Public Trust Board

Hertfordshire Community Trust, Abel Smith House, Gunnels Wood Road, Stevenage SG1 2ST

11/09/2024 09:30 - 12:00

Agenda Topic	Presenter	Time	Page
STANDING ITEMS			
1. Declarations of interest For noting	Trust Chair	09:30-09:35	
2. Apologies for Absence For noting	Trust Chair		
3. Patient Story For discussion		09:35-10:05	
4. Minutes of Previous Meeting held 10 July 2024 For approval	Trust Chair		3
5. Action Log For noting	Head of Corporate Governance		13
6. Questions from the Public For noting	Head of Corporate Governance		
7. Chair's Report For noting	Trust Chair	10:05-10:10	
8. Chief Executive's Report For discussion	Chief Executive	10:10-10:20	14
STRATEGY AND CULTURAL ITEMS			
9. Workforce Race Equality Standard (WRES) For approval	Chief People Officer	10:20-10:30	18
9.1 Workforce Disability Equality Standard (WDES)	Chief People Officer		37
ASSURANCE AND GOVERNANCE ITEMS			

10.	Quality Account	Chief Nurse	10:30-10:40	53
For approval				
11.	Complaints, PALS and Patient Experience Annual Report	Complaints, PALS, Patient and Carer Experience Lead	10:40-10:50	171
For discussion				
BREAK		Trust Chair	10:50-11:00	
PERFORMANCE				
12.	Integrated Performance Report	All Directors	11:00-11:15	187
For discussion				
13.	Maternity Assurance Report	Director of Midwifery	11:15-11:30	234
For approval				
14.	System Performance Report	Chief Finance Officer & Deputy CEO	11:30-11:35	247
For discussion				
COMMITTEE REPORTS			11:35-11:45	
15.	Audit and Risk Committee - 9/7	Chair of ARC		299
For noting				
16.	Finance, Performance and Planning Committee (FPPC) Report to Board - 23/7	Chair of FPPC		301
For noting				
17.	Quality and Safety Committee (QSC) Report to Board - 24/7	Chair of QSC		304
For noting				
18.	People and Culture Committee Report to Board - 16/7	Chair of People Committee		305
For noting				
OTHER ITEMS			11:45-11:50	
19.	Annual Cycle	Trust Chair		307
For noting				
20.	Any Other Business	Trust Chair		
For noting				
21.	Date of Next Meeting	Trust Chair		
Wednesday, 6 November 2024 - Online meeting				

East and North Hertfordshire NHS Trust

Minutes of the Trust Board meeting held online on Wednesday, 10 July 2024 at 9.30am.

Present:	Ms Anita Day	Trust Chair
	Mrs Karen McConnell	Deputy Chair & Non-Executive Director
	Dr David Buckle	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Ms Nina Janda	Associate Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Ms Theresa Murphy	Chief Nurse
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Dr Justin Daniels	Medical Director
	Ms Lucy Davies	Chief Operating Officer
	Mr Kevin Howell	Director of Estates and Facilities
	Mr Kevin O'Hart	Chief Kaizen Officer
	Mr Thomas Pounds	Chief People Officer
	Mr Mark Stanton	Chief Information Officer
	Ms Eilidh Murray	Director of Communications and Engagement
From the Trust:	Mr Namdi Ngoka	Associate Director of People Capability
	Ms Sylvia Gomes	Freedom to Speak Up Guardian
	Ms Alison Paterson	Deputy Divisional Director of Nursing & Quality for Cancer
	Ms Jennifer Godwin	Partnership Manager
	Ms Lesley Overy	Head of Midwifery (24/060a)
	Ms Kate Fruin	Divisional Director of Operations (24/060a)
	Mr Stuart Dalton	Head of Corporate Governance
	Mrs Debbie Okutubo	Deputy Company Secretary (Board Secretary - minutes)

No	Item	Action
	The Chair welcomed everyone to the meeting and commented that this was the first live streamed meeting of the Trust Board to ensure transparency to patients, staff and the wider community.	
24/065	**DECLARATIONS OF INTEREST** Mrs Karen McConnell, Deputy Chair & Non-Executive Director notified the meeting that she accepted the role of Chair at ENHPharma. There were no other new interests declared.	
24/066	**APOLOGIES FOR ABSENCE** There were no apologies for absence.	

East and North Hertfordshire NHS Trust

24/067 STAFF STORY

The Associate Director of People Capability introduced two doctors in training who joined the board for the staff story. They were Laura Mohan– Senior Clinical Fellow in Elderly care and Melody Talach - Langroudi – Foundation year 2. They shared their experience as doctors in training at the Trust, what it was like rotating into the Trust in terms of onboarding and why they decided on ENHT as a place to work/train.

Laura Mohan had been with the Trust for a year. She felt that it had a good culture of improvement and that the Executive listened to staff. She felt that generally that things worked well and hoped that it continued.

On matters that required improvement, she felt that car parking was a major one. Due to rotas, childcare and other responsibilities of the doctors, they found that when they got to the car parks as their shifts started at 8.30am there were no parking spaces. On Human resource (HR) matters, she gave an example of a personal experience where she had applied for a 12-month extension and felt that the HR process could have been better communicated and managed with all concerned.

Melody Talach-Langroudi - gave a personal experience of the lack of support when her mum died in January 2023. She was away on compassionate leave and when she returned, no emotional support was given. She was advised to contact bereavement support and that was all the support she got.

Another issue she raised was having nowhere to rest when they were not on the ward. She felt that the public transport to get to the Trust was inadequate; parking for staff as mentioned by Laura was very troublesome for them and that meant majority took taxis most of the time due to the unsociable hours that they needed to work.

On equipment, she suggested that it could be better managed which also applied to gaps in rotas not filled. She stated that things needed to improve.

Members were advised by the Associate Director of People Capability that the third doctor in training who was meant to attend had also raised concerns around the car parking but was unable to join the call due to logistical reasons.

When asked about the positives, Melody stated that the working relationships in Accident and Emergency (A&E) which was a multi-disciplinary team was good and there was a cohesive culture as everyone worked together for the care of the patients.

The Chair apologised on behalf of the board for Laura and Melody's bad experience.

Members thanked both Laura and Melody for being candid in their summations and apologised about the HR matter that Laura shared. The Board commented that it was certainly not the standard they were working to.

The Board was advised that there was a structured programme for doctors on the way placements were designed. At the national level, there was a piece of work that chief executives of Trusts had been made aware of which

would be discussed further when the resident doctors' representatives attended People and Culture Committee in the near future.

The Director of Estates and Facilities commented that work was ongoing in the staff car park and by September 2024, there should be an additional 50 to 60 car park spaces and the overflow car park in the garden centre would also be increased.

For clinical equipment, it was mentioned that tracking devices were being put on the equipment so that it was clear and we are able to identify where everything was. Equipment stores were also being established where clinical staff could pick up the required equipment.

The Board was advised that there was an Educational Supervisor and part of their role was to ensure that resident doctors had support including getting emotional support as and when required.

The Chief Executive thanked both resident doctors for sharing their experience and commented that there were some national challenges, but the Trust would look into what they had both shared.

In response to a question on how smooth they found the transition into ENHT, Laura commented that she joined 12 months ago and found the transition fairly smooth compared to some other places where she had worked, but her biggest issue was the contract extension.

Melody commented the onboarding went smoothly, including doing the ID checks on site at the Trust. The difficulty she found was when there were discrepancies in pay. She found the payslips difficult to understand.

The Chair thanked both Laura and Melody for attending and sharing their experiences and extended the board's appreciation to Sewa who had also made the effort to attend but could not due to logistical reasons. Lastly, the Associate Director of People Capability was thanked.

The Trust Board **RECEIVED** and **NOTED** the staff story.

24/068 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 1 May 2024 were **APPROVED** as an accurate record of the meeting.

24/069 ACTION LOG

The Board **NOTED** that the action on the log had been resolved and could be closed.

24/070 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

24/071 CHAIR'S REPORT

The Chair commented that she was glad that we were broadcasting on YouTube as it would improve our transparency with patients, staff and our community.

On the latest five-day resident doctors' industrial action, the Chair reiterated that the Board recognised and respected the rights of colleagues to take industrial action as they deemed it fit. She thanked all colleagues who stepped up to keep patients safe, and noted that the British Medical Association (BMA) was in conversation with the new Secretary of State for Health and Social Care to see how the industrial action could be resolved.

24/072 CHIEF EXECUTIVE'S REPORT

The Chief Executive presented his report. He outlined some of the highlights since the last board meeting under the four strategic priorities.

Quality

The Board was informed that the Care Quality Commission (CQC) had rated Hertfordshire County Council as good for its provision of Adult social care and congratulated them for that.

The Board were advised that Getting it Right First Time (GIRFT) team had been invited to the Trust to review the progress being made in emergency care to help shape our improvement programme.

Thriving People

Members were advised that the annual Thank You Week had occurred in the Trust and that they were looking forward to the annual staff awards, where excellence was celebrated. Lastly, at the annual rainbow run, £20k was raised.

Seamless service

The Board was reminded that a priority for the Trust this year was working with partners in community services, primary care and the voluntary and community sector to better provide care for those in our population affected by frailty.

Continuous improvement

The Board was advised that the fieldwork for our Orbis Electronic Patient Record (EPR) was continuing, and that Shella Sandoval had been appointed as the new Chief Nursing Information Officer.

Lastly, training in the ENH Production System was being rolled out across the Trust and staff were putting the tools they had learnt into practice. The Board were advised that the next area for targeted improvement focus had been selected and we would be running our next two improvement workshops in ophthalmology later this year.

The Chair agreed with the Chief Executive's comments on the ENHPS improvement work.

The Chair requested that the work on frailty should be shared with the Board at the appropriate time via status update.

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

East and North Hertfordshire NHS Trust

24/073 ENGAGEMENT STRATEGY

The Director of Communications and Engagement presented this item. The Board was advised that the strategy sought to address improvement in how the Trust listened to and involved our communities, to drive increased engagement in the areas as highlighted by the Care Quality Commission.

With the introduction of the East and North Herts Production System (ENH PS), it also sought to co-ordinate activity in co-production, across the Trust and in line with our system partners to avoid duplication.

The Board thanked the Director of Communication and Engagement for the strategy and asked how it would be applied. The Board also asked about patients who required assistance, including the blind and people who did not have English as their first language and how these issues would be addressed. In response it was noted that people who had extra requirements would have tailored information sent to them. The patient groups and charities would also be utilised to identify where there were gaps.

Members commented that it could be useful to see how things were done elsewhere and were pleased that we were reaching other communities that were not usually easy to reach.

It was noted that the good governance institute (GGI) had highlighted that engagement was a cross cutting theme and asked how the coordination would work.

In response, it was suggested that the Trust had regular ICB/system meetings. Also, that co-production work was ongoing and an example was given about the Trust working alongside the Council when visits were made to residents who were our patients at the same time as the Council was doing so.

The Chair thanked all members for their input and commented that this was a high-level strategy and implementation would come later

The Board **RECEIVED** and **APPROVED** the Engagement Strategy.

24/074 2023/24 STRATEGIC OBJECTIVES REVIEW

The Chief Kaizen Officer presented this item. The Board were informed that the Trust's performance benchmarked positively across a range of metrics throughout 2023/24 as reported through the NHSE Model Hospital Portal.

It was also noted that in addition, our elective recovery activities compared to pre-pandemic levels were reported in the top ten nationally, despite ongoing industrial action and wider pressures in urgent and emergency care pathways.

Members commented that the work being done through the ENHPS was permeating through the organisation and gave an example of Ward Managers across the Trust.

The Board was advised that there had been over 120 staff who had gone through the training and after six weeks, cohorts were invited to come back

to share what and how they had done things differently. It was stated that all feedback would be reported back at a later date.

Peter Carter, non-executive director commented that he had been on a ward round with one of the Executive Directors and found it to be a very good experience, in particular the fact that Ward Managers were budget conscious.

Members commented that what had been learnt would enable frontline staff spend more time with patients.

The Board **NOTED** the strategic objectives review.

24/075 FREEDOM TO SPEAK UP ANNUAL REPORT

The Freedom to Speak Up Guardian presented the annual report.

It was noted that there were increased speak- up cases. For 2023/2024 there were 270 speak up cases.

It was noted that most speak-up cases had been previously raised with line managers. As well as there being a good network of freedom to speak up champions.

It was suggested that staff were feeling confident that they were being listened to.

The Board was advised that the next step was to understand what training was needed for managers to support staff when they speak up. It was noted that the People Team were working on the competency for managers which would be rolled out once finalised.

It was reported that there were pockets in some divisions where concerns were being raised that would need to be targeted. The example was given of Mount Vernon Cancer Centre which was focused on last year and how it led to massive improvement which was evidenced in the staff survey carried out recently.

It was highlighted that it was planned to look at services where freedom to speak up issues were not being raised.

Regarding whistle blowing concerns raised in the maternity unit, it was noted that an external review had been commissioned.

Regarding the list of actions pertaining to patient safety concerns, members asked if there were processes, so that actions and recommendations could be actively implemented. The Freedom to Speak up Guardian commented that as part of the PSIRF launch group, part of the work being done was to implement some of the recommendations. Regular sessions were held with the divisions and reported into the People and Culture Committee. They also worked with the Associate Director of Capability and all reporting avenues formed part of the framework.

The Board **NOTED** the Freedom to Speak Up annual report.

East and North Hertfordshire NHS Trust

24/076 BOARD ASSURANCE FRAMEWORK

The Head of Corporate Governance presented this item. The board was advised that the 2024/25 BAF had been developed.

Risk 3, the system and internal financial constraints was discussed. It was noted that the Finance, Performance and Planning Committee (FPPC) discussed the potential ramifications of the system financial deficit risk to the Trust and recommended that the BAF Risk 3 (financial constraints) be amended to incorporate both the system and internal risk which had a current score of 12.

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

24/077 SUMMARY LEARNING FROM DEATH REPORT

The Medical Director presented this item. The Board was advised of the focus areas for improvement which included:

- Sepsis
- Stroke
- Emergency laparotomy.

In response to a question, it was noted that there were no significant concerns about the service therefore no need for an external review.

Members felt that coding was a critical element and asked if the mortality figures would change over time. In response, it was noted that the transition from our old in-house mortality review tool to using the SJRPlus tool and approach, presented a reporting challenge, as the data aligned differently. This might therefore change the figures slightly.

A member asked about cardiac mortality and when we would stop being an outlier. In response, the Medical Director agreed to respond to the member outside the meeting.

On emergency laparotomy, it was stated that we were doing reasonably well as there was a national audit looking at it and we had a high degree of the patients who were of the older age range.

The Board **RECEIVED** and **NOTED** the learning from death report.

24/078 INTEGRATED PERFORMANCE REPORT

The Executive Directors gave an update on their respective areas. Following the individual summaries members asked about the challenging work in the emergency department and how directors felt we would achieve the performance standards.

It was noted that Community Paediatrics sat at system level and we were working with the ICB on this. Work was being done on diagnostics on MRI capacity and there was assurance that work was taking place.

Karen McConnell, Chair, Finance, Performance and Planning Committee (FPPC) highlighted the financial challenges across the ICS and the challenges the Trust faced to remain within budget.

Val Moore, Chair, People and Culture Committee commented that it was good to see the sickness rate reducing. On the headcount rate, she commented that due to triple lock in-place and staff having to do mandatory training with no back fill, this would need to be managed properly.

Jonathan Silver, Chair, Audit and Risk Committee asked about not using international recruitment given the turnover rates. In response it was noted that it had not been cut off completely but still under review.

Members further commented that it was recently reported that midwives who had trained at the Trust had applied to become permanent staff members and found this news encouraging. There were also a good number of consultants who wanted to be part of ENHT.

Members commented on the front sheet and stated that they felt this enabled a more structured conversation.

The Board **RECEIVED** and **NOTED** the Integrated performance report.

24/078a MATERNITY ASSURANCE REPORT

The Director of Midwifery presented the item. The Board was advised that the unit was in year six of the NHSR maternity incentive scheme.

On digital transformation, the Board were advised that the proposed go-live date was on schedule for launch in July 2024.

Maternity Safety Support Programme - the Board were informed that representatives from NHS E, Local Maternity and Neonatal System (LMNS), and the Maternity and Neonatal Voices partnership (MNVP) undertook a site visit on 20 May in the form of a supportive review and assessment to advise whether the service was now in a position to commence the exit process from the maternity safety support programme (MSSP).

There were some strengthened areas and some areas that required improvement. The Director of Midwifery assured the board that plans had been developed to address the areas identified as requiring improvement.

Also, an assurance report would be prepared for the September Trust Board that would also be shared with the regional and national team with a recommendation to exit the programme.

The Chair commented that this was good progress on the inspection and wished them well with the digital transformation - EPR.

The Board **RECEIVED** and **NOTED** the Maternity Assurance report.

24/079 SYSTEM PERFORMANCE REPORT

The Deputy Chief Executive and Director of Finance introduced this item and commented that it was for information.

The Board **NOTED** the System performance report.

East and North Hertfordshire NHS Trust

BOARD COMMITTEE REPORTS

24/080 AUDIT AND RISK COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Audit and Risk Committee meeting held on 18 June 2024. The Board was advised that BDO the external auditors were yet to sign off the annual accounts.

24/081 FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and Planning Committee meetings held on 28 May and 25 June respectively.

The Committee Chair commented on the excellent piece of work on productivity and all the non-executive directors were encouraged to read the report.

24/082 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on 22 May and 26 June 2024.

The Chair commented that NICE notifications and the duty of candour were both being monitored.

24/083 PEOPLE AND CULTURE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the People Committee meeting held on 14 May 2024.

24/083a

REVIEW OF THE PEOPLE AND CULTURE COMMITTEE TERMS OF REFERENCE

The Committee Chair commented that the terms of reference was reviewed to accommodate the change in title to include the word culture.

The Board **APPROVED** the updated terms of reference.

24/084 CHARITY TRUSTEE COMMITTEE REPORT TO THE BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Charity Trustee Committee meeting held on 3 June 2024.

24/085 ANNUAL CYCLE

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

A Board member commented that the date should be agreed when the Safeguarding and Learning disability annual report would be presented.

24/086 ANY OTHER BUSINESS

The Chair commented that this was the final board meeting for Jonathan Silver and Val Moore. They were both thanked for their passion for the Trust, patients and staff and were wished well in their future endeavours.

It was noted that Val Moore would be taking up a role in ENH Pharma.

24/087 DATE OF NEXT MEETING

The date of the next meeting is 11 September 2024.

Ms Anita Day
Trust Chair
August 2024

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

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO September 2024

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
1 May 2024	24/060a	Maternity Assurance report	The team to look into the makeup of the future workforce.	This formed part of the work plan that went to the Quality and Safety Committee and is part of the report presented at this meeting.	Director of Midwifery	**September 2024** **Completed**

East and North Hertfordshire NHS Trust

Chief Executive's Report

September 2024

I outline some of the highlights from within the Trust since the last board meeting under our key strategic themes below.

Quality

Martha's Rule
The Trust has been selected as one of the first trusts in England to implement Martha's Rule – a new patient safety initiative to be rolled out in acute hospitals in England this year.

The implementation of Martha's Rule will provide a consistent and understandable plan for all acute hospitals, which gives seriously ill patients and their families easy access to a second opinion if their condition worsens and they feel they are not being listened to.

Martha's Rule expands on a Trust programme called Call 4 Concern, which was introduced in January 2024. It includes three components to ensure concerns about deterioration are responded to without delay.

- An escalation process enables patients and families to contact the Critical Care Outreach team (CCOT) who will assess patients and escalate care when they feel they need to do so.
- Staff will also have access to this same process if they have concerns about a patient's condition – this is already in place at the Trust
- Clinicians will formally record daily insights and information about a patient's health directly from their families, ensuring any concerning changes in behaviour or condition noticed by the people who know the patient best are considered by staff. This element will be introduced as part of the roll out of our new electronic patient record system next year.

Phoenix Room
We are pleased to announce the opening of a new designated space in the Lister Children's Assessment Unit (CAU) for families with children and young people (CYP) with a palliative or end-of-life condition, which has been named the Phoenix Room.

This new space will give families a comfortable and quieter area when at Lister, and can also be used by families with CYP who have special educational needs and disabilities.

The room was officially opened on Wednesday 21 August by the family of Charlie Farmer, who has been a young patient at the Trust for many years. Charlie's family have supported and campaigned for the space and wanted to name it the Phoenix Room to symbolise hope and strength.

A range of new equipment for the CAU has been purchased, including hand-held oxygen saturation monitors for the community children's nursing team, blankets and teddies for bereaved families, more reclining parent chairs in the CAU and a communication aid. The room also includes wheelchairs, a hoist and an ensuite.

