June
2023

East and North Hertfordshire
NHS Trust

Quality Account 2022-23

Quality Report Contents

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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

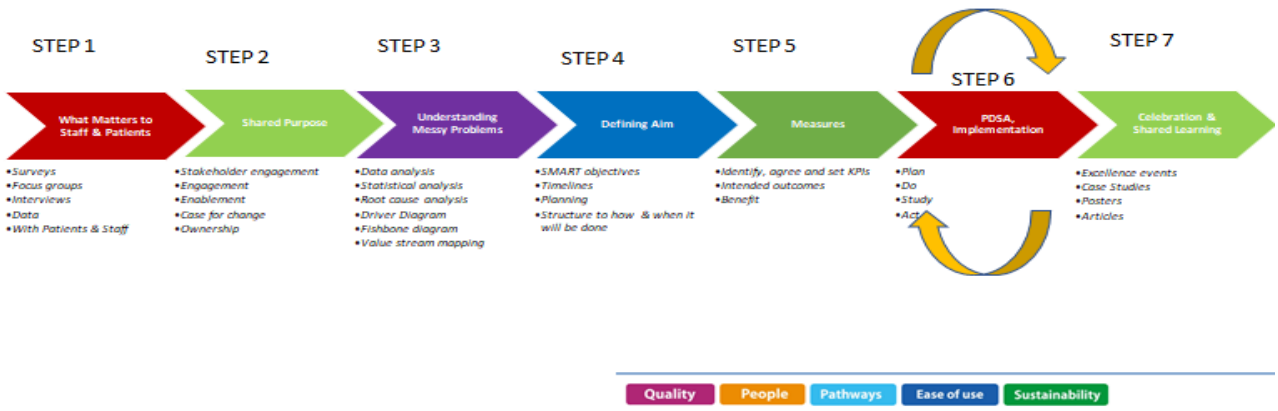
Key achievements made include:

- **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.

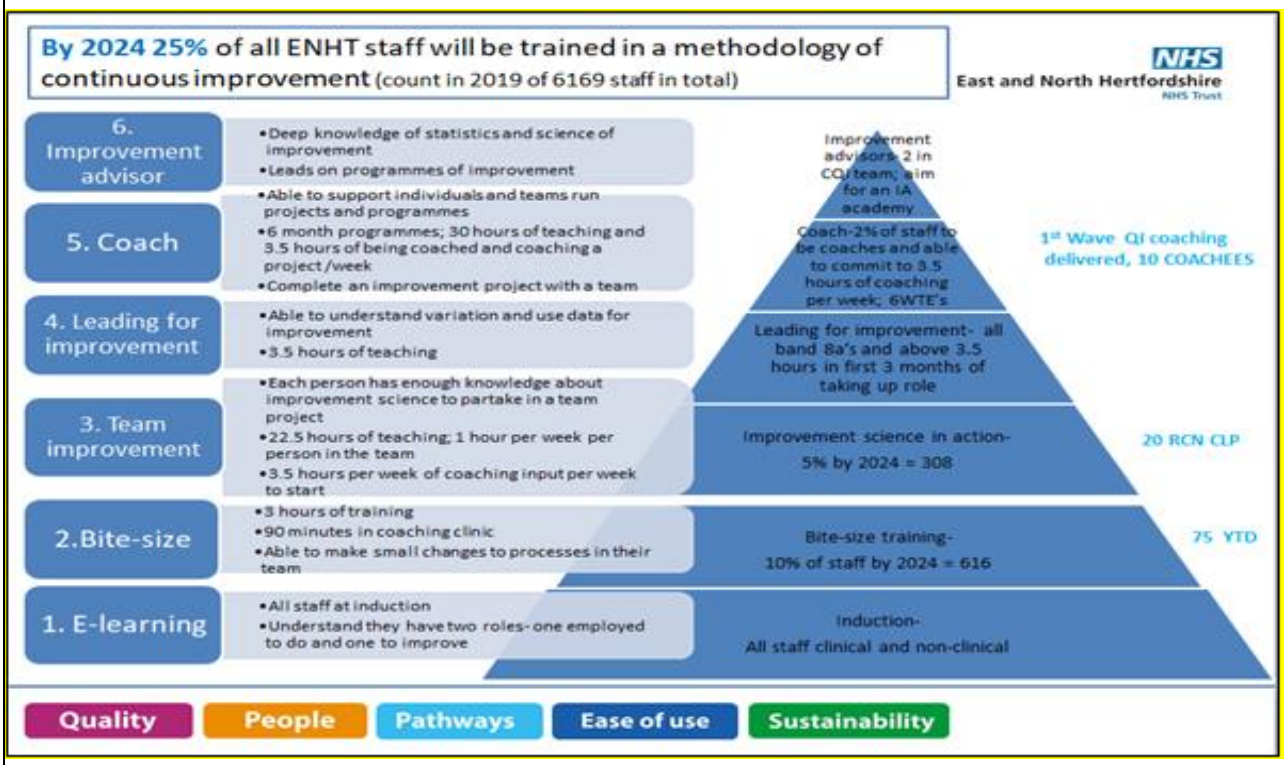
Unfortunately, the 'What Matters To You' project was not funded and as such, we have been unable to move forward with this. However, we plan to run a What Matters To You day in 2023/24 and build a group of What Matters To You champions to lead improvement on themes identified

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.	**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
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,	

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.

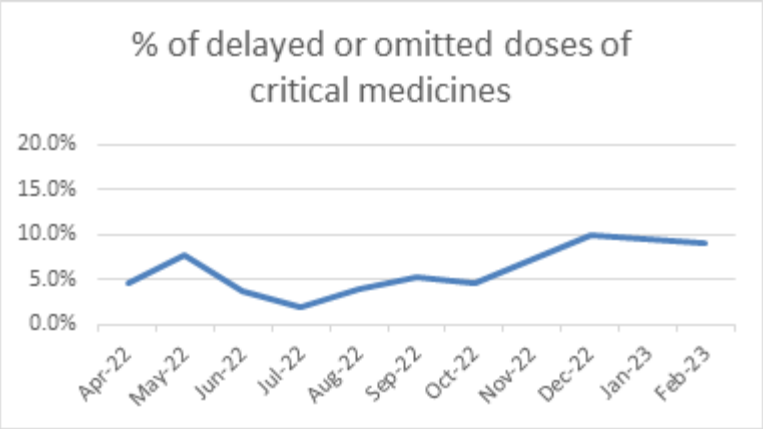
The highest recorded compliance in 2022/23 is seen between August- November 2022 at >80%- an improved position compared to same period last year. However, looking at the year, trends in sustained improvements is noted towards the second half of the year compared to compliance from April-September 2022.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

2. Medication Management

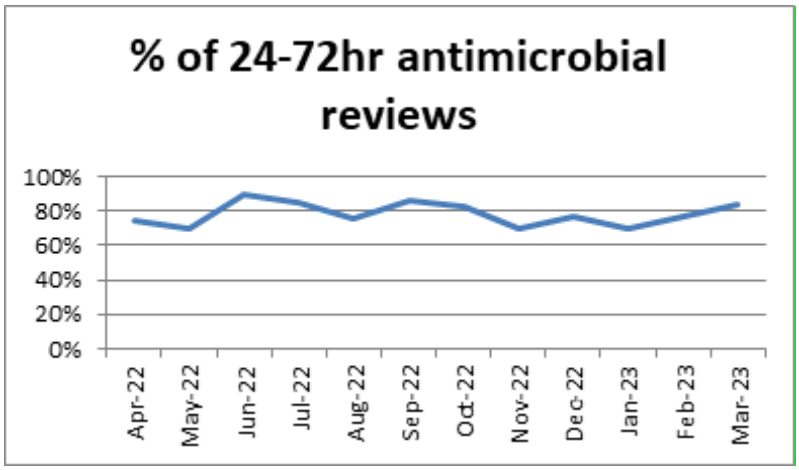
Over the last year the pharmacy department has focused on embedding electronic Prescribing Medicines Administration (ePMA) system into clinical practice. As an outcome of this, we have revamped our medicinal products policy with a new Medicines Management policy in place that details how medicines will 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.

