with the overall vacancy rate reducing to 7.84% (514 vacancies) in M2, there are 153 more staff in post than May 2022. Overall, the trust remains 3.4% above vacancy target.
- Nursing & Midwifery vacancy rate increased to 8.8% (180 vacancies) 8 international nurses arrived in month with a further 15 expected for M3.The Trust met it's NHE/I international recruitment targets for 22/23, the Trust now has 33 inclusion ambassadors trained.
- 72 student nurses have applied for posts with interviews planned for July. There are 264 applicants in the pipeline including 34 doctors, 102 nurses/midwives, 30 clinical support workers and 24 AHPs.
- Preparations are underway for the Health Education Junior Doctors rotations for F1's Shadowing in July and Trainees commencing in August, a total of 311 doctors to process.
- M2 showed the lowest Bank & Agency demand in over a year, Agency spend was 37k under M1 NHSI agency ceiling target. Proactive work linked to the upcoming 'Great for 8' initiative to be kicked off in June (linked to temporary pay bill less than 8%)
- Progress against 'Great for 8' shows we are currently 25 FTE out against target (20.5 FTE through Bank and 4.5 FTE through agency). This is monitored through the Workforce monitoring tool on QV.
- 89% of clinical staff are on eRoster with 6 new roster units live in M2. A refresh of roster system controls are due to go-live for July's rosters within N&M following discussion with Deputy Chief Nurse.
- 66% of N&M rosters approved >6 weeks (target 80%), slight improvement from M1. Work remains underway led by eRoster lead alongside ward managers and Heads of Nursing to improve metrics supporting flexible working.

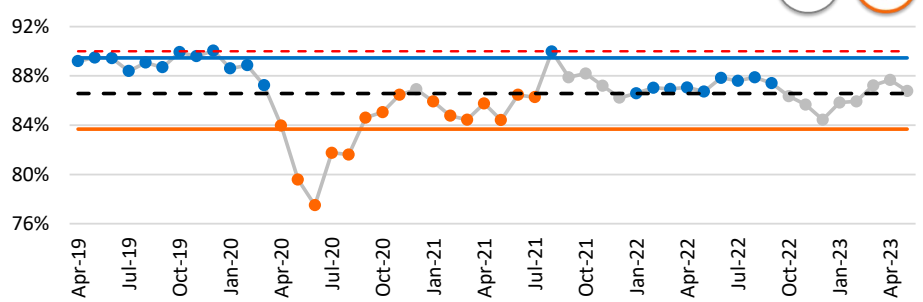
Month 02 | 2023-24

People

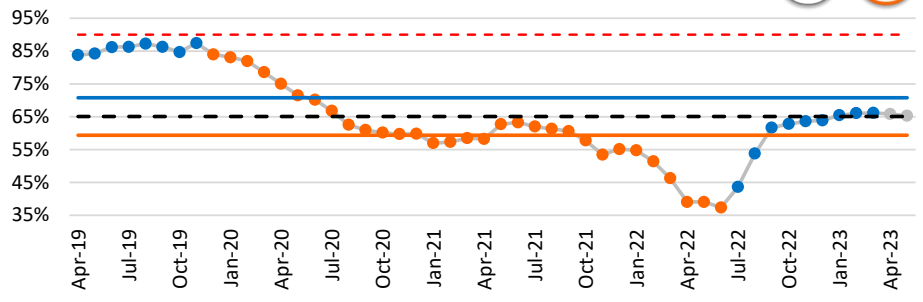
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- The Trust's appraisal window opened in April, with 27% of total staff having completed their Grow conversation within the window, so far. Overall compliance (full year look back) has slightly declined compared to last month, currently at 65.1%, however this is anticipated due to more staff becoming non-compliant, during the window.
- Grow together champions across the Trust have been identified in hotspots (circa 15), tasked with promoting and providing training locally. Grow Together training, drop-ins continue, with areas such as Estates and Facilities recently targeted for training.
- Mandatory training has shown a slight 1% decrease in May to 86.6%. This is due to some changes to the mandatory course compliance dashboard, with Resuscitation courses now included (difficulties with the way data was captured, meant the trust was previously unable to report on this training) and MCA DoLs being moved to role essential.
- Action is being taken to address issues impacting on compliance, in areas like Moving and handling and Resus training, where last-minute non-attendances (DNAs) still occur. Staff failing to attend are currently escalated to line managers and service leads. Where staff fail to attend the same course on a 2nd occasion, staff are met with by the relevant subject leads for a discussion before they are allowed to re-book. DNA lists are now being shared with HR Partners for discussion with services.
- One-day mandatory training events, combining several face-to-face sessions are taking place on 10th July and 15th August. This should improve compliance.
- Staff CPD - Confirmation from HEE regarding 23/24 CPD funding allocation for non-medical training, has been received - £690k similar to previous years. Funding distribution is in progress, based on needs analysis collated earlier in the year and head count in divisions.

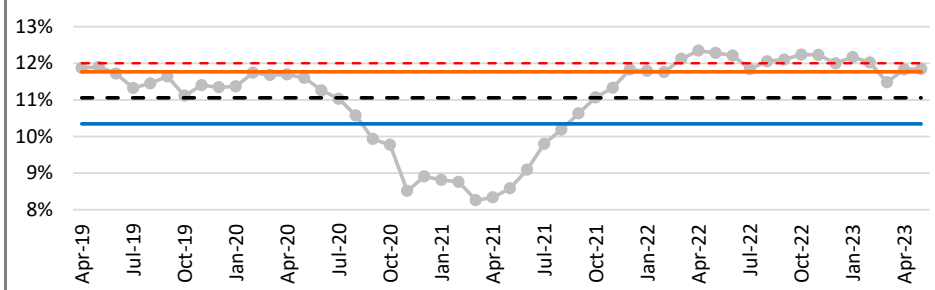
Month 02 | 2023-24

People

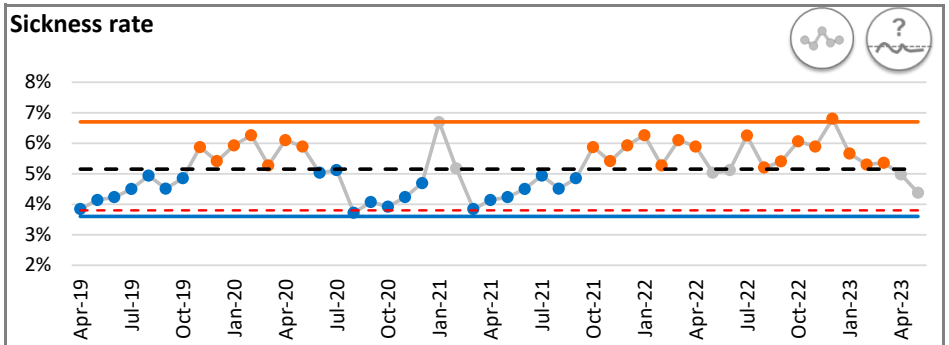
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

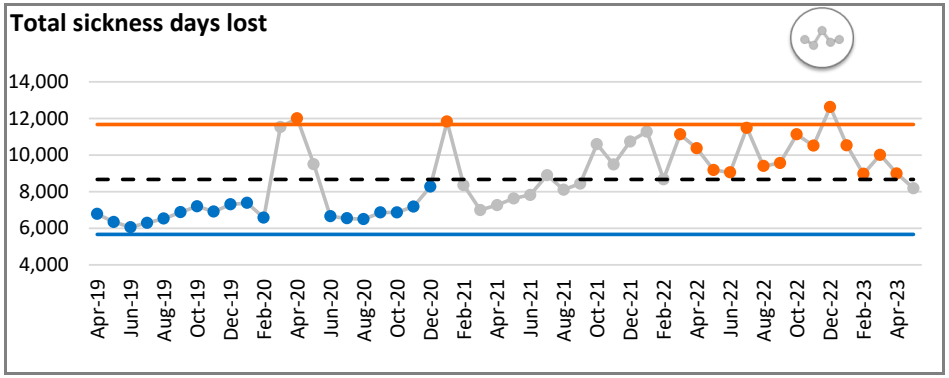
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Staff Networks have been recruiting new chairs/co-chairs with updates due to People Committee of outcomes from this exercise
- Engagement sessions underway to develop the EDI Strategy for ENHT and aim to publish by end July 2023
- Recruitment to cover EDI manager role underway as current post holder commences a regional, promotional secondment for 18 months from early July
- Work continues on staff survey action plans within divisions and teams

Care Together

- Colleagues are being regularly supported to make healthier lifestyle choices and encouraged to take up offers of support with monthly wellbeing promotion events and information shared by wellbeing champions.
- Mental Health Awareness week was promoted in May with anxiety awareness sessions for colleagues at Hertford County, QEII, Lister and Mount Vernon. The menopause staff support network has offered peer support and in May guest speakers have provided information about nutrition and therapy options.
- Sickness levels have further declined in May, with reductions in short and long term sickness absence with a focus on regular case reviews. Reductions in days lost due to the key priority areas of musculoskeletal health and mental health are within target.

Month 02 | 2023-24

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	ICS Monthly Performance Report			**Meeting Date**	5 July 2023
Presenter	Martin Armstrong - Deputy CEO				
Author(s)	Herts and West Essex – Integrated Care System				
Responsible Director	Martin Armstrong – Chief Finance Officer			**Approval Date**	23-02-23
Purpose *(tick one box only)*	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The report attached is produced by Hertfordshire and West Essex integrated care system and sets out performance against a range of access dimensions across the system and the organisations that compose its membership.

Impact: where significant implication(s) need highlighting

The board is asked to note system performance issues and challenges, within the context of ENHT delivery.

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

NA

Report previously considered by & date(s):

NA

Recommendation	The Board is asked to note the report

To be trusted to provide consistently outstanding care and exemplary service

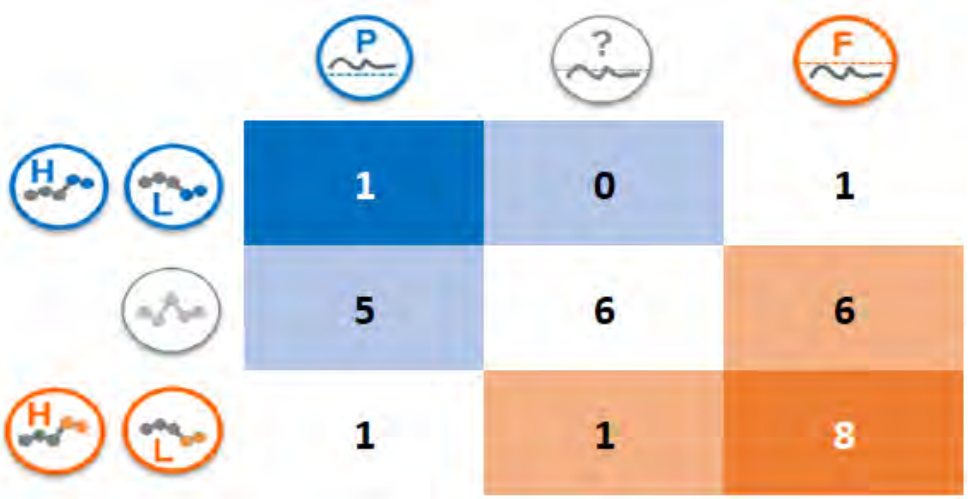
Hertfordshire and
West Essex Integrated
Care System

Presentation to: HWE ICB Board
HWE ICS Performance Report

May 2023

Working together
for a healthier future

Executive Summary – KPI Risk Summary



Highest Risk	Programme
ED 4 Hour Standard	UEC
% in ED > 12 Hours	UEC
Ambulance Handovers	UEC
Out of Area Bed Days	Mental Health
Adult 28 Day Standard	Mental Health
HPFT Early Memory Diagnosis (EMDASS)	Mental Health
RTT 78 Week Waits	Elective
RTT 52 Week Waits	Elective

Lowest Risk	Programme
RTT 104 Week Waits	Elective

Low Risk	Programme
90% Stroke Unit	Stroke
Mental Health EIP	Mental Health
Adult Crisis 4 Hour	Mental Health
62 Day Backlog	Cancer
CHC Assessments in Acute	Community

Variable Risk	Programme
GP Appointments	Primary Care
2 Hour UCR	UEC
NHS 111 Calls	UEC
% Not Meeting CTR	UEC
2 Week Waits	Cancer
28 Day Faster Diagnosis	Cancer
Community Waits (Adults)	Community
CHC Assessments < 28 Days	Community

High Risk	Programme
Dementia Diagnosis	Primary Care
Ambulance Response Times	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
62 Day Standard	Cancer
6 Week Waits	Diagnostics
Community Waits (Children)	Community

Executive Summary

URGENT CARE, Slides 7-13: Calls abandoned performance = better than regional and national position; ED 4 hour performance = better than regional but worse than national position

- Improvement in 111 performance against calls abandoned with activity returning to historic levels following Strep A related spike in December;
- Improvement in Cat 2 mean ambulance response times from spike in December, with March performance sitting at average 22/23 levels;
- Following some improvement at the start of the year in Ambulance Handover, a deterioration has been seen in March;
- ED 4 hour performance remains at similar levels and whilst worse than the national position, continues above the regional average;
- Whilst Data suggests that plans are starting to deliver small improvements in some areas, performance against improvement trajectories for UEC remains off track.

CANCER, Slides 21-22: 62 day first performance = better than regional and national position

- Continued improvement in 28 day Faster Diagnosis performance, returning to meet the 75% standard in February;
- The number of patients waiting >62 days continues to improve, meeting the operational recovery plan trajectory in March. Whilst referrals are c30% higher than pre-pandemic levels, treatment numbers have increased to reduce the backlog. On-going industrial action may further impact;
- Performance against 62 day standard remains below target with the treatment of the longest waiting patients, however remains better than both regional and national position.

PLANNED CARE, Slide 18: 18 week performance = better than regional and national position

- Number of patients waiting >78 weeks remains fairly static and did not meet the national ambition of 0 at March 31 with pressure remaining predominantly in Community Paediatrics and Trauma and Orthopaedics at ENHT. The 78 week ICB recovery trajectory was achieved however and reporting will now focus on patients waiting over 65 weeks. On-going industrial action continues to impact;
- ENHT to move back into Tier 1 management for elective recovery;
- The number of patients waiting over 52 weeks remains high and of concern.

DIAGNOSTICS, Slide 19: 6 week performance = worse than regional and national position

- Diagnostic performance continues at similar levels remaining below regional and national benchmarking, with PTL remaining static;
- System-wide diagnostic improvement plan in place, with 23/24 operational plan building on existing work to increase activity levels and decrease waiting times.

Community, Slides 14-17

- Number of adults on total list waiting list continues at lower levels with improvements seen in proportion waiting <18 weeks; improved longest wait of 63 weeks;
- Longest wait for children has increased to 71 weeks with total waiting list also continuing to increase; pressures remain in community paediatrics, therapies and audiology services;
- Widening inequalities in timely access to community services between adult and children patient groups.

MENTAL HEALTH, Slides 26-32

- Demand continues to remain high in Adult, Older Adult and CAMHS services with KPIs remaining below standard. Vacancies and recruitment remain a key challenge;
- Pressure for Mental Health Assessments and acute beds continues, with Out of Area Bed Days continuing to remain high; a continued decrease has been seen since Nov 22 peak however;
- Dementia diagnosis in Primary Care remains challenged in Hertfordshire with performance remaining static.

PRIMARY CARE AND CONTINUING HEALTHCARE, Slides 33-34

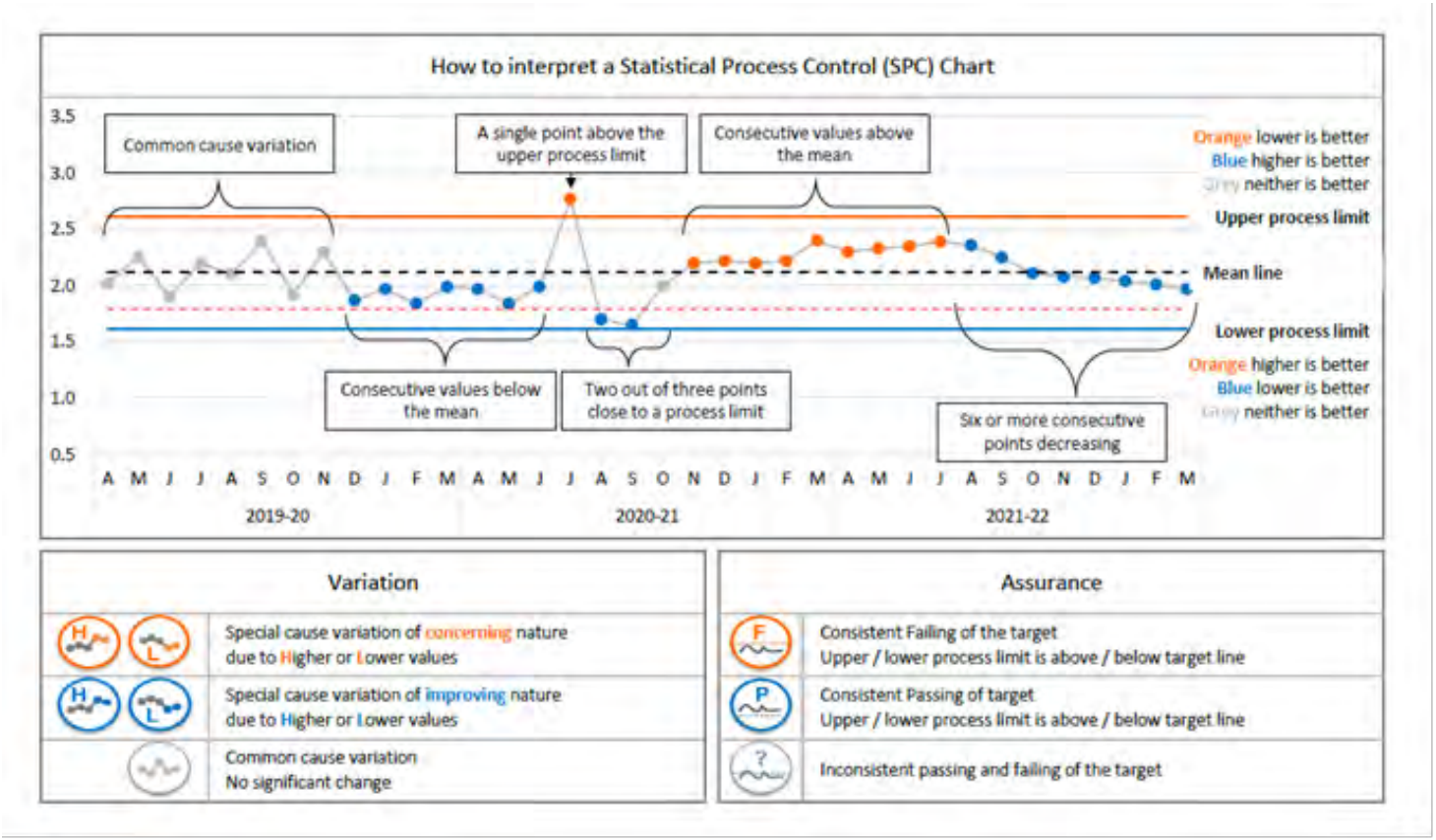
- Total number of GP appointments remain higher than pre-pandemic levels with the proportion of face to face appointments continuing above 70%. Further Primary Care reporting is being developed for inclusion in the next report;
- The number of CHC assessments completed within 28 days remains a challenge in South West Herts with an action plan in place.