The space has been beautifully painted and decorated by an artist in the local area.

Children's Urgent Treatment Centre
In addition to opening to adults earlier this year, our Lister Urgent Treatment Centre (sometimes called the UTC) is now open to children aged 1 year and above. This means that families have more options than ever when their child needs prompt, but non-emergency care.

The UTC is designed to care for non-life or limb-threatening conditions, such as minor burns, fractures, cuts, sprains, and infections. If a child has one of these conditions, the UTC is an excellent alternative to the Emergency Department, and patients are likely to be seen sooner. The UTC offers shorter wait times, skilled healthcare professionals, and a focus on minor injuries and illnesses, ensuring those that need emergency care are prioritised in our emergency department.

As the children's UTC is a new service, we are growing it slowly and safely. All parents of children who require medical attention are asked to attend our Children's Emergency Department first, where nurses will assess the care required and, if eligible, direct children to the UTC.

Carers of people with dementia
The dementia team recently offered a forum for carers of people living with dementia, where carers had the opportunity to give feedback about their experiences during their loved ones stay at Lister.

The team were given many positive examples of how our hospital is supporting our dementia patients, as well as areas where we can improve.

The team has introduced new dementia packs to all unplanned care wards at Lister, designed to improve the experience of people living with dementia during their inpatient stay.

These packs provide staff with everything they need to effectively care for someone living with dementia, including patient comfort booklets, the Admiral Nurse referral criteria, information on supporting carers and the Trust's dementia services leaflet.

Chemo at home award nomination
Congratulations to staff at Mount Vernon Hospital for being shortlisted as finalists in the Health Service Journal 'Medicines, Pharmacy & Prescribing Initiative of the Year' category!

This is for their brilliant work with Baxter on a scheme which enables breast cancer patients taking a type of drug therapy to administer the treatment themselves at home with an injection.

The team are also working on expanding the scheme in other tumour sites.

In a previous board meeting we heard from a patient whose life has been made easier through this initiative.

Thriving people

The Trust application for teaching hospital status remains with the Department of Health and Social Care. Due to the General Election this was paused during the pre-election period, and is due to be assessed for a decision now that parliament has returned from recess. We will provide an update to the Board as soon as we have any news.

During August we celebrated 25 student midwives who successfully attained qualified status and we are particularly delighted that, of those graduates, 23 will remain at the Trust in permanent roles.

Congratulations to the following individuals and teams for being shortlisted in the Nursing Times Workforce awards

Diversity and Inclusion Champion of the Year
Jan-Axle Enabore

Preceptorship Programme of the Year
The Trust Preceptorship Team

Overseas Nurse of the Year
Prabin Edayanattu Baby

Nurse Manager of the Year
Sister Arianne Joy Reyes – "AJ"

Preceptee of the Year
Nursing Associate, Aniisah Bibi Rostom

Inclusivity in Nursing and Midwifery
ENHT Carers Experience Programme

We wish you all the very best at the awards on Wednesday 23 October.

Seamless services

A priority for the Integrated Care System this year is a focus on patients affected by frailty with a particular focus on preventing avoidable admissions to hospital. Activity ranges from primary care based work to better support the prevention of falls through to schemes to offer alternatives to hospital admissions where appropriate. Ashwell Ward will be re-set as a Frailty Short Stay Unit from enabling a more seamless flow of frailty patients depending on their expected length of stay. The Frailty Team will control the beds meaning they will be able to control the flow between Frailty Assessment Unit and Ashwell.

We are in discussions with South Stevenage Primary Care Network to about the social prescriber in-reach model to support early and/or more robust discharges.

The Frailty Team has met with the Hospital and Community Navigation Service and will start referring simple discharges to the service to support reduced re-admissions. This is a replica of the Princess Alexandra Hospital model.

Continuous Improvement

The Trust's new online maternity hub aimed at digitalising maternity records – called My Pregnancy Notes – is now live.

The system creates a Maternity Electronic Patient Record (EPR) from the moment a woman presents for maternity care through pregnancy, birth and the postnatal period. It creates an electronic record which will enable conversations and updates between our clinicians and our service users, enabling parents to access information in real-time.

This could include information about a person's medical, pregnancy and obstetric history as well as any current risk factors and 24/7 access to important pregnancy information and resources.
The EPR website will also give service users access to information in their record and allow them to be involved in the decision-making process through a personalised care plan.

It is fully interactive and provides the opportunity to ask questions, create a birth plan and receive appointment reminders.

During the last month I have visited our children's emergency department and wards 7B, 6B and the Renal Intervention Treatment Area (RITA) as part of the positive leadership rounds which began last year and have developed as part of the ENH Production System (ENHPS) work. The purpose is for leaders to visit different areas across the Trust and see the improvements that are taking place. They are not about checking up – but supporting improvement and asking about any barriers and challenges.

The work on the ENH Production System is really gathering pace. For some it will still seem a bit distant, but we have already seen almost 300 people take part in the introduction to ENHPS training. That's 300 people who understand the background of the system, and the basic concepts of how we can begin to make small changes every day to improve. It really shows how this isn't just a new version of "management speak" but can make a real practical difference to your working lives and reduce the burden of work on you while benefiting our patients – whatever role staff hold. The introduction course has received really good feedback, and I know there are lots of staff now implementing the tools.

And leaders in the organisation have begun their ENHPS for Leaders programme – an extensive course which really goes into the detail of leading teams in the new way of working.

Adam Sewell-Jones
Chief Executive

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	9
Report title	Workforce Race Equality Standard (WRES) for ENHT			**Meeting Date**	11 September 2024
Presenter	Inclusion Diversity and Equality Manager				
Author	Inclusion Diversity and Equality Manager and Head of People Intelligence, Planning and Analytics				
Responsible Director	Chief People Officer			**Approval Date**	08.07.2024
Purpose	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

The purpose of this report is to:

1. Provide organisation's Workforce Race Equality Standard (WRES) data, including a brief analysis which highlights areas for improvement.

2. Recommendations on priority areas working towards Trust alignment with NHS People Plan, ENHT vision, EDI Strategy and People Team strategic priorities.

The Trust Board is requested to:

1. Approve and sign off WRES data
2. Review, discuss and approve the high priority areas for improvement

Impact: where significant implication(s) need highlighting

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

Delivering on the recommendations in this report has direct impact on our workforce turnover, the workplace culture in ENHT, our recruitment and will impact our ability to deliver safe care to our communities' safety and care outcomes.

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

CQC – well led standard.
Equality Act 2010
NHS Standard Contract

Report previously considered by & date(s):

July 2023

Recommendation	The Board/Committee is asked to discuss and approve this paper and the action plans.

To be trusted to provide consistently outstanding care and exemplary service

July 2024 WRES Report

East and North Hertfordshire NHS Trust

Workforce Race Equality Standard (WRES) Report 2024

1. Introduction and Scope

Since its introduction in 2015, NHS England's Workforce Race Equality Standards (WRES) programme has been providing direction and tailored support to the NHS, enabling organisations to continuously improve their performance. The WRES has required NHS trusts to annually self-assess against nine indicators of workplace experience and opportunity in relation to race, and to develop and implement robust action planning for improvement.

This report focusses on ENHT return, the national and regional data for 2023/24 will be available early autumn.

ENHT has committed to making anti-racism a reality[1], incorporating respect, dignity and human rights, and by ensuring equitable opportunities free from discrimination for people with protected characteristics as defined by the Equality Act 2010. Our ENHT EDI Strategy approved by the board in March has a comprehensive action plan on how we will be addressing local challenges on our journey to becoming a more inclusive organisation where everyone feels valued.

In accordance to our EDI Strategy, ENHT is committed to becoming a leading organisation in promoting equality, diversity, and inclusion in Hertfordshire, by creating a place where every person in our organisation is responsible for enabling an environment which is supportive, fair, and free from discrimination.

This report seeks to understand trends and patterns of inequality and outlines detailed information about our Black and Minority Ethnic (BME) staff, covering the period April 2023 to March 2024, and documents our progress, continuing work, and actions still to deliver equity in relation to the national NHS Workforce Race Equality Standard (WRES).

2. Context

The WRES contains nine indicators covering workforce data, national NHS Staff Survey results and Trust Board composition as follows:

1. Percentage of staff in each of the NHS pay bands 1-9, plus those on Medical & Dental and
   Very Senior Managers contracts (including Executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process
4. Relative likelihood of staff accessing non-mandatory training and CPD
5. Percentage staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (from NHS Annual Staff Survey)
6. Percentage staff experiencing harassment, bullying or abuse from staff in the last 12 months (from NHS Annual Staff Survey)
7. Percentage staff believing that the organisation provides equal opportunities for career progression or promotion (from NHS Annual Staff Survey)
8. Percentage staff having personally experienced discrimination at work from manager, team leader, or other colleagues in the last 12 months (from NHS Annual Staff Survey)

[1] Making anti-racism a reality, East of England Race Strategy 2021 (Appendix 1)

9. Percentage difference between the organisations' Board voting membership and its overall workforce.

All work undertaken in 2023/24 is underpinned by the People Strategy four pillars (Work, Grow, Thrive & Care together) and by working together through and with our BAME network (renamed Race Equity And Cultural Heritage (REACH) network) delivering the equity and inclusion agenda. The Trust continues to ensure our staff networks flourish, championing the principles of intersectionality, whilst delivering on the equity and inclusion agenda. As opportunities arise at Board and senior level, we will increase diversity. Our freedom to speak up guardian work and people policy reviews continue to support and enable staff to speak up about their experiences and to confidentially raise concerns to be addressed and resolved.

3. Our priority areas of focus 2023/24

Our approach this year has been to be as current as possible with our analysis and action plans. To support this mindset we have used the most up to date data from our WRES Data Collection Framework 2024 submission. This data has highlighted where good progress has been made and some priority areas for our attention. We have continued to do well in race disparity ratios for non-clinical workforce appointment in the band movement from lower to middle bands, middle to upper bands and lower to upper bands. There are also some areas to focus on that have been highlighted;

Priority areas as per our currently submitted data
Indicator 2: Relative likelihood of White staff being appointed from shortlisting compared to BME staff – ↑1.43
Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to White staff – ↑1.96
Indicator 8: Percentage of BME staff personally experienced discrimination at work from manager/team leader/other colleagues – 16.7% compared to 8.1% for white colleagues

Our 2023 WRES report shed some light on priority areas and we can report that there is on-going work on these with updates on setting up processes that will continue to effectively address the highlighted issues.

1. Continuous improvement on equity of access to development opportunities.
2. Increasing diversity at senior and board level roles.
3. Improve our standing on the likelihood of BME staff entering formal disciplinary processes compared to white staff.
4. Career progression in clinical roles has continued to be a challenge.
5. Co-create equitable, inclusive environments, recognise and appreciate differences through cultural change approaches.

4. Progress:

We have seen improvements in 1 and 2 above and the narrative is contained in section 4c-f below. However, as we acknowledge this good progress, there is more to be done to increase diversity at senior and board level. More inclusive recruitment practices with targeted positive action campaigns are supporting us improve. We recognise that priority 3 and 4 above, requires more zoned-in work to reduce the likelihood of BME staff entering disciplinary processes compared to white staff and reduce the career progression race disparity ratios in clinical roles for minority ethnic colleagues.

Clearly the checklist introduced as an interceptor and to provide more scrutiny before entering anyone through the disciplinary process is not having the desired impact …. yet. There is a need for more focused work, discussions and scrutiny before BME workforce are entered into the disciplinary process.

In relation to 5 above, Civility Saves Lives campaign is on-going, our Freedom To Speak Up guardian is well established with an increased number of cases and issues raised, mostly, anonymously. More work is required to create psychologically safe team environments that promote and support open, in-team sharing. We launched our Reciprocal Mentoring for Inclusion pilot cohort with plans to roll this our across the Trust in 2024/25. There is on-going work to redevelop core people policies and embed restorative justice practices appropriately within policies such as grievance and disciplinary and demystifying language in these policies is key. This should work to support our work in addressing point 3, above.

For 5 above we continue to triangulate staff survey results, complaints, and reported incidents to identify teams where cultural change approaches are needed and we have provided a range of interventions and support these areas; an example – the multi-professional work on cultural improvement in Women and Maternity teams cultures. In the last year we have delivered extensive workshops on Civility Saves Lives. We are embedding our ENHT values – Include Respect and Improve, with team ownership of team charters, bringing the values to life, supported by the Healthy Leadership Programme, on-going team talks on staff survey results with locally developed and owned actions. Our staff networks and the events both celebrate and challenge us in this space.

The 2023 WRES report outlined a comprehensive delivery work plan combined with and the above demonstrates delivery of some of this work and the deliverables for 2024 – 2025 are outlined in the section 7 of this report.

5. Current Workforce Race Equality Standard (WRES)

a. ENHT data from 2020/21 to 2023/24 is shown in the table below and narrative for ENHT 2023-2025 is set out **in 4c-g** below.

b. WRES comparison regional and national data 2023 is the most up to date currently available

Workforce Race Equality Standard (WRES) Indicators	East & North Herts (ENHT) WRES Data						WRES Comparison to Regional & National Data	
	Staff	ENHT 2020/2021	ENHT 2021/2022	ENHT 2022/2023	ENHT 2023/2024	ENHT WRES Progress in comparison to last year	East of England WRES 2021/2022	National WRES 2022/2023
	White	59.60%	56.70%	55.20%	53.36%	Increase in Workforce Diversity	69.90%	-
WRES 1 – Overall workforce % by Ethnicity	BAME	32.60%	34.50%	37.70%	40.84%		25.30%	26.40%
	Unknown	7.70%	8.80%	7.10%	5.81%	Improvement	4.80%	-
WRES 2 - Relative likelihood of White staff being appointed from shortlisting compared to BME staff		1.32	1.39	1.34	1.43	Further work to be done	1.96	1.59
WRES 3 - Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		2.25	1.41	1.47	1.96	Further work to be done	1.11	1.03
WRES 4 - Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff		1.22	1.37	0.86	0.80	Improvement	1.01	1.12
WRES 5 - Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months		BAME 30.6%	BAME 34.6%	BAME 32.2%	BAME 27.0%	Improvement	BAME 30.6% White 28.1%	BAME 30.5% White 26.9%
		White 25.9%	White 30.4%	White 32.2%	White 27.4%			
WRES 6 - Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months		BAME 32.7%	BAME 31.1%	BAME 30.8%	BAME 26.8%	Improvement	BAME 27.6% White 24.7%	BAME 27.5% White 21.7%
		White 25.1%	White 26.5%	White 26.5%	White 24.9%			
WRES 7 – Percentage of BME staff believing that Trust provides equal opportunities for career progression or promotion		BAME 69.9%	BAME 49.2%	BAME 50.2%	BAME 51.1%	Improvement	BAME 56.8% White 45.5%	BAME 46.7% White 59.4%
		White 83.8%	White 55.0%	White 54.7%	White 54.4%			
WRES 8 - Percentage of BME staff personally experienced discrimination at work from Manager/team leader/other colleagues		BAME 19.6%	BAME 16.8%	BAME 15.8%	BAME 16.7%	Further work to be done	BAME 17.8% White 7.7%	BAME 16.4% White 6.6%
		White 7.2%	White 7.4%	White 8.9%	White 8.1%	Improvement		
WRES 9 - Percentage of voting members of the Board representation by ethnicity	BAME	0.0%	8.3%	0.0%	9.1%	Improvement	-	15.6%

c. WRES Data Key Findings

The overall representation of minority ethnic staff is 40.8% and has continued to increase year on year. However, when analysing the data further this representation is varied across different professions: health care sciences, nursing & midwifery and scientific and technical roles are at or above 37%; allied health professionals sits at 42% whereas admin and clerical roles have 18% representation with medical and dental at 55%.

It remains the case that all data sets show better representation in lower band roles. For roles at 8A and above there has been an increase, however not yet meeting the model employer targets. In the last 12 months changes in board and VSM roles has impacted the level of representation with the appointment of the new Trust chair improving the minority representation for voting members at Board level. Though it should be noted that both our board and VSM share other protected equality characteristics. A particular current opportunity exists to attract and encourage BME candidates to apply to support ENHT increasing board representation.

d. WRES Indicators 1-4

White staff are 1.43 times (approx. 6.7%) likely to be appointed from shortlisting, compared to minority ethnic staff. This gap has increased from 1.34 times in 2022/23. We are working with our system colleagues together with our own workforce to implement initiatives that will positively and sustainably impact this data set. Data shows more minority ethnic staff are applying for senior roles, are successful at the shortlisting stage demonstrating minority ethnic workforce keenness to progress to senior roles, yet not as successful in securing senior roles. Work continues with initiatives to support bridging this appointment gap. We are working with colleagues across the ICS to understand how we can effectively bring inclusive improvement in our minority representation in senior roles. The 90-Day Challenge initiative from the national team started in June 2024 to showcase initiatives with positive impact this indicator. There is an ICS-wide agreed item on all job descriptions setting out behaviours required around equality, diversity and inclusion alongside an inclusivity commitment statement and clear essential criteria on diversity and inclusion, tailored to band role started in the 2022/23 reporting cycle. Analysis on success of the 90-Day Challenge will happen in due course and be available in the wider update to board in Q3 (autumn/winter) reporting.

There has been a steady increase since 2020/21 figures on likelihood of minority ethnic staff experiencing formal disciplinary procedures. We continue to utilise a checklist introduced to determine whether any disciplinary case, regardless of ethnicity, has merit in progressing to formal stages. Other work continues to better understand the processes and behaviours between managers and staff by supporting managers and staff to explore and resolve tension and conflict through psychologically safe facilitated conversations. We will be setting up an EDI Steering Committee to review EDI trends across the Trust and promote active discussion, support and accountability within teams for the triangulated EDI data metrices from WRES, WDES, Staff Survey, Gender Pay Gap and all other measures we have. We are also going to set up an EDI dashboard to showcase all the EDI information and make it easy to review and analyse trends, prompt discussions and the joint-leadership and team accountability for the work environment at ENHT. EDI Steering Committee to be set up by October 2024 and to present initial report to the People Committee by end of 2024. Availability of EDI dashboard will highlight trends and guide the transparency of EDI Steering Committee discussions.

The relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff metric has improved significantly from 1.37 in 2021/22 to 0.80 in 2023/24. This directly reflects work undertaken to increase the importance of development for all and focus on ensuring

CPD opportunities and apprenticeships are promoted across the organisation with staff networks utilisation, discussions during Grow Together Reviews, follow up 1:1 discussions and other informal channels e.g., targeted email cascades of developmental opportunities via Practice Educators.

e. WRES Indicators 5-8

Overall, there is an improving decrease of minority ethnic workforce experiencing discrimination at work from a manager/team leader or other colleagues - metric 5 to 7. However, minority ethnic workforce continue to suffer higher rates of discrimination – double the rate White staff endure, as shown in metric 8. Metrics of indicators five to eight are represented in the staff survey results.

Work will continue to educate our staff and communities on incivility and its impact whilst also ensuring accountability. Our Civility Saves Lives film is being used externally, we had team charters to follow on our refreshed our Trust values, encouraging and building confidence for all our staff to hold each other to account on uncivil behaviours within teams. As we increase psychological safety in the workplace, we should start to see an increase in staff's ability to positively advocate for others, through active allyship supported with the introduction of EDI champions initiatives within teams. We have also started the roll out of the management competency framework where work on equality diversity and inclusion is a key component and is aimed at building cultural intelligence and improved line management practices.

f. Model Employer

Model Employer targets were set in 2018 over a 10-year period through to 2028 and the NHS People Plan 2020 set an ambition to increase senior leader representation by 2025 to equate to either the organisational or community percentage, whichever is highest.

In ENHT the overall representation of Black, Asian and minority ethnic workforce currently sits at 40.8% as of March 24 compared to 19.2% in the Hertfordshire County.

Progress is being made with greater proportionate representation at AfC band 8A and 8B less so at bands 8C, 9 and VSM. Transparency and professional breakdown of this data is a key step towards understanding the current situation and the challenges towards working to achieving inclusive model employer goals. Professional breakdown data shared in the appendix highlights areas that need active focus and action. There is need to be proactively more inclusive, reconsider our structural and procedural barriers. This needs on-going, co-designing and working together with a committed leadership team and our minority ethnic workforce. It needs looking beyond operational changes to systemic debiasing of our recruitment and promotion processes enabling cultural and transformational changes, for example, consider monitoring access to stretch/secondment opportunities in divisions by protected characteristics.