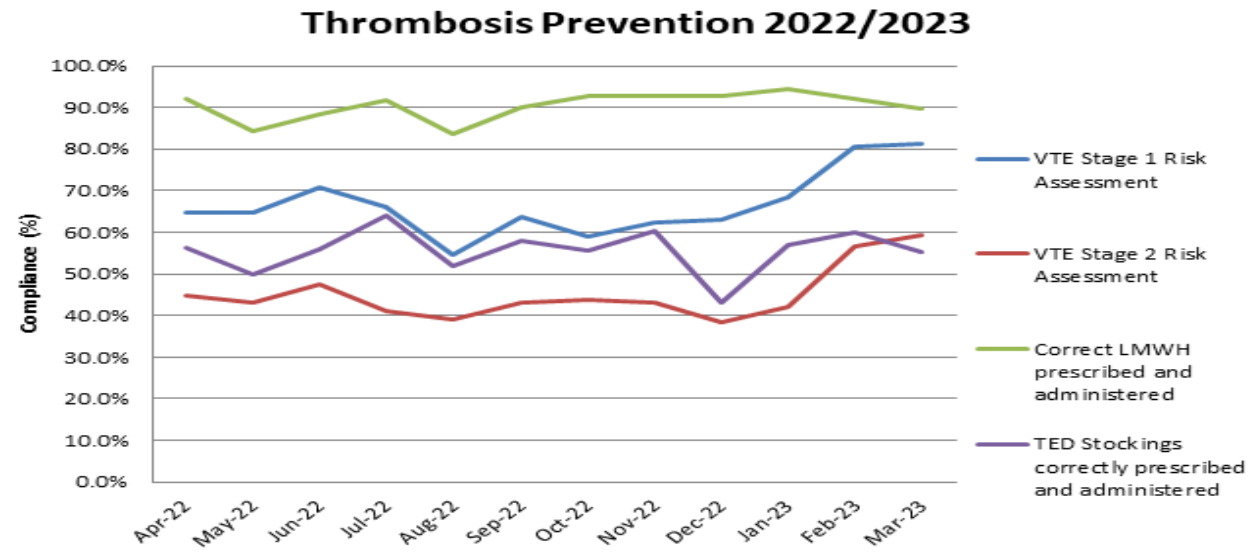
In January 2023, we successfully recruited a children's independent sexual violence advisor to support and align our work with patients under the age of 18.

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

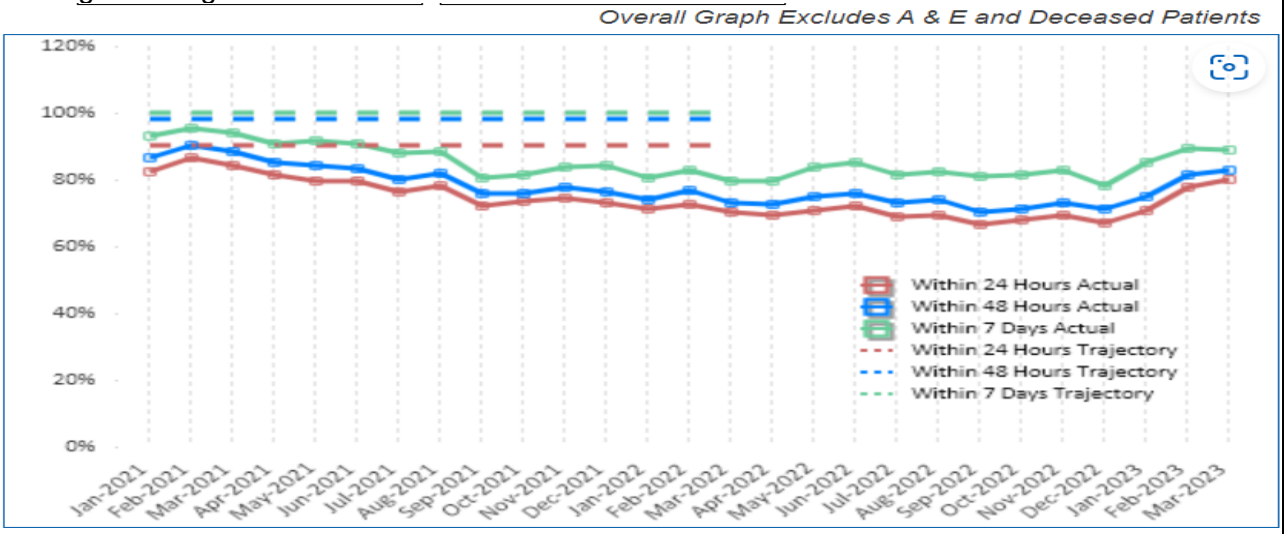
- >95% of patients requiring a stage 1 and 2 VTE assessments by March 2024
- Embed digital risk assessment platform into clinical practice. For instance, utilisation of VTE status on NerveCentre dashboard as a prompt for assessment completion.
- Continue to review, assess and improve VTE digital assessment 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 %

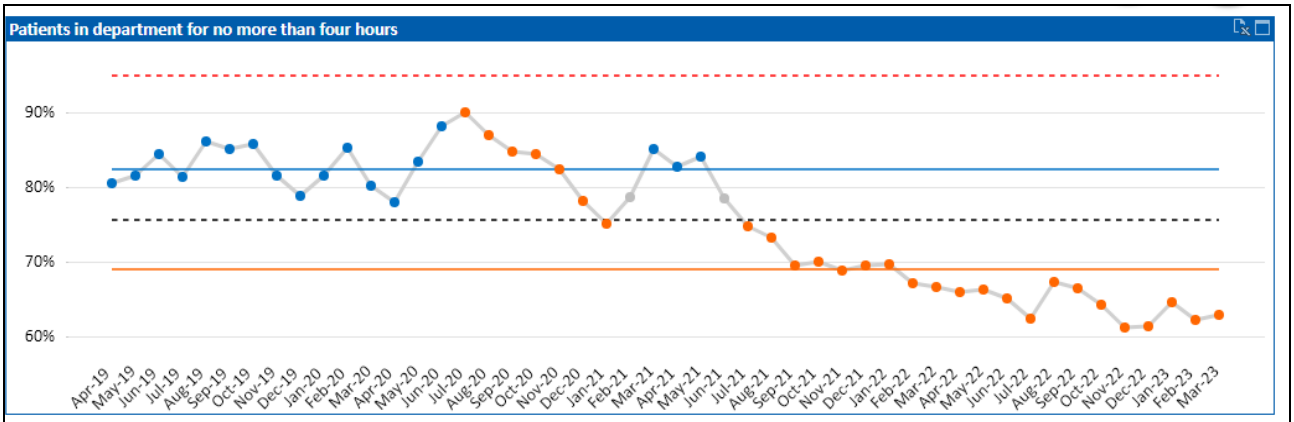
ENHT has also successfully established a new board and ward round standard operating procedure aimed at supporting timely discharges as well as developing a criteria led discharge competency framework (CLD).

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.