Executive Summary – Performance Overview

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Mar 23	62.0%	76.0%			66.8%	61.5%	72.2%
A&E - % spending more than 12 Hours in Dept	Feb 23	7.3%	-			6.8%	5.0%	8.6%
A&E - ED Average Attendance	Mar 23	41429	-			40183	33641	46725
Trolley Waits	Mar 23	238	-			179	-50	407
2 Hour Community Response	Mar 23	78.9%	70.0%			83.6%	65.9%	101.2%
14 day LOS	Mar 23	24.8%	-			25.1%	21.0%	29.2%
Ambulance - Handover >60 Mins	Mar 23	1581	-			991	680	1303
EEAST: Cat 1 - Mean (<7min)	Mar 23	00:09:30	00:07:00			00:09:38	00:07:47	00:11:29
EEAST: Cat 2 - Mean (<18 Mins)	Mar 23	00:56:22	00:15:00			00:54:36	00:14:16	01:34:57
RTT - 18 Weeks	Feb 23	53.2%	92.0%			57.4%	54.1%	60.7%
RTT - 52 Week Waits	Feb 23	8747	-			7253	5740	8765
RTT - PTL Size	Feb 23	138822	-			122029	114860	129198
RTT - 78 weeks	Feb 23	649	-			991	646	1336
Diagnostics - 6 Week Wait	Feb 23	66.0%	99.0%			64.7%	56.6%	72.8%
Diagnostics - PTL Size	Feb 23	24590	-			24653	19833	29472
Cancer - 2 Week Wait Standard	Feb 23	90.6%	93.0%			80.8%	68.6%	92.9%
Cancer - 2 Week Wait Referrals	Feb 23	5400	-			5289	4025	6553
Cancer - 62 Day Standard	Feb 23	64.9%	85.0%			73.2%	62.5%	84.0%
Cancer - 62 Day Total Waiting	Mar 23	405	-			595	372	818
Cancer - 104 Day Total Waiting	Mar 23	158	-			155	103	207
Cancer - 28 Day Faster Diagnosis Standard	Feb 23	78.0%	75.0%			69.8%	58.8%	80.7%
Mental Health - Out of Area Bed Days	Feb 23	1169	-			928	585	1270
Mental Health - Dementia Diagnosis	Feb 23	62.1%	66.6%			61.6%	60.9%	62.2%
Mental Health - IAPT Entering Treatment	Feb 23	2312	-			2399	1502	3295
Early Intervention in Psychosis	Feb 23	88.9%	60.0%			84.0%	66.7%	101.3%

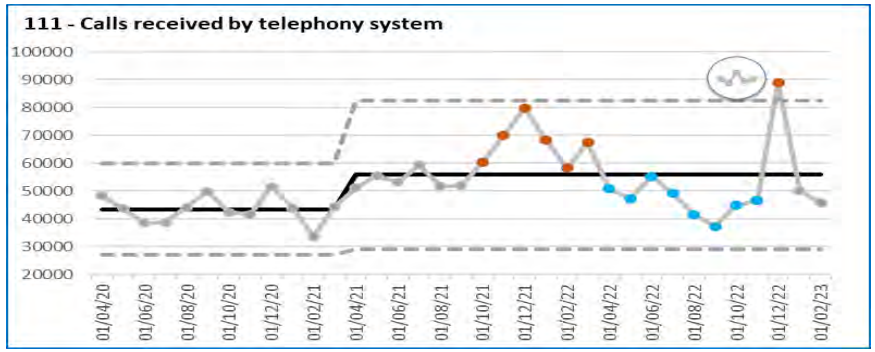
A Dashboard including Place and Trust based performance is included within Appendix A of this report

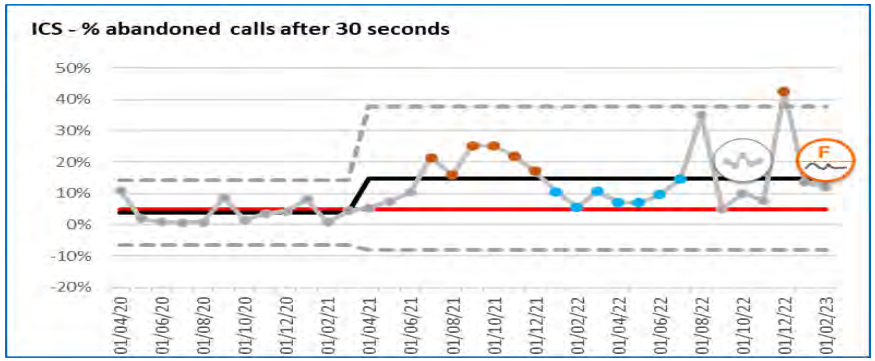
Statistical Process Control (SPC)



Performance by Work Programme

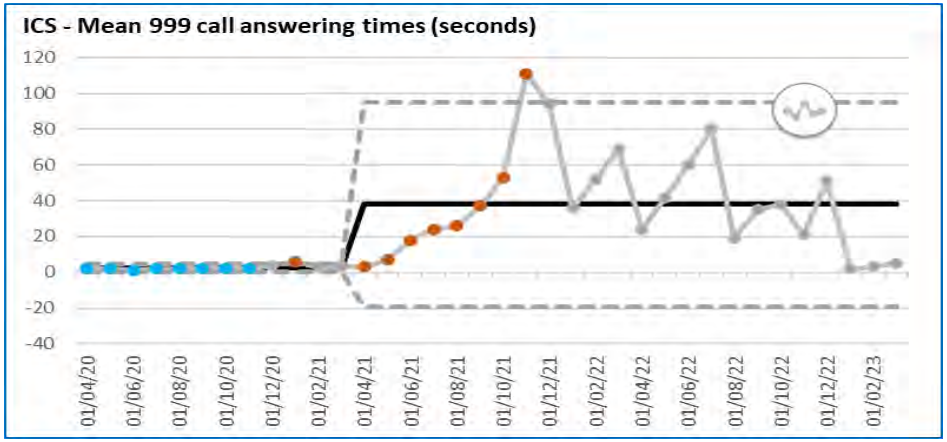
NHS 111

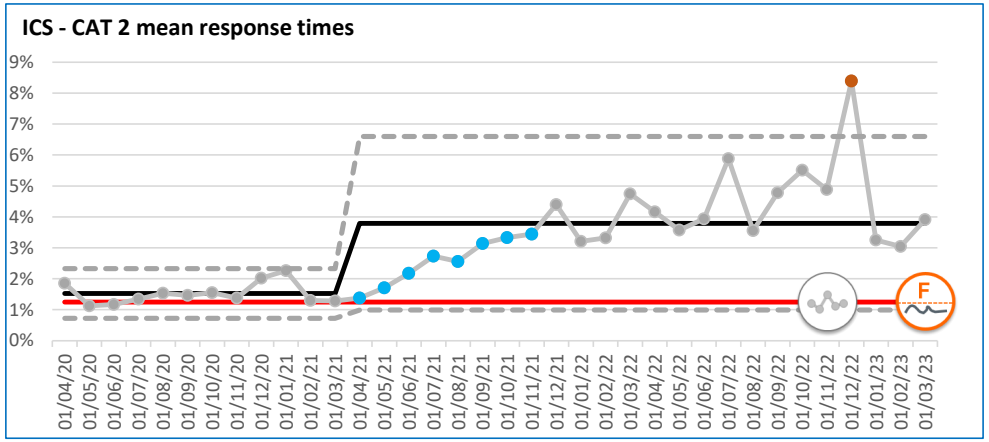


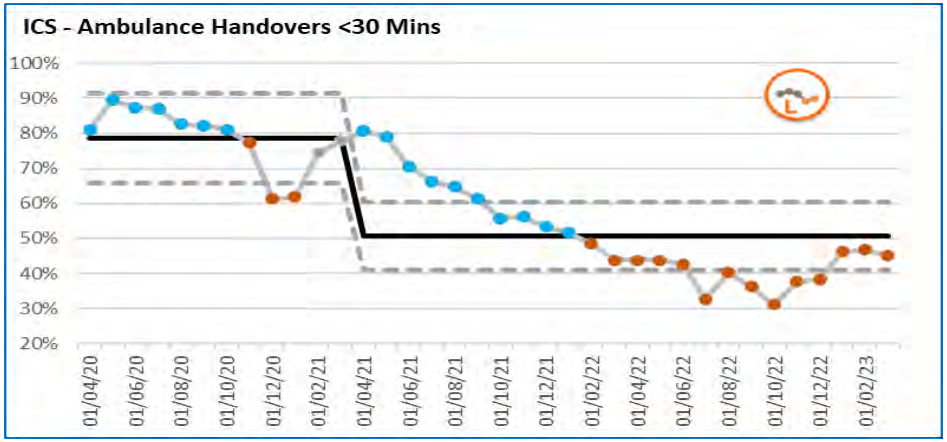


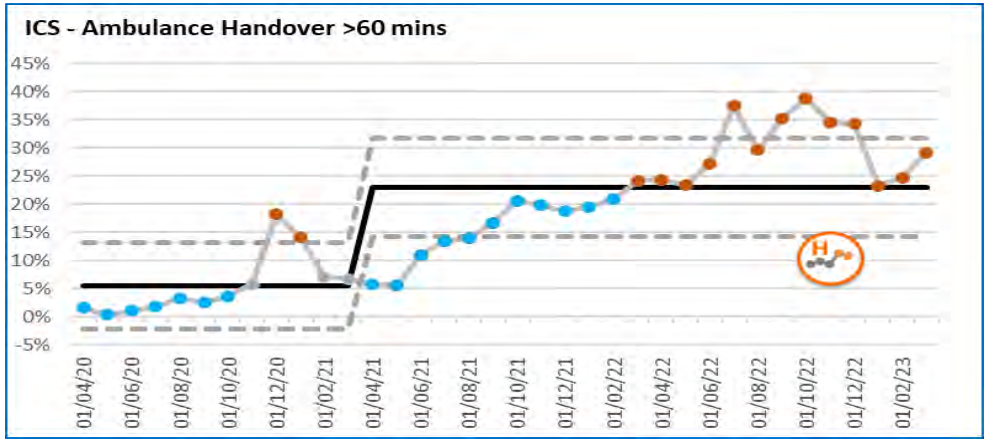
ICB Area	What the charts tell us	Issues	Actions	Outcomes
HUC	• Call volumes returned to historic levels in Jan / Feb following the Strep A driven spike in December • Abandoned call performance has significantly improved, but remains above the standard • Hertfordshire saw 11.9% of all calls abandoned in February; West Essex saw 13.7% of all calls abandoned.	• High attrition rates and short notice sickness • Call volumes remain high at weekends • Increasing 111 online activity	• Respiratory Hubs established until end of March 2023. Two hubs extended by two weeks to support services until mid-April • Weekly IUC Overview Reports from the Provider with monthly updates on workforce • Formalised Pooled CAS agreement between Commissioners across HUC-Footprint • Range of staff support and welfare measures put in place by HUC • Review of 111 online activity • HUC Footprint group fortnightly meetings in place to agree 23/24 contracts as well as identify and implement efficiencies improving the service	• Respiratory Hubs expected to divert activity from 111 and ED • Sharing CAS resource to strengthen clinical support where required across HUC Footprint (HWE, BLMK, C&P)

UEC - Ambulance Response and Handover



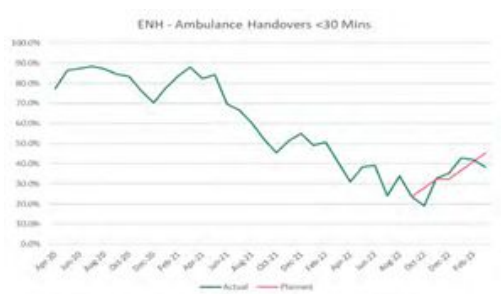




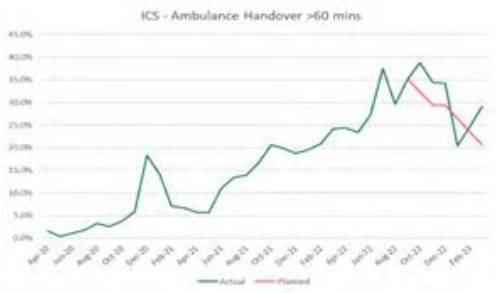


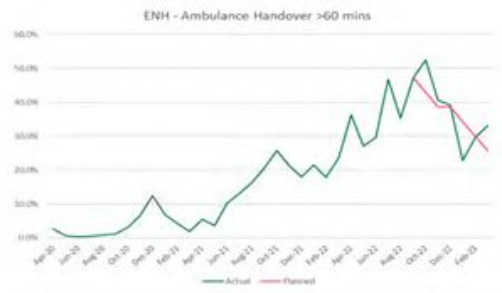
UEC - Ambulance Handover Improvement Trajectories

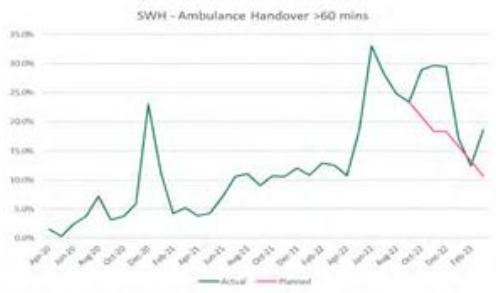
< 30 Minute Ambulance Handover Trajectories

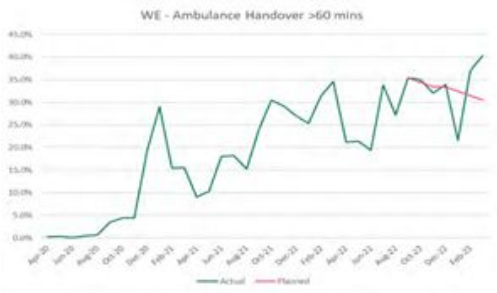


> 60 Minute Ambulance Handover Trajectories

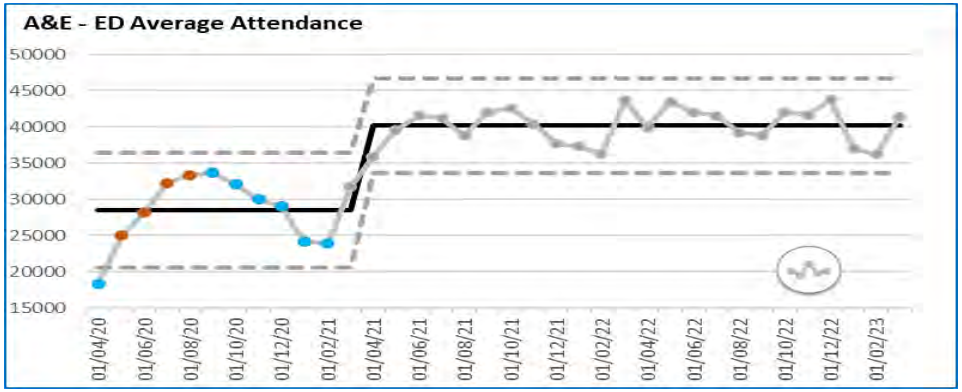


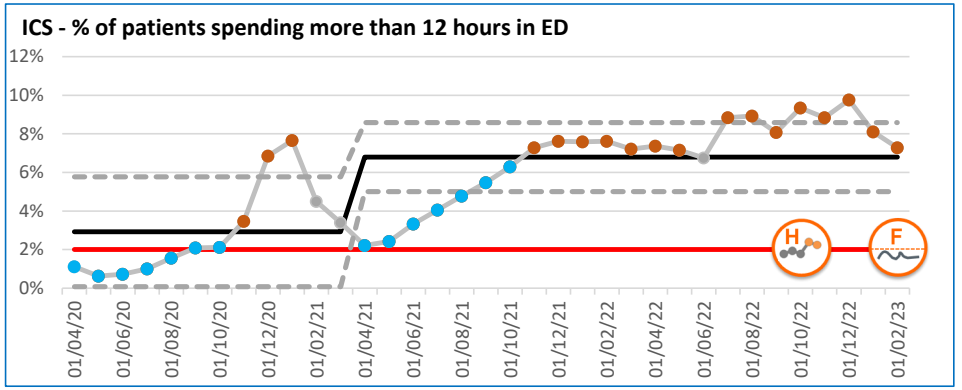


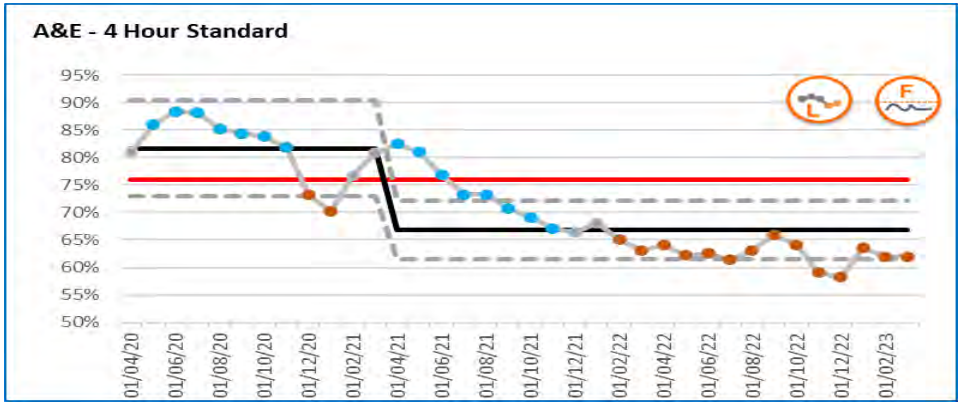


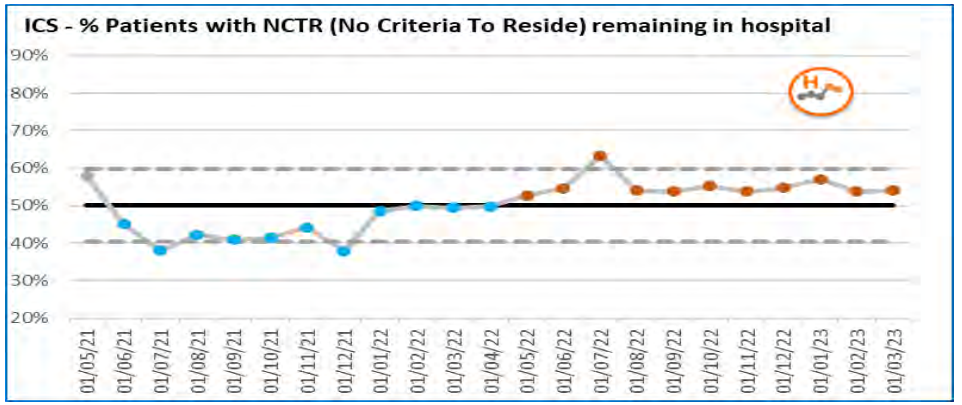


Urgent & Emergency Care (UEC)







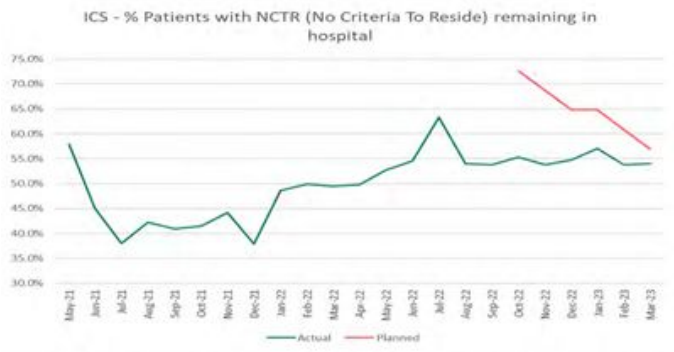


Place	Patient Journey	Area	Indicator	Target	Previous Month	Current Month	Latest Month	Month Change
WE CCG	At Hospital	Hospital flow	% Patients with NCTR (No Criteria To Reside) remaining in hospital	-	56.6%	57.7%	March	
SWH CCG	At Hospital	Hospital flow	% Patients with NCTR (No Criteria To Reside) remaining in hospital	-	52.6%	51.2%	March	
ENH CCG	At Hospital	Hospital flow	% Patients with NCTR (No Criteria To Reside) remaining in hospital	-	53.4%	55.6%	March	

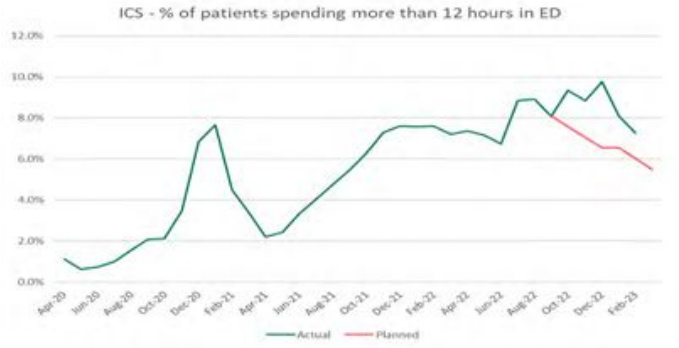
Urgent & Emergency Care (UEC) Improvement Trajectories