ENHT continues the improvement journey and our mission of providing high quality, compassionate care to our community, with an inclusive proportionately represented workforce at all levels of the organisation's leadership aligned to the communities we serve or workforce percentages, (whichever is higher).
The tables below show targets and our data as at April 2024 and progress against targets:

Model employer targets set over 10 years

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Band 8a	29	31	33	36	38	40	42	44	46	49	51
Band 8b	11	12	12	13	13	14	15	15	16	16	17
Band 8c	12	12	12	12	12	12	12	12	12	12	12
Band 8d	0	1	1	2	2	3	3	4	5	5	6
Band 9	1	1	1	2	2	2	2	2	2	3	3
VSM	0	1	1	2	3	4	4	5	6	6	7

Year on year comparison (from band 5)

	Sep-20	Sep-21	Sep-22	Mar-23	Mar-24	Movement from Mar 2023
Band 5	525	579	646	702	774	+72
Band 6	307	317	374	415	447	+32
Band 7	145	153	166	192	214	+22
Band 8a	38	46	50	57	62	+5
Band 8b	18	19	19	18	17	-1
Band 8c	11	11	10	10	10	0
Band 8d	5	5	8	8	7	-1
Band 9	1	1	1	1	0	-1
VSM	0	2	0	0	2	+2
TOTAL	**1050**	**1133**	**1274**	**1403**	**1533**	**+130**

Performance against target

BAME STAFF IN POST	Mar-24	Model Employer Targets	Target Met?
Band 8a	62	42	Y
Band 8b	17	15	Y
Band 8c	10	12	N
Band 8d	7	3	Y
Band 9	0	2	N
VSM	2	4	N
TOTAL	**98**	**78**	**80%**

The tables demonstrate in March 2024 we meet and exceeded set role model employer targets across grades 8a; 8b and 8d. More work is required at Band 8c, 9 and VSM representation.

The Trust has managed to recruit a new Chair and a non-exec director from minority ethnic background.

6. Areas of Focus and review of Actions 2023/24

Within the Healthy Culture Team, the EDI manager holds overall responsibility for highlighting challenges and bringing in best practice for inclusion within the Trust as delegated by the Chief People Officer with overall Chief Executive Officer accountability. This is delivered with support from and through staff networks, the People Business Partners, Employee Relations Advisory Service team, wider People team along with active support from senior leadership and wider workforce engagement. All work in this space leans heavily on and must include data analytic collaboration with the People Intelligence, Planning and Analytics team (PiP) to share granular divisional/departmental data details on all the EDI reports. There is need to consider continued analysis of our medical WRES and temporary workers (NHSP WRES) data.

EDI objectives historically have been set in view of metrics from various available data such Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), Gender Pay Gap (GPG), themes from NHS Staff survey, qualitative input from staff Networks, as we now move to a more holistic approach to deliver and embed sustainable changes aligned to the Trust's EDI Strategy and the National EDI improvement action plan, shown in the diagram below.

Looking ahead 2024/25

Our priority areas are well set out in our responsive and live EDI Strategy aligned to the NHS EDI improvement plan. We will triangulate all our data and have a single document tracker with areas of concern, action plans and with quarterly updated progress. Progress on these will be reviewed regularly and reported on.

NHS equality, diversity, and inclusion improvement plan
https://www.england.nhs.uk/wp-content/uploads/2023/06/B2044_NHS_EDI_Workforce_Plan.pdf

High-impact actions

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

The table below shows the work undertaken over the last year and into the remainder of 2023/24 on our WRES.

WRES Action Plan Update and Plans for 2023/24

Objective	Actions	Metrics	Updates at July 2024	RAG rating
Equality, Diversity and Inclusion training To increase the view of BAME staff believing that trust provides equal opportunities for career progression or promotion	First steps towards - Leading inclusively with Cultural intelligence Plans to launch Reciprocal Mentoring across the wider Trust in a different format from the pilot offer to ensure wider impact and scaling up across the Trust. Create data base of mentors ICS and Inclusive Career Development Programme for BME and Disabled members of staff Engaging on Regional Maternity/Neonatal Equity & Inclusion Ambassador scheme Diversity in Health and Care Partners programme Restorative Just Culture – engagement with Mersey Care NHS FT	**WRES 8 -** Percentage of BME staff personally experienced discrimination at work from Manager/team leader/other colleagues **WRES 2** - Relative likelihood of White staff being appointed from shortlisting compared to BME staff **WRES 4** - Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff **WRES 7** – Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion **WRES 5 & 6** - Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months / Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months	• Pilot Reciprocal mentoring completing in July 2024. Evaluation and setting next steps on launching this offer across our Trust to be shared. • Two Maternity/Neonatal Equity and Inclusion Ambassadors identified, now working to secure allocated time to focus on EDI matters in Maternity and Neonatal areas. • Specific development programmes from system and national shared widely informally and formally to increase up take by colleagues. • Have EDI champions and active by-standers in all teams. Encourage regular team discussions on team charters application within teams. • Targeted team support highlighting uncivil behaviours and early proactive addressing of	**Green** **Amber – Green** **Amber -Red** **Amber – Green** **Green**

			issues by team members and line managers. • Head of ERAS trained in restorative just culture, wider sessions planned with more colleagues to be trained in restorative just culture.	
Inclusive recruitment Ensuring fairness in recruitment and selection process with attention given to employee life cycle. To have an inclusive representative workforce that reflects the community served or the workforce percentages, whichever is higher.	Positive action and practical support for candidates Accountability and assurance framework in recruitment reviewed Secondment policy to be created and ratified, soon to be published, to support equity in opportunities within the Trust Onboarding and induction seamless and consistent for all Board representation and 8D increase in diversity	**WRES 1** – Overall workforce % by Ethnicity **WRES 2** - Relative likelihood of White staff being appointed from shortlisting compared to BME staff - Relative likelihood of White staff being appointed from shortlisting compared to BME staff **WRES 7** – Percentage of BME staff believing that Trust provides equal opportunities for career progression or promotion **WRES 9** - Percentage of voting members of the Board representation by ethnicity	• Introducing more accountability for appointing managers on their duty of care for the shortlisted applicants with effective constructive feedback and developmental gaps discussion for the appointed applicants together with support on how to address all the above. Appointing managers to be held accountable and randomly selected interviewees to feedback their experience to the EDI Steering Committee, People Committee and the Trust Board. Recurrent trends and impact to be analysed. • Recruitment and Selection Training continues with greater focus on ED&I & values-based recruitment, including unconscious bias, job descriptions, person specifications and adverts. • A new guide on Recruitment and Selection to be launched by Autumn to support managers. Considering making this training	**Green** **Green** **Green – Amber (work to communicate required)** **Green** **Amber- Red**

			mandatory for all appointing managers. • Secondment Policy launched April 2023 with review of all current secondments. • Improved induction in place since Feb 2023 and review of e-learning underway throughout year • Vacancy arising at board provides opportunity for a more representative team.	
Engage on Anti-Racism strategy Reducing uncivil behaviour and raising awareness of discrimination in all forms, and creating advocates and allies across the workforce Reducing incidents of discrimination and experience of bullying and harassment in the workplace measured through staff survey which has remained at double the experience of White staff since 2020/21 .	Delivery of Civility Saves Lives programme and staff values charters for local teams Board representation and 8D increase in diversity	**WRES 5 & 6** - Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months / Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months **WRES 5 & 6** - Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months/ Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months **WRES 8** - Percentage of BME staff personally experienced discrimination at work from Manager/team leader/other colleagues	• Values team talks and Civility Saves Lives for awareness and behaviour change continues within teams. • Public notifications promoting our Trust values from all who use and work at ENHT highlighting that non-compliancy will be addressed swiftly and effectively, including reporting to the Police, where necessary. • EDI Steering Committee via the EDI dashboard to monitor trends – to highlight these, discuss, support and hold individuals and leaders to account on the cultures within teams. • Peer reviews of team charter relevancy and application to be launched to ensure continued updating and team discussions. • Continued opportunity to increase representation at	**Green** **Green** **Amber**

			board into 2023/24 due to vacancies and tenures expiring	
EDI Strategy approved by the Trust board in March 2024. **EDI policy to be reviewed at Trust Partnership July 2024.** The above documents result from a co-production approach with staff side and staff networks and all relevant stakeholders to ensure its effectiveness, inclusivity, and sustainability. To increase morale and engagement – by creating a better feeling of inclusion and belonging where people are happier, more productive and deliver better quality care with positive outcomes for patients/service users.	On-going restorative just culture training and work to be embedded across the Trust aiming to reduce the likelihood of minority workforce entering formal disciplinary process compared to white staff.	**WRES 3** - Relative likelihood of BME staff entering the formal disciplinary process compared to White staff **WRES 5 & 6 & &** - Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives, staff or managers in last 12 months **WRES 8** - Percentage of BME staff personally experienced discrimination at work from Manager/team leader/other colleagues	• EDI Strategy action plan aims to work with all teams to reduce minority ethnic colleagues experiencing harassment, bullying or abuse from any source by setting up an EDI Steering Committee with a Central Investigations Team to review all cases needing to enter disciplinary processes. • Reviewing and ensuring all Investigating Officers have the relevant training to be able to support investigations effectively and objectively. • Having active EDI Champions within teams, active allies/by-standers. • Sharing of lived experiences from all available resources within teams for impact awareness, discuss learning, support health working environments for all whilst also enforcing accountability.	

Appendices

Appendix 1: Making Anti-Racism a Reality

https://www.england.nhs.uk/east-of-england/nhs-east-of-england-equality-diversity-and-inclusion/antiracism-strategy/

Appendix 2: Role Model employer data broken down by occupational groups

https://www.enherts-tr.nhs.uk/wp-content/uploads/2024/04/EDI-Strategy-2024_V10.pdf

Appendix 2: Representation by staff group @ March 2024

Healthcare Scientists

Banding	BAME		WHITE		Not Known		TOTAL STAFF
	Headcount	%	Headcount	%	Headcount	%	
Band 4	1	33%	2	67%		0%	3
Band 5	22	67%	8	24%	3	9%	33
Band 6	33	61%	18	33%	3	6%	54
Band 7	20	37%	29	54%	5	9%	54
Band 8A	3	15%	15	75%	2	10%	20
Band 8B	2	29%	5	71%		0%	7
Band 8C	1	20%	4	80%		0%	5
Band 8D		0%	2	100%		0%	2
Total	**82**	**46%**	**83**	**47%**	**13**	**7%**	**178**

Allied Health Professionals

Banding	BAME		WHITE		Not Known		TOTAL STAFF
	Headcount	%	Headcount	%	Headcount	%	
Band 5	37	61%	21	34%	3	5%	61
Band 6	64	51%	52	41%	10	8%	126
Band 7	32	28%	76	67%	6	5%	114
Band 8A	7	23%	18		5	17%	30
Band 8B	1	17%	5	83%		0%	6
Band 8C		0%	1	100%		0%	1
Band 8D		0%		0%	1	100%	1
Total	**141**	**42%**	**173**	**51%**	**25**	**7%**	**339**

Professional & Technical

Banding	BAME		WHITE		Not Known		TOTAL STAFF
	Headcount	%	Headcount	%	Headcount	%	
Band 3	1	33%	2	67%		0%	3
Band 4	10	77%	3	23%		0%	13
Band 5	31	46%	32	48%	4	6%	67
Band 6	30	48%	30	48%	2	3%	62
Band 7	15	45%	17	52%	1	3%	33
Band 8A	18	45%	18	45%	4	10%	40
Band 8B	4	50%	4	50%		0%	8
Band 8C	2	40%	3	60%		0%	5
Band 8D	2	67%	1	33%		0%	3
Band 9		0%	1	100%		0%	1
Total	**113**	**48%**	**111**	**47%**	**11**	**5%**	**235**

Admin & Clerical

Banding	BAME		WHITE		Not Known		TOTAL STAFF
	Headcount	%	Headcount	%	Headcount	%	
Band 2	37	15%	191	78%	17	7%	245
Band 3	49	14%	297	82%	16	4%	362
Band 4	79	18%	353	79%	17	4%	449
Band 5	35	26%	95	70%	6	4%	136
Band 6	22	20%	86	78%	2	2%	110
Band 7	18	23%	56	71%	5	6%	79
Band 8A	20	31%	43	66%	2	3%	65
Band 8B	9	24%	27	73%	1	3%	37
Band 8C	5	13%	32	82%	2	5%	39
Band 8D	4	25%	12	75%		0%	16
Band 9		0%	11	85%	2	15%	13
Trust Pay	2	15%	11	85%		0%	13
Total	**280**	**18%**	**1214**	**78%**	**70**	**4%**	**1564**

Nursing & Midwifery

Banding	BAME		WHITE		Not Known		TOTAL STAFF
	Headcount	%	Headcount	%	Headcount	%	
Band 5	641	73%	184	21%	54	6%	879
Band 6	292	43%	359	53%	29	4%	680
Band 7	129	30%	280	66%	15	4%	424
Band 8A	14	15%	74	81%	3	3%	91
Band 8B	1	5%	19	95%		0%	20
Band 8C	2	33%	3	50%	1	17%	6
Band 8D	1	33%	1	33%	1	33%	3
Band 9		0%	2	67%	1	33%	3
Trust Pay		0%	1	100%		0%	1
Grand Total	**1080**	**51%**	**923**	**44%**	**104**	**5%**	**2107**

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	9.1
Report title	Workforce Disability Equality Standard (WDES) for ENHT			**Meeting Date**	11 September 2024
Presenter	Equality and Diversity Manager				
Author	Deputy Chief People Officer and EDI team				
Responsible Director	The Director who has vetted the paper as fit for purpose			**Approval Date**	11 Sept 2024
Purpose *(tick one box only)*	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

The purpose of this report is to:

1. Highlight ENHT progress on equality and inclusion at local and system level.
2. Provide organisation Workforce Disability Equality Standard (WDES) data, including a brief analysis which highlights areas for improvement.
3. Recommendations as to priority areas which align with NHS People Plan, ENHT Vision and People Team strategic priorities, to deliver and drive forward the equity and inclusion agenda .

The Trust Board is requested to:

1. Approve and sign off WDES data
2. Review, discuss and Approve the high priority areas for improvement

Impact: where significant implication(s) need highlighting

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

Benefits of meeting and delivering recommendations in this report indirectly link to a number of organisational BAF risks, turnover, recruitment and absence levels.

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

CQC – well led standard
Equality Act 2010
NHS Standard Contract

Report previously considered by & date(s):

July 2023 Board

Recommendation	The Board is asked to discuss and approve this paper.

To be trusted to provide consistently outstanding care and exemplary service

July 2024 WDES Report

East and North Hertfordshire NHS Trust

Workforce Disability Equality Standard (WDES) Report 2024

1. Introduction

In 2019 NHS England, with its partners, prioritised its commitment to tackling discrimination and the Workforce Disability Equality Standard (WDES) came into force. It contains 10 metrics to compare the experiences of disabled and non-disabled staff, which is then used to implement action plans. The Trust is required to submit the data set using the national format.

In 2023/24 we identified several high priority areas for improvement as part of our ED&I objectives designed to drive positive change towards equity and inclusion underpinned by strategic priorities from the People Directorate as well as the Trust mission, strategic themes, and vision for 2030 this report updates our progress on these priorities.

2. WDES Metrics and context

The 10 metrics of the WDES are set out here for clarity and context of the report:

1. Percentage of disabled staff in the workforce
2. Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts.
3. Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance
4. Relates to Q14a-d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse
5. (Relates to Q15 in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. (Relates to Q11e in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
7. (Relates to Q4b in the NHS Staff Survey): Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
8. (Relates to Q30b in the NHS Staff Survey); Questions are related to staff with Long Term Conditions (LTC): Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.
9. (Relates to the staff engagement theme of the NHS Staff Survey, made up from Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d in the NHS Staff Survey); Questions are related to staff with Long Term Conditions (LTC), the staff engagement score for disabled staff, compared to non-disabled staff.
10. The percentage of the board's membership who have declared a disability

3. WDES Metrics and performance

During 2023 work has continued and our performance overall in our WDES metrics requires continued focus to generate further improvement. We are seeing the benefit from our refreshed staff network ENH Able and this has hosted a range of big conversations with external speakers and explored different challenges for staff with a range of disabilities, alongside this in March 2024 our EDI strategy 2024 – 2026 was published.

The WDES metrics data below shows our performance since 2021/22. For the latest data set we have seen steady improvements around metrics 5, 6, and 7 this has been instigated in part by a focus from ENH Able to highlight via network meetings and trust communication channels support available to staff and line managers around reasonable adjustments, our Employee Assistance Programme and NHSEI work around ESR declaration.

	East & North Herts (ENHT) WDES Data					
Workforce Disability Equality Standard (WDES) Indicators		**ENHT**	**ENHT**	**ENHT**	**ENHT WDES Progress in comparison to last year**	**National WDES 2022/23**
		2021/2022	**2022/2023**	**2023/2024**		
Metric 1 - % of disabled staff in the workforce	**Cluster 1: AFC Bands under 1, 1, 2, 3, and 4**	Non-Clinical = 4.0% Clinical = 3.0%	Non-Clinical = 4.8% Clinical = 3.2%	Non-Clinical = 5.5% Clinical = 3.7%	Improvement	4.9%
	Cluster 2: AFC Bands 5, 6 and 7	Non-Clinical = 4.1% Clinical = 2.0%	Non-Clinical = 4.9% Clinical = 2.8%	Non-Clinical = 4.9% Clinical = 3.2%	Improvement	
	Cluster 3: AFC Bands 8a and 8b	Non-Clinical = 2.2% Clinical = 1.0%	Non-Clinical =3.0% Clinical = 1.9%	Non-Clinical = 5.7% Clinical = 1.8%	Improvement for non-clinical Clinical requires improvement	
	Cluster 4: AFC Bands 8c, 8d, 9 and VSM	Non-Clinical = 0% Clinical = 0%	Non-Clinical = 1.4% Clinical = 3.0%	Non-Clinical = 7.4% Clinical = 3.2%	Improvement	
	Cluster 5: Medical and Dental staff, consultants	Non-Clinical = n/a Clinical = 0%	Non-Clinical = n/a Clinical =0.25%	Non-Clinical = n/a Clinical =0.9%	Improvement	
	Cluster 6: Medical and Dental staff, non-consultant career grades	Non-Clinical = n/a Clinical = 0.48%	Non-Clinical = n/a Clinical = 1.52%	Non-Clinical = n/a Clinical = 3.5%	Improvement	
	Cluster 7: Medical and Dental staff, trainee grades	Non-Clinical = n/a Clinical = 1.46%	Non-Clinical = n/a Clinical =0.75%	Non-Clinical = n/a Clinical = 1.4%	N.B: The EoE Deanery is responsible for recruitment and placement of doctors in training.	
Metric 2- Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all post.		1.6	1.23	1.26	Requires Improvement	0.99
Metric 3- Relative likelihood of non-disabled staff compared to disabled staff entering the formal capability process on the grounds of performance.		0	0	0	No Change	2.17

Metric 1 demonstrates our continued work is showing positive progress in our workforce representation. The most progress has happened for bands 8a and above in the non-clinical roles. In part, this is due to increased confidence to share protected characteristics and combination of our approaches on inclusive recruitment, we continue to use inclusive language and encourage people with protected characteristics to work with ENHT. Further work is required across bands 5, 6 and 7, where there is stagnation and in clinical roles at bands 8A and 8B where there is a slight decline in representation.

The table below shows the national data taken form the 2023 staff survey benchmark average, we indicated last year that metric 4 (relating to staff experiencing bullying and harassment in the workplace) required further work. This year we are beginning to see improvement, the work that has contributed

to this includes; values teams charters continuing to be implemented; refreshed people policies; encouraging staff to speak up; some historical issues being managed to conclusion as well as an increased support available through FTSU and ambassadors, and the staff network supporting raising awareness of differences.

Whilst we have improved in each of the elements in metric 4, we remain above the national WDES average, and our ambition is to match the national benchmark whilst aiming to continuously improve our work environment for all at ENHT. We will continue our work on creating a workplace that is psychologically safe, that enables individuals to be themselves and flourish in work.