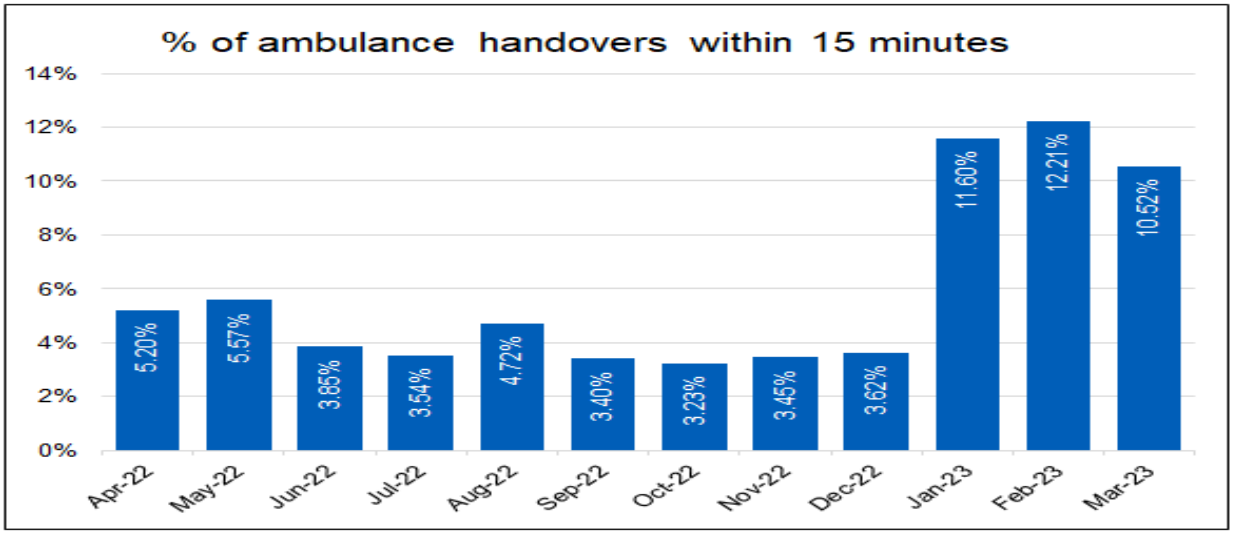
The Trust has made progress with implementing its Patient initiated follow up (PIFU) programme and this continues to be rolled out throughout the Trust. 12 specialities are now using PIFU, and 8 additional specialities went live in April 2023. The Trust continues to work towards its target for all specialities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

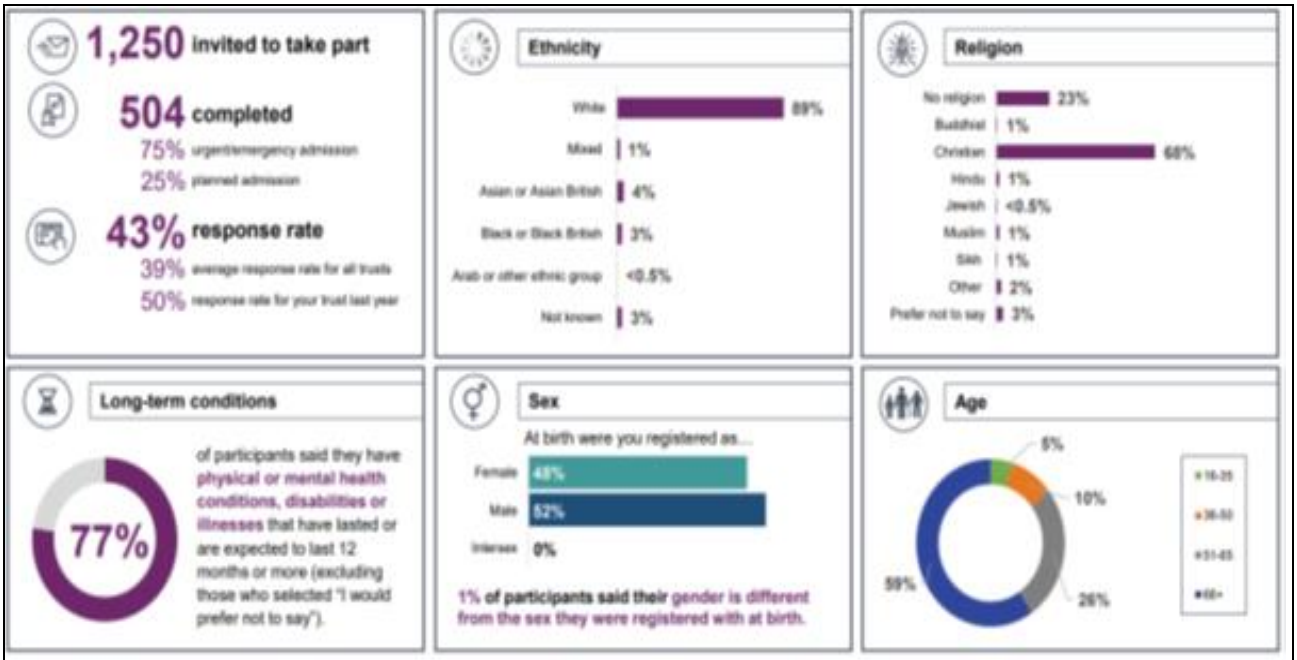
Friends and Family Test Scores:
We have continued to have sustained performance in all categories of our Friends and Family test scores with positive feedback received. Through developing and implementing specific initiatives based on themes from the previous year's FFT survey, utilising feedback data 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

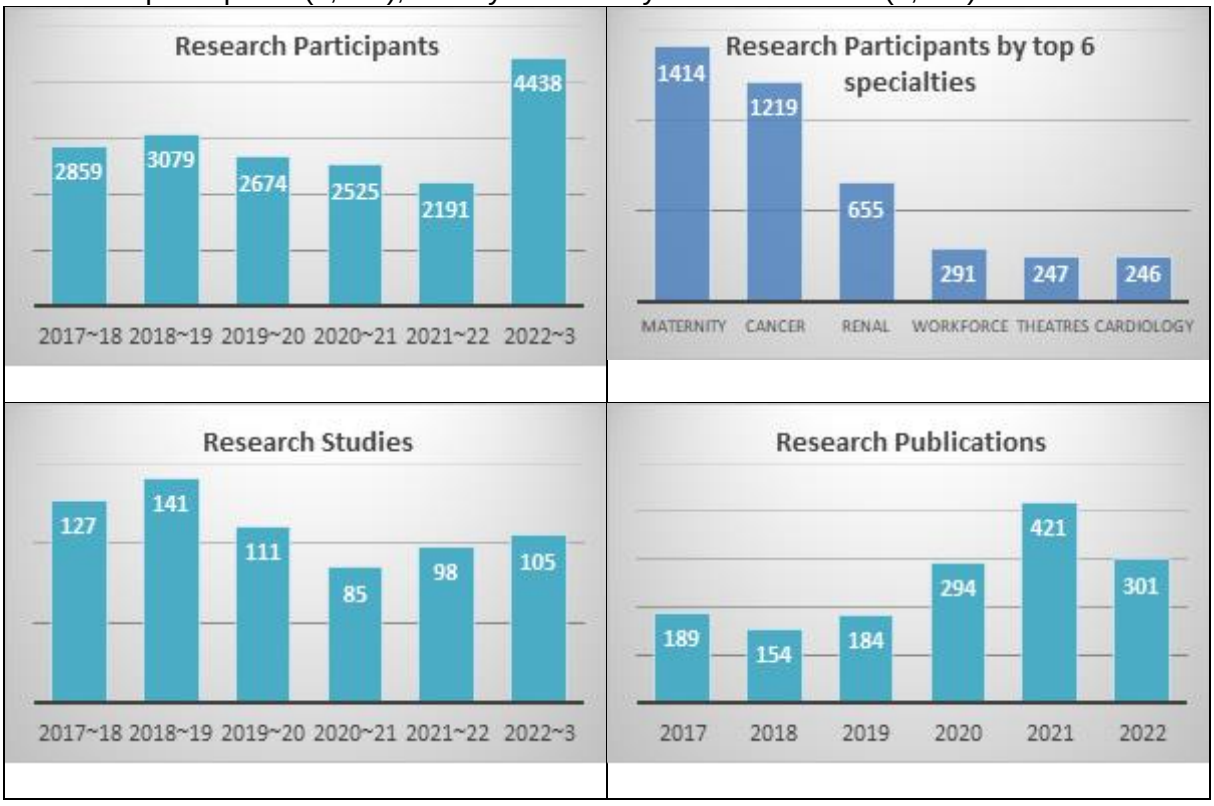
Treatment Technique (18200)	laid down in Radiotherapy Technique Documents for Prostate treatment. **Outcome** – Reaudit showed full compliance. **Actions** – None.
An audit on the investigation of acute Renal colic with CT KUB (18227)	**Audit aim** - Improve appropriate investigation of renal colic. **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.