4 Hour Standard Improvement Trajectory

No Longer Meet Criteria to Reside (NLMCTR) Improvement Trajectory



12 Hours in ED Improvement Trajectory

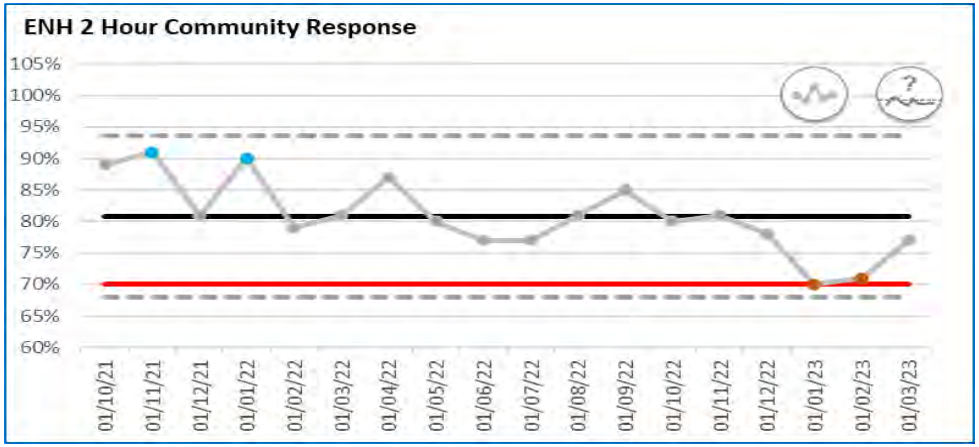


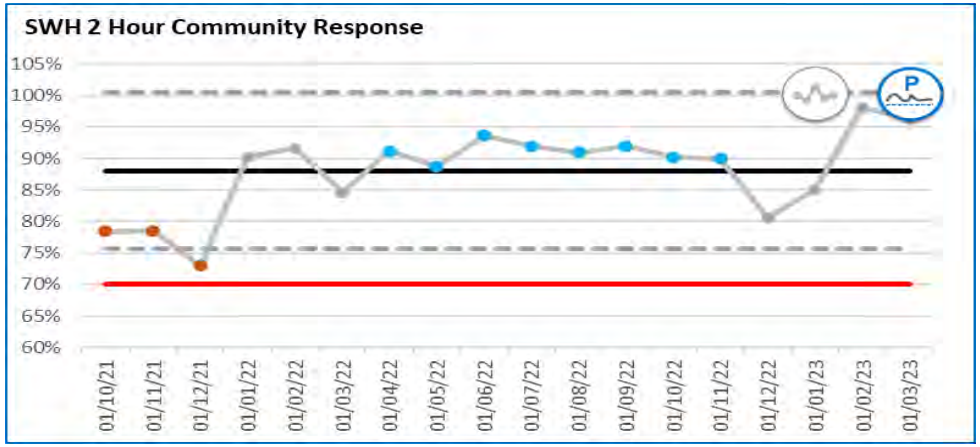
11

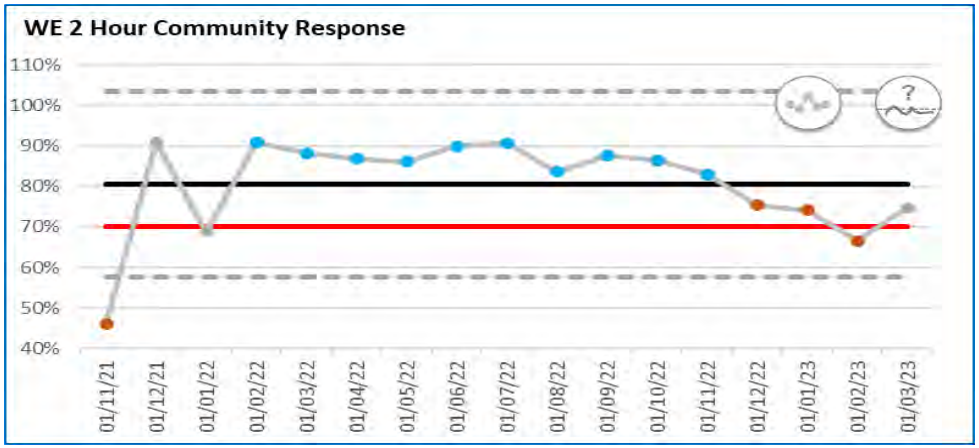
Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• 999 call answering times are close to where they were pre-pandemic – Mar-23 average = 5 seconds • Category 2 ambulance response times increased to 56 minutes in March. This is similar performance to most of 22/23 • At an ICS level, ambulance handover performance (both for % under 30 minutes and % over 60 minutes) has remained at similar levels to the rest of 22/23. Improvements were seen at the start of the year, however a deterioration has been seen in March • In East and North Hertfordshire and South West Hertfordshire, ambulance handover performance has generally been improving since Oct-22 • In West Essex, ambulance handover performance has remained largely static since Q2 of 22/23 • The % of patients spending >12 hours in ED improved for the second consecutive month in Feb-23 to 7.3%. However, performance remains behind the agreed recovery trajectory. • The % of patients spending <4 hours in ED remained static at 62% in Mar-23 and is below the agreed recovery trajectory • However, there is a variation at a Trust level for performance against the 4 hour standard in March: – WH = 68.1% – ENHT = 62.9% – PAH = 51.8% • Delayed discharges from adult G&A beds is impacting ED performance for admitted patients, in particular at Princess Alexandra Hospital	• Continued high demand for UEC services albeit lower than they were in Q3 22/23 • Ongoing industrial action across various staffing groups • Staffing vacancies – e.g. c.70 vacancies at EEAST • Staffing rotas in ED not always aligned to daily peaks in demand • Handover delays having a knock-on effect on ambulance response times • Reduced staffing of handover units / cohorting areas • Mental Health assessment delays and bed shortages • Acuity of walk-in patient sometimes higher than ambulance arrivals • Access to ring-fenced diagnostics in ED • Referral to stack rates remain low • Low utilisation of virtual wards in West Essex	• EEAST 45 minute handover initiative gone live in Mar-23. For patients who are fit to remain in ED unassisted on a seat / trolley, the ambulance crew complete a checklist which remains with the patient so crew can go to their next patient • EEAST recruitment drive • Access to stack / #handover@home delivery group meeting weekly and weekly exec oversight group • EPUT extending the auto reject to 2 hour slot to help with surge pressures • PAH pilot to relocate ED doctors to Rapid Assessment and Treatment area to improve flow and ensure appropriate diagnostics are requested • PAH CDU Phase 1 now live - chairs and 2 assessment trolleys • Proposed expansion of SDEC operating hours and surgical assessment unit on the Lister site • Review of ED staffing rotas at Lister to better match staffing levels with peak ED arrival times • Virtual ward comms launch in West Essex • Utilisation at St Albans IUCH increased during March and April and averaged 79% 1st – 20th April 2023 • Hemel UTC weekend radiology: assessment on cost and opportunity in development • West Herts 10x assessment spaces released from surge beds

UEC - Urgent 2 Hour Community Response







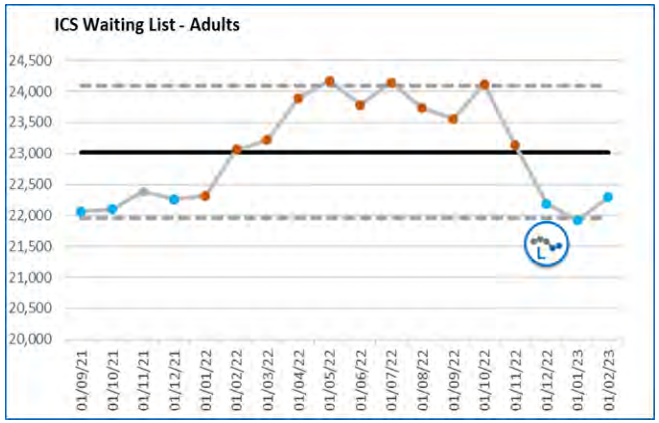
Activity	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
West Essex	289	353	468	465	428	337	451	519	395	403	442	415
East & North Herts	94	145	166	160	195	204	168	158	232	386	337	335
South & West Herts	147	142	157	162	165	124	163	139	165	154	103	136

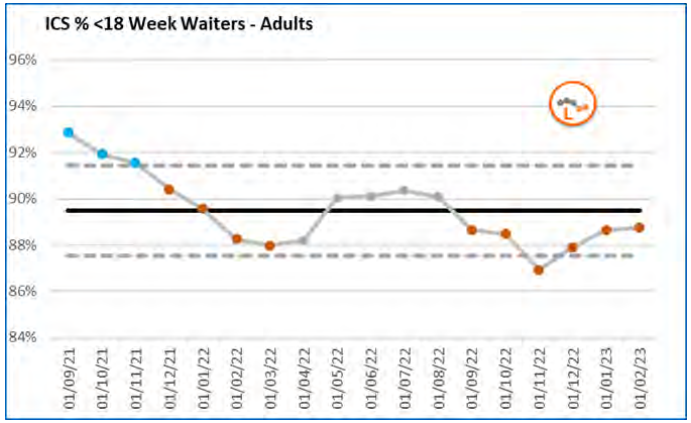
ICB Issues, escalation and next steps

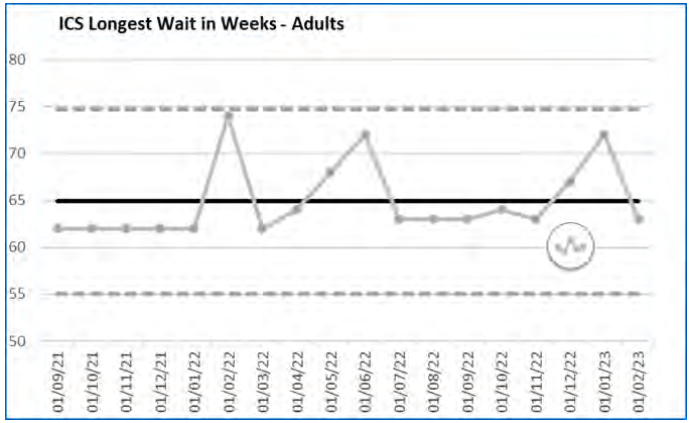
- % within 2 hours performance is once again achieving the 70% standard in all three places
- Activity levels in ENH have increased as 2 hour Emergency Intervention Vehicle (EIV) data is now being captured
- The SWH EIV is commissioned to a 4 hour standard, and therefore currently not reportable as UCR
- Work is ongoing to capture additional reportable activity for all three places. This should be completed for the next round of reporting

13

Community Waiting Times (Adults)







		Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	21915	22296	↑	88.64%	88.74%	↑	72	63	↓	February

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	8663	8430	↓	89.15%	89.86%	↑	50	63	↑	February
ENH	AJM/Millbrook	321	346	↑	80.69%	82.66%	↑	36	36	→	February
ENH	**All**	**8984**	**8776**	↓	**88.85%**	**89.57%**	↑	**50**	**63**	↑	**February**

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	4778	5235	↑	77.75%	77.19%	↓	72	51	↓	February
SWH	Connect	4366	4578	↑	92.49%	93.43%	↑	52	52	→	February
SWH	HCT	888	974	↑	96.40%	96.41%	↑	37	41	↑	February
SWH	AJM/Millbrook	375	367	↓	84.27%	83.38%	↓	40	39	↓	February
SWH	**All**	**10407**	**11154**	↑	**85.76%**	**85.74%**	↓	**72**	**52**	↓	**February**

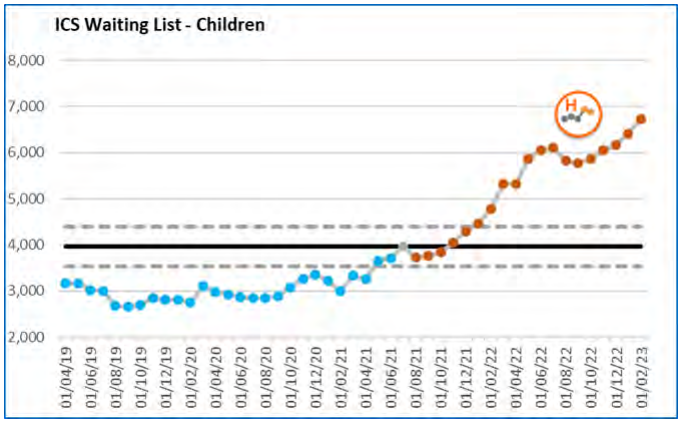
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	2410	2238	↓	100.00%	100.00%	→	17	15	↓	February
WE	EPUT - Wheelchairs	114	128	↑	94.74%	96.88%	↑	26	25	↓	February
WE	**All**	**2524**	**2366**	↓	**99.76%**	**99.83%**	↑	**26**	**25**	↓	**February**

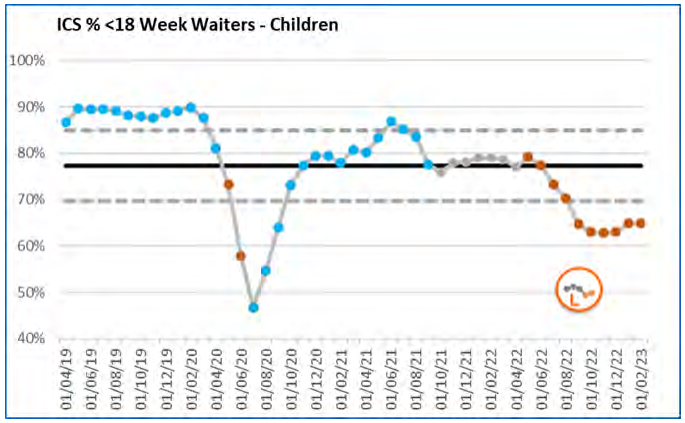
Community Waiting Times (Adults)

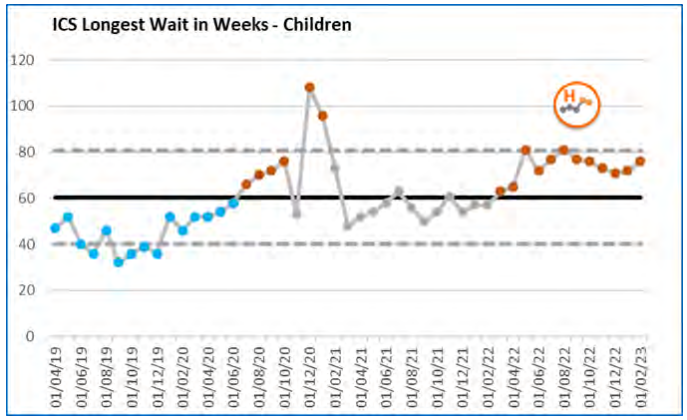
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full detail of commissioned services in HWE is contained within Appendix C.

ICB Area	What the charts tell us	Issues	Actions
ICB	• The % of patients waiting less than 18 weeks improved for the third successive month, but remains below the historic mean. Current performance is 88.7%, compared to the national average of 83.0% • Across the ICS, the total number of adults waiting on waiting increased in February, but remains below the historic mean • The waiting list increase was entirely within South & West Hertfordshire, but volumes remain within common cause variation limits • East & North Hertfordshire and West Essex both saw a reduction in patients waiting, but volumes remain of concern • The overall longest wait improved from 72 to 63 weeks in February • Whilst longest waits improved across the ICS, HCT saw an increase from 50 to 63 weeks • Consultant led 18 week RTT performance: ENH Skin Health – 90% SWH Respiratory – 65% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Waiting times for the MSK Physio Service show clear improvement and are now close to 2019/20 levels. • Pain Management waiting lists and contacts have increased due to demand for Covid rehab. **South & West Hertfordshire (SWH)** • Referrals have increased across Heart Failure, Respiratory, Pulmonary Rehab, Planned Care, SLT and Bladder and Bowel services • Respiratory holds the majority of long waiters. Consultant clinic capacity offered by WHTH does not meet current demand. However engagement has commenced with an external provider to support the service • Longest waiter currently within the Neuro service. This is an Acquired Brain Injury (ABI) patient waiting for Psychology input • Staff sickness and vacancies are improving and processes are in place to monitor progress **West Essex (WE)** • Pulmonary Rehab - increased demand, return to face to face classes and long term sick impacting capacity • Bladder & Bowel waiting list doubled over December and January – combination of capacity & demand	**East & North Hertfordshire (ENH)** • Increasing MSK Physio capacity though estates and recruitment. Also continuing to review pathways. Initiatives working well • Pain Management service pilot of screening tool highlighted the need for clearer criterion to help patients benefit from the service. Substantive roles are being recruited. **South & West Hertfordshire (SWH)** • Continue to review Respiratory long waits daily, prioritising those waiting the longest • Temporary Respiratory consultant capacity via bank and alternative Hospital Trusts • Respiratory consultant sessions with external provider implemented in February. This began with the provider reviewing the follow up caseload. In April, the provider began with clearing the 1st appointment backlog • External provider in place to support Neuro Rehab long waits. Initially 100 appropriate patients have been referred and seen. Further 175 patients identified • Division specific recruitment plan developed which includes developing videos to compliment adverts and targeting social media channels • On going discussions with two Trusts with regards to ABI patients **West Essex (WE)** • Pulmonary Rehab deep dive completed and 23/24 funding discussions under way • Bladder & Bowel February breaches are all booked in March. Recovery plan in place to return to full compliance by 31st May • Children's Wheelchair service has returned to 100% compliance

Community Waiting Times (Children)







		Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	6411	6724	↑	64.83%	64.93%	↑	72	76	↑	February

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1006	1030	↑	81.51%	80.49%	↓	64	52	↓	February
ENH	AJM/Millbrook	108	112	↑	84.26%	86.61%	↑	37	38	↑	February
ENH	**All**	**1114**	**1142**	↑	**81.78%**	**81.09%**	↓	**64**	**52**	↓	**February**

		Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	4557	4808	↑	55.52%	55.97%	↑	72	76	↑	February
SWH	AJM/Millbrook	85	89	↑	77.65%	76.40%	↓	33	37	↑	February
SWH	**All**	**4642**	**4897**	↑	**55.92%**	**56.34%**	↑	**72**	**76**	↑	**February**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT - Wheelchairs	30	35	↑	90.00%	100.00%	↑	26	16	↓	February
WE	HCRG / Virgin	625	650	↑	99.52%	99.38%	↓	36	18	↓	February
WE	**All**	**655**	**685**	↑	**99.08%**	**99.42%**	↑	**36**	**18**	↓	**February**

*** NOTE: Community Paediatrics data for ENH Place is not currently included in the above data. Development work underway with ENHT to include in future reporting**

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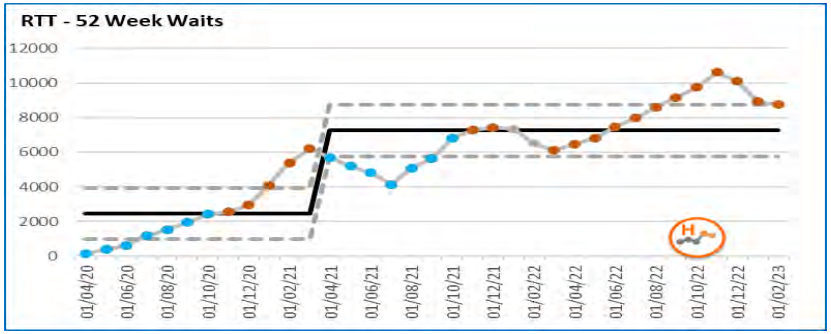
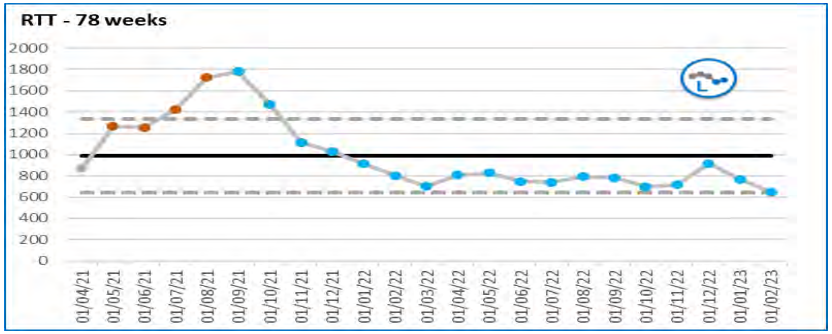
Community Waiting Times (Children)

The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full detail of commissioned services in HWE is contained with Appendix C.