	East & North Herts (ENHT) WDES Data					
Workforce Disability Equality Standard (WDES) Indicators		**ENHT**	**ENHT**	**ENHT**	**ENHT WDES Progress in comparison to last year**	**National WDES 2022/23**
		2021/2022	**2022/2023**	**2023/2024**		
Metric 4 (Relates to Q14a-d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	Patients/Service users, their relatives or other members of the public	With LTC = 38.4% Without LTC = 30.5%	With LTC = 39% Without LTC = 30.4%	With LTC = 33.61% Without LTC = 25.11%	Improvement	33.2%
	Managers	With LTC = 21.6% Without LTC = 12.9%	With LTC = 22.3% Without LTC = 12.3%	With LTC = 17.08% Without LTC = 10.78%	Improvement	16.1%
	Other colleagues	With LTC = 32.4% Without LTC = 19.8%	With LTC = 32.6% Without LTC = 20.5%	With LTC = 26.6% Without LTC = 18.9%	Improvement	24.8%
	Percentage of Disabled staff saying they or a colleague reported the harassment/bullying or abuse.	With LTC = 47.2% Without LTC = 46.0%	With LTC = 49.7% Without LTC = 47.1%	With LTC = 50.2% Without LTC = 49.1%	Improvement	51.3%
Metric 5 (Relates to Q15 in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.		With LTC = 42.1% Without LTC = 55.6%	With LTC = 46.7% Without LTC = 54.3%	With LTC = 46.9% Without LTC = 54.6%	Requires Improvement	52.1%

Metric 5 above is stable and reflects our inclusive recruitment practices of anonymised and positive action is taking effect, we now need to bring in other initiatives for continued significant improvement and further action to be above average for ENHT to meet the national WDES survey

In metric 6 below we have achieved the national average that staff with a long-term condition do not feel pressured to come to work when they are not feeling well enough and we are seeing an increase in requests and confirmation of a variety of different flexible working patterns, which all contribute to this improvement.

	East & North Herts (ENHT) WDES Data					
Workforce Disability Equality Standard (WDES) Indicators		**ENHT**	**ENHT**	**ENHT**	**ENHT WDES Progress in comparison to last year**	**National WDES 2022/23**
		2021/2022	**2022/2023**	**2023/2024**		
Metric 6 (Relates to Q11e in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		With LTC = 38.2% Without LTC = 26.2%	With LTC = 33.2% Without LTC = 22.3%	With LTC = 27.7% Without LTC = 21.2%	**Improvement**	27.7%
Metric 7 (Relates to Q4b in the NHS Staff Survey) Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.		With LTC = 31.7% Without LTC = 45.7%	With LTC = 28.3% Without LTC = 43.0%	With LTC = 32.0% Without LTC = 44.8%	**Improvement**	35.2%
Metric 8 (Relates to Q30b in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.		-	71.7%	73.7%	**Improvement**	73.4%

Metric 7 shows a significant improvement, whilst still below the national average, The Trust is making great strides to ensure everyone counts, which is our underlying message in our EDI strategy approved by the Trust board in March 2024 and now available on the Trust website.

In relation to metric 8 above we are continuing to encourage on-going two-way conversations utilising our person-centred annual Grow Together Review and the regular one to one conversations covering 'what matters to me' discussions and honesty about health and long-term conditions. We will continue this in the coming year with the development of clearer guidance on how access to work can support with adjustments in the workplace, this is also reflective in metric 10, where specific focus at senior board level around feeling safe and able to declare characteristics has improved this measure for ENHT.

The table below shows metric 9 has moved positively upwards and reflects ongoing work related to metric 4, 6 and 8 above. Metric 10 has opportunity to improve with vacancies arising at Board level and plans to introduce a shadow board in 2024.

	East & North Herts (ENHT) WDES Data					
Workforce Disability Equality Standard (WDES) Indicators		**ENHT**	**ENHT**	**ENHT**	**ENHT WDES Progress in comparison to last year**	**National WDES 2022/23**
		2021/2022	**2022/2023**	**2023/2024**		
Metric 9a (Relates to the staff engagement theme of the NHS Staff Survey, made up from Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) The staff engagement score for Disabled staff, compared to non-disabled staff.		With LTC = 6.26 Without LTC = 6.98	With LTC = 6.26 Without LTC = 6.84	With LTC = 6.40 Without LTC = 6.91	**Improvement**	6.4
Metric 10 - The percentage of the board's membership who have declared a disability	**Voting Membership of the Board**	0%	0%	27%	**Improvement**	5.6%
	Non-Voting Membership of the Board	0%	0%	0%		6.1%
	Executive Membership of the Board	0%	0%	11%		5.4%
	Non-Exec Membership of the Board	0%	0%	29%		6.0%

The action plan from 2022/23 mapped against the WDES and with updates are listed below:

Update on WDES action plan 2022/23

Objective	Actions	Metrics	Updates in July 2023	RAG rating	Update June 2024
Career progression for staff with disabilities To support the progression of staff with disabilities to ensure representation across the whole workforce and achieve year on year increase in percentage number of staff with disabilities progressing within agenda for change bands.	ICS Inclusive Career Development Programme for BME and Disabled members of staff – first cohort Sep 2022 and continues '**Share your story' / Case studies** of disabled members of staff with across different grades/professions and publicised widely	**WDES 1** Percentage of staff in AFC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with percentage of staff in the overall workforce **WDES 5** Percentage of Disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion.	As, part of deaf awareness week we shared staff stories of disabled staff and what support is available via the leadership forum. A wider, regular rhythm of stories in trust news or on the Knowledge Centre	Green Green	As part of Learning at Work Week, there was a focus on staff sharing their experiences via an online webinar of the ICDP, this was recorded for wider sharing and for those unable to attend on the day. We, are still promoting and recruiting colleagues to join this programme. New cohorts are advertised via our Trust News and through discussions with team leaders to support and encourage uptake from their team members that could benefit from this.
	Develop Career Development Programme with focus on disabled members of staff linking with Talent Management and Grow Together conversations - **WDES Innovation funding application**		Via the 2022 staff survey the score on this metric has been improved from 42.1% to 46.7%. However, despite having staff on initial cohorts the promotion of the programmes due to review of internal capacity has slowed progress.	Green Green – Amber	Increase in promotion via Trust Comms and Learning at Work Week has led to more uptake in the programme. There is more structured career development support/talent pool for alumni from HWEICS to move to senior AfC banding.

	Embed Quality Improvement methodology with aim of driving improvement.		More work needs to be done in promoting inclusive career development programme for staff in the system between bands 2/4 and bands 5/7		
Reasonable Adjustments To achieve year on year increase in percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Review the process, how the fund is accessed and the marketing of the scheme to build awareness and utilisation. Share summary take-up report with Equality & Inclusion committee. Targeting staff that may need reasonable adjustment fund support e.g., cohort of staff who were shielding. Engage with relevant stakeholders and discuss implementation of training such as Public Sector Equality Duty. Creating an ambition to become Disability Confident Leader by 2023- ensuring initiative such as Project Search and other schemes are being embedded in our organisation when appropriately.	**WDES 3** Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure **WDES 6** Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. **WDES 8** Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	The wider work around the reasonable adjustment passport has stalled due to network chair leaving, will be recommenced in August 2023. Project Search is planned for 2024 September start. Exec sponsor is Lucy Davies and there is a core working group linked in with ICS work. Next step is for Project Search to update on the education partner and for expression of interest forms to be sent out to teams to host a placement.	Amber – Green Green Amber – Green Green Amber – Green	Promotion via the network of our new EAP (Employee Assistance Programme) and trust reasonable adjustment support as part of ENH Able's regular rhythm. Discussions around reasonable adjustments passport and induction support for line managers re-started and looped into trust line management competencies training. ENH Able network has 1:1 Meeting with colleagues factored in to support personal discussions and awareness of members and line managers. This is a response to what the ENH Able members requested.

		WDES 9 The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	We are also waiting on a new EDI Lead to ensure the process is all running smoothly on the ground. The score around reasonable adjustments from the staff survey is slightly below the national acute average Engagement score has stayed the same compared to last year.	Amber	Provider is now North Herts College we have 2 Interns starting in September and they will be based at our Hertford County Hospital site undertaking Portering and Reception/front of house (FOH) admin work, respectively. Plan is to increase awareness for all and provide reassurance of our transparency in our recruitment process and promoting of another avenue to raise concerns in a safe way.

Culture Change **To secure an increase in the number of staff reporting disability on ESR** and narrowing the gap in their reported experience of working at ENHT compared to all staff by third quarter of year 2023 (measured by staff survey & ESR Data))	Disability Equality Awareness Training to be incorporated into Recruitment & Selection training for hiring Managers Understand impact of COVID-19 on disabled members of staff by working with wellbeing team to guide our actions/response. To drive the quality of the inclusive recruitment and selection process To complete the review of recruitment & selection process with 3 priority areas identified as follows: a) Train more Inclusion Ambassadors. b) Recruitment & Selection Training for hiring managers. c) Advertising job opportunities to the wider communities d) assurance on reasonable adjustment and guarantee interview scheme	***WDES 1** **WDES 2** Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts. ***WDES 9**	There has been an increase in FSTU representation and wider work in the system around making the interview process more inclusive for applicants, with a slight change in our wording on Trac to be in line with the system. More work needs to be done around disability equality awareness training and reviewing the guaranteed interview scheme	Green Amber – Green	Skill booster training programmes for staff and improved representation in Freedom to Speak Up (FTSU) champions and Inclusion Ambassadors (IA)

	Health, wellbeing, and diversity conversations into the appraisal process to empower and support staff. Continued support for staff returning from long term sickness Launch **'Ability Not Disability'** campaign and start with teams taking part in education about matters that affects disabled members of staff Celebrating Difference Events such as Day of Persons with a Disability	**WDES 7** Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work ***WDES 9**	Via staff survey this metric has decreased by 3% Ability not disability campaign to be scoped and launched. Stalls for disability history month and international day of disabled people.	Amber Red Green	Campaign yet to launch and will be scoped with the new co-chairs and ENH Able as part of network performance indicators and through Grow Together conversation to empower and support colleagues. During 2024/5 to also learn from other organisations with higher ESR disability declaration rates. However, have looped in with NHSEI regional ESR campaign. Month-long events for disability History month and a regular rhythm of network events on topics like ESR declaration.

Dignity at Work The experience of bullying, harassment, and abuse within the workplace.	Reviewing relevant work-related Policies (Dignity at work, Disciplinary, Reasonable adjustment) Finalise and Launch the Use of **Disability Passport** embedded/recorded by Health at Work Team Process and ESR by December 2022.	***WDES 4** **a)** Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives, or other members of the public ii. Managers iii. Other colleagues **b)** Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Increase via staff survey in staff reporting bullying or harassment and very slight increase in the instances of bullying and harassment	Amber – Green	Improved FTSU champion representation.

Inclusive Recruitment Practice Ensuring fairness in recruitment and selection process with attention given to employee life cycle.	Continuing to strengthen governance of the Equality and Inclusion process with a focus on strengthening our leadership narrative, embedding delivery within sites and corporate functions, and setting aspirational and achievable annual goals that we can strive to achieve. Disabled Members of Staff Network Chair and ED&I team continue to link and presenting on Staff Experience Groups & People Committee Working with Regional and National teams on new initiatives and opportunities for key areas that we aspire to develop.	***WDES 1** ***WDES 2** ***WDES 5** **WDES 10** Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated • By voting membership of the Board By Executive membership of the Board.	We have seen green shoots with executive backing for project search and work around the ICS career development programme We now have new co-chairs in place and are looking to create a mission statement for the network and action plans by Sept/October 2023.	Green Green	New exec sponsor for the network, Internship programme ready to go ahead for September 24 and improved declaration at exec and board level. New regular rhythm of events in place and networks on pager for next year started.
Equitable representation in entering Capability process To enable proportionate representation of Disabled staff compared to non-disabled staff entering the formal capability process.	Targeting staff who may need Reasonable Adjustments Fund support Deep dive into data to identify any themes relating to poorer experiences and outcomes for disabled members of staff. A review related policies and procedures through	***WDES 3**	This work is a priority to scope and commence before end of 2023/24 fiscal year	Amber	Discussions around reasonable adjustments passport and induction support for line managers re-started and looped into trust line management competencies training

	Equality, Diversity & Inclusion lens to include the lived experiences of disabled members of staff.				

4. **Conclusion**

ENHT continues with an honest evaluation of its WDES. There have been small and sustained improvements with focus on actions that count. Evaluation of delivery will continue to take place in collaboration with the wider Healthy Culture team, people partners and EHN Able staff network with the aim of continuing to improve staff engagement and experience of staff with disabilities.

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	10
Report title	**Quality Account 2023/24- Update**			**Meeting Date**	11 September 2024
Presenter	Chief Nurse				
Author	Associate Director of Governance (interim)				
Responsible Director	Chief Nurse			**Approval Date**	June 2024
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

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.

The processes for producing Quality Accounts remain the same as previous years, with the following exceptions to NHS providers:

•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 2023-24.
• 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; 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 has been amended for this year, as noted below.
• Integrated care boards (ICBs) have assumed responsibilities for the review and scrutiny of quality accounts. ICBs must clarify with providers where they are expected to send their quality account.

Organisations are also reminded that schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires "a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account".

The Quality and Safety Committee (QSC) approved the final version of the Quality Account on 26 June ahead of publication on 28 June 2024.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability

1

CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources	
Legislative requirement.	
Risk: *Please specify any links to the BAF or Risk Register*	
Links to the BAF - Quality and Governance risks. Providing assurance on the previous year.	
Report previously considered by & date(s):	
N/A	
Recommendation	To note and endorse the approval of the Quality Account 23/24 and publication

To be trusted to provide consistently outstanding care and exemplary service

2

June
2024

East and North Hertfordshire
NHS Trust

Quality Account 2023-24

Contents

Part one

1.1 Chief Executive's Foreword

Much of my and the board's focus over the last 12 months has been on the implementation of the ENH Production System – the Trust's new partnership with the world-renowned Virginia Mason Institute which will place the patient at its centre and focus on a safety culture, reducing waste, and improving the experience of both patients and staff.

I know first-hand the positive impact this process has on health and care systems and I'm looking forward to seeing the improvement projects begin to take shape across our sites. This 2023/24 Quality Account will outline our achievements over the last 12 months, will identify where improvements could be made and will shape our future continuous improvement plans to be delivered through the ENH Production System.

In 2023/24 we published the Trust's Patient Safety Incident Response Framework (PSIRF) plan and policy, which has included recruiting our first patient safety partner who will support us with enabling safer systems within the Trust. We also introduced better standardisation and oversight of quality through ENHance – providing ward to board oversight of key quality priorities such as risk management, incidents, compliance, claims and requests. ENHance not only enables us to capture and respond to incidents, but also enables us to learn from good care. Through our good governance review we have also re-designed our risk management processes and, through an improvement programme, have seen a gradual reduction in the number of overall risks.

I'm delighted that our Friends and Family Test scores improved across all areas in 2023/24 and, even with the ongoing challenges, feedback from our emergency department has improved by 4% from last year. The dedication of our maternity colleagues has also been highlighted by the results of the 2023 CQC maternity survey, where we were the most improved Trust and performed significantly better on 15 questions compared to last year.

We continue to put patients and their loved ones at the heart of what we do – in 2023 we developed our offer for patient carers, providing them with much needed support whilst their loved one is in hospital; we also implemented the new Call 4 Concern service where inpatients and their loved ones at the Lister can ask for a second opinion if they have concerns about their care.

Despite the successes we have experienced, it's important to recognise the areas where we need to improve. This includes working with our partners in the community to focus on ensuring the timely discharge of patients, making use of Hospital at Home where clinically appropriate and continuing to reduce the amount of time patients are waiting in our emergency department. As an organisation we are committed to making these improvements, working closely with our staff and service users.

I'd like to take this opportunity to thank all those who have worked hard to ensure we can continue to provide high-quality compassionate care for our communities.

Adam Sewell-Jones

Chief executive

comms

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.

1.2.1 Refreshed Trust Values

Our values underpin everything we do and describe 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.

1.2.2 Clinical and Quality Strategy, 2019-2024

Our Quality Strategy has continued to support the continuous improvement journey toward an ‘East and North Herts Trust' quality management system. The successful procurement of a single Improvement Partner will enable a systems approach to manging quality. These will continue to build on the current quality objectives (see below).

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:

1. Valuing the basics
2. Keeping our patients safe
3. Good governance
4. Patient experience
5. Staff capability

Priorities identified through the strategy 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.

1.2.3 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 NHS Trust. The people strategy details plans based on four key pillars - work, grow, thrive and care. Despite the changing background and environment in which we are operating, the people strategy set out at the start of 2020 is still fit for purpose and is a key enabler for the Trust in delivering its strategic priorities.

Integrated business and workforce plans highlight what, where and how we as an organisation will focus on key areas to enable change in delivery models, workforce composition, including the types of roles needed in the future to meet the demands of the community we serve. These are aligned to the NHS Long Term Workforce plan and People Promise requirements.

1.2.4 Organisational Structure

The Trust has four operational divisions. These are women and children, planned care, unplanned care and cancer services. Each division has a divisional medical director, who is a senior clinician, a divisional nursing and quality director, and an operations director. This triumvirate structure is replicated at specialty level.

Supporting our clinical divisions are corporate teams covering areas including finance, business information and planning; digital; medical practice, education and research; nursing practice; estates and facilities; transformation, workforce organisational development, communication and engagement.

Part two: Priorities for improvement and statements of assurance from the board

2.1. Progress with 2023/2024 priorities

Quality Priorities 2023 to 2024		
Domain	**Description**	**Key Focus Areas**
Effective	Excellent responsiveness Learning from incidents	Reduce unwarranted variation. Oversight of quality Good governance
Safe	Valuing the basics	Quality Fundamentals • Medication management • Sepsis pathway compliance • Safer invasive procedure standards • Deteriorating patients • Safeguarding adults and children • VTE risk assessments
Well Led	Good governance	Oversight of quality Good governance framework
Patient Experience	Respect patient's time	Improving discharge processes Waiting lists

In 2023/2024 opportunities to build knowledge on quality improvement methodologies continued through the successful procurement of a single improvement partner. A sustainable governance framework will support the Trust's new operational management model structures.

The Trust has also published the patient safety incident response plan and policy. We have recruited the first patient safety partner; this role is key to supporting recruitment and development of more patient safety partners to co-design improvement and enable safer systems within the Trust.

Effective: The Trust has supported the standardisation and oversight of quality through introducing a digital system platform called 'ENHance'. This platform allows ward to board oversight of key quality priorities such risk management, incidents, complaints, NICE compliance, Claims and Inquests, Policy Compliance, Clinical Audits and key Nursing Quality Indicators. Audits and feedback can be captured in real time on handheld devices and data sets are triangulated and provide ability to link information across different domains.

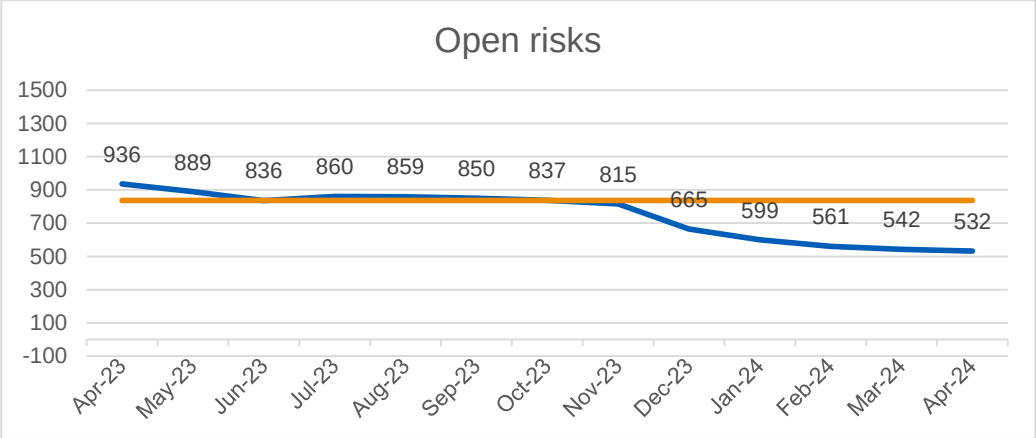
Safe: The Trust has published a Patient Safety Incident Response Plan and Policy. This has achieved compliance towards key National Safety Standards. This change has also enabled the new national Learning from Patient Safety Events (LfPSE) reporting criteria to be embedded and has provided the opportunity to report and learn from episodes of good care and excellence. Good care is analysed for themes and trends and shared in equal measures as patient safety incidents.
Some examples of good care have been:

A patients grandma told me how pleased the mum was after Sharon assisted with feeding support. The mum had been reluctant to start pumping, however Sharon discussed the options with mum and she was much happier.

Preoperative Assessment team identified new symptoms possibly related to a patient's AAA whilst conducting a preoperative phone call. They urged the patient to attend ED and escalated to the vascular surgical team. The patient was assessed, deemed to have impending rupture and successfully operated on.