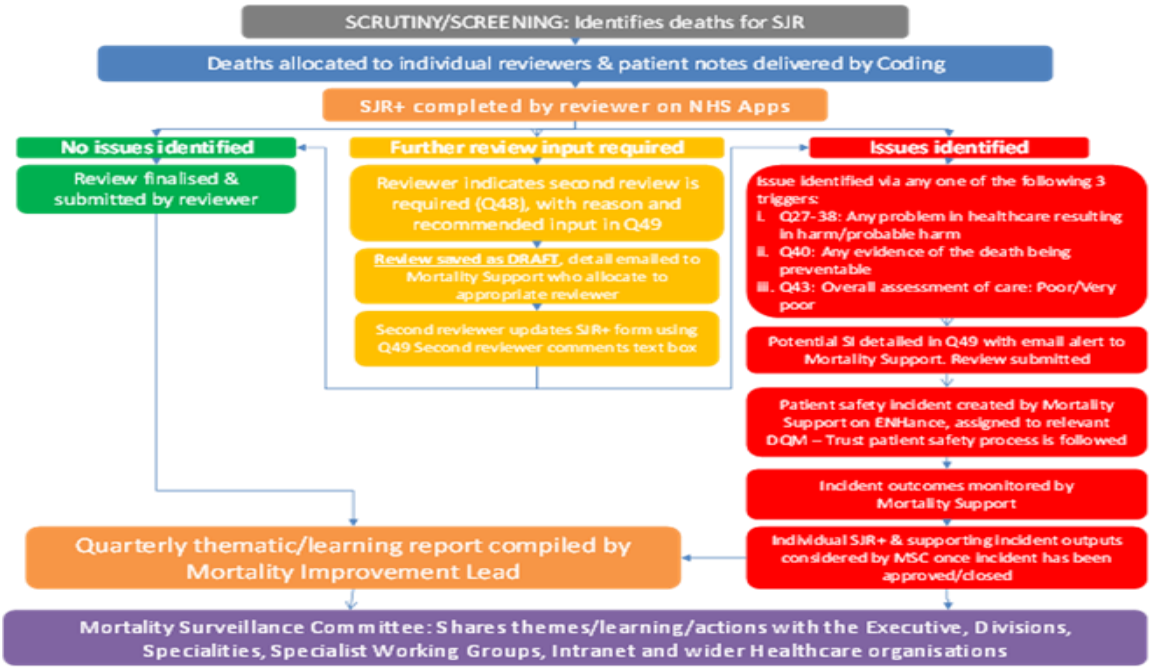
The Trust is committed to continuously seeking ways to strengthen our governance and quality improvement initiatives to support the learning from deaths framework.
While our mortality rates have remained strong, it is increasingly recognised that while monitoring these rates has a role to play in mortality 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).

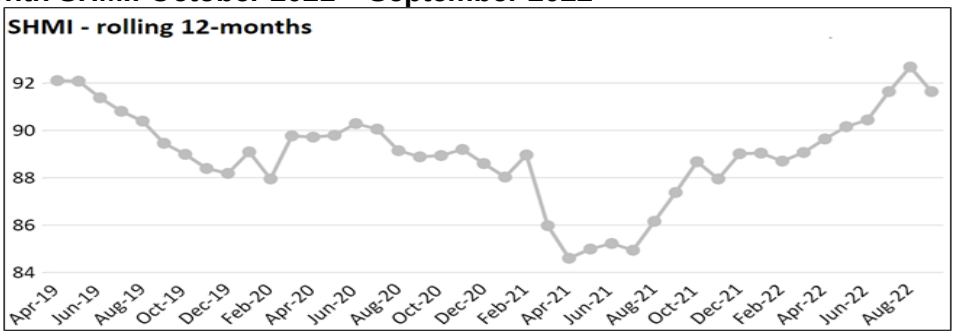
NHS Digital has excluded COVID-19 activity from the SHMI metric. Of note is that the fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, which provides some assurance that our response to COVID-19 has not generally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

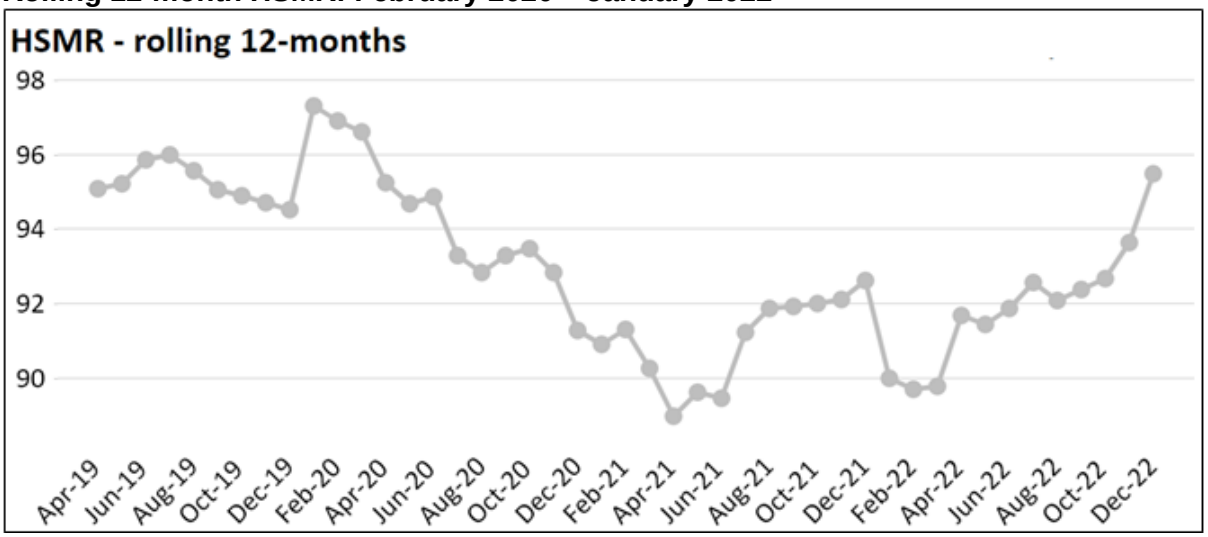
Rolling 12-month SHMI: October 2021 – September 2022



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**.