ICB Area	What the charts tell us	Issues	Actions
ICB	• There was a small improvement in the % of children waiting less than 18 weeks, but special cause variation remains • Performance in February was 64.9%, the same as the national average • Overall, the total number of children on waiting lists continues to grow. There were 313 more children waiting in February than in January across the system • The increase in Children waiting was predominantly within HCT services in South & West Hertfordshire • After a period of improvement, longest waits increased in both January and February • The longest wait is 76 weeks within HCT services in South & West Herts • Consultant led 18 week RTT performance: SWH Community Paediatrics – 44% SWH Children's Audiology – 45% ENH Community Paediatrics – 26% WE Community Paediatrics – 99%	**Hertfordshire** • Waiting times across Hertfordshire for Children's Therapies (OT, Speech & Language and Physiotherapy) are under pressure including education elements (EHCP). • Waiting times in the SWH HCT Community Paediatrics service remains challenged. Service productivity shows clear improvement since 2019/20 (34%) but referrals have increased by 33%. • There is a rise in long wats for Paediatric Audiology in SWH. Additional investment in Audiology and Paediatrics is planned for 2023/24. **West Essex (WE)** • There are no particular issues of concern to report for December. There are only 4 patients exceeding 18 weeks across all services	**Hertfordshire** • Children's Therapies – increasing capacity through recruitment, waiting list initiatives and outsourcing • Working closely with commissioners on wider improvements across Special Education Needs (SEN) / Education, Health & Care Plan (EHCP) processes focusing on initial assessment backlogs • Community Paediatrics in SWH is receiving non-recurrent additional investment, increasing workforce capacity and introducing new specialist nursing posts. Risk remains on recruitment to these roles. Transformation Programme group established to take forward service redesign • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow up appointments. Signposting to interim advice whilst awaiting assessment. Analysis for workforce business case has resulted in Increasing capacity with recruitment of 2 posts, as capacity is not currently sufficient to meet demand **West Essex (WE)** • WE Community Paediatrics Business Case discussions are ongoing. The ask for additional investment into the overall contract is being reworked to be prioritised and phased over a 3 year period.

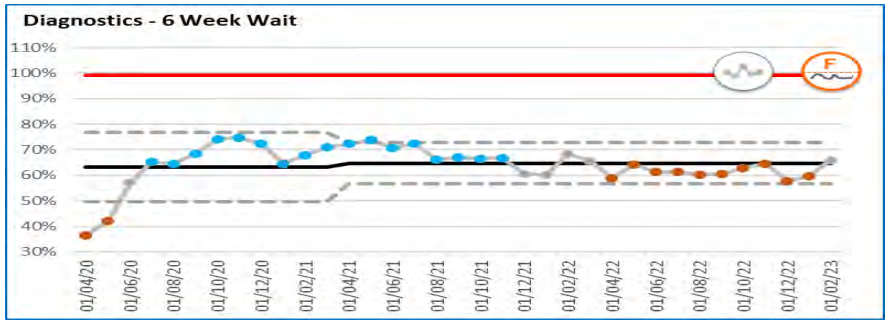
Planned Care – 52 & 78 Week Breaches

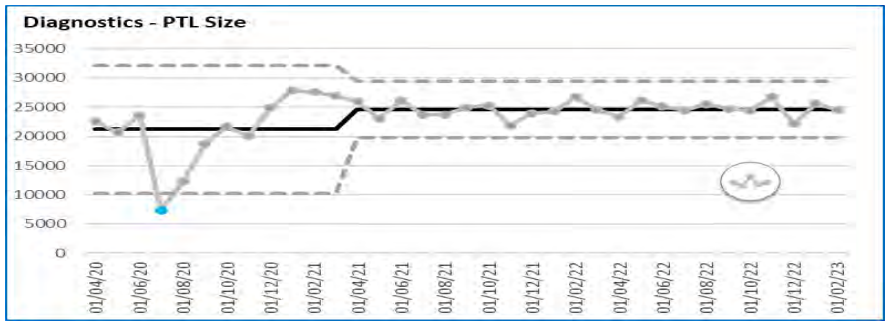




ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWE	• January & February have seen a decreased number of patients >78 weeks with particular improvement at both PAH and WHHT • The end of March position also shows further improvement • The number of patients waiting over 52 weeks has seen a decrease since peak levels in Nov however remains an area of high concern.	• Although a reduction in longest waiting patients, not enough activity is being delivered to manage backlog effectively • 78 wks did not deliver national target of '0' by March 23 with 445 breaches - 412 at ENHT (269 in community paeds), however ICB recovery trajectory was delivered • High referral volumes in early 21/22 now reaching their 52 week wait • Staffing remains a challenge, particularly anaesthetics & community paeds at ENHT • Lack of WLI additional capacity due to rate change • Trauma and Orthopaedics and Community Paediatrics remain the main areas of pressure • Impact of on-going industrial action	**Management of waiting lists:** • System focus on reducing number of patients waiting >78 weeks, with regional and national oversight; • ENHT will return to Tier 1 for elective recovery, date tbc; • The industrial action impacted the 78ww trajectory; PAH & WHTH now projected to clear 78ww in June '23 and ENHT in September '23 (excluding community paeds) • Demand, capacity & recovery plans in place with weekly specialty trajectories to monitor 78 weeks; • Weekly KLOEs in place with NHSE to track 78/104 week position; • 65ww has been added into the operational plans and will be monitored weekly from April • Fortnightly performance meetings with NHSE support; • Validation and robust PTL management in place. **Increasing Capacity and Improving productivity:** • Pro-active identification of pressured specialties with mutual aid sought vial local, regional & national processes; • Maximising use of ISP capacity and WLIs where possible • Community Paediatrics escalated to national level for mutual aid to support recovery; • New clinical models and pathways at ENHT to be agreed for ASD & ADHD diagnostic services and business case to be prepared • Theatre Utilisation Programmes in place including an ICB wide programme; • Anaesthetist recruitment	• Actions delivering overall reductions to long waiting patients • National emphasis on prioritising patients in order of clinical need resulting in longer waits for routine patients • Clinical harm reviews and regular patient contact to manage patient safety and experience.

Planned Care – Diagnostics





ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWEICB	• 6 week wait performance remains fairly static however has seen an improvement in last two months • Demand continues to increase, but the overall PTL remains at mean levels • WHHT Imaging is performing well, with the exception of DEXA • The PAH position has improved in all modalities • ENHT is performing well in Audiology and Cystoscopy. MRI, CT and DEXA remain challenged	• Workforce is the key challenge, particularly for DEXA, Audiology, and ECHO • Urgent/Cancer referrals have increased and reviews have shown all appropriate • There is no additional revenue funding available for mobile units so is reliant on Trust funding • Time for onboarding and training of international Radiographer recruits at ENHT and PAH	• New QEII CDC – over 16k new investigations undertaken. DEXA has now commenced • Additional CDC modalities will be live from Q1/2 2023 (Respiratory and Holter monitoring) • CDC mobilisation commenced at WHHT and PAH. WHHT expecting to be live from March 2024; PAH March 25, but PAH have secured funding to extend some existing services • WHHT investigating insourcing and mobile DEXA options and will share resources with ENHT. Imaging Network also supporting with training, staffing options and utilisation of equipment • iRefer CDS has been implemented at PAH and the team have been nominated for an award for this work. Plans to roll out across other Trusts in place for 23/24. • Audiology system wide group meeting and a number of actions have been identified taking good practice from ENHT and N&W. E&NHT are offering PAH 6 months of mutual aid, although numbers are limited. Staffing at PAH is improving. • ENHT secured funding as part of the diagnostic focus month in March for backlog improvement. This saw an additional 3 days of MRI scanning • PAH have secured 1 months funding for additional NOUS activity in March 2023. This saw an additional 500 scans take place • A system wide mutual aid policy and process is being developed	• Continued use of insourcing / outsourcing where funding permits • WHHT flexing operational hours for each modality • PAH MRI mobile unit on an ad-hoc basis to try and manage waiting times • Ambitions for the 2023/24 operational plan build on the existing work around increasing activity levels and decreasing waiting times

Planned Care – Theatre Utilisation

October 22

Theatres	ENH	PAH	W Herts
Utilisation - Capped	83%	69%	59%
Utilisation - Uncapped	85%	73%	62%
Average late starts (Minutes)	29	61	38
Average inter case downtime (minutes)	15	16	22
Average early finish (Minutes)	57	76	128
Average unplanned extensions (Minutes	32	51	125
Average cases per 4 hour session	2.5	1.8	1.7
BADS Day Case	83%	77%	67%

Source: Model Health System, NHSE (9/10/22)

March 2023 (latest model hospital data)				
Metric	**HWE System**	**ENHT**	**PAH**	**WHTHT**
Number of Theatres	42	19	11	12
Utilisation – Capped	80%	81% ↓	93% ↑	70% ↑
Utilisation – Uncapped	88%	90% ↑	104% ↑	74% ↑
Average Late Starts (mins)	40	27 ↑	54 ↑	40 ↓
Average intercase downtime (mins)	12	13 ↑	11 ↑	13 ↑
Average early finish (mins)	69	56 ↑	66 ↑	81 ↑
Average unplanned extensions (mins)	57	66 ↓	43 ↑	66 ↑
Average cases per 4 hour session	2.4	2.7	2.3	2.2
Day case rate – Dec 2022	74.9%	85% ↑	76.7% ↓→	73.8% ↑

ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Comparison of Model Hospital theatre utilisation data from October 22 to March 23, rag rated against quartile performance. • Whilst there continues to be variation between the providers, the majority of metrics have improved since the Oct 22 data report	• All trusts need to improve data quality and ensure data is captured at source and submitted in a standardised way. • Further improvement is required to meet the operating plan guidance of 85% utilisation and 85% DC rates	**GIRFT High Value Low Complexity Targets (HVLC):** 1. Theatres Capped Touch time Utilisation = 85% 2. BADS Day Case Rates = 85% • EoE Regional Improvement Manager has worked with PAH to ensure consistency of data capture and submission to model hospital. This work will now be extended to do the same with ENHT and WHTHT • The ICS Theatre Utilisation Clinical network meets monthly and is supported by EoE Regional Improvement Manager. • A half day focus session attended by all three trusts was held in March and trust theatre programme plans shared and discussed. Best practice shared across the network.

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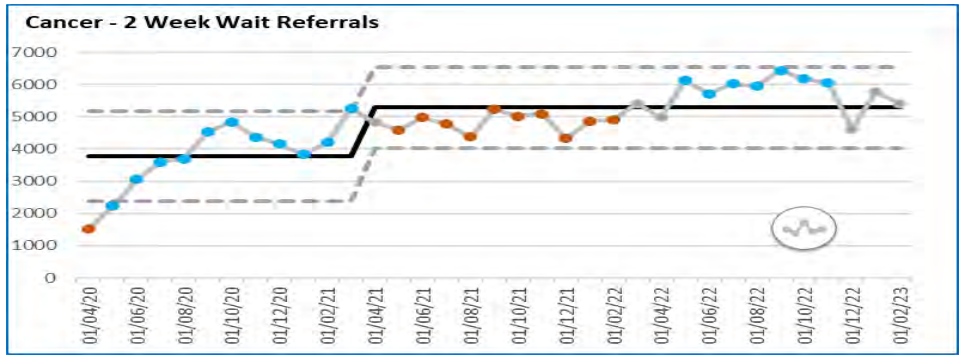
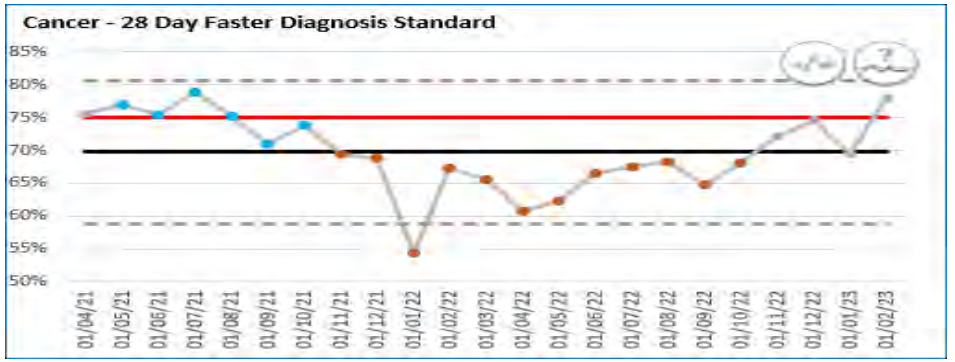
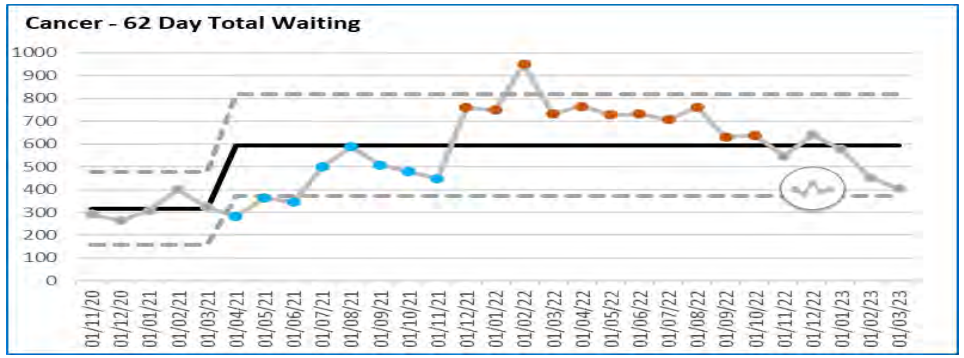
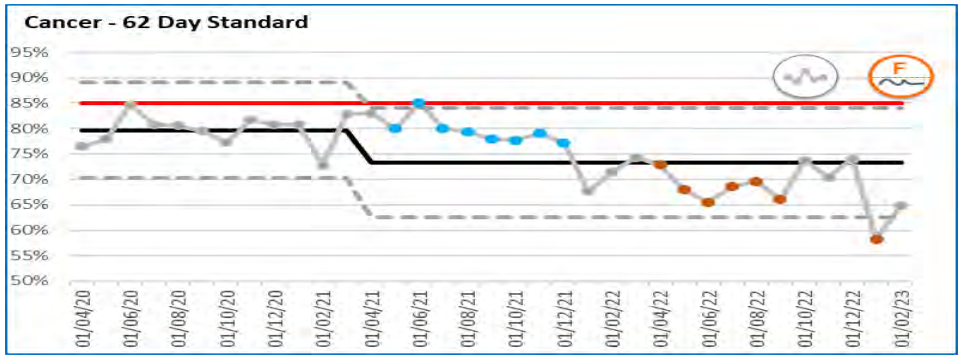
Cancer







	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	73	76	96	105	79	83	109	88	132	179	130	128	129	331	347	374	307	261	297	297	277	270	257	233	195	191	184	129	125
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	129	118	200	187	127	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125	162	152	163	149	193	182	153	120
EAST AND NORTH HERTFORDSHIRE NHS TRUST	90	70	120	106	117	92	114	96	155	184	178	160	193	253	226	272	232	322	275	306	304	329	221	242	203	256	211	170	160



Cancer

ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• 2week wait referrals increased in January but reduced again in February in line with the mean • 28 day Faster Diagnosis Standard performance improved significantly in February to return to standard • Recovery of the number of patients waiting >62 day improved significantly from 640 in December to 405 in March, surpassing the March operational recovery plan of 427 • Performance against the 62 day standard remains below standard with the treatment of the longest waiting patients, however did see an improvement in Feb	• Cancer referrals remain high • 62 day performance remains non compliant • Contributing factors at WHTH are: increase in demand, insufficient diagnostic and outpatient capacity and surgical capacity. • At ENHT pressure areas are Urology and Lower GI with the largest backlogs • Endoscopy cancellations and patients delaying procedures have impacted Lower GI • Insufficient capacity at PAH & ENHT for Urology to meet demand • The impact of industrial action meant that 69 patients were rescheduled who were on the 62 day suspected cancers (PAH 34 / 35 ENHT) • PAH: Urology and Lower GI capacity and workforce • PAH: Increasing number of Gynae tertiary 62 week backlog patients at UCLH • ENHT: High volumes of inter-trust-referrals over 62 days (current = 42 vs plan =25)	**PAH** • Prioritisation and rebooking of patients cancelled due to industrial action • Super PTL days is in place to target booking and validation on a service by service basis • Cancer Alliance funding bids progressing for Urology, Lower GI and Frailty. Subject to agreement, monies likely to flow from June • Urology one stop model reinstated. Alliance funding will enable expansion if agreed • Achievement of national ambition to return to pre-Covid 62 day backlog levels **WHTH** • Additional consultant posts (substantive and locum) for Upper GI, Breast, Radiology and Urology • Outsourcing diagnostics (Gastro/Endoscopy, Breast, additional Prostate MRI capacity) • Increasing straight to test (STT) pathways and additional Lower GI theatre capacity created • Work continues on development on a Breast pain pathway. • Patients are tracked bi weekly, early escalation of potential breaches or patients booked to breach escalated to the service and cancer management team. • Weekly huddle meetings for each tumour type to ensure early sight of issues and improve communication. • Patient-level scrutiny for all long waiters (>49 days) during the weekly Cancer Long Waiters' meeting • Expanding NSS pathway to internal referrals to expedite the diagnosis of patients who have had site specific (e.g. GI) cancer excluded. **ENHT** • Lower GI: new FIT guidelines started; tumour lead attending weekly PTL meetings; CNS in post and reviewing / communicating negative results • Breast: two locum breast radiologists have been appointed • Upper GI: tumour lead removing negative results live at the PTL meeting for all consultants • Plastics: negative letter implemented for all patients and CNS clinics	**PAH** • System support and oversight in place with bi-weekly meetings • New "real time" Cancer Harm Review process launched in April **WHTH** • Although WHTH is no longer in any tier for cancer, this is still scrutinised in detail as part of the fortnightly Tiering and performance oversight meetings with NHSE, Cancer Alliance and the ICB. • Clinical harm reviews for those who have a cancer diagnosis and waited >28 days for a 2WW appointment, patients who are treated after Day 62 and patients found to have cancer after 104 days. **ENHT** • Fortnightly system oversight meetigs • Urology: ENHT is reviewing options internally before seeking mutual aid for RALP patients; hoping to clear backlog through waiting list initiatives • Trust is planning to increase endoscopy capacity at QEII and also use Pinehill • Breast: demand vs capacity exercise to be undertaken to confirm what resources are needed to deliver the increased demand and sustain performance

Performance v. 22/23 Operational Plans

Herts and West Essex Providers (please see Appendix B for performance by Place)

Baseline	22/23 Activity Plan	22/23 M1-11 Activity Plan
246,604	330,131	297,917
	+34%	
N/A	0	2
N/A	0	156
6,109	6480	6696
956,620	890,984	819,269
	-7%	
N/A	3.1%	2.9%
8%	25%	26%
N/A		
417,182	448,818	414,701
	+8%	
289	267	291
69%	69%	80%