The nurse listed below has been highlighted for utilising the sepsis screening tool effectively. Consistently performing the screening assessment and completing it accurately on Nerve centre. We have also seen increased use of the digital fluid balance chart. Through consistent use of the tool, we can see that patients are receiving good sepsis care aiding with preventing further deterioration and meeting the NICE guidance on sepsis

Well led: The Trust commissioned a good governance review to enable progression and strengthening of board oversight and assurance. Risk management processes have been redesigned, following the publication of our 2023 risk management strategy. An improvement program has been delivered in 2023/24 that has seen a gradual reduction in the overall number of risks. This remains a priority for 2024/25.



Patient Experience: The Trust saw a significant improvement in the CQC maternity survey 2023. The Trust performed significantly better on 15 questions; there was no significant difference on 38 questions, and we were not significantly worse on any questions making us the 'most improved trust'. We have included seven results in our action plan to improve our services.

2.2.1 Quality Domain: Effective

Quality Domain: Effective

Priority 1: Build quality improvement (QI) capability and capacity:

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

Quality improvement methodologies supported services lead transformation through collaborative partnership working.

Our priority for 2023/24 has been to work towards achieving substantive improvement partner. Following a competitive procurement process through 2023/24 the organisation is very proud to have now engaged with Virginia Mason Institute (VMI) and their client partner, Surrey and Sussex Healthcare NHS Trust (SASH) as our improvement partners over the next three years. As partners VMI and SASH will co-design and support our implementation of a Quality Management System (QMS), allowing us to learn from their proven expertise and experience.

We have chosen VMI as they work with various healthcare systems across the globe, including the NHS, winning multiple awards and accreditations. SASH was one five trusts involved in an NHSI collaboration with VMI, as part of their journey they moved from one of the worst performing trusts, to been rated as 'outstanding' by the CQC.

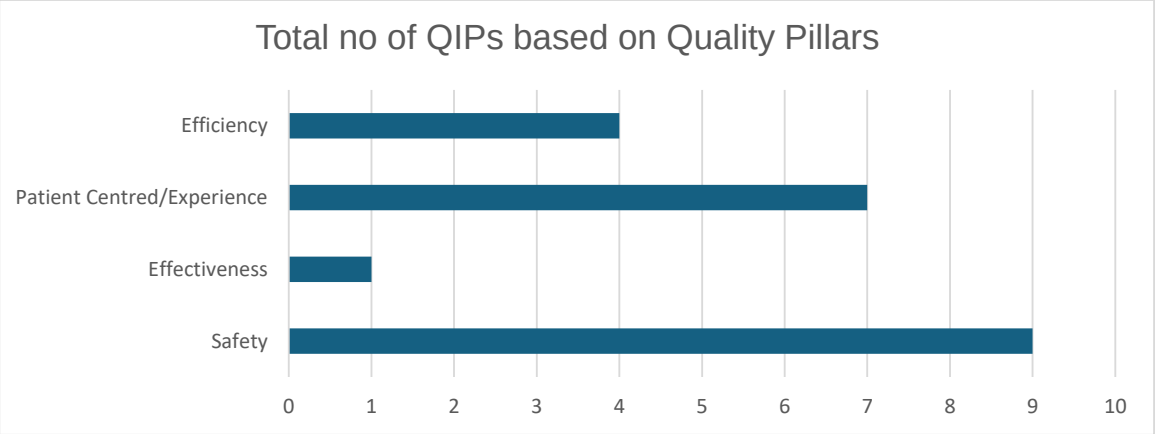
In 2023/24 the quality improvement team successfully delivered a programme of building improvement skills and knowledge through teaching and coaching and by demonstrating the impact of the methodology through running safety programmes for

harm free care and the deteriorating patient. Multiple curriculum offers through coaching clinics and bitesize teaching session were delivered through 2023/24.

The Trust successfully delivered a fourth cohort of our Clinical Leadership Programme through external accreditation by the Royal College of Nursing (RCN). The programme is a one-year curriculum delivered to 20 clinical leaders across nursing, midwifery and therapy teams to develop leadership skills through the lens of leading quality improvement initiatives.

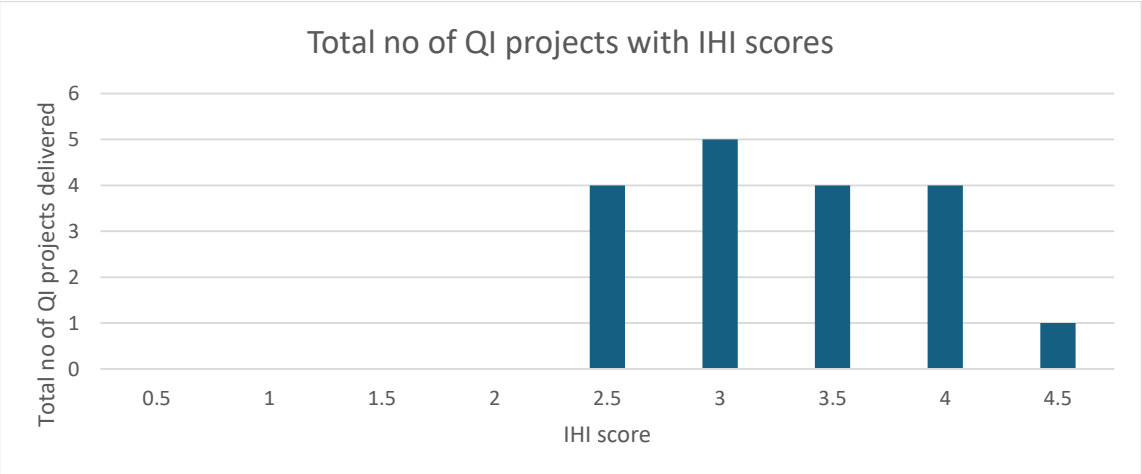
Most of our participants this year are in second-tier line management positions with a few first line management positions. All QI projects (QIPs) impact a defined quality pillar (see table 3).

Table 3: Total number of QIPs based on quality pillars



78% (14/18) of QIPS have demonstrated modest to sustainable improvements with rest of them still in the testing phase (see table 5).

Table 4: Total number of QI projects measured against an Institute for Healthcare Improvement (IHI) project score.



As we progress with our new improvement partner, we are re-designing a three-year capability building plan for all staff. This will be published in early 2024/25.

Progress on our communication plans and celebrations
Local recognition awards are now in place and a specific category celebrates 'Improvements' through monthly nominations. Each month multiple 'improve' nominations are submitted and winners are recognised through celebratory leadership briefings and thanked by our senior executive team.

National recognition was also celebrated during the year. See table 5 below:

Table 5: Team and individual awards and wins for 2023/24

Commendations/Conferences/Presentations	**Team/Individual winners and finalists**
HSJ Patient Safety Congress, 2023	Faith O'Donoghue
East of England, Stroke Forum, 25 July 2023	Julia Sartorius, Stroke therapy team
NHS Fab Awards, December 2023	• ENHT QI Team, Fab QI team Award Winner • Faith O'Donoghue – Deteriorating patients QI project, Fab QI Individual award, Highly commended. • Jan-Axle Enabore – Improving Carer Support at ENHT, TNT Award, Highly commended. • Elizabeth Hale – Same Day Emergency Care In-reach team to improve patient care, Penguin Award – Winner • Faith O'Donoghue – Deteriorating patients QI project, 4 Candles Award, Winner • Mirriam Adey – Reducing HbA1c related cancellations for surgery in pre-op assessment, Hartley Larkin Award, Winner • Sharne Byrne – Here to improve patient experience post discharge in ED, 4 Candles Award, Nominee

In summary, the previously established QI coaching clinics, QI cafes and newsletters have enabled us to build readiness in preparation for the next phase of sustained continuous improvement with our improvement partner.

Other key highlights
In June 2023, the Trust's QI team have supported the co design and development of our newly launched Herts and West Essex QI ICS network (HWEQI network). We also successfully hosted a QI webinar in February 2024 sharing best QI practices across our local ICS network. During the course of the year, we have continued to support the recruitment of patient safety partners as part of our national requirement for meeting the National Patient Safety Incident Response Framework (PSIRF) and were involved in supporting the design and implementation of each of the four PSIRF work streams throughout last year.

Plans for 2024/25 Continuous Improvement

- Work with our improvement partner, Virginia Mason Institute (VMI), in the ongoing development of our new improvement method – the East and North Herts Production System.
- Achieve certification and accreditation for our new Kaizen Promotion Office.
- Roll-out new training and education programmes across all levels of the organisation to increase knowledge, awareness, and capability in our new improvement method.
- Establish a series of value streams to target incremental improvements using Rapid Process Improvement Workshops and Kaizen Events.
- Implement leader rounds to embed and sustain continuous improvements, led by those that do the work, where the work is done.
- Introduce daily management processes and standard work across wards and departments to foster a culture of continuous improvement.
- Ongoing network learning and sharing of best practice across the Integrated Care System.

Nursing Excellence
The Clinical Excellence Accreditation Framework (CEAF) was revised in April 2023. The revised CEAF now contains two parts. Part one is aligned to the CQC compliance standards and includes 71 fundamental standards of care. Part two includes standards relating to 'clinical excellence'. Wards will only progress to part two of the framework when a minimum of 85% of all fundamental standards of care are achieved. All 71 fundamental standards of care must be achieved, and the 'clinical excellence' part of accreditation completed, to become an accredited ward.

All adult and paediatric inpatient wards have commenced the accreditation framework. A formal assessment is undertaken to demonstrate compliance with the fundamental standards of care. This includes observation of practice, talking to staff and patients, reviewing documentation and performance/compliance data and reviewing the CEAF staff survey responses. Significant progress has been made to embed fundamental standards of care within all inpatient areas across the Trust. At our first panel meeting Barley ward were successful in achieving over 85% compliance with the standards and have progressed onto part 2 of the framework.

Embedding fundamental standards of care

- Development of the audit steering group for nursing, midwifery and allied health professionals.
- Digitalisation of nursing audits and key performance indicator dashboards.
- Monthly CEAF progress meetings with ward managers and focus groups to agree specific actions to improve fundamental standards of care and sharing of good practice.
- Review of organisational progress with the Pathway to Excellence programme, in line with our designation requirements.

2.1.2 Quality Domain: Safe

Quality Domain: Safe

Priority 2: Keeping our patients safe

Reason: Part of our quality goals within the Trust's quality strategy- valuing the basics and keeping our patients safe (2019-2024)

Our priority for 2023/24 has been to work towards achieving:

2.1.2.1 Sepsis

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 claims the lives of at least 52,000 people and costs NHS £2 billion through claims.

Aims:

- Achieve >95% in sepsis pathway compliance
- Achieve 50% compliance with reliability of all observations
- Improve Physiological Observation Assessment Competencies for nursing staff
- Roll out patient status at a glance (PSAAG) dashboards on all wards

Compliance to date:

Sepsis pathway compliance

	Aim	**Achieved**
Antibiotics in Emergency Department (ED) within an hour	>95%	83%
Antibiotics on the ward within an hour	>95%	64%
Neutropenic sepsis antibiotic within an hour	>95%	67%
ED Sepsis six bundle	>95%	60%
Inpatient (IP) Sepsis six bundle	>95%	37%

Compliance with achieving timely delivery of the sepsis pathway bundle continues to be an improvement priority. Individual elements of the 'sepsis six' have shown fluctuating compliance, however improvements have been targeted at achieving more reliable fluid balance monitoring. Changes to improve this have included the transfer of fluid balance documentation to the same digital platform as observations, and now fluid balance management is mandatory. Looking at the year, sustained improvement is noted particularly in the Emergency Department (ED) during Q4. Inpatient areas' compliance rates are in response to smaller sample size in comparison to ED. In order to push for improvement a sepsis task and finish group

has been implementing quality improvement projects to strive for better sepsis management. Some of these projects have included rolling out the SBARD communication tool as well as the digital implementation of mandatory fluid balance for all patients with NEWS2 above 5 or 3 in one parameter. These changes have seen improvement in fluid balance compliance across the Trust and we will be looking to now sustain this going into 2024/25.

Our key focus in 2023 was devising and implementing a digital sepsis screening tool which was rolled out in the summer across adult settings. This tool is designed to aid in sepsis compliance and clear documentation of sepsis management, which is something which has been absent since the Trust documentation became digitalised. It is being discussed and taught in all teaching sessions provided by the team.

Education and Training
The team have continued to focus on optimising sepsis education. The team regularly deliver sepsis sessions at Trust inductions, at team times and have spent three months providing weekly sepsis sessions in ED/AMU. The team have delivered a varied range of education (formal, informal, face to face, teams and simulation) and continues to cover sepsis during BEACH (Bedside Emergency Assessment Course for health care assistants) sessions alongside the critical care outreach team (CCOT) and resus teams. 2024 will see the introduction of sepsis/acute kidney injury (AKI) link nurses across the Trust with study days for link nurses happening in May and June. Through having link nurses across the Trust it is hoped they will aid the team in championing improved sepsis management and therefore compliance. Mandatory sepsis e-learning is live on ENH academy and is currently being updated by the team to reflect latest guidance released in February 2024. Multi-disciplinary sepsis/AKI simulation sessions have been hugely successful since their introduction in 2023 and are an education resource we are aiming to continue to utilise further throughout the upcoming year. Sepsis refresher sessions have also been delivered to medical junior doctors and surgical junior doctors as well as repeated sessions to the frailty team which has been well received with further sessions planned across the year.

2.1.2.2 Venous thromboembolism (VTE) risk assessments

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.

Aims:

- Achieve >95% compliance with VTE risk assessment stage 1 and 2 by March 2024
- Embed digital risk assessment platform into clinical practice.

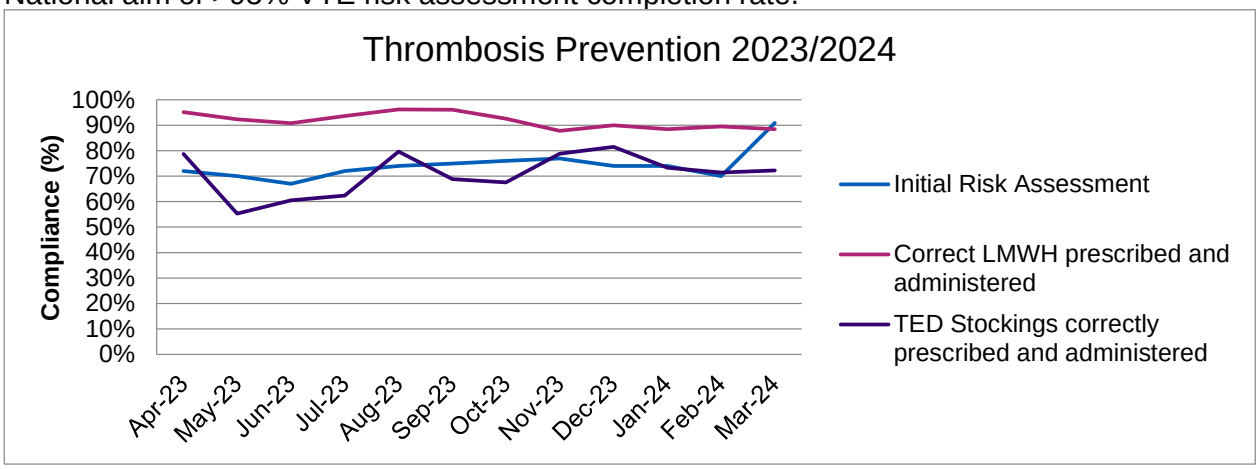
Achievements to date:
As per our Trust guidance, the initial risk assessment is completed on admission or by the time of the first consultant review (within 24 hours). Subsequent risk assessments are completed when the patients' clinical condition changes.

VTE risk assessments were audited regularly via the digital system producing weekly data at the speciality, ward and consultant level. Reporting is presented at ward and divisional meetings and at the Trust's Thrombosis Action Group which reports to the Patient Safety Forum and subsequently into the Quality and Safety Committee.

The graph below demonstrated the Trust performance against the audit criteria throughout the year. The March data set was pulled later in the month resulting in higher VTE compliance for March than expected.

Figure 1: Audit data of clinical area's compliance with VTE prevention 2023/2024.

National aim of >95% VTE risk assessment completion rate.



At the beginning of the financial year 2023/2024 the Trust rolled out digital reporting which allowed for robust data, better oversight, real time feedback and targeted quality improvement (QI) work. Correct prescribing and administration of low molecular weight heparin (LMWH) continued to be maintained above 85%. In June 2023, Trust guidance moved in line with VTE Exemplar Centre guidance to focus on timing of risk assessments, with the first on admission and subsequent as clinical condition changes, removing the requirement for a second reassessment within 24 hours. The Trust focused on quality improvement to increase risk assessment compliance from generally below 70% in 2022/2023 to achieve greater than 70% from July 2023 onwards following implementation of the updated guidance.

Root Cause Analysis (RCA) investigations are undertaken when potential hospital associated thrombosis (HAT) cases are identified. The learning is then fed back through the Trust's Thrombosis Action Group then disseminated through various channels including areas like quality huddles, FY1/FY2 training sessions and Trust rolling half days. This financial year saw a comparative percentage of preventable HATs to the previous financial year, 2022/2023. In 2023/2024 there were 14 potentially preventable HATs, one of which was declared an incident and was reviewed in line with the PSIRF, sparking a full system and process learning review.

Thrombosis prevention improvement work is one of our harm free care priorities in our Patient Safety Incident Response Plan.

Common themes include:

- Inappropriate omissions of LMWH ie LMWH held prior to surgery but surgery subsequently cancelled and LMWH not reinstated
- VTE risk assessment completed but LMWH not prescribed
- As platelets or renal function improve or worsen, chemical prophylaxis isn't always reviewed, restarted or reduced/increased

Since the quality improvement work began in July 2021 the following changes and improvements have been made:

- Reviewed and strengthened the VTE/HAT governance structure, this is in line with the Trust priority regarding VTE prevention.
- VTE training became essential training for relevant clinical staff
- 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.
- The successful appointment of a VTE lead practitioner
- The Trust's VTE policy was reviewed, updated and relaunched
- Established regular clinical engagement to share VTE data, improvement work and learning from HATs.
- Reporting in real-time on the 'patient safety at a glance' (PSAAG) board to provide a 'prompt' as a visual reminder.
- Digital reporting at the ward, speciality and consultant level to support targeted improvement projects.
- 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.

Since the beginning of this financial year, the following changes and improvements have been made to support the Trust's VTE compliance improvement:

- Regular engagement sessions with junior doctors and clinical staff to obtain learning from the service user and then feedback to enable change
- VTE team focussing on areas with the lowest compliance
- Digital reporting at the ward, speciality and consultant level to support targeted improvement projects.
- Reviewed and strengthened guidance for risk assessments in line with VTE Exemplar Centres
- Scale and spread local QI projects with sustained improvement. All wards involved in VTE QI projects in 2023/2024 have seen sustained change through several PDSA cycles focused on an MDT approach. In the upcoming

financial year, to continue to take the local learning and lessons and spread to additional areas.

Plans for 2024/25:
Improvement priorities to ensure we meet our Trust and national aim of >95% of patients have a VTE risk assessment by March 2025 include:

- Achieve Trust target of greater than 85% by December 2024 then roll out second stage of improvement work to reach greater than 95%
- Continue to embed
- Continue to improve patient engagement and review VTE patient information via roll out of a digital admissions package
- Continue regular clinical engagement to share VTE data, improvement work and learning from HATs.

2.1.2.3 Medicines management

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.

Aims:

- Achieving less than 3.5% in omissions of critical medications
- Achieving greater than 90% in antimicrobial stewardship
- Work towards ePMA benefits realisation

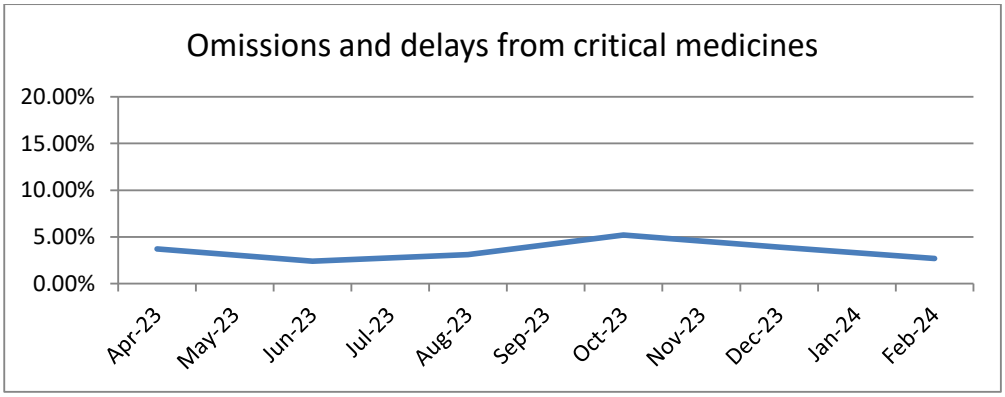
Over the last year the pharmacy department has focused on rewriting and launching the new Trust medicines optimisation strategy and working towards benefits realisation of ePMA. Examples include obtaining antimicrobial reports to supports antimicrobial stewardship (AMS) and the clostridium difficile agenda and supporting the review of high risk antibiotics over weekends and bank holidays. The pharmacy department has also focused on fundamental standards such as reducing the number of delayed and omitted doses of critical medicines, venous thromboembolism (VTE) prevention and AMS.