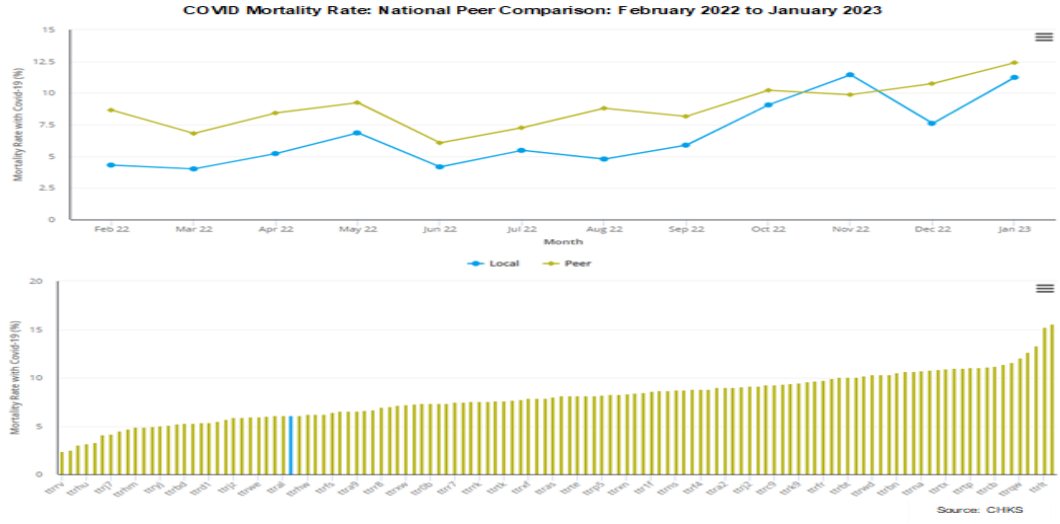
Rolling 12-month HSMR: February 2020 – January 2022



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.

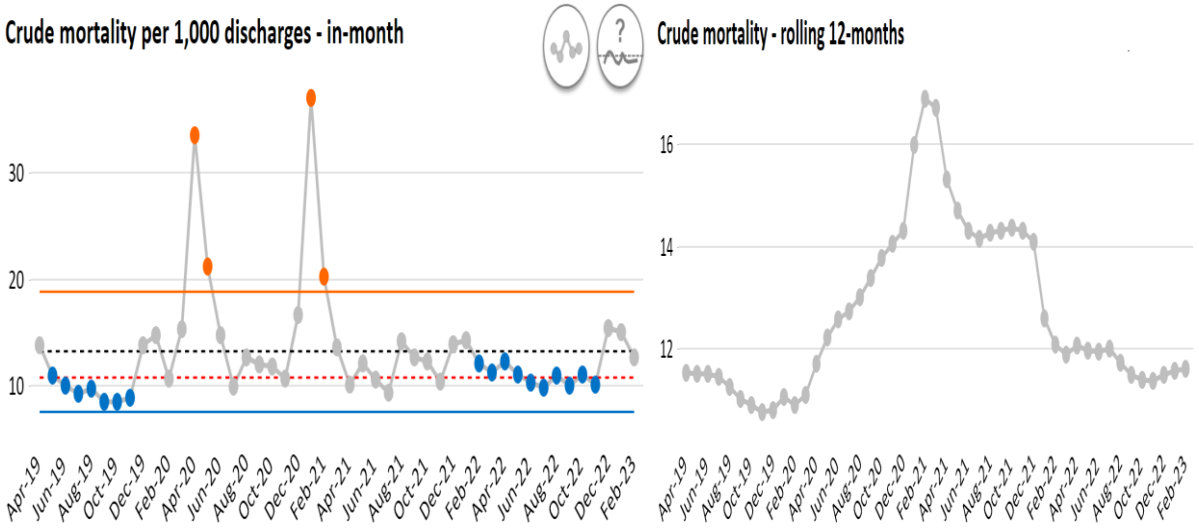
Crude mortality

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.

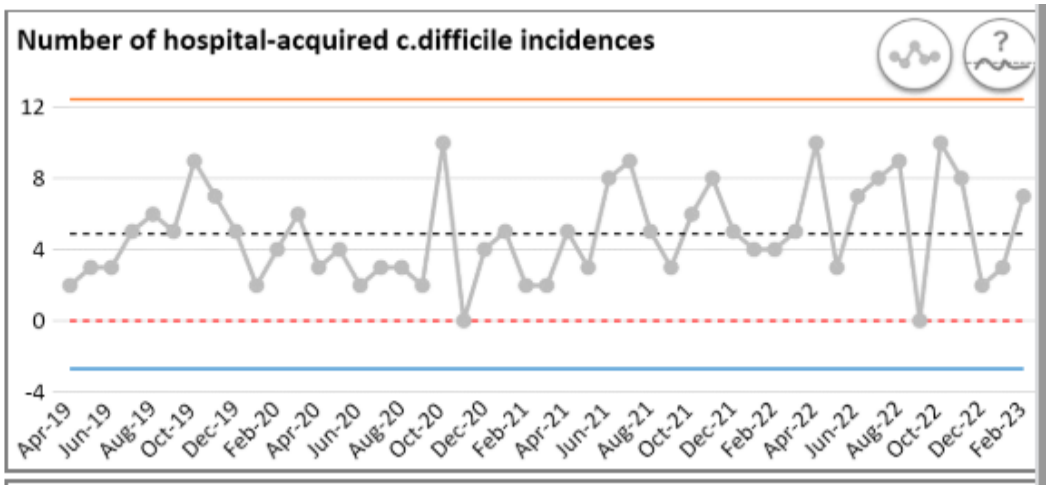
2.3.7. Clostridium difficile

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.

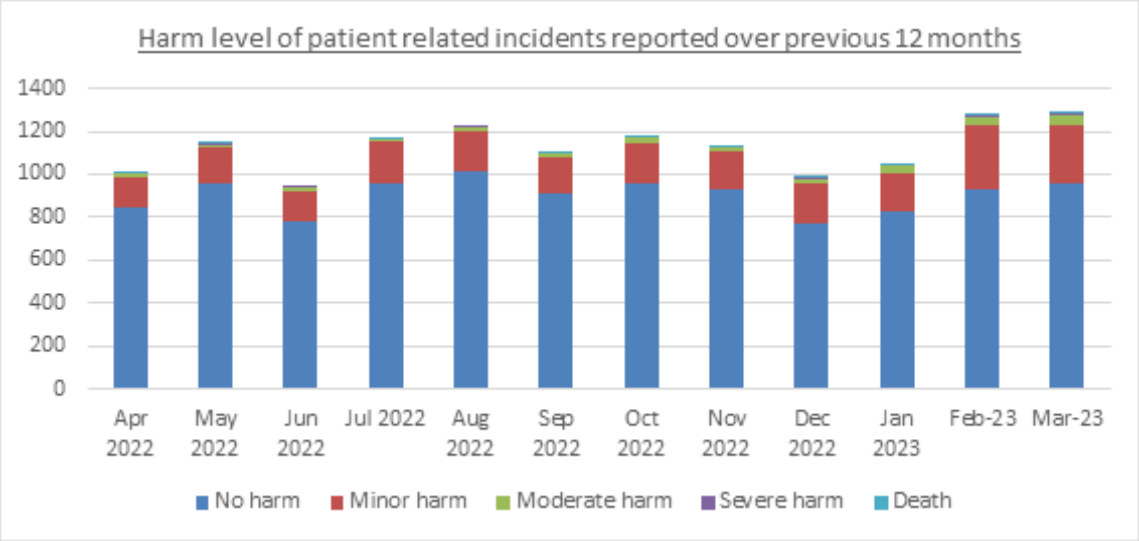
2.3.9. Patient safety incidents

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).