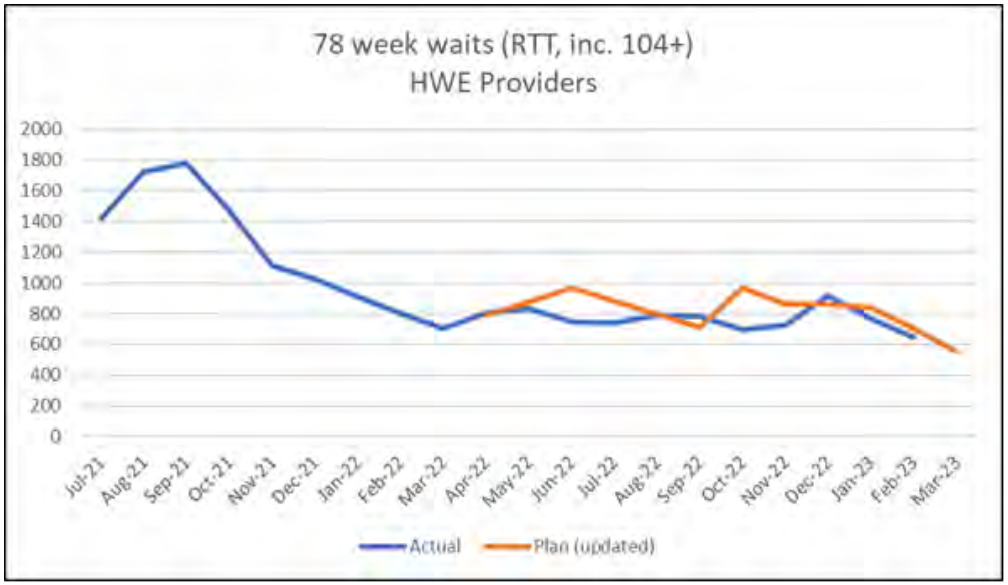
Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathway)
Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
	Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
	52 week waits trending down across 22/23
Outpatients	25% reduction in outpatient follow-ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions *(Measure is % decisions delivered in 28 days or less)*

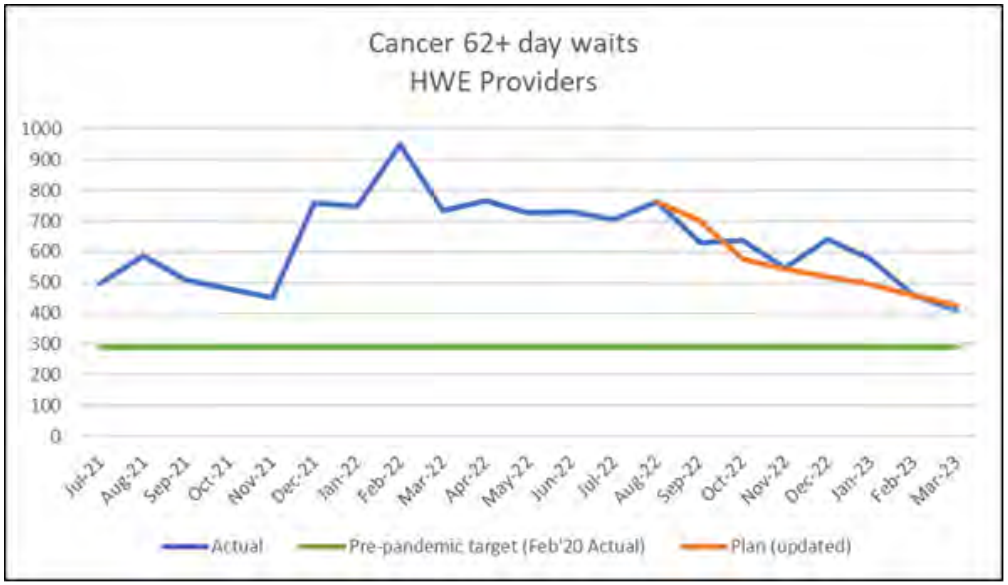
	M1-10 Actual											
	April	May	June	July	August	September	October	November	December	January	February	Total
Plan	16,815	19,497	22,586	30,620	29,143	30,317	30,467	31,091	27,896	30,335	29,150	**297,917**
Actual	16,815	20,581	19,866	18,336	18,833	20,939	21,207	23,267	17,409	21,180	20,647	**219,080**
Variance	0	1,084	-2,720	-12,284	-10,310	-9,378	-9,260	-7,824	-10,487	-9,155	-8,503	**-78,837**
Actual	124	77	35	15	9	5	4	5	3	1	1	**1**
Actual	806	829	748	741	792	782	697	725	915	767	649	**649**
Actual	6484	6804	7472	7988	8615	9173	9744	10611	10095	8935	8747	**8747**
Plan	72,089	76,682	73,718	82,239	74,852	75,573	77,741	76,117	68,868	73,584	67,806	**819,269**
Actual	70,256	79,357	72,553	71,481	72,114	72,744	72,809	80,399	72,722	82,981	75,064	**822,480**
Variance	-1,833	2,675	-1,165	-10,758	-2,738	-2,829	-4,932	4,282	3,854	9,397	7,258	**3,211**
Actual	1.1%	1.2%	1.4%	1.1%	1.2%	1.2%	1.2%	1.1%	1.2%	1.2%	1.3%	**1.3%**
Actual	23%	22%	23%	23%	22%	23%	23%	24%	24%	23%	23%	**23%**
Actual	25	25	25	27	27	25	25	25	25	25	23	**25**
Plan	33,749	36,708	35,018	39,879	37,842	38,186	39,654	38,376	37,551	39,800	36,782	**413,545**
Actual	30,029	33,868	31,968	32,034	33,068	32,603	32,543	35,116	29,716	33,458	31,839	**356,242**
Variance	-3,720	-2,840	-3,050	-7,845	-4,774	-5,583	-7,111	-3,260	-7,835	-6,342	-4,943	**-57,303**
Actual	765	728	731	706	761	630	638	547	640	577	457	**457**
Actual	61%	62%	66%	68%	68%	65%	68%	72%	75%	69%	78%	**68%**

ICB Issues and escalations

- Activity significantly off planned levels for both elective and diagnostics (as seen nationally);
- Revised recovery trajectories agreed with NHSE/I and planning submissions updated;
- Good delivery against patients waiting over 104 weeks, with remaining patient a result of choice;
- Patients waiting over 78 weeks has reduced; whilst trajectory is not forecast to deliver national target of zero by March 23, activity remains largely to revised recovery plan – see next slide;
- 52 week waits remain high and of concern;
- Out Patient programmes of work remain largely on track however percentage of patients moved or discharged to PIFU remains low;
- Cancer backlogs have reduced, and are on revised recovery trajectory – see next slide.

Performance v. 22/23 Operational Plans

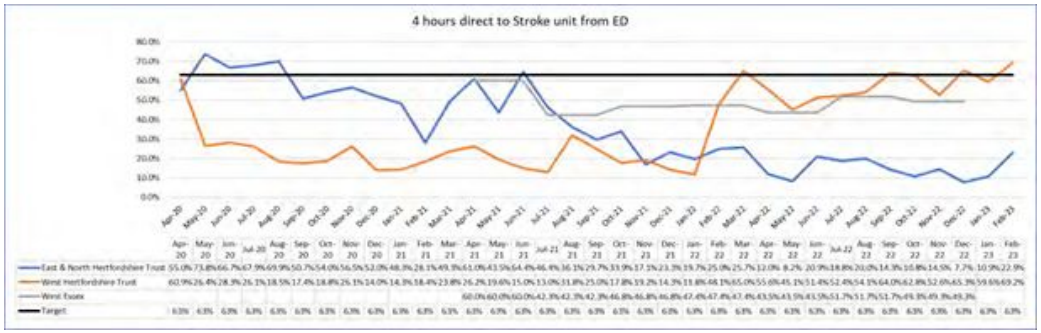


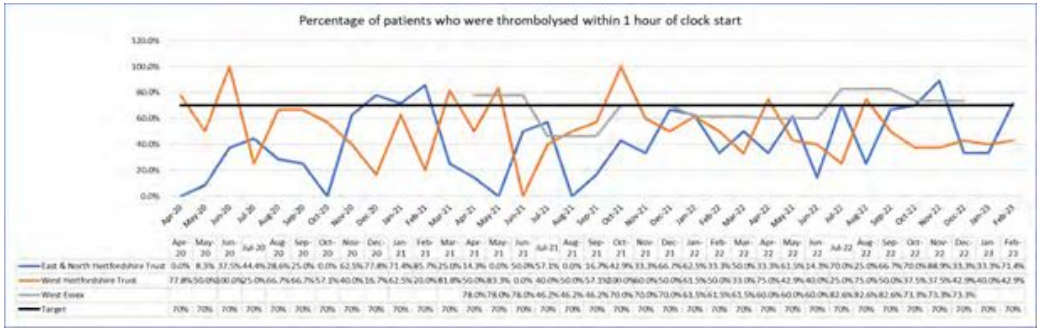


ICB Issues and escalations

- 78 week activity has continued largely to revised recovery plan. As at the 24th April, the unvalidated 78 week backlog was 501;
- Cancer 62 day backlogs have continued to improve, meeting the recovery plan in March 23. As at 16th April, the unvalidated 62 day backlog was 488.
- On-going impact to 78 week and 62 day recovery from Industrial Action;

Stroke





ICB Issues, escalation and next steps

West Essex: Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for WE patients, reported quarterly via SSNAP. Two of the three key metrics are being achieved. Latest key actions include:

- My Personal Stroke Record pilot in Queens - feedback in May
- Pre-hospital Stroke Video Assessment pilot: Ambulance crews suspecting a stroke can call a consultant directly via ipad to support the most appropriate / timely next steps. Started direct to CT pathway
- Stroke Association contract extended to March 25. Working with HCC re possible contract alignment
- ICB Squire bid £13K, 0.2wte successful for CLCH and HCT nominated staff to complete a gap analysis of community across the ICB. Outcomes to be reported end of April 2023
- Catalyst funding bid £183K successful to pilot the implementation of vocational rehab. EPUT are the lead provider across the ICB. Starting in June – delayed due to recruitment issues

ENH

- The ENHT SSNAP performance for Oct-22 to Dec-22 remained as a D rating, however, the rating improved for Occupational Therapy (D to C) and Physiotherapy (D to B)
- In Feb-23, ENHT met the 70% standard for % patients thrombolysed within 1 hour of clock start and almost met the 80% target for the % of patients who spent at least 90% of their stay on a stroke unit
- However, only 22.9% of patients met the 4 hours direct to stroke unit from ED target.
- This is partly a reflection of the general adult ED performance at Lister, with work in underway to address this
- There are 3 Task & Finish Groups for stroke improvement (TIA, Acute Stroke Care & Community/ICSS)
- The Stroke team at ENHT have undertaken a re-write of nearly all of SOPs
- A new international recruitment drive for SLTs is underway

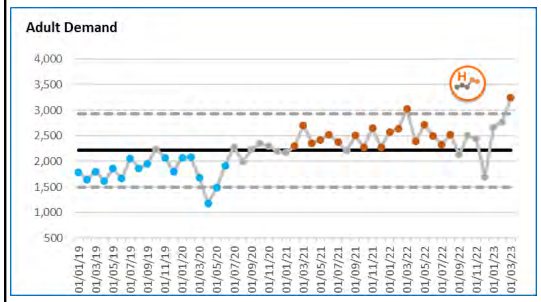
S&W Herts

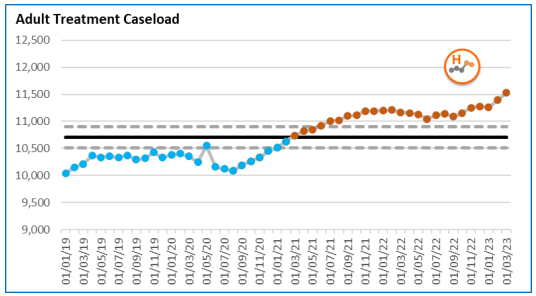
- SSNAP performance (Sept-Dec 2022) has been maintained at an **A** rating however has been a challenge.
- February performance for the percentage of patients who spent at least 90% of their stay on a stroke unit continues to meet the 80% standard at 87%.
- The standard for the percentage of patients who were thrombolysed within 1 hour of clock start was met in February with WHTHT achieving 50% (Local target 50%).
- Performance remains below standard (90%) for 4 hours direct to stroke unit from ED, however continued improvement in performance at 69% up from 65% in De 22 with a return to pre covid performance. Patients receive stroke consultant input for their care while waiting for admission to stroke unit.
- Continued pressures on the system as a whole; ongoing challenges around patient flow and bed occupancy.
- Workforce remains a challenge across the system, especially within the OT and SLT workforce
- ESD performance also impacted by increased referrals and workforce issues, current wait times for ESD are between 1 and 6 days.
- Rehabilitation Gym in WHTHT continues to be used as a bed occupancy surge area, which impacts gym usage even if the beds aren't occupied.

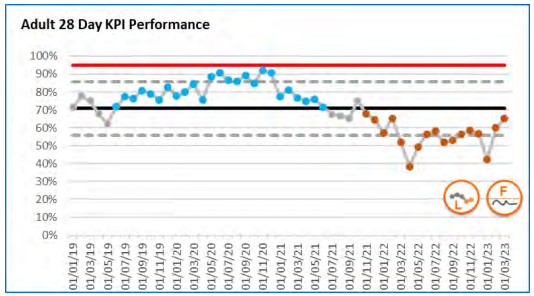
Next Steps

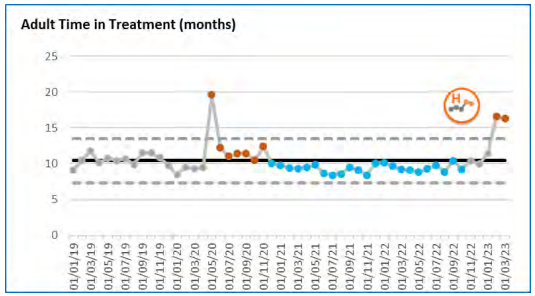
- Therapy teams at WHTHT are meeting with E&NHT Team to share 'good practice' around SSNAP Performance
- Governance paper to be submitted to Trust Board re usage of Rehabilitation Gym as an admission surge area

Mental Health – Adult Services



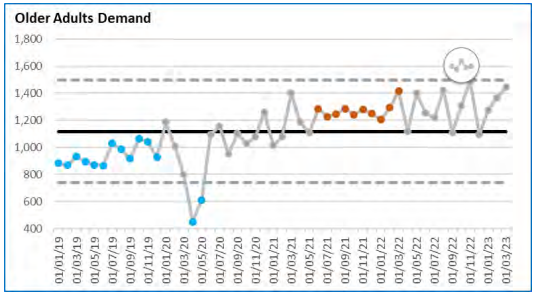


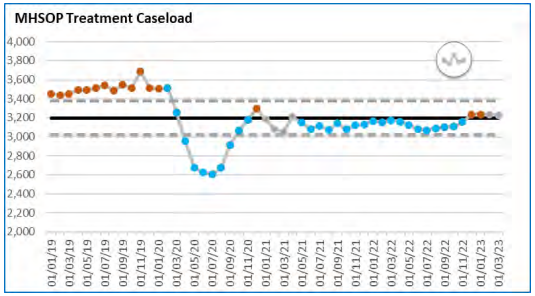


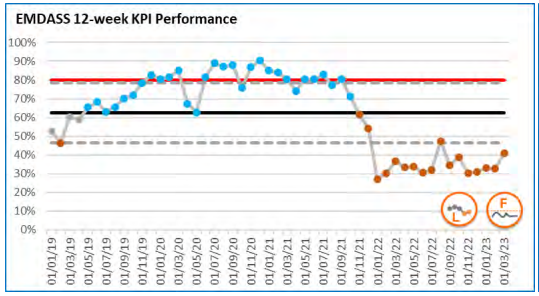


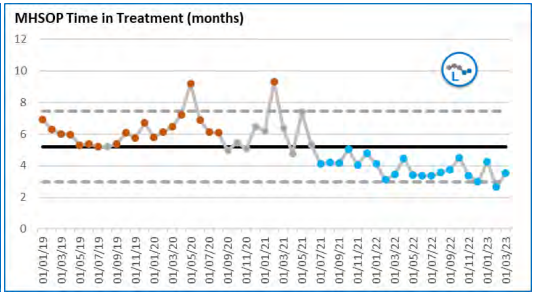
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Adult Community Mental Health Services	Referral demand continues on an upward trajectory across the ICS. The caseload in community services continues to increase in Herts but remains stable in West Essex. The time it takes from referral to assessment has increased in line with high referral volumes and caseloads, however has improved since January 23. EPUT continue to meet the 28 day KPI.	Across the ICS, sustained high demand has resulted in a waiting list for initial assessments, with high levels of vacancies in some teams, where recruitment is particularly challenging	Agency staff recruited, who are currently undertaking additional assessments every week Workforce implementation Group set up with focus on recruitment and retention Additional administrative support to community mental health teams The commissioned external process efficiency consultant (LEAN) to optimise current processes has been completed and has been successful in improving flow. HPFT implementing digital solution to support initial assessments Out of hours clinics to provide extra capacity from substantive staff and make access easier for service users	Robust waiting list management and risk management protocols in place RAG system oversight of cases discussed at daily huddles Equality review of waiting list carried out in Herts, work to be shared across the system Recovery for performance in Herts is expected in Q1 2023/24. However, increasing referrals in south west Herts present a risk to recovery.

Mental Health – Older Adults Services



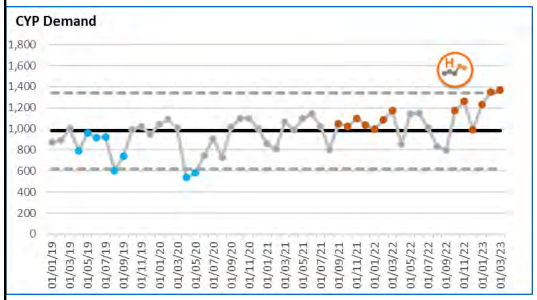


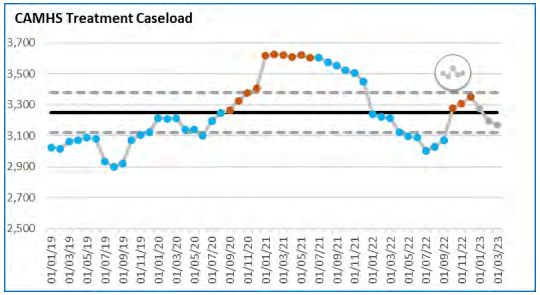


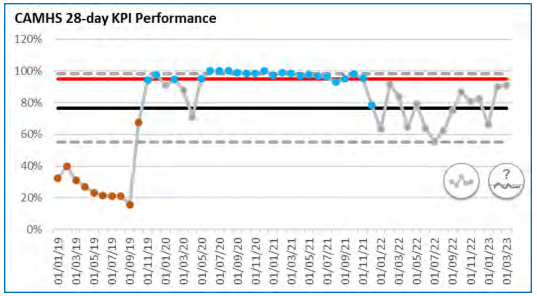


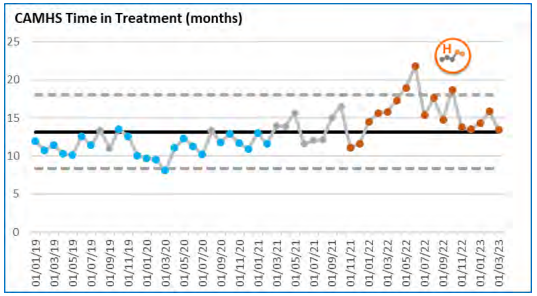
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Older Adult Community Mental Health Services	Increase in referral demand since Jan 2021 across the ICS Caseloads continue to be stable Performance remains below target in Herts, but continues to meet in West Essex Overall time spent on treatment pathways has improved	In Herts the EMDASS service was temporarily halted due to re-deployment of staff over the winter in 2021-2 which led to a backlog of diagnosis. Recruitment vacancies continue to be a significant issue across the ICS	Recovery programme continues with weekly planning meetings in Herts Workforce implementation Group set up with focus on recruitment and retention Dementia nurses in primary care model (aligned to PCNs) to improve diagnosis West Essex and Herts working to share best practice Future expansion of community diagnostic capacity across ICB	Risk review and prioritisation for service users who have been waiting Additional clinics for evening and weekends to improve waiting times Herts EMDASS recovery is expected in Q3 2023/24.