Compliance to date:

KPI	Target	Achieved 2023/24
Omitted and delayed doses of critical medicines	<3.5%	3.5%
Antimicrobial stewardship, 24-72 hour review	>90%	80.7%
Trusts medicines optimisation strategy	Launch the strategy	Achieved
KPI dashboard	Review	In progress
Epma	Work towards ePMA benefits realisation	Achieved
Trust's medicines management training	>90%	77%

Update on Critical medicines

The critical medicines audit is conducted across the Trust on a bimonthly basis. The numerator is the number of doses of critical medicines that have been delayed (>2hours) or omitted in the previous 24-hour period. The denominator is the total number of doses of critical medicines prescribed in the previous 24 hours.

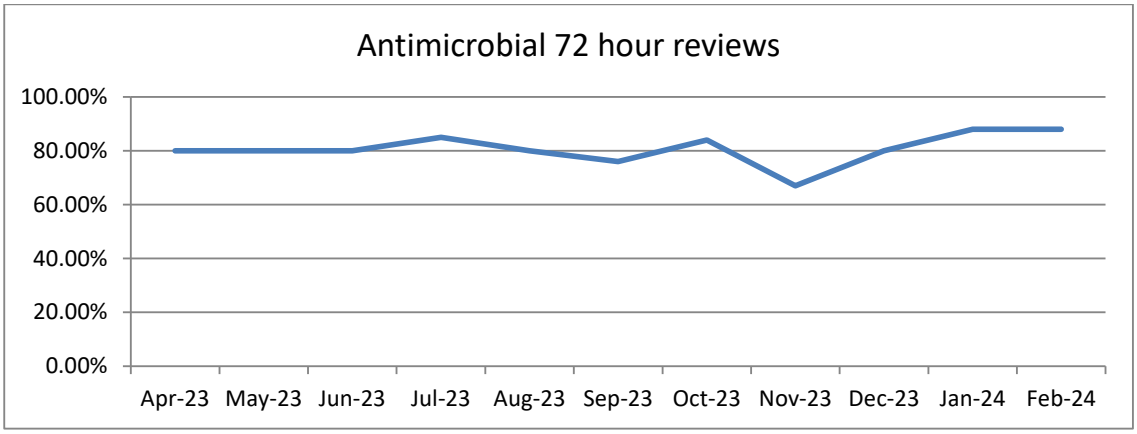


Aims: To achieve less than 3.5% omissions of critical medications that should not be missed or given late. During 2023/2024 the Trust achieved an average of 3.5%.

Update on Antimicrobial stewardship

Antimicrobial stewardship (AMS) is 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. The aim is to achieve >90% compliance with good governance and antibiotic stewardship.

Various training sessions have been delivered throughout the year – including undergraduate medical teaching, junior doctor inductions and liaising with the clinical practice nursing team to provide an interactive stewardship talk to student nurses/midwives as part of World Antimicrobial Awareness Week. Additionally, due to increased cases of clostridium difficile within the region, a Trust-wide presentation was delivered on initiatives to ensure appropriate prescribing and review of antimicrobials. In order to avoid antimicrobial medication incidents, the clinical pharmacy team have started to review patients prescribed high risk antibiotics which require therapeutic drug monitoring to ensure appropriate blood samples are taken to assess effectiveness of the medication and advice on dose adjustment where necessary.



The graph above demonstrates the results of the monthly audit that assesses the antimicrobial reviews for inpatients admitted to the Trust. The team have been focusing on targeted education and training towards AMS, which has led to an increase in audit compliance in January and February to 88%.
The Trust has taken part in the NHSE Commissioning for Quality and Innovation (CQUIN) on appropriate intravenous (IV) to oral switches at 72 hours (target <40% of patients at time of review remaining on IV antibiotics.) The average percentage throughout the year was 15% and microbiology IV to oral switch ward rounds have supported us meeting the target. The Trust is one of the best performing trusts in the East of England for this CQUIN.

Update on medicines optimisation
The new medicines optimisation strategy was approved at Quality and Safety Committee in January 2024 and launched across the Trust at quality huddle and corporate rolling half day in March and April respectively.

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 care divisional board, the nursing quality huddle, medication forum and pharmacy rolling half day.
- Therapeutics Policy Committee and New Drugs and Formulary Group biannual report was presented to the Clinical Effectiveness Committee in January 2024.
- Trust wide medicines management training was launched in 2023 and to date 77% of all doctors, nurses and pharmacists have completed the online training.

Plans for 2024/25:

- Working towards the launch of Orbis the integrated EPR and ePMA system
- Implement the updated pharmacy and medicines management KPI dashboard in terms of reporting, targets and presentation
- 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 2024/25.
- 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 Trust's work on improving discharge processes.

2.1.2.4 Deteriorating patients

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.

Aims:

- Achieve compliance with 50% reliability of all observations
- Improvement work aimed at supporting physiological observation assessment competencies with our nursing staff (registered and non-registered) to NEWS2 training
- Roll out improved patient status at a glance (PSAAG) dashboard on all our wards

Achievements to date:

Education and Training: To improve our nursing staff (registered and non-registered) knowledge and abilities in identifying and swiftly responding to patients who are deteriorating, we implemented extensive education and training programmes. We have therefore successfully re-rolled out ALERT (Acute Life-Threatening Events Recognition and Training) Trust wide with courses now booked throughout 2024/2025. We also continue to provide BEACH (Bedside Emergency Assessment Course for HCAs) training to our non-registered staff to teach and embed the basic skills of recognising and responding to deterioration. To compliment the BEACH course, the critical care outreach team (CCOT) are supporting the training of all new clinical support workers with observation training.

The CCOT have also supporting the implementation of PROMPT training with our maternity colleagues. PROMPT training is a maternity safety and learning programme. The program covers the clinical management of obstetric emergencies with an emphasis on communication, teamwork, and the role that human factors play. Training is based in the clinical setting with all members of the multi-disciplinary team. The overarching goals of PROMPT are to reduce preventable harm and enhance maternity care outcomes. In addition to CCOT supporting the clinical practice teams, we are now involved with individualised training on an 'ad-hod' basis for wards across the Trust. We meet with specific wards and tailor our training to their needs.

Standardised Communication: This year we have created and implemented standardised communication tools and processes to provide prompt, effective communication between healthcare professionals. Regular interdisciplinary meetings, the use of standardised documentation templates, and the implementation of methodical handover procedures can all help achieve this. This has been done by launching and implementing SBARD, throughout the Trust (including maternity) with success. The goal is to keep rolling out to Hertford County, New QEII, and Mount Vernon.

Call 4 Concern (C4C) : This year, the CCOT has implemented a significant project. Patients and their families have the option to escalate their concerns if they feel their condition is deteriorating. Improving patient outcomes is the main aim of this initiative. The next part of this project is to roll out the guidance mandated by Martha's Rule. After falling off her bike and becoming sepsis-ridden in the hospital, Martha Mills passed away in 2021 from pancreatic injuries. When Martha's family expressed worries about her failing health, no action was taken. A coroner concluded in 2023 that Martha would have likely lived if she had been admitted to intensive care sooner at Kings College Hospital London. The Secretary of State for Health and Social Care and NHS England pledged to implement "Martha's Rule" in response to this and other cases involving the management of deterioration. This rule aims to guarantee that the patient's and those closest to them have the most important concerns heard and taken seriously.

We were successful in our expression of interest submission and will now be one of the first sites implementing Martha's Rule. Being part of this, we will help the NHS devise and agree a standardised approach to all three elements of Martha's Rule. Once fully implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from critical care outreach.

The three elements of Martha's Rule that have been suggested are:

Martha's Rules	Status
If any member of staff in an NHS trust has concerns about a patient, they should have round-the-clock access to a critical care outreach team for a speedy review.	Achieved
Every patient, along with their families, carers, and supporters, should have equal access to a critical care outreach team's 24/7 quick review. This team can be contacted by mechanisms posted around the hospital and beyond if there is cause for concern over the patient's status.	Achieved
The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily.	To be achieved by 2025-2026.

Update on Hospital at Night plans

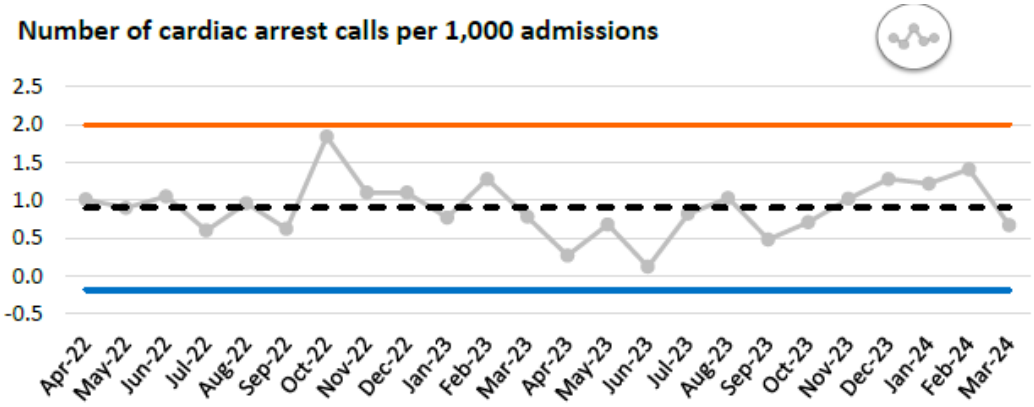
The term "hospital at night" describes an organisational structure intended to make hospital services safer at night. It entails putting in place a complete systems

approach to care coordination at night. This programme provides clinical jobs at night in a safe and equitable manner. A multidisciplinary team-based approach is employed to deliver our patients safe and effective patient-centered treatment overnight. The team is composed of medical professionals, clinical support workers, and senior nurses. The concept is that the night team works as a cohesive unit, with clinical responsibilities assigned to team members based on their qualifications and experience by a clinical coordinator. A viable hospital at night (HAN) approach is necessary to sustain ongoing control over patient safety and staff well-being. Currently, the Trust has our Critical Care Outreach Team (CCOT) that is available 24/7 to answer to emergency calls on the Lister site as well as alerts regarding patients who are deteriorating. They act as the senior nurse on site in this role. We are planning to recruit to a (senior practitioner) coordinator role for the hospital at night team by September 2024. This additional role would help with prioritising our sickest patients and improving outcomes. The coordinator role would triage all calls and assist with troubleshooting and escalating to the most appropriate member of the night team.

Update on cardiac arrest prevention and management

The Trust cardiac arrest rate remains stable (rate = 0.8) and demonstrates normal variation The Trust continues to submit cardiac arrest data into the National Cardiac Arrest Audit (NCAA).

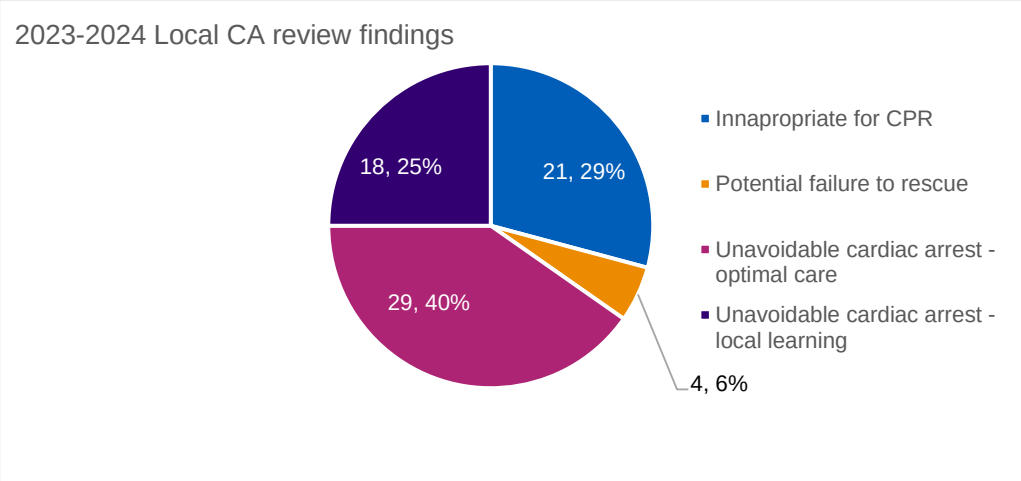
Figure 1 below represents Trust wide cardiac arrest rate per 1000 admissions.



Cardiac arrest rates per 1000 admissions across the wards is below the national average. This excludes areas that may manage their own deterioration and cardiac arrest, such ED, CCU and ACU.

Analysis of the care preceding 2222 calls can provide great opportunity for learning. Understanding the local data in relation to unavoidable cardiac arrest, potentially inappropriate CPR attempts and potential failures to rescue, are key for driving improvement.

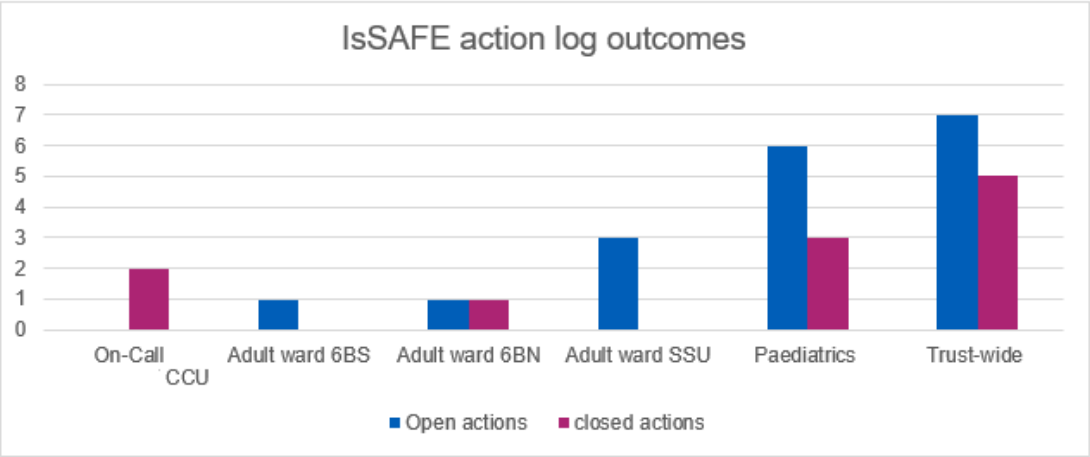
Figure 2 below shows the local CA findings.



40% (n=29) of cardiac arrests were deemed unavoidable, 6% (n=4) reviewed as potential failures to rescue, 25% (n=18) had learning identified and 29% (n=21) reviewed as may have potentially benefitted from improved decision making in relation to the suitability for resuscitation intervention. Advanced care conversations are key to establishing patient's wishes.

Studying 'human factors' to improve learning from 2222 events has been undertaken in 2022-2023. An analysis of all 2222 calls took place for a six-month period. The data has undergone a thematic analysis during 2023-2024 to inform system-change in relation to acute patient deterioration. Human factors analysis has increased opportunities to understand the key factors which influence human behaviour when responding to patient deterioration. As a direct response from the initial findings a further service evaluation was launched in March 2023 exploring both the human factors that impact the response, management and debrief of 2222 calls (deterioration and cardiac arrest). The service have adopted the use of in-situ simulation, to facilitate muti-disciplinary team (MDT) evaluation of human factors impacting the care management of deteriorating patients, in a safe and controlled environment.

Update on IsSAFE (In-situ simulation applying human factors evaluation)
IsSAFE was launched and is now embedding into practice. The learning from Trust patient safety incidents informs the themes and scenario to be explored through simulation in the clinical areas. Real-time patient care episodes are simulated using live systems, environments, processes and responding teams, facilitating evaluation of organisational systems and processes which impact human behaviour and the care of patients. MDT debriefs evaluate human factors (focusing on behaviours and context) and key learning outcomes are established, enabling improvement actions. Trust wide themes are escalated via the Patient Safety Forum and are monitored on the Trust risk register. Figure 3 below shows IsSAFE action log outcomes.



2.1.2.5 Safeguarding Adults and Children

Safeguarding adults and children remain an integral priority for all Trust services. The Trust is committed to ensuring that our statutory safeguarding responsibilities are routinely executed as outlined in the Care Act (2014), Children's Act (1989 and 2004), Working Together to Safeguard Children (2023) and the Mental Capacity Act (2005).

The Trust safeguarding team members along with the chief nurse (who is the executive lead for safeguarding) continue to be members of the Hertfordshire wide safeguarding partnerships for both adults and children. We are also involved in the workings of the various subcommittees associated with these partnerships thus continuing our longstanding emphasis on a multi-agency approach to safeguarding through effective collaboration with our key partner agencies.

Aims:

- Increased focus on Trust wide safeguarding education
- Recruitment of a lead nurse for learning disabilities

Achievements to date:

During 2023/24 through a grant provided by the police and crime commissioner's office we employed a domestic violence adviser and a sexual violence advisor to work alongside our children's sexual violence advisor. We continued to make enhancements to our electronic patient records system to insure prompt and efficient communication of safeguarding management plans directly to our patient facing staff. A key development during the year was the introduction of a discharge passport to enhance communication with care providers in the community for patients who are reliant on others to meet their care needs.

During Q4 of 2023/24 our safeguarding team developed an improved 'was not brought system' to monitor and escalate safeguarding concerns for individuals under the age of 18 years or individuals with a learning disability who are not being taken to hospital outpatient appointments. A practitioner within the Trusts children's

safeguarding team developed a child exploitation pathway which has been adopted by other NHS organisations. During 2023 we set up a revised safeguarding champion's forum in the organisation. All safeguarding related policies are in date and published on the Trust's intranet for our staff to reference. Currently our children's, adults and maternity safeguarding teams are staffed to funded establishment.

Both children's and adult safeguarding referrals have continued to rise and remain above pre-Covid levels; this is likely to be a result of improved detection and escalation of concerns by frontline staff brought about through staff education and the employment of specialists' practitioners in domestic abuse and sexual violence who work alongside our patient facing staff. The incidence of domestic abuse is noted to be high amongst residents living in the Trust's catchment area and accounted for 24% of all safeguarding concerns escalated by our frontline staff during 2023.

Deprivation of liberty (DoL): 701 applications for deprivation of liberty safeguards were made in 2023 which represents a 23% increase when compared to 2022.

The Trust's safeguarding committee, through its associated clinical governance processes, continues to ensure that learning from various types of safeguarding reviews is incorporated into practice and that the business of safeguarding is communicated to the Trust board.

Plans for 2024/25:

- Continue to develop Trust procedures in response to learning identified from section 42 enquiries, serious adult case reviews, domestic homicide reviews, rapid reviews and child safeguarding practice reviews.
- Continue the Trust trend noted in 2023/24 in respect to an increase in the numbers of DoLs applications made by clinical areas within the Trust and focus on education across the Trust in respect of the MCA for 16 and 17 year olds.
- Increase focus and spotlight on consolidating learning from reviews within maternity services and developing a strong quality assurance approach to sustaining improvements.
- Consolidate the success of our safeguarding champion's forum with an emphasis on providing staff with safeguarding educational content focusing on a 'think family' approach.
- Recruit a lead nurse to oversee our learning disability strategy in our children's services.

2.1.2.6 Safer invasive procedures standards

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-launch the World Health Organisation (WHO) checklist. The checklist mandates key stop moments when the standard pathway is confirmed, and patient-specific details clarified.

There are local safety standards for invasive procedures (LocSSIPS) in place with continuous audit of maintenance of the standards in all of the main areas where

invasive procedures take place (theatres, cath lab, radiology and endoscopy). These audits show good adherence to all standards. Work is ongoing to ensure that they are in place for every single invasive procedure done anywhere in the organisation.

2.1.3 Quality Domain: Patient experience

Quality Domain: Patient experience

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 2023/24 has been to work towards achieving:
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.