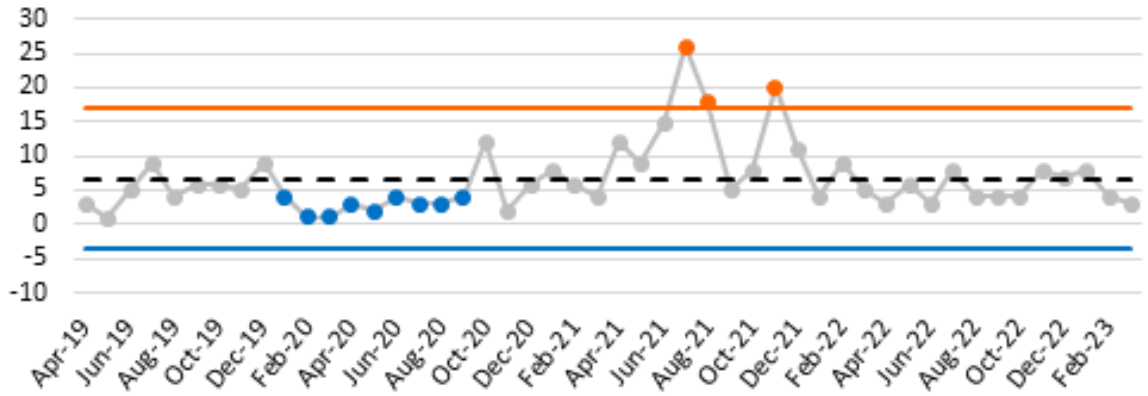
The data shows total number of all incidents reported by us for the period between 1 April 2022 – 31 March 2023 was 13,464 patient safety incidents. Of those, 98% reported resulted in no or minimum harm. Of the total incidents reported, 77% relate to patient safety incidents and 12% relate to staff. 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

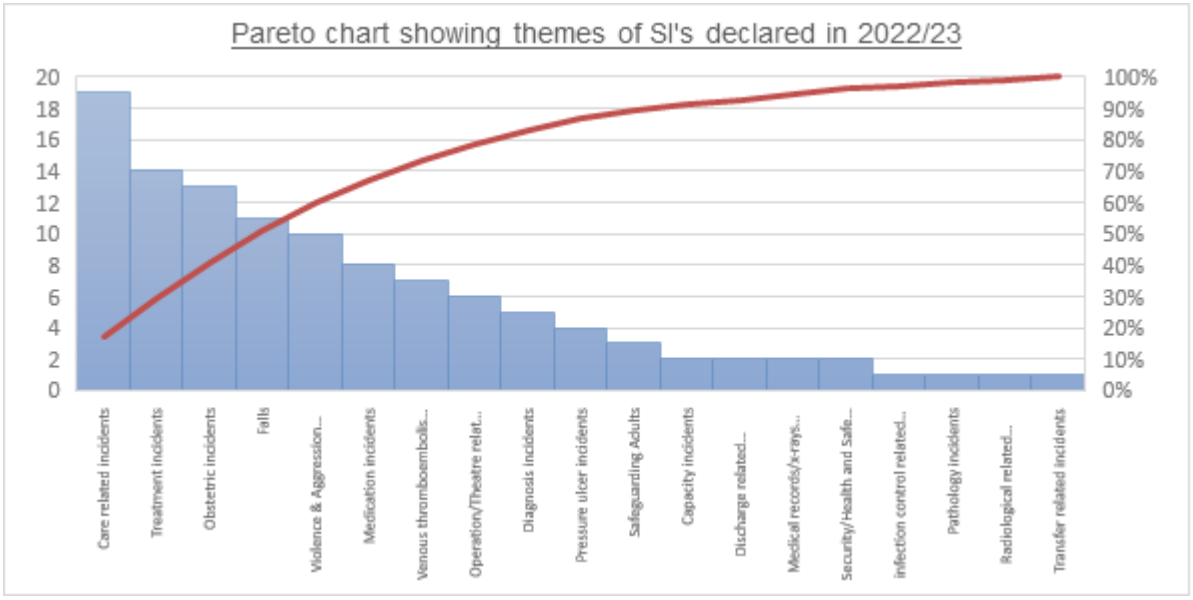


It is recognised that the biggest driver to improvement in reporting is feedback; the ways in which we can improve our feedback are being explored. Teams are being encouraged to ensure incidents are part of local discussions at quality huddles and team meetings. The Enhance system provides greater oversight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

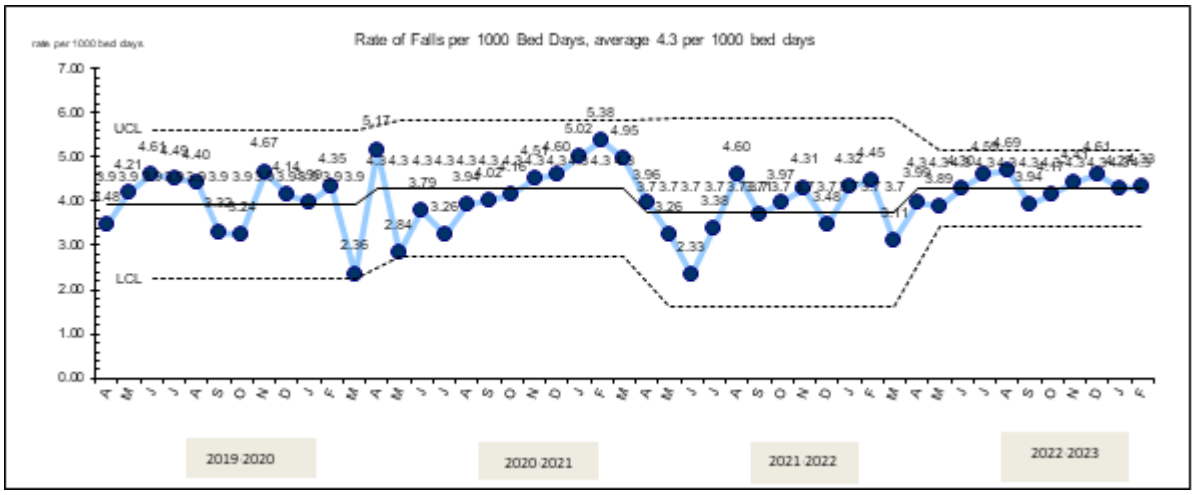
The Trust is committed to being open and honest with our patients. The Duty of Candour is a legal requirement that for all safety incidents recorded as ‘moderate’ or ‘severe’ harm, a formal apology to the patient and/or family involved is carried out and an investigation into their care is undertaken; 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.

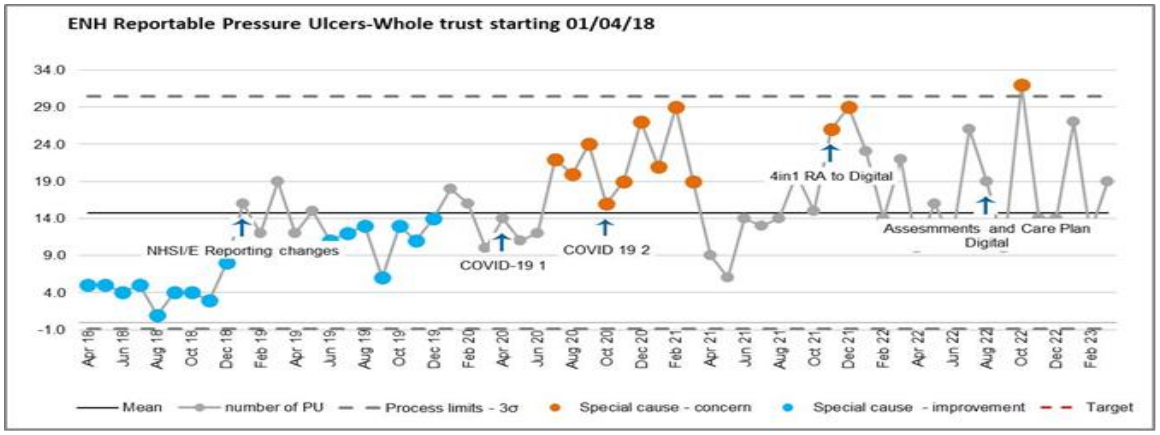
Despite of the increase in falls rate, the Trust continues to record a lower falls rate compared to the national average of 6.6 (NHSE).