Mental Health – CAMHS Services



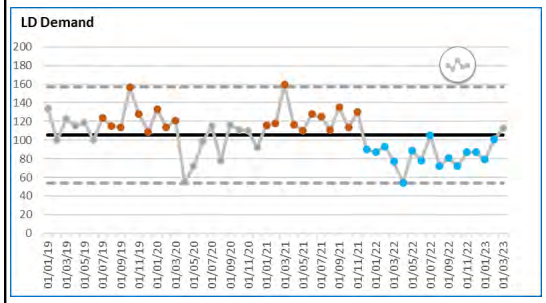


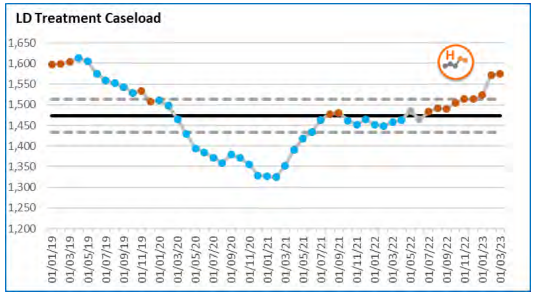


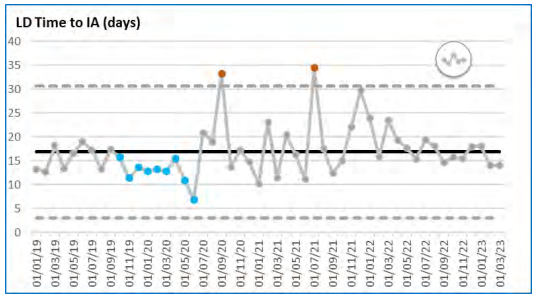


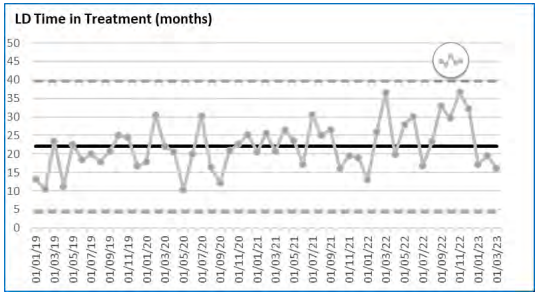
ICB Area	What the charts tell us	Issues	Actions	Mitigation
CAMHS (Herts only for CAMHS 28 day KPI and CAMHS time in treatment)	Referrals into CAMHS have passed 1,000 per month over the last 12 months (20% up from pre-pandemic levels). This has translated to pressure on initial assessments but has not yet converted into increased caseloads in CAMHS. From Jan 2023 Herts have not met the performance KPI for initial assessments (Choice) Length of time from referral to discharge has grown by 3 months over the last year from a mean of 12 months to 15 months. However, there has been an improvement over the last 5 months from a peak of 17 months +.	Referral demand has led to an increase in the number of initial assessments needed to be provided. Some services have seen unexpected demand (e.g. Tier 3 Specialist CAMHS ED, Crisis, and Looked after children). Difficulty in recruiting to vacancies in the South West of Herts impacting on capacity and performance.	Recovery programmes in place for CAMHS with weekly review meetings for demand and capacity. Ongoing focus on recruitment and retention.	SPA Triage Tool improved to meet 5 day pass on to teams Ongoing job planning in all quadrants to ensure qualitative approach Caseload and resource management across quadrants to support areas under pressure Recovery for referral to assessment times to 28 days expected at the end of Q2 2023/24 CAMHS Eating Disorders and Crisis services recovered in FY 2022/23

Mental Health – Learning Disabilities Services



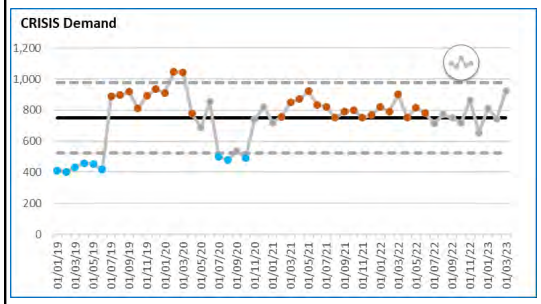


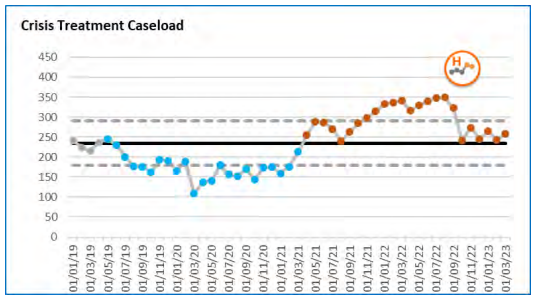


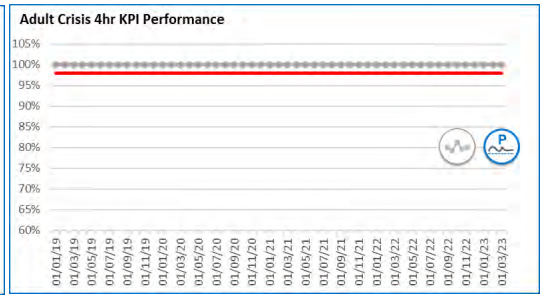


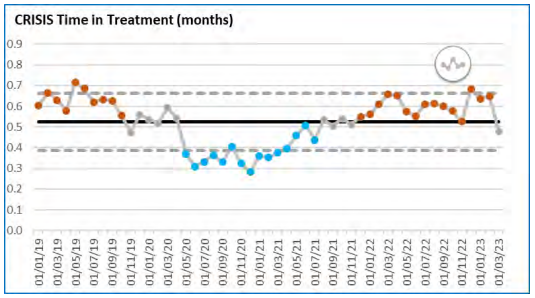
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Learning Disabilities Service Herts only	Referrals and caseloads services dropped during Wave 1 and Wave 2 of the pandemic but have returned to pre-pandemic levels. We expect these to continue at this level for the foreseeable future. Service Users are seen consistently within 28 days of referral and the average time it takes from referral to a completed assessment is further reduced to 15 days (from 17 previously) Time in treatment is subject to common cause variance. Within the LD&F Care Group there is a wide range of treatment times ranging from many years to a few days.	Frailty is very clear area of focus for our LD care group based on the outcome of LeDeR reviews and findings.	Service user and carer engagement and involvement programme continues aimed at improving care planning, service delivery and outcomes for LD service users across Herts and Essex. Enhanced physical health clinics, health co-ordination and frailty. Herts Secure initiated a project on healthy lifestyles including co-produced healthy lifestyle and wellbeing plans with service users in Forensic units	Continuing work with commissioners ensure that GPs are aware and know how to refer directly into LD services. Developed a frailty LD screening tool (existing frailty tools do not work for people with Learning Disabilities) and developed a frailty pathway which also used health coordination when required.

Mental Health – Crisis Services



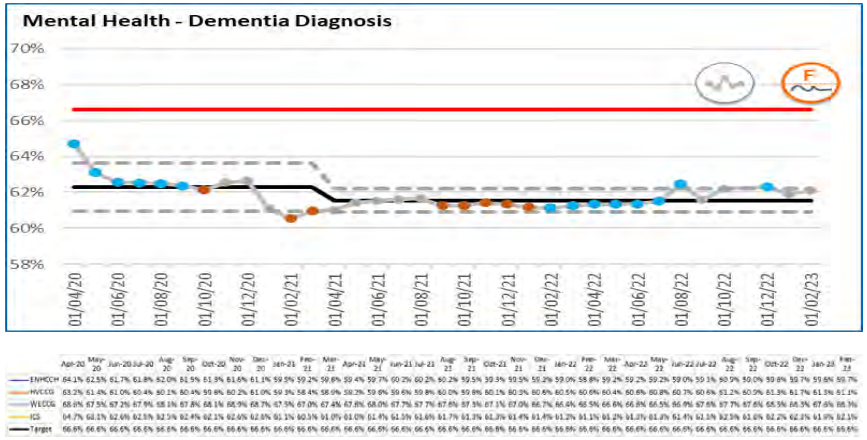


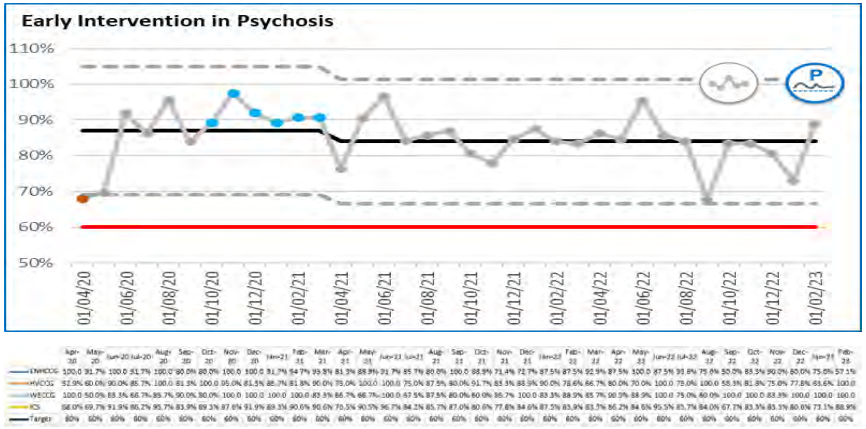




ICB Area	What the charts tell us	Issues	Actions	Mitigation
Crisis Services – Adults and Older Adults	Crisis demand is high against historical baselines but remains stable Caseloads are on high against historical baselines which reflects an increase in case complexity, however there has been a decrease since July 22 Service Users are seen consistently within 4 hours of referral and the average time under caseload management in the Crisis and Home Treatment Team is 1 month Note: West Essex caseloads currently not included in charts (part of home treatment team) however collation of data is being reviewed	Recruitment to vacancies continue to be a significant issue across the ICS	Workforce implementation Group set up with focus on recruitment and retention	Ongoing monitoring

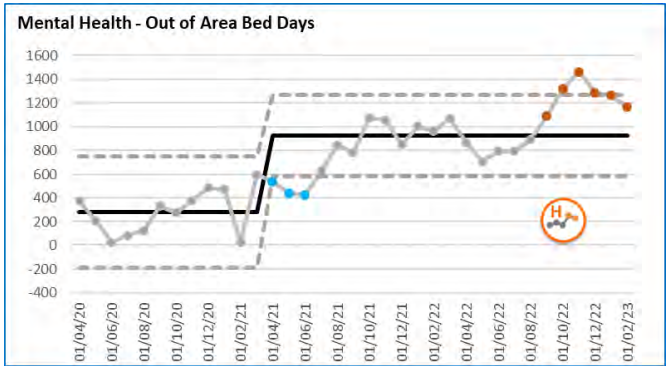
Mental Health – Dementia Diagnosis in Primary Care and Early Intervention in Psychosis (EIP)





ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Recorded Dementia Diagnosis in Primary Care in January 2023 for Hertfordshire improved to 59.95% although remains below standard. The estimated population numbers for Hertfordshire changed in the national data collection for these publications. A total of 868 people are required to meet the target. West Essex continue to meet target at 68.3%. • The EIP national standard continues to be achieved in all three Places.	**Dementia Diagnosis Herts** • Waiting list remains high for Early Memory Diagnosis at 761 • Only 50% EMDASS are seen within 12 weeks (80% target) • Commissioners continuing to follow up to get Practice Data to review monthly in order to offer support to the poor performing practises.	**Dementia Diagnosis Herts:** • Recovery action plan agreed with actions commencing in January 2023 • Staffing: Now fully recruited to the total number of four Dementia Specialist Nurses, who are working at the Primary Care Networks, and focusing on the over 80s • Conversion rate is improving at 61% with the support of region • Framework (ECF) for GPs to complete coding exercise to capture true diagnosis rate • Admin role in Primary Care Diagnosis Service to free Nurse Specialists	**Herts:** • Continue with current actions to increase access to Dementia Diagnosis services • Dementia Diagnosis actions will deliver recovery to trajectory by 2023/24 • Bring Recovery Action Plans into one forum to ensure central oversight • Ongoing support to identify causes of low conversion rates at memory clinics

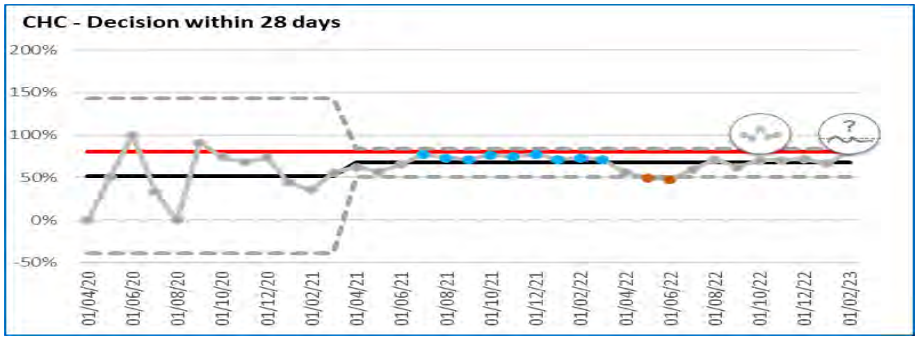
Mental Health – Out of Area Bed Days

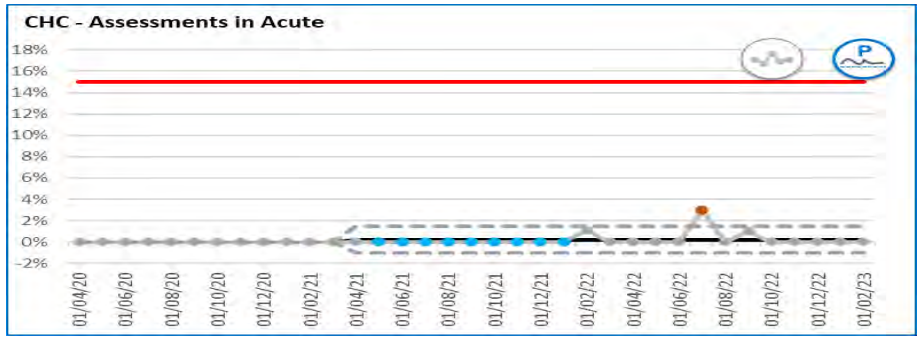


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Hertfordshire	372	207	26	83	125	331	277	376	486	471	26	596	452	337	336	574	834	759	936	745	674	779	830	987	767	691	775	757	817	1034	1177	1221	1080	1062	1003
Hertfordshire Target	33	33	34	20	20	20	10	10	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
WECCG													86	102	90	51	12	22	140	314	177	225	134	83	100	16	21	38	76	55	145	242	209	203	166

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Out of Area Bed Days peaked in November • February beds days improved for the third consecutive month	• Pressure for Mental Health increased substantially over the Covid period, and has continued post-Covid, coupled with winter pressures, leading to a national shortage of beds, high occupancy rates and use of OOA beds	• SMART (Surge Management and Resilience Toolset) providing real time ward data • Essex review of bed model has identified county-wide issues with oversight and availability of bed stock and voids. Continued work underway to address	• Out of Area Placement (OOAP) Elimination & Sustainability Impact System Group (Essex wide) in place to monitor the impact of the NHSE OOAP Action Plan • Continued engagement with national Getting It Right First Time (GIRFT) programme to identify areas of improvement • Bed management system and new arrangements in place to monitor demand and capacity
Herts	• Out of Area Bed Days continue to reduce from the peak in November 23	• Demand is continuing to exceed capacity • Low number of beds per population • Pressure for MH beds increased substantially over Covid, and post-Covid, a national shortage of beds, high occupancy rates and use of OOA beds is likely to continue • Challenges finding suitable placements for service users with complex needs • Workforce recruitment across inpatients & community, affecting capacity.	• Daily OOAP reviews /dedicated clinical ownership for OAP • Gatekeeping process; on call gatekeeping consultant and clear reasons for admissions • Introduction of Enhanced Discharge Team, dedicated to supporting discharge pathways • Multi Agency Discharge Event (MADE) in January highlight issues, review DTCs and plan discharges with ongoing regular MADE events • Block beds in place to improve flow across the system • Enhanced community offers for rehab and assertive outreach. • Introducing further alternatives to admission – Crisis House	

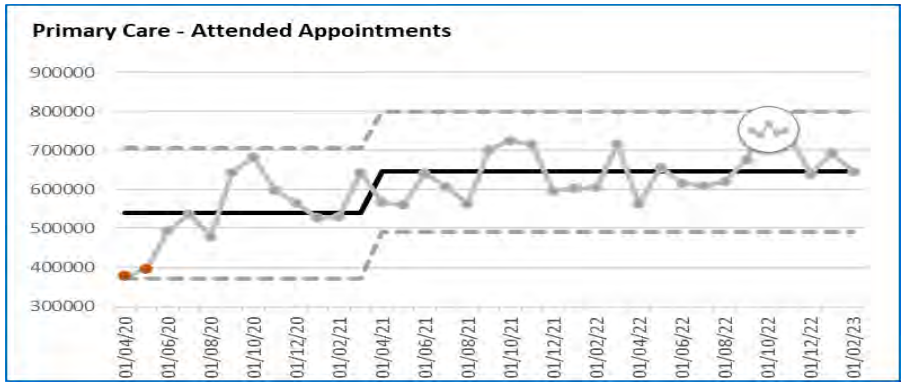
Continuing Health Care (CHC)

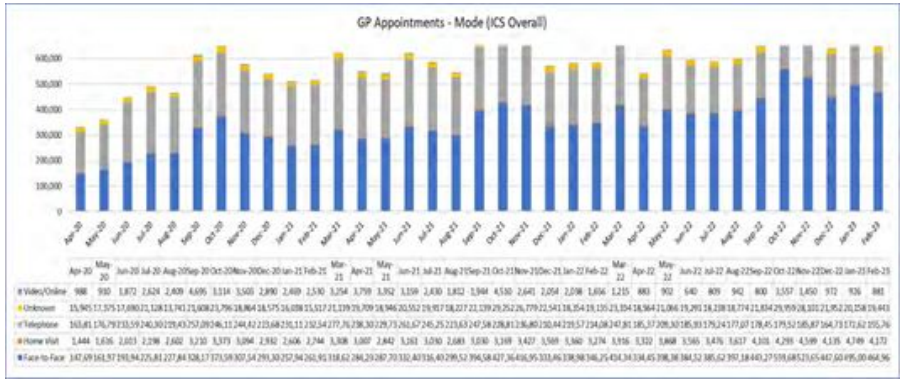




ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• West Essex continued to be compliant with the 28 day assessment standard in March, with 89% being achieved • No patients received assessments in an acute setting	• Ongoing increasing backlog of CHC, FT and FNC reviews due to prioritising new assessments and D2A's. New reviews project paused due to number of D2A assessments coming through. • Recruitment process slow and some nurse positions unfilled. However a new nurse has started and will help with this backlog as they become more confident. • Annual Leave was an issue in March, but not expected to impact performance this quarter.	• The West Essex CHC Team continues to work alongside EPUT to provide additional resource and support. • Recruitment for vacancies ongoing. 1 nurse recruited in the last round of interviews. • Weekly tracking of 28 day assessment ongoing. EPUT full engaged with this process.	• SWH action plan in place, supported by NHSE • Performance standards continue to be monitored, issues escalated and risks mitigated • Agency cover requested for vacancies whilst recruitment continues • Setting trajectory and drive on clearing cases over 28 days
South West Herts / WHTHT	• Performance against decisions within 28 days was not met in March at 67%. • No patients assessments carried out in an acute setting.	• Workforce issues including high number of resignations within the senior members of the team. • Ongoing backlog of CHC & FNC reviews due to prioritising new DSTs and checklist completion. • Referrals numbers continue to be high which impact on 28 day performance.	• Recruitment drive continues, • Prioritisation of fast track and 1:1 reviews. • Allocation and weekly tracking of 28 day assessments remains a priority • Case management in place for all cases over 6 weeks. • Collaborative working with system partners; weekly meetings • Timely verification of cases, monitoring of non- agreed recommendations and decision making panels arranged in timely manner • Face to face Nursing needs assessments are completed and evidenced. • Focus on checklist completion, resulting in backlog reducing.	
East & North Herts / ENHT	• 87% of CHC referrals in East & North resulted in a decision within 28 days, meeting standard. • No patients received assessments in an acute setting	• Workforce issues such as sickness and annual leave • Ongoing delays receiving signed assessment paperwork from community, particularly Mental Health, may impact performance going forward	• Weekly tracking of referrals over 28 days by caseload and CHC manager • Performance levels expected to be achieved	