Achievements to date:

2.1.3.1 Discharge summaries:

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

- Efforts underway to enhance communication between secondary and primary care via improved discharge summaries.
- Surgical Assessment Unit (SAU) is the main hotspot for outstanding summaries, focus to improve in this area. A Surgical SDEC is to open and will use Nervecentre to process their patients with an easier quicker discharge summary. Backlog of Lorenzo summaries is the main focus for improvement.
- Quality concerns escalated to educational leads.
- Ongoing evaluation to determine appropriate correspondence for patients with outpatient procedures, leading to increased outstanding summaries. Discussions and planning taking place to have a robust plan going forward to capture all the outpatient procedures and complete suitable discharge summaries on the day of procedure.
- Organisation remains committed to improving the transfer of patients' care information.

2.1.3.2. Midday discharges:

On average, the Trust achieved 15.6% of midday discharges-a slight decrease in comparison to the previous year.

Although the data shows that the number of discharges before midday remained more or less the same there was an actual decrease by 0.18% from 15.78% reported the year 2022-2023 to 15.6% for year 2023/2024

To improve the above 2 year averages and be in line with the national 40% before midday discharge target, the Trust has implemented the following strategies and actions:

- Re-focus on 40% of discharges before midday.
- New discharge lounge policy has been launched and gives staff guidance on the actions required to optimise the use of the discharge lounge as a single point of discharge
- The Trust has committed to aim to discharge two patients per ward before midday, and all clinicians are encouraged to use the SHOP model (reviewing the sick patients first and then all patients being discharged on that day)
- The Trust has introduced the get ready model supported by the patient flow co-ordinators, site operations, discharge lounge and IDT (the model supports clear lines of communication between the wards site and the discharge lounge. The focus is on optimal use of the lounge and supporting the wards to unlock any barriers to early discharge)
- Launch of discharge task and finish group aimed at engaging ward leaders and clinicians around discharge planning and removing barriers to discharge ; focus on discharge letters, TTOs and pathways; this feeds into other work-streams within the wider system
- The Trust introduced the criteria lead discharge model, which has since been rolled out on two services. The Trust is in the process of rolling out this model to other services; this model aims to support early discharges

2.1.3.3 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.

The Trust has 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).

The average length of stay for patients with a LOS >14 and > 21 days has significantly decreased by 5.53% on average from 28.31% to 22.78% for 14 day delays for year 2023 /2024 and by 9.72% from 22.78% to 13.06 % for 21 day delays for 2023/2024.

This was driven by the implementation of the ward and board rounds, the roll out of criteria lead discharges across two services and the collaborative working between the acute Trust and the transfer of care hub (TOCH).

There has been a real focus on addressing delays both internal and external and there is still some work around understanding the root cause of delays and hence the following strategies and actions are being adopted both at place and at system level.

This improvement work has been picked up at ‘place’ through the newly launched discharge task and finish group; this group aims to embed the processes that were agreed and implemented by the Trust’s discharge improvement group and this feeds into the various work-streams at system level, aimed at standardisation of processes and improve discharges across the system.

- Ward and board rounds compliance: focus on updating expected date of discharge (EDDs), criteria to reside (CTR) data and to ensure the patients pathways are updated in real time throughout the patients journey
- Optimise the use of already embedded alternative pathways on offer and drive the hospital at home (H@H) agenda which has already seen an significant increase in the number of referral to that service in the last year (for example there were 91 referrals in the month of August 2023 and a 35% rejection rate those referrals have continued to improve since then with 154 referrals in March 2024 alone and a rejection rate of 20%; one thing to note is that 15% of the rejections are not driven by capacity but by location, the service is on offer for patients within the localities and not out of area patients. The introduction of the QDS intravenous antibiotic pathway, in-reach nurses by TOCH as well as the collaborative work between site operations team and TOCH has had a significant impact on the discharge process and well as the overall length of stay; this piece of work has now been picked up by the newly appointed H@H service manager who is now focused on exploring new opportunities around trauma and orthopaedic oncology, colorectal and general surgical pathways
- The Trust is linking in with TOCH and ICB to explore ways to improve delays affecting out of area patients, patients going to new care home placements (care homes do not offer a seven day service), equipment delays (equipment delivery is offered fine and a half days a week instead of seven days a week
- The Trust is supporting admission avoidance pathways offered by TOCH and has welcomed the introduction of the garden hospice frailty pathways which initially focused on ED and frailty unit. This has now been rolled out to the rest of the Trust. On average, two patients are discharged into that pathway daily and the aim is to save at least 800 bed days a year; that will have a significant impact on the average length of stay for the 7,14 and >21 day measures.

2.1.3.4 Reduce delays by >90% for ED 4 hour waiting time

To improve performance against the four-hour standard, the Trust embarked on a multi-project programme to develop a new emergency care model.

The national four-hour standard still remains at 95% with a recovery trajectory set at 76% of patients arriving at the Emergency Department (ED) to be admitted to hospital, transferred to a more appropriate care setting, or discharged home within four hours by the end of March. In April 2023 the Trust's 4-hour performance was 64.2% and the Trust achieved 73.8% in April 2024

The ambition of the programme was to transform emergency care pathways to provide alternative(s) to the ED where appropriate, thereby reducing the volume of patients in ED and improving patient flow and experience.

With the support of Hertfordshire and West Essex Integrated Care Board (HWE ICB) funding, a new Adult Urgent Treatment Centre (UTC) opened in January 2024 on the Lister Hospital site. The service is open from 8am to 10pm/7 days per week and can treat a range of minor illnesses and minor injuries for adults aged 16 years and over that would otherwise have gone to ED. In the first seven weeks of opening, the UTC treated more than 2,500 patients, with the average time from arrival to discharge of 1 hour 43 minutes. Plans are in development to expand the service to include children (under 16 years) which will enable the Lister UTC to fully mirror the successful model at the New QEII Hospital.

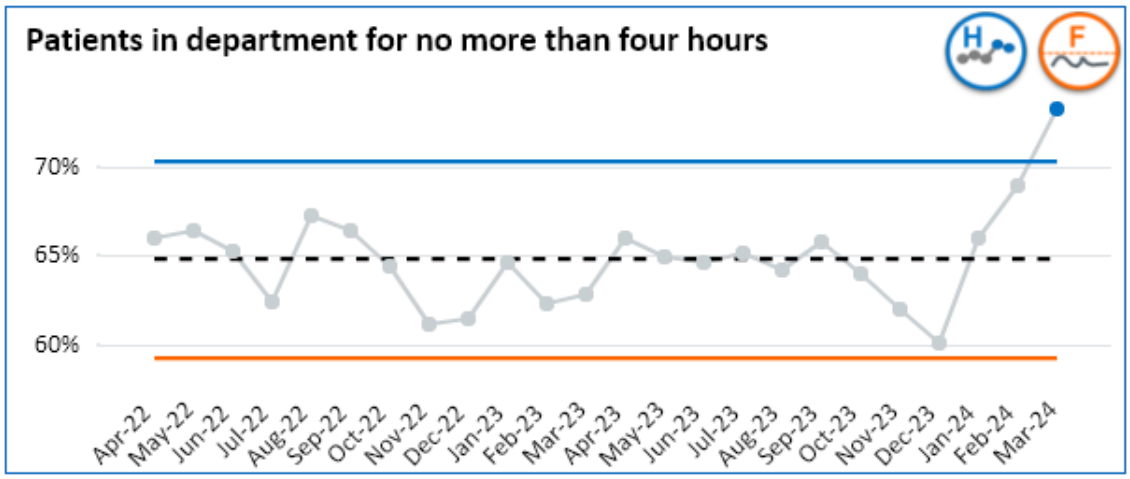
Acute Medical Services (AMS) reset their service model to increase the flow through the department, resulting in a 148% increase in transfers from the Acute Medical Unit to either a patient's preferred place of discharge or to an inpatient bed. The Medical SDEC opening hours were also extended until 10pm to provide additional capacity for patients who had either been directed to the medical team by their GP, or who were identified as requiring medical team intervention by the ED.

A Surgical Assessment Unit (SAU) was formally re-established in January 2024 having been stood down during the COVID-19 pandemic. This is a dedicated service for the assessment of emergency surgical patients who may be referred directly by their GP or who have presented to the ED and referred to surgical specialties for further assessment and possible inpatient admission. Since opening the SAU has cared for over 1,000 patients. The service also supports a Surgical SDEC which will continue to expand its capacity in line with recruitment of workforce.

In addition to alternative services, the ED has revised nursing and medical workforce rosters to ensure the staffing model aligns with expected peak times in patient arrivals to the department. The new rosters came into effect in January 2024 and continue to be embedded across all staffing groups, providing more support during peak hours. Work is also ongoing to increase diagnostic capacity with an additional CT machine expected to open for ED patients and inpatients from April 2024. Paediatric ED has also been part of the ED improvement programme and further focus on new space for time to triage during peak times, development of the CDU and redesign of the medical workforce to align with expected peak demand is forecast to improve paediatrics ED four-hour performance further in 2024/25.

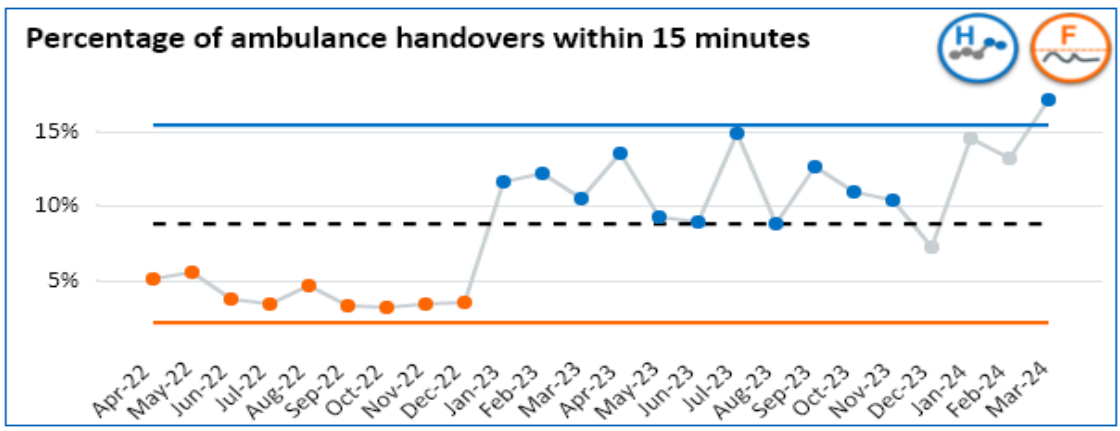
All Urgent and Emergency Care (UEC) services are operating under a model of continuous improvement with processes constantly reviewed to identify areas of opportunity. The ED has reviewed and refined their streaming and triage models to ensure patients are directed to the most appropriate service at the earliest opportunity. Further areas of development and improvement will be identified and driven in 2024/25.

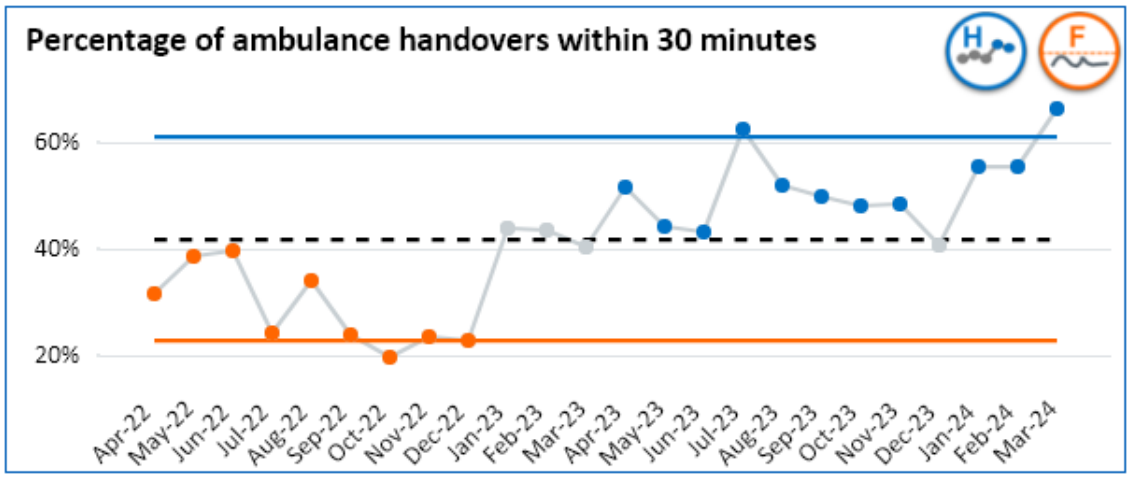
In March 2024, the Trust's four-hour performance standard increased to 73.18%. Many of the improvement initiatives did not commence until January 2024 therefore it is anticipated that as new pathways and services embed performance will continue to improve in this area in-line with the target of 78% for 2024/25 but will remain under close observation.



Update on Ambulance handover

The Trust with East of England Ambulance Service NHS Trust (EEAST) and other partners such as Hertfordshire Community Trust and the other acute providers, worked hard to significantly reduce handover time for those patients bought to the department by ambulance. Despite the number of conveyances, the Trust through its actions and work on the urgent care pathways has significantly improved handover time therefore enabling ambulances to get back out into the community and patients arriving to the department getting the care they require in a quicker timeframe.





Plans for 2024/25:

ED 4 hour waiting times

- Continued focus on improving ED 4 hour waiting times in-line with the target of 78% for 2024/25
- Increase diagnostic capacity with an additional CT machine expected to open for ED patients and inpatients from April 2024.

2.1.4. Quality Domain: Patient experience

Quality Domain: Patient experience

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 2023/24 has been to work towards achieving:

- 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.

Compliance to date:

Friends and family test (FFT) 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	21/22	22/23	23/24
Patient feedback	Inpatient 96.69 Outpatient 95.52 Maternity 95.90 Emergency Department 85.98	Inpatient 96.37 Outpatient 96.09 Maternity 96.25 Emergency Department 88.10	Inpatient 96.45 Outpatient 96.34 Maternity 98.17 Emergency Department 92.61

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

Develop and implement an electronic system for the capture of identified carers
The Trust now has the ability to record on electronic records if someone is a carer, unpaid carer, young carer or cared for. This has been a great improvement to ensure we are monitoring and providing any additional support to these groups whilst in hospital.

Quarterly carer's forums ensure that the objectives are being met and challenged
The Trust has been successful in setting up quarterly forums, both face to face during the day and online in the evenings to ensure we are capturing everyone's views and experiences. This attended by the Trust carers lead, and engages with people with lived experience as a carer from the community.

Initiatives to improve patient and carer experience during the year included

- An elderly care ward has taken a proactive approach to improving communication with carers through a quality improvement project. Feedback from carers highlighted that carers are not consistently receiving timely updates.
- From April 2023 to March 2024 the Forget-Me-Not volunteers have given over 918 hours of their time, equating to 24 working weeks, to provide 924 support visits. Forget-Me-Not Dementia Volunteers are a dedicated group of individuals who offer individual, companionship support for people living with dementia. The service aims to provide comfort and bespoke interactions to dementia patients that come to our hospital, as well as providing support and guidance for their loved ones.
- Alerts on the hospital digital system so carers and cared for can be identified when using any of the hospital services.

- Promotion of local resolution meetings when a formal complaint is raised to provide compassionate resolution when difficult experiences have been shared.

2.2 Quality Priorities for Improvement 2024-2025

Introduction to 2024/25 quality priorities

The Trust's 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 Trust mission is to provide high quality compassionate care for our communities.

We will drive our system to develop expertise and business as usual approaches to continuous improvements through embracing a quality management system approach through our 'ENH production system' (ENH PS).

In 2023, we started the next phase of our improvement journey supported by our partner the Virginia Mason Institute. This will provide an infrastructure that ensures we put the patient first, lead with quality and remain a sustainable organisation. We are committed to trying new approaches and positively learning from failures through the adoption of a method that champions the voice of the people who know the work best and contribute to improving our systems. We have called this improvement method, the ENH production system (ENH PS).

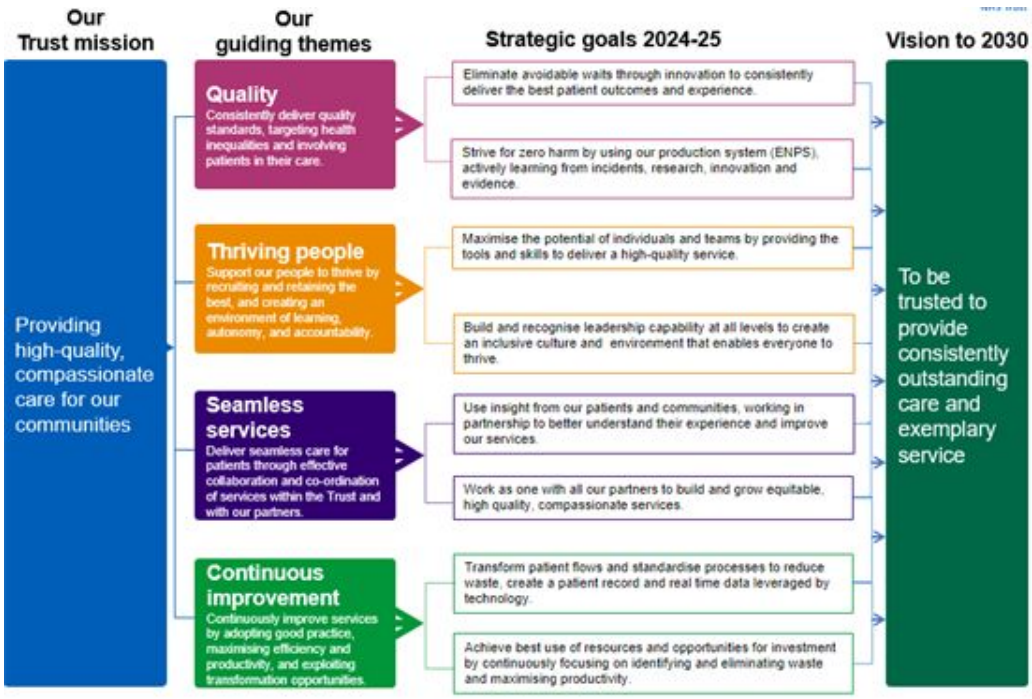
The ENH PS is based on lean methodologies that will provide a unified way of thinking and acting through a set of philosophies and practices. This approach has been grounded in a wealth of evidence that is built on the foundational belief that by eliminating waste, organisations can improve quality and safety and increase staff satisfaction. It is from this belief that our improvement philosophy was created.

Through focusing on high quality and high reliability within our systems, the tools of the ENH PS will be delivered through behaviours and attitudes that emanate inclusion of our patients and partners, being respectful of everyone's contributions and with a driving focus of continuous improvement.

A key action will involve developing approaches to standard work, for example executive rounding throughout the organisation. Senior leaders will spend time engaging staff where they work, to listen and solicit feedback and opportunities for making their departments and the whole organisation better.

We acknowledge that staff experience directly connects to patient satisfaction; therefore the ENH PS will proactively offer patients the opportunity to engage in our improvement events, especially those who may have had a less-than-perfect interaction with our Trust or system.

Strategic goals 2024 to 2025



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

Quality Priorities 2024 to 2025		
Domain	**Description**	**Key Focus Areas**
Effective	Good governance • Excellent responsiveness to incidents • Learning from incidents	Digital transformation Ward to board assurance of Patient Safety Incident Response Framework (PSIRF) safety standards Pathways to excellence - drive effective outcomes in response to service level quality standards
Safe	• Valuing the basics: Keeping our patients safe	Nursing quality fundamentals improvement programme Medicines management and antibiotic stewardship

		Medical devices – improved EBME service and equipment library Infection prevention control (IPC) – C.Diff improvement programme Safeguarding oversight and triangulation with other domains of quality Documentation – adopt new documentation standard to include SBARD Adult and paediatric deteriorating patients (including sepsis) – National pilot for Martha's rule and imbed call for concern End of life care – Gold Standards Framework Invasive procedures LocSSIP compliance across non theatre specialities Discharge transformation programme - safe and timely discharges
Patient Experience	• PACE programme	Responsiveness to complaints – driving improvements across key themes Excellent engagement and co-design following patient safety incidents
Well Led	• Good governance compliance framework	Staff survey Clinical leadership programmes- nursing excellence faculty Quality assurance framework – standardised across new operational management model Freedom to speak up- strengthening the FTSU MDT network People strategy – Equality diversity and inclusion (EDI) actions Imbedding risk management strategy

These quality priorities and other key quality indicators will be monitored regularly with oversight at various quality and patient safety fora. A quarterly report on progress against these priorities will be produced for the Trust Management Group and the Quality and Safety Committee.