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



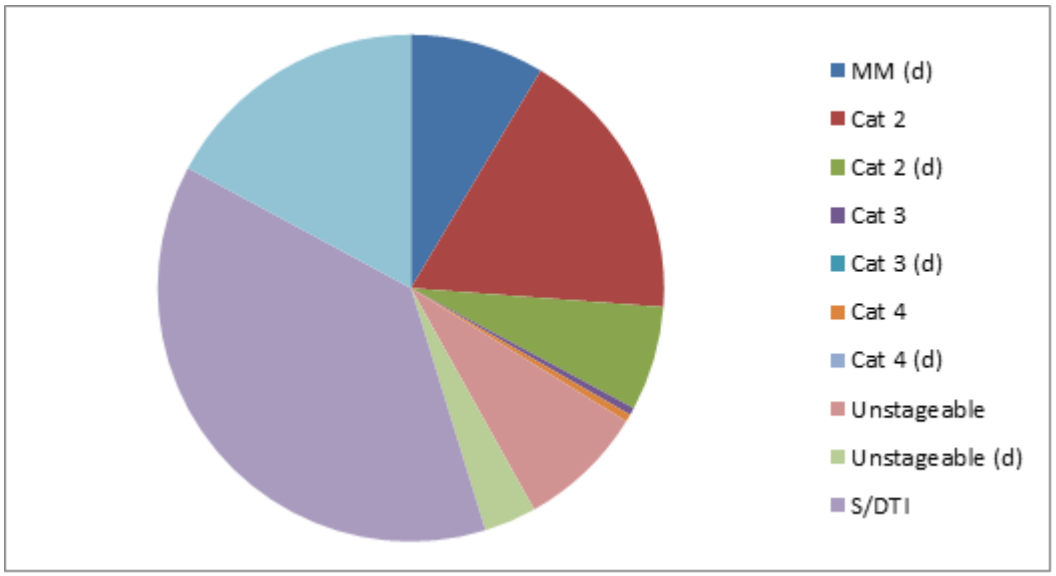
Due to the 2018 reporting changes 2019-20 has become our new baseline year because additional reporting categories of damage are now included compared to previous reporting periods.

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.

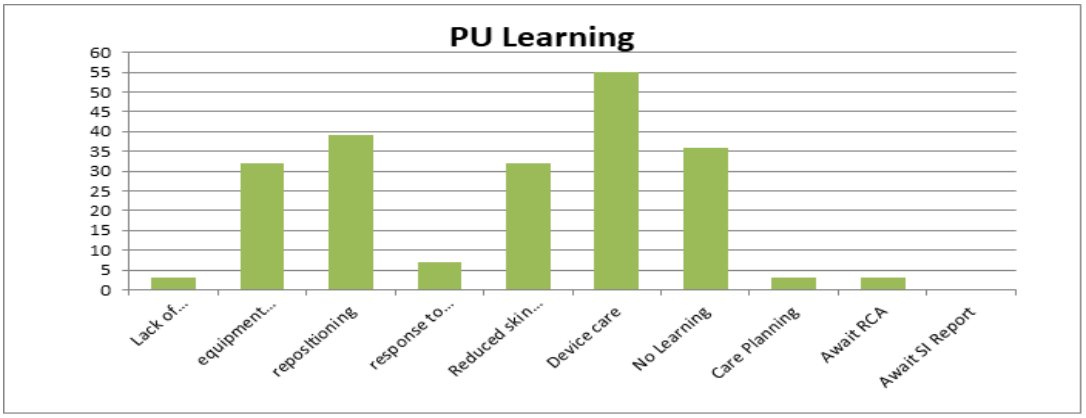
MM (D)	CAT 2	CAT 2 (D)	CAT 3	CAT 3 (D)	CAT 4	CAT 4 (D)	SDTI	SDTI (D)	US	US (D)
18	37	14	1	0	1	0	79	36	17	7

(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

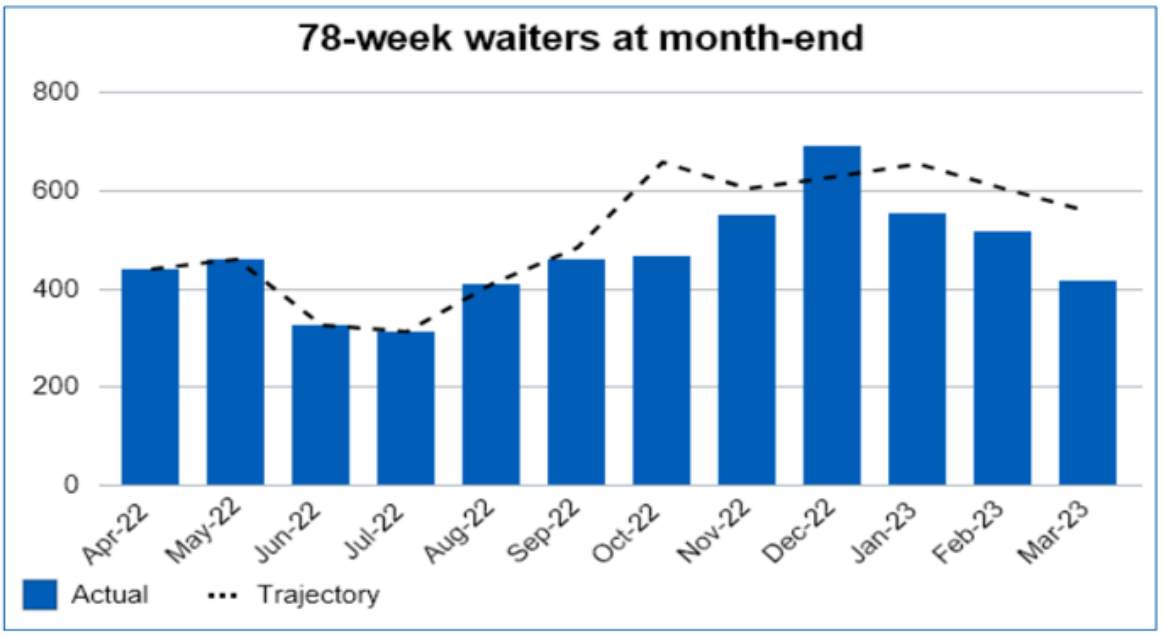
A summary of performance against the key metrics is provided below:

- **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.