Primary Care





ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Total appointments increased in Q3, and continued at mean levels in January and February • The proportion of face to face appointments continues to increase and was over 70% in Q3, January and February	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • Significant pressure from Respiratory illness • Rapid increase in 'spot booking' hotels set up without notice by Home Office to house asylum seekers with significant health needs, including Scabies and Diphtheria outbreaks	• There is national repurposing of Investment & Impact Fund monies to support additional capacity – template for plans shared with PCNs for return to ICB 12 May • Data sets shared with practices/PCNs via Ardens and developing patient questionnaires to support analysis • Access Recovery Plan expected from NHSE end of May • Continue to implement advanced telephony and offsite storage of notes • Access dashboard now available and used by MDT group • Discussion with each PCN planned to assist development of access and capacity plans • Practices offered an extended period (additional 3 months) in which to achieve their QOF targets to recognise the ongoing prioritisation of on the day demand over winter • Continued work to promote use of the Community Pharmacy Consultation Service (CPCS)	• Continue to support return of business as usual to General Practice through the relaunch of the ECF across the ICB, supported by investment reporting to free up practice capacity • QOF period extension means that some annual review actions for LTC will be reprofiled to spring and should have a benefit next winter • Continued access trend analysis in the 3 places to identify individual practices with poor access through complaints and patient contacts • PCCC and Primary Care Board oversight of the GPPS results, and action plan developed through the Access MDT Group • Recruitment & Retention of Primary Care Workforce –initiatives are offered to the Primary Care Workforce to support recruitment and retention which are supported by the HSE ICB Training Hub • Continued funding for spot booking hotels for health checks and MDT site visits agreed by PCCC at the February meeting • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices continuing

Appendix A – Performance Dashboard

February 2023

Area	Activity	Target	Herts & West Essex ICS (Commissioner) Latest published data	Data published	Trend *1	Variation	Assurance	NATIONAL position (ICB vs National)	REGIONAL position (ICB vs EoE Region)	ICB Ranking	ICS Aggregate Provider	Trend	Individual Trust ENHT	Trend	PAH	Trend	WHTHT	Trend
111	Calls answered < 60 seconds	95%	43.1%	February 23	-11.42%			47.79% (Worse)	42.62% (Better)	13th highest	43.1%	-11.42%						
	Calls abandoned after 30 seconds	5%	12.0%	February 23	-12.06%			12.88% (Better)	12.42% (Better)	17th highest	12.04%	-12.06%						
A&E	% Seen within 4 hours	76%	64.8%	March 23	0.003%		F	71.50% (Worse)	52.96% (Better)	7th lowest	62.03%	0.17%	62.87%	0.85%	51.63%	1.51%	68.09%	-1.30%
	12 Hour Breaches	0	238	March 23	58.82%			39,671	3,534	8th highest	238	58.82%	106	50.94%	132	65.15%	0	0.00%
Cancer	2ww All Cancer	93%	89.1%	February 23	1.83%	H	F	86.10% (Better)	81.20% (Better)	15th highest	90.61%	2.57%	96.26%	0.25%	81.01%	5.17%	92.71%	1.84%
	2ww Breast Symptoms	93%	95.8%	February 23	1.71%	H		78.94% (Better)	71.90% (Better)	5th highest	95.77%	1.01%	100%	4.41%	97.37%	3.00%	92.17%	-2.78%
	31 day First	96%	94.6%	February 23	2.81%			91.97% (Better)	91.39% (Better)	11th highest	95.76%	2.09%	97.38%	0.84%	89.87%	-1.06%	96.34%	4.70%
	31 day Sub Surgery	94%	84.0%	February 23	1.23%		F	78.72% (Better)	75.31% (Better)	13th highest	90.48%	-0.73%	84.21%	-6.12%	83.33%	-8.00%	100%	4.55%
	31 day Sub Drug	98%	99.0%	February 23	1.18%			98.04% (Better)	98.40% (Better)	19th highest	99.03%	0.87%	99.35%	0.69%	100%	4.00%	95.65%	0.00%
	31 day Sub Radiotherapy	94%	91.4%	February 23	-2.04%			89.35% (Better)	92.16% (Worse)	17th lowest	94.19%	0.01%	94.19%	-0.25%	N/A		N/A	
	62 day First	85%	62.4%	February 23	9.02%		F	58.15% (Better)	58.27% (Better)	11th highest	64.92%	10.42%	81.78%	3.85%	44.86%	28.35%	58.62%	12.65%
	62 day Screening	90%	75.0%	February 23	12.20%			63.91% (Better)	67.76% (Better)	10th highest	76.74%	18.24%	77.78%	-2.86%	100%	29.41%	62.50%	20.00%
	62 day Upgrade	85%	64.2%	February 23	-11.55%			73.55% (Worse)	70.12% (Worse)	7th lowest	68.79%	-1.97%	67.80%	5.18%	75.56%	11.16%	62.16%	-31.62%
	28 days Faster Diagnosis	75%	76.6%	February 23	9.80%			75.03% (Better)	71.81% (Better)	12th highest	78.05%	11.11%	76.28%	13.79%	77.36%	6.65%	79.92%	12.29%
RTT	Incomplete Pathways <18 weeks	92%	56.6%	February 23	0.91%	L	F	54.7% (Better)	55.7% (Better)	17th lowest	53.22%	0.86%	50.91%	0.10%	50.67%	0.65%	57.44%	1.84%
	52 weeks	0	10,441	February 23	-1.89%	H	F	32,009	49,018	9th lowest	8,738	-2.17%	4,615	4.57%	1,814	-1.98%	2,309	-15.81%
	65 weeks	0	3,103	February 23	-18.69%		F	10,203	16,176	8th lowest	2,696	-21.96%	1,627	-11.43%	537	-22.53%	532	-53.57%
	78 weeks	0	703	February 23	-21.48%		F	2,823	3,455	14th lowest	648	-18.21%	515	-6.80%	95	-54.74%	38	-81.58%
Diagnostics	6 week wait	5%	30.0%	February 23	-17.80%		F	31.28% (Worse)	35.96% (Worse)	16th lowest	34.02%	-18.77%	38.17%	-19.07%	25.36%	-35.21%	35.33%	-7.67%

Area	Metric	Target	Herts & West Essex ICS (Commissioner) Latest published data	Data published	Trend *	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking	ICS Aggregate Provider	Trend	Individual CCGs East & North Herts	Trend	South & West Herts	Trend	West Essex	Trend
111	Calls answered < 60 seconds	95%	43.1%	February 23	-11.42%			47.79% (Worse)	42.62% (Worse)	13th highest	N/A		43.21%	-10.78%			42.45%	-14.06%
	Calls abandoned after 30 seconds	5%	12.0%	February 23	-12.06%			12.88% (Better)	12.42% (Worse)	17th highest			11.89%	-9.55%			12.65%	-21.23%
Mental Health	Dementia Diagnosis rate	66.6%	62.1%	February 23	0.28%		F	62.0% (Better)	59.8% (Better)	n/a			59.68%	0.16%	61.10%	-0.25%	68.31%	1.10%
	OOA placements	0	2,231	February 23	43.30%		F	n/a	n/a	n/a			2,065	48.57%			166	-22.29%
CHC	% of eligibility decisions made within 28 days	80%	80.0%	February 23	17.65%			n/a	n/a	n/a			90.63%	8.05%	71.67%	12.50%	86.96%	26.07%
	% of assessments carried out in acute	15%	0.0%	February 23	0.00%		P	n/a	n/a	n/a			0%	0.00%	0%	0.00%	0%	0.00%

LEGEND On/above target | Below target | Improvement on previous month's performance | crease on previous month's performance | hange on previous month's performance

Appendix B: Performance v. 22/23 Operational Plans by Place

East and North Herts Trust

Baseline	22/23 Activity Plan	22/23 M1-11 Activity Plan	Area	Target
104,880	138,641	125,375	Activity	10% elective activity increase (19/20 levels RTT pathway)
	+32%			
N/A	0	0	Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
N/A	0	77		Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
3313	2914	2991		52 week waits trending down across 22/23
400,242	359,706	333,047	Outpatients	25% reduction in outpatient follow-ups by 2023
	-10%			
N/A	4.7%	4.2%		5% of outpatients moved or discharged to PIFU
0%	26%	26%		25% of consultations via video/telephone
N/A				16 specialist advice requests per 100 outpatient firsts
180,261	184,372	173,493	Diagnostics	20% increase in diagnostic capacity against 19/20 levels
	+2%			
87	87	100	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
75%	74%	77%		Reduction in missed 28 day cancer decisions

	M1-10 Actual											
	April	May	June	July	August	September	October	November	December	January	February	Total
Plan	7,816	8,554	11,535	12,112	12,688	12,688	12,112	12,688	11,535	12,112	11,535	**125,375**
Actual	7,816	9,494	9,139	8,072	8,241	9,353	9,015	10,187	7,364	9,380	8,826	**96,887**
Variance	0	940	-2,396	-4,040	-4,447	-3,335	-3,097	-2,501	-4,171	-2,732	-2,709	**-28,488**
Actual	96	56	21	9	7	2	2	3	3	1	1	**1**
Actual	439	408	324	312	407	458	464	548	689	551	516	**516**
Actual	3473	3699	4027	4294	4628	4688	4527	4618	4778	4404	4618	**4618**
Plan	33,377	33,990	31,737	34,856	28,372	28,950	31,901	30,135	25,066	29,640	25,023	**333,047**
Actual	30,904	34,899	31,661	31,545	32,011	33,021	32,679	35,982	32,050	33,812	30,948	**359,512**
Variance	-2,473	909	-76	-3,311	3,639	4,071	778	5,847	6,984	4,172	5,925	**26,465**
Actual	0.6%	0.7%	0.7%	0.6%	0.8%	0.8%	0.9%	1.0%	1.2%	1.2%	1.4%	**1.4%**
Actual	26%	26%	26%	27%	25%	26%	26%	27%	26%	26%	27%	**26%**
Actual	24	24	23	24	25	22	23	22	23	22	20	**23**
Plan	14,839	16,359	16,071	16,432	15,611	15,674	16,429	15,456	15,009	16,269	14,188	**172,337**
Actual	11,414	13,529	13,068	12,957	13,040	13,439	13,731	14,492	12,734	14,196	13,725	**146,327**
Variance	-3,425	-2,830	-3,003	-3,475	-2,571	-2,235	-2,698	-964	-2,275	-2,071	-463	**-26,010**
Actual	322	275	306	304	329	221	242	203	256	211	175	**175**
Actual	68%	64%	71%	72%	73%	70%	72%	72%	77%	66%	66%	**71%**

Appendix B: Performance v. 22/23 Operational Plans by Place

PAH

Baseline	22/23 Activity Plan	22/23 M1-11 Activity Plan
70,011	75,816	68,579
	+8%	
N/A	0	0
N/A	0	63
1737	3,059	3,169
225,486	271,151	248,085
	+20%	
N/A	2.0%	1.9%
4%	27%	27%
N/A		
110,523	117,630	107,778
	+6%	
121	75	75
61%	73%	75%

Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathway)
Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
	Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
	52 week waits trending down across 22/23
Outpatients	25% reduction in outpatient follow-ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions

	M1-10 Actual											
	April	May	June	July	August	September	October	November	December	January	February	Total
Plan	5,317	5,941	6,678	6,643	5,902	6,232	6,484	6,824	6,007	6,181	6,370	**68,579**
Actual	5,317	6,088	5,911	5,646	5,644	5,953	6,076	6,220	4,669	5,405	5,775	**62,704**
Variance	0	147	-767	-997	-258	-279	-408	-604	-1,338	-776	-595	**-5,875**
Actual	14	12	10	3	0	0	0	0	0	0	0	**0**
Actual	223	266	281	296	248	208	141	108	157	147	95	**147**
Actual	1818	1674	1785	1911	1909	1898	1804	1721	1773	1850	1814	**1850**
Plan	19,736	22,231	23,018	23,120	22,398	22,968	23,099	23,179	22,726	22,725	22,885	**248,085**
Actual	19,754	22,354	19,593	18,917	18,371	17,497	18,088	19,628	20,769	23,414	21,605	**219,990**
Variance	18	123	-3,425	-4,203	-4,027	-5,471	-5,011	-3,551	-1,957	689	-1,280	**-28,095**
Actual	0.9%	1.3%	1.3%	1.1%	1.2%	1.2%	1.2%	1.4%	1.2%	1.5%	1.3%	**1.5%**
Actual	27%	27%	28%	28%	27%	28%	28%	31%	31%	30%	28%	**29%**
Actual	5	5	5	5	6	6	6	6	5	5	4	**5**
Plan	9,258	9,852	9,852	9,852	9,852	9,852	9,852	9,852	9,852	9,852	9,852	**107,778**
Actual	9,258	9,793	9,073	9,604	10,193	9,242	9,491	9,888	8,087	9,493	8,815	**102,937**
Variance	0	-59	-779	-248	341	-610	-361	36	-1,765	-359	-1,037	**-4,841**
Actual	182	156	128	125	162	152	163	149	193	182	153	**182**
Actual	64%	66%	74%	72%	73%	68%	70%	74%	75%	72%	72%	**71%**

Appendix B: Performance v. 22/23 Operational Plans by Place

West Herts Teaching Hospitals Trust

Baseline	22/23 Activity Plan	22/23 M1-11 Activity Plan
71,713	115,674	103,963
	+61%	
N/A	0	2
N/A	0	16
1059	507	536
330,892	260,127	238,137
	-21%	
N/A	2.1%	2.1%
8%	25%	24%
N/A		
126,398	146,816	133,430
	+16%	
81	105	116
72%	69%	83%

Area	Target
Activity	10% elective activity increase (19/20 levels RTT pathway)
Waitlist	104 week waits eliminated by Jul 22 (waitlist, end of Jun 22)
	Eliminate 78 week waits by Apr 23 (waitlist, end of Mar 23)
	52 week waits trending down across 22/23
Outpatients	25% reduction in outpatient follow-ups by 2023
	5% of outpatients moved or discharged to PIFU
	25% of consultations via video/telephone
	16 specialist advice requests per 100 outpatient firsts
Diagnostics	20% increase in diagnostic capacity against 19/20 levels
Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels
	Reduction in missed 28 day cancer decisions

	M1-10 Actual											
	April	May	June	July	August	September	October	November	December	January	February	Total
Plan	3,682	5,002	4,373	11,865	10,553	11,397	11,871	11,579	10,354	12,042	11,245	**103,963**
Actual	3,682	4,999	4,816	4,618	4,948	5,633	6,116	6,860	5,376	6,395	6,046	**59,489**
Variance	0	-3	443	-7,247	-5,605	-5,764	-5,755	-4,719	-4,978	-5,647	-5,199	**-44,474**
Actual	14	9	4	3	2	3	2	2	0	0	0	**0**
Actual	144	155	143	133	137	116	92	69	69	69	38	**69**
Actual	1193	1431	1660	1783	2078	2587	3413	4272	3544	2681	2315	**2681**
Plan	18,976	20,461	18,963	24,263	24,082	23,655	22,741	22,803	21,076	21,219	19,898	**238,137**
Actual	19,598	22,104	21,299	21,019	21,732	22,226	22,042	24,789	19,903	25,755	22,511	**242,978**
Variance	622	1,643	2,336	-3,244	-2,350	-1,429	-699	1,986	-1,173	4,536	2,613	**4,841**
Actual	2.4%	2.5%	2.8%	2.3%	2.1%	2.2%	2.0%	1.5%	1.6%	1.5%	1.7%	**1.5%**
Actual	15%	13%	14%	13%	13%	14%	14%	14%	13%	13%	13%	**13%**
Actual	47	46	45	49	48	45	45	45	44	43	42	**45**
Plan	9,652	10,497	9,095	13,595	12,379	12,660	13,373	13,068	12,690	13,679	12,742	**133,430**
Actual	9,357	10,546	9,827	9,473	9,835	9,922	9,321	10,736	8,895	9,767	9,299	**106,978**
Variance	-295	49	732	-4,122	-2,544	-2,738	-4,052	-2,332	-3,795	-3,912	-3,443	**-26,452**
Actual	261	297	297	277	270	257	233	195	191	184	129	**184**
Actual	51%	58%	56%	60%	60%	58%	63%	72%	73%	70%	70%	**64%**

Appendix C: HWE Adult Community Services

Elective & Specialist	E&NH	S&WH	West Essex
Cardiac Rehab	HCT/ENHT	CLCH	EPUT
Diabetes	HCT	HCT	EPUT
Continence services	HCT	CLCH	EPUT
Nutrition and Dietetic Service	HCT	HCT	EPUT
Speech and language therapy	HCT	CLCH	EPUT
Podiatry	HCT	CLCH	EPUT
Specialist palliative care	HCT	CLCH	EPUT
Heart failure service	-	CLCH	EPUT
Lymphoedema	HCT	CLCH	HCT
Tissue Viability	HCT	CLCH	EPUT
Leg Ulcer	HCT	CLCH (Herts one)	EPUT
Respiratory	HCT/ENHT	CLCH/WHHT	EPUT
MSK	HCT	Connect	EPUT
Chronic pain management	HCT	Connect	EPUT
Community Neuro/rehab	HCT	CLCH	PD/MS only
Pulmonary Rehab	HCT	CLCH	EPUT
Specialist Dentistry	HCT	HCT	-
Community Dermatology	HCT	-	GP Fed
Community ENT	-	Communitas	-
Community Gynaecology	-	The Gynaecology partnership	-
Long Covid	HCT	CLCH	EPUT
Diabetes eye screening	ENHT	HCT	Health intelligence Ltd
Sexual Health Services	CLCH	CLCH	Provide

Urgent & Emergency Services	E&NH	S&WH	West Essex
2 hour urgent response	HCT	CLCH	EPUT
Hospital at home/rapid response	HCT	CLCH	EPUT
Discharge to assess (at home)	HCT	CLCH	EPUT
Virtual ward/hospital	HCT	CLCH/WHHT	EPUT
Inpatient rehab beds	HCT	CLCH	EPUT
Inpatient stroke Neuro rehab beds	HCT	CLCH	EPUT
Respiratory services	HCT	CLCH	EPUT
Stroke (Early supported discharge)	HCT	CLCH	EPUT
Neuro ESD (NETT)	-	CLCH	-

Core community Services	E&NH	S&WH	West Essex
District Nursing	HCT	CLCH	EPUT
Community therapies (OT/PT)	HCT	CLCH	EPUT
Frailty clinics	HCT	CLCH	PAH
Enhanced health in care homes	HCT	CLCH	EPUT

Appendix C: HWE Children's Community Services

Children's Services within Hertfordshire and West Essex ICS is complex with a range of existing governance forums and a broad range of services provided primarily by NHS Trusts, but with a number of independent and 3rd sector organisations

Service	E&NH	S&WH	West Essex
ADHD	ENHT	HPFT	HCRG
Advocacy	KIDS	KIDS	Rethink / Open Door
Allergy	ENHT	WHHT	HCRG / PAH
ASD	ENHT	HCT	HCRG
Asthma Nurse specialist	n/a	HCT	To be established
Audiology	ENHT	HCT	PAH
Wellbeing Practitioners	HCT	HCT	HCRG
CHIS	HCT	HCT	Provide
Com. Nursing	ENHT	HCT	HCRG
Comm Paeds	ENHT	HCT	HCRG
Continence	n/a	HCT	HCRG
Continuing Care	ENHT	HCT	HCRG & Various Independent
CSAIS	EPUT (s/c HCT)	EPUT (s/c HCT)	EPUT
CYP Counselling	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT
CYP Therapies	HCT	HCT	HCRG (SLT inclusive of dysphagia, PT inclusive of MSK)
Designated Medical Officer for SEND	ENHT	HCT	HCRG
Diabetes Nurse Specialist	ENHT	WHHT	PAH
Dietetics	HCT	HCT	HCRG / PAH
Eating Disorders	HPFT	HPFT	NELFT / BEAT
Epilepsy Nurse Specialist	ENHT	WHHT	PAH
Equipment	HCT	HCT	EPUT
Eye Care	ENHT	HCT/WHHT	PAH