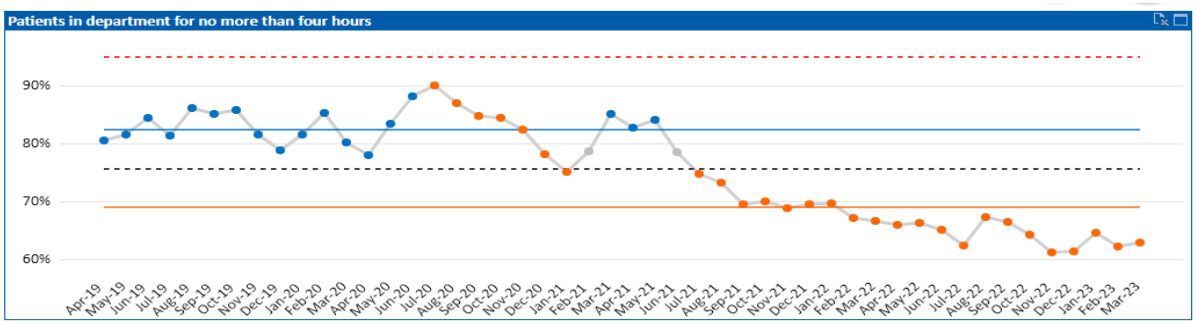
The Trust invited the Elective Intensive Support Team to review its processes and pathways to follow up on the work which was commenced prior to the pandemic. The demand and capacity work which the Trust undertakes was reviewed by the team and the feedback was that this was a very comprehensive piece 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%

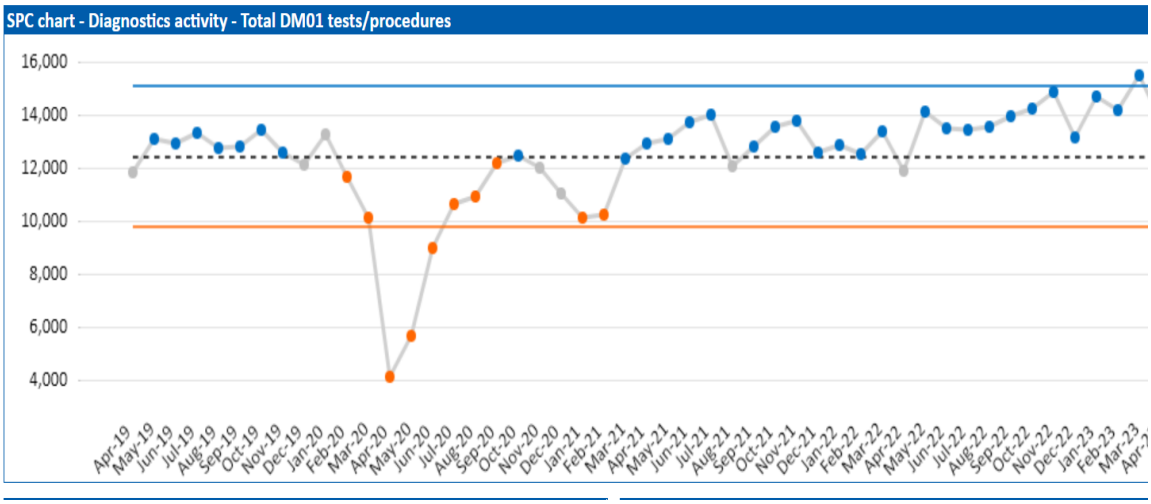
A factor for this underperformance was the high number of 2 week wait referrals putting substantial pressure on the Trust capacity in Endoscopy, Radiology and Histopathology.
Staffing issues in Anaesthetic, radiology and radiotherapy departments caused delays in the cancer pathways; these all have remedial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

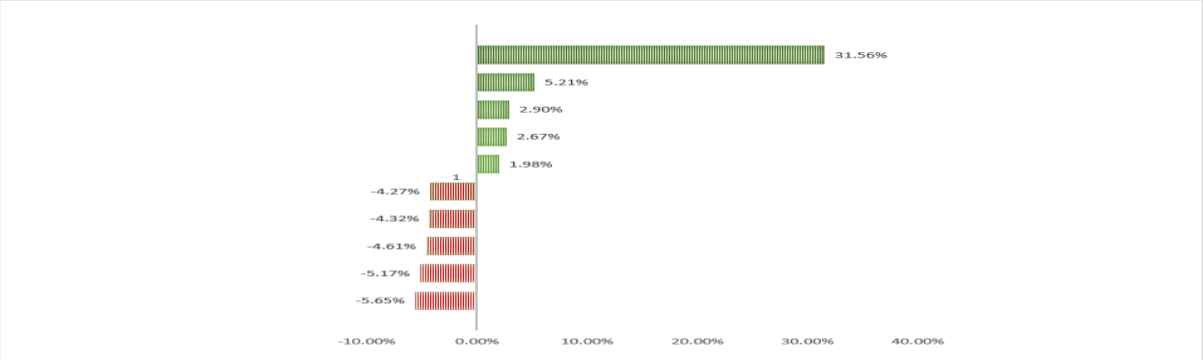
Standard 8 – patients with high dependency needs should be seen by a consultant twice daily; then daily once a clear plan of care is in place. A recent audit identified that approximately 60% of a sample of patients were reviewed within 14 hours of admission.

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

Staff/ National staff survey

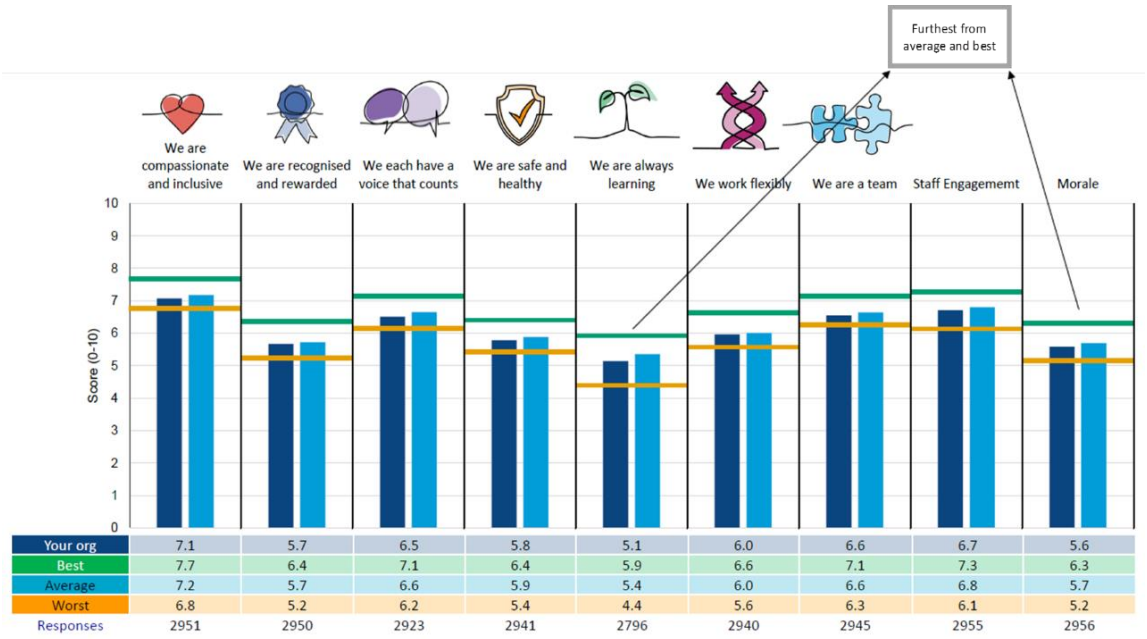
For 2022/23, we will focus primarily on themes around the following and continue work in other areas:

- 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.



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.

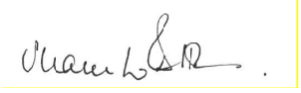
The Trust has undertaken a significant amount of work to improve the quality and timeliness of discharge summaries. Whilst the ICB recognises the strong focus in this area, it is aware that ongoing work is needed to achieve the Trust standard. The ICB expects this to be an ongoing focus for 2023/24 and 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.



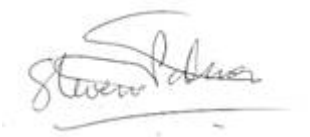
Sharn Elton
Place Director, East and North Hertfordshire

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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