Service	E&NH	S&WH	West Essex
Family Hubs/Children's Centres	Family Centre Services/Family Support Services/ HCT	Family Centre Services/Family Support Services/ HCT	HCRG
Health Visiting	HCT	HCT	HCRG
Hospice Care	Keech	Keech/Noah's Arc/ Rennie Grove	Haven House, EACH
Infant Mental Health	HCT	HCT	EPUT
LAC	HCT	HCT	HCRG
Lymphoedema	HCT	n/a	HCT
Mental Health Support Teams	HPFT/HCT	HPFT/HCT	West Essex Mind (mainstream) / HPFT (special schools)
Neuro-Rehab	Specialist commissioned	Specialist commissioned	Tadworth Children's Trust
Palliative Care Respite Service (EPIC)	Noah's Arc	Noah's Arc	Little Haven's
Palms	HCT	HCT	n/a
Parenting Support	HCC	HCC	Triple P (YCT from April)
Perinatal Mental Health	HPFT	HPFT	EPUT
School Nursing	HCT	HCT	HCRG
Sickle cell	HCT	HCT	PAH
Special care dentistry	HCT	HCT	PAH
Specialist CAMHS	ENHT	HPFT	NELFT
Specialist Healthcare Tasks	n/a	n/a	Provide
Specialist school nursing	ENHT	HCT	HCRG
Step 2 Service	JHCT	HCT	n/a
Therapeutic Health Based Coaching	n/a	n/a	NOW
Tier 4 CAMHS	HPFT	HPFT	EPUT
Transition coordinators	HCT	HCT	HCRG
Weight Management & other wellbeing services	Beezee Bodies	Henri/ Beezee Bodies	Provide

N.B. Virgin Care has now been transferred to HCRG Care Group

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	19
Report title	Finance Performance and Planning Committee 30 May 2023 highlight report			**Meeting Date**	5 July 2023
Chair	Karen McConnell - Committee Chair and Non-Executive Director				
Author	Debbie Collins – Corporate Governance Officer				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Board Assurance Framework
- Community Diagnostic Centre Reflection
- Green Plan Update
- Backlog Maintenance Works at MVCC
- RTT Spotlight
- Elective Care Checklist
- Performance Report Month 1
- Tier 2 for Urgent Emergency Care
- Finance Report Month 1
- Elective Recovery Fund
- CIP Programme Update
- Procurement Delivery Update

Alert:

- The highest proportion of breaches of patients waiting for 78 weeks or more was community paediatrics, which equated to 360 of the 461 breaches.
- The Committee were advised there had been an ongoing increase in referrals to the hospital.
- Recent industrial action had a negative impact on lost activity and the service the Trust could provide during that time. It resulted in an increase in attendances in ED immediately following industrial action. There was concern that the planned industrial action on 14-17 June would have the same negative impact, along with any other potential industrial action in July and August.
- The was some concern that there could be a shortage of specific parts required for operations and this was being investigated by the Trust.
- The four hour performance in ED was not consistently being met. This was primarily because of an increase of patients presenting in ED and not enough use of assessment units. Work is ongoing to address this issue.
- There had been no improvement in discharges before 17:00, and patients not meeting criteria to reside had risen, along with bed occupancy, particularly bed occupancy over seven days. Senior nurses will be focussing on long length of stay patients.
- Trauma and orthopaedic work was an area of concern for the Committee because of the significant under performance in this area. An improvement was expected in May.
- The Committee were concerned that the uptake of WLI sessions had not been at the expected level for month 1. The Committee expected this to improve in May.

Advise:

- FPPC reviewed and agreed the packages of backlog maintenance work at Mount Vernon Cancer Unit following the liquidation of the previously selected contractor for one of the packages. Package A has been referred to the Board for approval in accordance with SFIs.
- There were two new items added to the Board Assurance Framework (BAF) which were Digital, and Autonomy and Accountability. The BAF will be reported to committees bi-monthly going forward, rather than monthly.
- There had been a successful recruitment campaign for the Community Diagnostic Centre (CDC).
- The Trust has invested in a transport tracker system to monitor usage of non-patient transport.
- Work was being carried out with the Intensive Support Team to validate patients on waiting lists.
- Avoidance of admissions and alternative pathways was being reviewed.
- As a learning exercise, some of the Trust's staff will be carrying out peer reviews in other hospitals.
- The Trust is reporting against a £2.5m deficit control plan. At the end of Month 1 the Trust planned for a deficit of £3.5m and the actual deficit was £3.4m.
- The Trust was broadly within budget for pay in Month 1, however there still needs to be better control on the use of temporary staff..
- The Trust CIP performance was lower than planned in Month 1. The target was £2.1m and the actual achievement was £1.2m. Much of this related to ERF/marginal savings shortfall within the Planned Care Division.
- As at Month 1, £2.4m of the CIP plan remains unidentified. This balance sits within the Unplanned Division.

Assurance:

- The Committee were advised that space utilisation was being reviewed.
- The Green Plan has been refreshed, reducing from eight to seven workstreams. People and Corporate workstreams have merged under the Green Ambassadors Network. Four of the workstreams have been launched with the remaining workstreams being launched in the near future.
- A decarbonisation strategy will be launched mid-June.
- There will be an anticipated reduction of 25% in services like water, gas and electricity over the next year.
- Patients waiting 78+ weeks were reviewed every two weeks. Patients waiting 104 weeks or more were reviewed daily.
- There had been improvements in ambulance handover times compared to the same
- The Committee received a report from the Director of Procurement who reported that savings were strong in 22/23. £2.5m savings have been projected for 23/24.

Important items to come back to committee (items committee keeping an eye on):

None

Items referred to the Board or a committee for a decision/action:

- The FPPC recommended the Trust Board review and approve over £1m spending for backlog maintenance work at MVCC. This will be presented to an extraordinary Trust Board meeting on 7 June 2023.
- The Trust Board will also be noting data in the Elective Care Checklist once completed as requested by the NHSE in their letter of 23 May 2023.

Recommendation	The Board is asked to note the Finance, Performance and Planning report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	16.1
Report title	Finance Performance and Planning Committee 20 June 2023 highlight report	**Meeting Date**	5 July 2023
Chair	Karen McConnell - Committee Chair and Non-Executive Director		
Author	Chloe Milton - Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Finance Report
- CIP Programme Update
- Divisional CIP Plan – Planned Care Division
- Outpatient Strategy Spotlight
- Productivity and ERF report
- Capital Programme Update
- Performance Report
- Workforce Establishment Review
- Board Assurance Framework

Alert:

- Spend for bank, temporary and medical staffing remains high, with rota utilisation a contributing factor.
- Workforce establishment: whilst permanent recruitment is on track, temporary staffing levels are not reducing at the same rate. The Committee was advised that ways of tackling this, including improving controls are being explored.
- High-cost drugs spend is high. This is a pass-through cost but will be an extra cost for our ICS. Possible causes, such as changes in demand or prescribing, are being investigated. Other Trusts have reported a similar trend.
- Unplanned Care CIP Plan - £2.4m of CIP is still unidentified.
- Planned CIP are fully identified but a significant proportion relates to elective recovery funding.
- SNNAP D rating: Given the D rating remains; it was agreed to explore causes and solutions with the Stroke Network.
- Microbiology – 3 of 4 consultant positions are vacant and the substantive consultant is on sick leave. There is a national shortage and locum cover is very costly. JD to discuss possible job sharing with CUH.

Advise:

- Directors of Finance across local Trusts supported a collective system approach should budget challenges materialise. Collective control measures are being developed for further consideration.
- Elective recovery: there was better elective recovery activity in May (110%), with elective recovery crucial to delivering the CIP targets. Industrial action impact was the biggest risk to meeting elective recovery targets.

- Performance: Discussions included causes of ambulance handover performance, exceptionally high A&E attendance and discharge timeliness. The community paediatrics over 78 weeks remained high. - Capital programme delivery: No major risks were highlighted at this early point in the programme for the year. An additional £9.1m has been identified for a vascular hub/theatre through national and ICS funding. - The spotlight covered Outpatient strategy. Progress was welcomed. The Chair asked for further discussion on saving opportunities at a forthcoming meeting, reporting back in 6 months to the Committee to assess delivery. - BAF: The Committee particularly focused on the new digital transformation risk prior to it going to Board for the first time. The issue of the historic ability to capitalise digital spending no longer being available was the committee's largest concern in how to mitigate the risk.	
Assurance:	
- The Trust was on plan after Month 2 of the budget. - Planned Care CIP: The Committee was assured there were plans in place where there were gaps.	
Important Items to come back to committee:	- Outpatient strategy Spotlight opportunities and targets in 1 to 2 months followed by delivery review in 6 months. - Report to be made in the next 3 months on analysis of medical staffing overspend with benchmarking, if possible.
Items referred to the Board or a Committee for decision or action:	None.

Recommendation	The Board is asked to **NOTE** the Finance, Performance and Planning Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	20
Report title	Quality and Safety Committee 24 May 2023 highlight report		**Meeting Date**	5 July 2023
Chair	Dr Peter Carter – Committee Chair and Non-Executive Director			
Author	Julia Smith – Assistant Trust Secretary			
Quorate	**Yes**	☒	**No**	☐

Agenda:

- Venous thromboembolism (VTE) Revised Measurement Pathway
- Theatre Staffing Review
- Risk Management Report
- Board Assurance Framework
- Quality and Safety Report – Month 1
- Mental Health Emergency Department Patient Pathway
- Maternity Assurance Report
- Maternity Patient Experience Report
- University of Hertfordshire Partnership Annual Report
- Mount Vernon Cancer Centre Gynaecological Oncology

Alert:

- Within Theatre's issues with staffing rotas, processes, training, and the use of temporary staffing were highlighted. There is an action plan in place, but significant work will be required to ensure the right people are in the right place at the right time with the correct skill mix.
- C.diff has spiked across the Trust, likely causes are antimicrobial stewardship, escalation spaces and technical nurse cleaning.
- There are risks to patients and staff with the number of mental health presentations in the Emergency Department and the impact on patient experience. Lack of specialist skills were identified.
- The Trust is a negative outlier for the national 30-day mortality data for ovarian cancer. Actions are being taken by the Executive and the Divisional leadership teams to address this issue.

Advise:

- The number of overdue risks has increased on the previous month. Monitoring is undertaken by the Risk Management Group in line with the Trusts risk strategy.
- Acute Myocardial Infarction (AMI) has been highlighted as a mortality outlier; there were coding issues as well as more unwell patients and multiple comorbidities. A remedial action plan is in place.
- Policies compliance across the Trust requires improvement as a significant number of those published are out of date. A weekly governance meeting has been established to support the compliance.
- The committee agreed to receive the Board Assurance Framework at committee on a bi-monthly basis as changes are minimal.

Assurance:

• Venous thromboembolism (VTE) process is being updated in-line with health service best practice and where this has been implemented, improvement is slow but evident. • Key competencies and actions have been developed to support the quality assurance oversight framework which includes a range of recommendations and oversight to triangulate information. • Improvements are being seen in the number of completed friends and family tests, work is underway on the Children's ward to generate satisfaction data from young patients.
Important items to come back to committee (items committee keeping an eye on):
• Mount Vernon Cancer Centre Gynaecological Cancer position.
Items referred to the Board or a committee for a decision/action:

Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	20
Report title	Quality and Safety Committee 28 June 2023 highlight report		**Meeting Date**	5 July 2023
Chair	Peter Carter – Committee Chair and Non-Executive Director			
Author	Karla West – Assistant Trust Secretary (Interim)			
Quorate	**Yes**	☒	**No**	☐

Agenda:

- Patient Safety Incident Response Framework
- Safe, Care, Effective IPR Report
- Gynaecology – Mount Vernon Hospital
- Audiology – Lister Hospital
- Infection Prevention & Control – Clostridioides difficile run rate
- Learning from Deaths Report
- Maternity Assurance Report
- Stroke Update
- Risk Management Report
- Nursing and Midwifery Strategy Progress – Annual Review
- Estates & Facilities PAM and Health and Safety Assurance Report
- Quality Account Annual Report
- Health and Safety Annual Report
- Research and Development Annual Report
- Escalation Reports

Alert:

- Sepsis data point issues highlighted
- Concerns regarding suggested pause of audiology service.
- Stroke section consistently at D rating. Staff looking at how this could be improved.

Advise:

- It is hoped that the Patient Safety Incident Response Framework will get sign-off by the Integrated Care Board in September. An oversight approach is required.
- The Discharge summary position is improving, however, further work needs to take place.
- Awaiting response from Care Quality Commission regarding vaginal deliveries including the best method of helping patients.
- Sharing best practice and expanding training with ambulance crews on thrombolysis cases to upskill them is being considered. This is expected to take place as a pilot audit form.
- Estates & Facilities PAM and Health and Safety Assurance Report will be discussed in a further meeting in September.
- Quality Account Annual Report approved at the June Quality and Safety Committee meeting.

Assurance:	
• Work is ongoing to ensure continued engagement with staff.	
Important items to come back to committee (items committee keeping an eye on):	
•	
Items referred to the Board or a committee for a decision/action:	
• Patient Safety Incident Response Framework •	
Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	21
Report title	Extraordinary Audit Committee 17th May 2023 highlights report			**Meeting Date**	5th July 2023
Chair	Jonathan Silver - Audit & Risk Committee Chair and Non-Executive Director				
Author	Julia Smith – Assistant Trust Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Internal Audit Annual Report
- Final Audit Planning Report 2022/23

Alert:

- An amber report had been issued at the end of January for discharge summaries and further issues had been identified from the management comments. 84 discharge areas had been identified some of which did not exist.
- Two new risk areas had been identified with the implementation of ISA315.

Advise:

- The final internal audit reports would be issued in the coming weeks and would have no impact on the final Head of Internal Audit Opinion.
- The Trust deficit position had been improved since the completion of the final report and would be subject to final checks as part of the formal responsibilities.
- Due to a sample component instructed by the National Audit Office, additional fees in this area would be incurred by the Trust.

Assurance:

- The final Head of Internal Audit Opinion was Reasonable Assurance.

Important items to come back to committee (items committee keeping an eye on):

Discharge Summary Internal Audit Data Quality issue.

Items referred to the Board or a committee for a decision/action:

N/A

Recommendation	The Board is asked to **NOTE** the Extraordinary Audit Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	21
Report title	Audit and Risk Committee 26 June 2023 highlights report		**Meeting Date**	5 July 2023
Chair	Jonathan Silver – Audit and Risk Committee Chair and Non-Executive Director			
Author	Karla West – Assistant Trust Secretary (interim)			
Quorate	**Yes**	☒	**No**	☐

Agenda:

- Internal Audit Progress Report and Action Tracker
- Internal Audit Annual Report and Head of Internal Audit Opinion
- Anti-Crime / Local Counter Fraud Annual Report
- External Audit Progress Report
- Draft Letter of Representation
- Final Accounts 2022-23
- Annual Report and AGS 2022-23
- Quality Account Process Update
- Premises Assurance Model
- Anti-Fraud and Bribery policy
- Cyber Security Report
- Data Quality and Clinical Coding Report

Alert:

- The Annual Accounts and Annual Report were not approved as further work is to be completed.

Advise:

- A shortened version of the Premises Assurance Model will be discussed at the Audit and Risk Committee in September. A further deep dive is due to take place.
- Control Recommendations within External Audit Progress Report are being reviewed. Further discussions are expected to take place at the October meeting.

Assurance:

- The Annual Report and Accounts is in very good shape and it is not expected that there will be significant further amendments.

Important items to come back to committee (items committee keeping an eye on):

- Internal Audit Annual Report and Head of Internal Audit Opinion
- External Audit Progress Report

Items referred to the Board or a committee for a decision/action:

N/A

Recommendation	The Board is asked to **NOTE** the Extraordinary Audit Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	22
Report title	Charity Trustee Committee 5 June 2023 Highlight Report	**Meeting Date**	5 July 2023
Chair	Dr David Buckle – Committee Chair and Non-Executive Director		
Author	Karla West – Interim Assistant Trust Secretary		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- Terms of Reference for 23/24 Review
- Charity Finance Report
- Charity Impact Report
- External Auditor's Report – Audit Planning & Timetable
- Investment Portfolio Report (from Rathbones)
- Approvals in Excess of £5,000
- Charity Highlight Report
- Major Project Update – Sunshine Appeal

Alert:

- Significant audit fees increase. Written explanation for increase sought from Director of Finance.

Advise:

- The Committee **approved** the following applications over £5,000:

Area	Project	Cost
Cancer	3 x dual paxman scalp cooling systems to assist patients post SACT treatment and reduce hair loss	£35,256 – two in MVCC chemotherapy suite £15,188 – one in new Ambulatory bay on Ward 10
Planned care	An enclosed decking/garden area to be installed on cubicle four within the Bluebell ward.	£17,352 including VAT
Thank you week	Tent, provisions for food	£15k max
Staff awards	To celebrate the success of our workforce	£8,000 (£16,800 already awarded)
Corporate	Refurbish the library space at Lister Hospital	£35,000
Cancer	Refurbishment of Chemotherapy suite waiting room, painting and decoration, new artwork	£10,000
Children's	Purchase ChargeBoxFast for Children's Emergency Department	£14,396 excl. VAT (after first 3 year SLA it will cost an additional £2,540 for another three years maintenance)
Children's	Project Bluebell - fitting of new kitchen and bathroom on Bluebell ward and refresh of the lobby/corridor and day room to benefit parents and families	£43,384 in total for the four spaces (project breakdown costs in appendix)

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Cancer MVCC	Create a new dedicated waiting area and procedure room for a novel targeted therapy - Lutetium-177-PSMA-617 for Metastatic Prostate Cancer	Estimate for the works of £35,000.00 +VAT £10,000.00 +VAT for internal structural alterations. £1500.00 +VAT for a Structural feasibility survey.

- Charity Finance Report – The charity income for 22/23 was £1,032K with an expenditure of £1,469K giving a deficit of £436K against a planned deficit of £614K. Legacy income (£55K) is often volatile and in 22/23 it was significantly below target.
- Major Project Update – The Committee were updated on the Sunshine Appeal project. The meeting handover space was discussed. £30k for staff room. £393,500 was raised with £440k being the original estimate.

Assurance:

- The Committee approved the budgets and forecast.
- Charity Highlight Report – The Committee noted the Report.

Important items to come back to committee (items committee keeping an eye on):

- External Auditors Report – BDO same timetable as last year. Therefore, Audit in September 2023. Bringing planning report to September Committee meeting. Aim for approval at the December Committee meeting.

Items referred to the Board or a committee for a decision/action:

None.

Recommendation	The Board is asked to **NOTE** the Charity Trustee Committee report.

Board Annual Cycle 2023-24

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	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
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
Corporate Risk Register		X				X				X		
Patient/Staff Story (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		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
People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		
Trust Strategy refresh and annual objectives												X
Strategy delivery report				X [previous year]						X		
Strategic transformation update				X				X				X
Integrated Business Plan								X				
Annual budget/financial plan												X

Board Annual Cycle 2023-24

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Digital Strategy Update				X								
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)		X		X		X		X		X		X
Estates and Green Plan								X				
Equality, Diversity and Inclusion										X		
Clinical and Quality Strategies												X
People Strategy										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												

Board Annual Cycle 2023-24

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Complaints, PALS and Patient Experience Annual Report						X						
Safeguarding and L.D. Annual Report (Adult and Children)								X				
Staff Survey Results		X										X
Learning from Deaths		X				X		X		X		
Nursing Establishment Review										X		
Patient Safety and Incident Report (Part 2)		X						X				
University Status Annual Report				X								
QSC TOR and Annual Review				X								
People Committee & Culture												
Workforce Plan								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						X		