2.3 Statements of Assurance from the Board

Review of services

The Trust continued to provide a range of acute and specialised services in 2023/24, including directly provided and sub-contracted services across four care divisions. The Trust has reviewed the data across all the relevant health services and operated in accordance with the NHS Operating Framework. For further details please refer to the Trust Annual Report.

Participation in clinical audits

The Trust continues to maintain an active clinical audit programme and reviews current clinical audit processes to ensure we are able to evidence improvements in clinical practice, patient experience and outcomes.

During 2023/2024 the Trust participated in 60 National Clinical Audit and Patient Outcomes Programme (NCAPOP) and other national quality improvement programmes NHS England advises Trusts to prioritise for participation. During this period the Trust participated in 92% of the NCAPOP and other prioritised national quality improvement programmes relevant to the Trust's provided services.

National Clinical Audit and Patient Outcomes Programme (NCAPOP) and NHS England prioritised national quality improvement programmes participation

The National Clinical Audit and Patient Outcomes Programme (NCAPOP) and other prioritised national quality improvement programmes the Trust has participated in, for which data collection was completed during financial year 2023-2024 are listed below alongside the number of cases submitted, expressed as a percentage of the number of eligible cases required.

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
Adult Respiratory Support Audit		Y	62 patient questionnaires (100% case ascertainment) 1 organisational questionnaire (100% case ascertainment)
British Association of Urological Surgeons (BAUS) Nephrostomy Audit	Nephrostomy audit	Y	7 cases (100% case ascertainment)
Breast and Cosmetic Implant Registry		Y	20 cases
British Hernia Society Registry		**N	**Trust unable to participate because the registry was trialled amongst BHS committee

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
			member sites.
Child health clinical outcome review programme (National confidential enquiry into patient outcome and death NCEPOD)	Juvenile idiopathic arthritis	Y	4/5 (80%) clinical questionnaires 5/5 case notes 1 (100%) organisational questionnaire
Case Mix Programme (CMP)		Y	Intensive Care Unit: 873 cases (Q4 data in validation) Respiratory High Dependency Unit: 295 cases (100% case ascertainment)
Elective surgery national PROMs programme		N	
Emergency medicine QIPs	Care of older people	Y	Data collection in progress. Project cycle commenced in October 2023 to October 2024
	Mental health (self-harm)	Y	Data collection in progress. Project cycle commenced in October 2023 to October 2024
Epilepsy12: national clinical audit of seizures and epilepsies for children and young people		Y	Cohort 5 submission, and non-participation organisational audit.
Falls and fragility fracture audit programme (FFFAP)	National audit of inpatient falls (NAIF)	Y	13 (61.5% case ascertainment)
	National hip fracture database (NHFD)	Y	459 (100% case ascertainment)
Improving quality in Crohn's and Colitis (IQICC)		N	Trust did not participate
Learning from lives and deaths of people with learning disability and autistic people (LeDeR)		Y	15 notifiable cases (100% case ascertainment)
Maternal, newborn and infant clinical outcome review programme (MBRRACE)	Perinatal mortality surveillance	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	Perinatal morbidity	Y	Continuous data submission.

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
	and mortality confidential enquiries		Exact case numbers submitted not available at the time of reporting
	Maternal mortality surveillance and mortality confidential enquiries	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	Maternal morbidity confidential enquiries	Y	Continuous data submission. Exact numbers of cases submitted not available at the time of reporting
Medical and Surgical clinical outcome review programme (National confidential enquiry into patient outcome and death NCEPOD)	Endometriosis	Y	6/6 (100%) clinical questionnaires and case notes 1 (100%) organisational questionnaire
	Care at the end of life	Y	6/6 clinical questionnaires (100%) 5/6 case notes (83% case ascertainment) Organisational questionnaire not yet released
National adult diabetes audit (NAD)	National diabetes footcare audit (NDFA)	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National diabetes inpatient safety audit (NDISA)	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National pregnancy in diabetes audit (NPID)	Y	48 Cases
	National diabetes core audit	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National asthma and COPD audit programme (NACAP)	COPD secondary care	Y	550 cases
	Adult asthma secondary care	Y	138 cases
	Children and young people's asthma secondary care	Y	29 cases

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
National audit of cardiac rehabilitation		Y	Initiating Event Record: 392 Patient Record: 314 Early CR: 393 Core CR: 284 Assessment 1 Records: 142 Assessment 1A Records: 7 Assessment 2 Records: 80
National audit of care at the end of life (NACEL)		Y	Project commenced January 2024 and is in progress
National audit of dementia (NAD)	Round 6 care in general hospitals	Y	60 cases (100% case ascertainment)
National cancer audit collaborating centre	National audit of metastatic breast cancer	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National audit of primary breast cancer	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National cardiac arrest audit (NCAA)		Y	93 (data for Q4 in validation)
National cardiac audit programme (NCAP)	National heart failure audit (NHFA)	Y	305 cases
	National audit of cardiac rhythm management (CRM)	Y	681 cases
	Myocardial ischaemia national audit project (MINAP)	Y	363 cases
	National audit of percutaneous coronary intervention (NAPCI)	Y	376 cases
National child mortality database (NCMD)		Y	Data not submitted directly by the Trust
National comparative audit of blood transfusion	2023 audit of blood transfusion against NICE quality standard 138	N	0 cases submitted
	2023 bedside	Y	Audit in progress, cycle closes at

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
	transfusion audit		the end of April 2024.
National early inflammatory arthritis audit (NEIAA)	Year 6	Y	123 cases submitted
National emergency laparotomy audit (NELA)		Y	125 cases submitted
National gastrointestinal cancer audit programme (GICAP)	National bowel cancer audit (NBOCA)	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National oesophago-gastric cancer audit (NOGCA)	Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National joint registry (NJR)		Y	Hips 397 Knees 240 Ankles 8 Elbows 16 Shoulders 30
National lung cancer audit (NLCA)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National maternity and perinatal audit (NMPA)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National neonatal audit programme (NNAP)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National ophthalmology database (NOD) audit	National cataract audit	N	
National paediatric diabetes audit (NPDA)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
National prostate cancer audit (NPCA)		Y	Exact numbers of cases submitted not available at the time of reporting
National vascular registry (NVR)		Y	*CQUIN* **35** AAA repair **33**

NCAPOP	Work stream	2023/2024 data submitted	Submission and case ascertainment
			Carotid procedure **25** Bypass procedure **12** Angioplasty procedure **53** Amputation Procedure **23**
Perinatal mortality review tool (PMRT)		Y	Continuous data submission. Exact case numbers submitted not available at the time of reporting
Perioperative quality improvement programme		Y	254 cases submitted
Sentinel stroke national audit programme (SSNAP)		Y	941 cases (≥90% case ascertainment)
Serious hazards of transfusion UK national haemovigilance scheme		Y	20 (100%)
Society for acute medicine benchmarking audit	SAMBA23	Y	Lister: 76 QEII: 21
Trauma audit and research network (TARN)		Y	
UK renal registry	Chronic kidney disease audit		Continuous data submission. Exact case numbers submitted not available at the time of reporting
	National acute kidney injury audit	Y	Stage 1: 3315 cases Stage 2: 507 cases Stage 3: 295 cases

During 2023/2024 the Trust was ineligible to participate in the following 18 NCAPOP projects because the services are not provided by the Trust.

NCAPOP
Cleft registry and audit network (CRANE) database
Falls and fragility fracture audit programme – fracture liaison service database (FLS-DB)
Mental health clinical outcome review programme
National asthma and COPD audit programme (NACAP) - pulmonary rehabilitation
National audit of cardiovascular disease prevention in primary care (CVDPrevent)
National audit of pulmonary hypertension
National bariatric surgery registry

National cardiac audit programme (NCAP) - National adult cardiac surgery audit (NACSA)
National cardiac audit programme (NCAP) - National congenital heart disease audit (NCHDA)
National cardiac audit programme (NCAP) - National audit of mitral valve leaflet repairs (MVLR)
National cardiac audit programme (NCAP) - UK transcatheter aortic valve implantation (TAVI) registry
National clinical audit of psychosis (NCAP)
National obesity audit (NOA)
Out-of-hospital cardiac arrest outcomes (OHCAO)
Paediatric intensive care audit network (PICANET)
Prescribing observatory for mental health (POMH) - use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services
Prescribing observatory for mental health (POMH) - monitoring of patients prescribed lithium
UK cystic fibrosis registry

Reviewed National Clinical Audit and Patient Outcomes Programme (NCAPOP) reports

Seventeen national clinical audit and patient outcomes programme (NCAPOP) reports were reviewed by the Trust during 2023/2024. The Trust intends to use the intelligence derived from participation in NCAPOPs to improve the quality and effectiveness of clinical care and ensure it is based upon nationally agreed standards of good practice and evidence-based care.

NCAPOP	Key successes, lessons learned and actions
National Paediatric Diabetes Audit (NPDA) Parent and Patient Reported Experience Measures (PREMs) 2021 (based upon 02/08/2021-02/01/2022 data)	Key successes: Trust conforms to 7/8 (87.5%) of the published national recommendations relevant to the Trust. Key actions: • To meet the recommendation of children and young people having access to a Psychologist with diabetes expertise, a second Clinical Psychologist has been recruited. This will reduce patient waiting times support the increased number of referred patients and reduce waiting times. • Additionally, ongoing action is being taken to improve the waiting area for transitional care patients
National Paediatric Diabetes Audit (NPDA) (based upon 01/04/2021 to 31/03/2022 data)	Key successes: The Trust conforms to 2/4 (50%) of the Trust relevant published recommendations. Key actions: • To ensure diabetes multidisciplinary team is adequate staffed to manage the increasing numbers of type 1 and type 2 diabetes patients a business case is being developed. Additional actions include:

NCAPOP	Key successes, lessons learned and actions
	• Discussions about the roll-out of a new IT system across all diabetes services, supporting the collection of good quality data, ensure consistent healthcare checks in accordance with NICE and automatically submit data towards NPDA. • Although HbA1c is offered 4 or more times per annum, ongoing action is being taken to increase clinic capacity by increasing the number of Consultants to ensure children and young people are consistently offered 4 face to face clinics per year.
UK Parkinson's Audit report 2022	Key successes: Trust conforms to 4/7 (57%) of the national recommendations Key actions: • Ongoing work is taking place in relation to Parkinson's patient referral access to community support occupational therapy, physiotherapy and speech and language therapy services in accordance with NICE quality statement 3 which was less than 100% (93.8-97.7%). • Ongoing action is being taken to ensure the recording of non-motor symptoms in clinics, Parkinson's UK risk and consent form to ensure they are used more frequently. • Ongoing work taking place to ensure the use of standardised guidance, assessments and outcome measures in occupational therapy, physiotherapy and speech and language therapy provided by Community support. • Ongoing work taking place to ensure all appropriate patients have access to Clozapine in accordance with NICE quality statement 5 for treating hallucinations and delusions provided by Psychiatry services. Additional actions include: 1) To address inpatient medicines management in terms of levodopa being administered within 30 mins of prescribed time in accordance with NICE quality statement 4 and outpatient clinic patients being asked about the development of side effects, Trust self administration policy is being reviewed and Trust's EPMA system has become helpful at deriving reports; 2) To ensure the Parkinson's service is part of an integrated delivery model ongoing pathway discussions and workshops with ICB and system partners are to take place.
National Joint Registry 20th Annual report on 2022 data	Key successes: • Trust awarded gold award for quality data entry. • Trust was a positive outlier for use of valid NHS number

NCAPOP	Key successes, lessons learned and actions
	(Trust 98.2% vs National 95%) • Trust was in line with the national average for NJR consent submitted (Trust 82.4% vs National 90%) and time taken to enter data (Trust 40 days vs National 30 days) Key actions: • Dedicated NJR data manager is required to improve the rate of obtaining consent and entering NJR forms in a more timely manner.
National Cancer Audit Collaborating Centre (NATCAN) – National oesophago-gastric cancer audit (NOGCA) annual report 2022 (based upon 01-04-2019-31/03/2021 data)	Key successes: Trust conforms to 5/7 (71%) of the national published recommendations. Key actions: • Local clinical audits and presentations will be used to address the need for reviewing stage 4 diseased patients and patients diagnosed after an emergency admission to identify opportunities for earlier detection.
Perinatal Mortality Review Tool (PMRT) (Fourth annual report)	Key successes: The Trust conforms to 4/5 (80%) of the national recommendations met Key actions: • To ensure adequate PMRT review team resourcing, a band 4 MSW job description is being developed and job matching to support data entry to PMRT. • In addition to in identify the needs of Asian and Black women, an equity and equality action plan has been developed and continued engagement will take place to ensure a better understanding of their reproductive needs.
Falls and Fragility Fractures Audit programme (FFFAP) – National hip fracture database (NHFD) The 2023 National Hip Fracture Database annual report based on data from 1 January 2022 to 31 December 2022.	Key successes: The Trust conforms to 7/10 (70%) of the national recommendations. Above national mean achievement of BPT despite system issues around beds, physio and theatre pressure. Key lessons learned: 2023 discussion focussed on procedures for inter-trochanteric fractures and audit results. Key actions: 1) Planned Trust wide initiatives to improve early ED assessment and bed availability will support patients being offered pain relief and admitted within 4h. 2) Discussions taking place around the development of a fast-track protocol in addition to specialist nurses liaising with peer units to support all patients reaching an appropriate bed promptly. 1) A peer unit is to be liaised with as to how they have been able to follow up patients after IV zolendronic acid

NCAPOP	Key successes, lessons learned and actions
	infusions.
National Audit of Care at the End of Life (NACEL) Fourth round audit report 2022-2023 report	Key successes: The Trust was above the national summary scores for 6/7 identified areas. The Trust performed above the national average at discussing the possibility a patient may die with families and others (National mean = 96% vs Lister mean= 97.7%). The Trust conforms to 3/8 (37.5%) of the national recommendations. Key lessons learned: • Only two members of staff responded to the staff quality survey, which meant our responses were not featured in the reports. Lack of conversations about nutrition and hydration options and the associated risks and benefits were noted. Also noted, the low numbers of conversations around the possibility that medications may make the dying person drowsy. Overall, the need for consistent documentation of the reasons why conversations have not been had. All these elements will be considered and factored into teaching and practice. Ongoing key actions: 1) Patient owned ReSPECT document has been launched, replacing the DNACPR forms. This is supported by the Trust's "Introduction to Planning Your Care" leaflet and introduction of the gold standards framework (GSF) which will encourage advanced care planning discussions and remain with patients upon discharge into the community. Three wards are being prepared for GSF training. ReSPECT is audited with the results influencing training. 2) The recent digitalisation of the Individual Care Plan for the Dying Person (ICPDP) has been mandated in the majority of areas to avoid areas being missed or not holding early discussions. Training in the use of the digitised ICPDP is being delivered and usage is being audited. Staff are being supported in having early advanced care plan conversations and raising the importance of having these conversations. 3) All current staff training opportunities are regularly reviewed and where possible new opportunities are identified 4) The team are working to educate and support nursing and medical teams to recognise and manage thirst and reinforce the need for conversations around nutrition and hydration options, in addition to the risks and benefits. 5) Bereavement has been identified as an area for improvement
National Audit of Dementia	Key successes: 1) Trust conforms to 2/2 (100%) of the national

NCAPOP	Key successes, lessons learned and actions
(National audit of dementia care in general hospitals 2022-20223 round 5 audit report)	recommendations. 2) The Trust collects feedback from 2-3 people with dementia per month as recommended by NAD and the feedback is used to inform our improvement focus. 3) Completion of “This is Me” document enables staff to deliver person catered care. It is included in dementia training and audited on ward as part of the Clinical Excellence accreditation. 4) The Tier 2 dementia training program has been expanded to include simulation training and Tier 2 is delivered as a rolling program to all trainee Clinical support workers. 5) The dementia team now includes a dementia volunteer coordinator, 1-year fixed term post funded by ENHT charity. 6) The Trust now has a nutrition and hydration group creating the opportunity to incorporate the specific needs of the patients living with dementia during a hospital stay. 7) Refurbishment of ward 10A has followed Department of Health Dementia- Friendly health and social care environment guidance. 8) The Trust’s incident reporting management system (ENHance) allows for the additional codification of patients living with dementia Key actions: 9) A quality improvement project is underway on an elderly care ward focusing on improving communication between carers and hospital staff. This builds on communication improvement activity already undertaken in other areas of the Trust. 10) Following review of the Lister hospital environment, recommendations have been made to ensure all areas have large clocks that display the date and time.
National Comparative Audit of nice quality standard QS138 (Published February 2022)	Key successes: Trust conforms to 2/2 (100%) of the national recommendations. Key lessons learned: The Trust continues to encourage the recording and promotion of iron supplementation for anaemia, liaising with the pre-operative assessment team.
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP) (Published March 2022)	Key successes: Neonatal team conformed to 5/5 (100%) of the relevant national recommendations.
National Prostate Cancer Audit (NPCA) (Published January 2024)	To note: 1) The Trust conformed to 2/4 (50%) of the relevant national recommendations. 2) The trust is a high-volume centre and the 5th largest prostectomy centre in the country and have one of the lowest readmission rates in the country.

NCAPOP	Key successes, lessons learned and actions
	Key lessons learned: More support is required to upload data to ensure we achieve full case ascertainment. Key actions: 1) Discussions are to take place with MDT data support teams to ensure performance scores from GP 2 week wait referrals, TNM and Gleason scores are captured and uploading, to support the achievement of a higher degree of key data items completeness. 2) In response to a GU toxicity post prostectomy outlier notification, a full root cause analysis and audit was undertaken. In response to a slightly higher bulbar stricture rate identified, Surgeons have been advised related to some surgeons using a larger catheter and leaving them in for too long.
BAUS data and audit programme – muscle invasive bladder cancer at transurethral resection of the bladder audit (MITRE)	Key successes: The Trust conformed to the audit's standards.
Society for Acute Medicine's Benchmarking Audit (SAMBA) – SAMBA 2023 report: A national audit of acute medical care in the UK	Key successes: The use of the SDEC pathway has optimised admission avoidance/early supported discharge. Key lessons learned: Improvements are required to the time to first clinician review and Consultant review. Key actions: 1) ED planned improvements to improve patients being seen by a tier 1 clinician within 4h of arrival to hospital 2) Planned initiatives to decongest ED, supporting the achievement of 76% of ED patients being reviewed by a competent clinical decision maker within 4h of arrival across HWE. 3) Planned initiatives to improve unplanned admissions reviewed by a competent clinical decision maker within 4H of arrival in SDEC, include Nervecentre documentation trail for clinical review lag pending investigation results made available and enhanced SDEC staffing across 7 days. 4) Planned staffing and bed flow initiatives to improve percentage of unplanned admissions with Consultant review within target time 5) Improvements to support bed management for flow model via AMU to improve Consultant review of unplanned admissions arriving during the daytime within target time. 6) Improvements to staffing for post take ward rounds for overnight boarded medical patients, decongesting ED

NCAPOP	Key successes, lessons learned and actions
	and single clerking to improve unplanned overnight admissions having a Consultant review within the 14h target time.
Learning from lives and deaths – people with a learning disability and autistic people (LeDeR) (published July 2022)	Key successes: 90.5% (19/21) of Trust SJR reviews concluded learning disability patient's care to be either adequate, good or excellent, comparable to national findings. Key lessons learned: 1) During 2022/23, 21 adults with a learning disability died in the Trust. The Trust's leading causes of death were sepsis, respiratory failure, cancers or complications of cancer. In ENHT males accounted for 48% of the deaths and females 52% 2) In the Trust during 2022/23, 81% of patients with a learning disability had a DNACPR in place at the time of their death. **3)** Between the periods of June 2021 - May 2022 and June 2022-May 2023 the following trends were observed: • There was a 40% increase in the numbers of individuals with an LD referred to the Trust for an elective procedure or outpatient assessment whereas for the non-LD population this was 9.14% • There was a 7.17% increase in the number of registered learning disability patients registered on our EPR system • 20% of individuals with an LD waited six months or longer for an appointment or elective procedure, which was 4.7% higher than the general patient population (15.3%) • Potentially attributed to wider health care system inequalities pulled through from the COVID and industrial actions. The Trust intends to close the 4.7% waiting time gap difference between the LD and non-LD populations. The Trust is unable to determine whether inequality was a direct or indirect factor between the two time periods. Key actions: 1) Development of an LD nursing associate role. 2) Develop easy to read appointment letters. 3) Change individuals with LD alerts to 'was not brought'. 4) Changing places toilet facility. 5) In terms of the Trust's scheduling policy, develop a system for learning disability waiting list oversight (Specific system to monitor LD patients required particularly to monitor cancellations which may place individual at risk. 6) Trust to develop a hospital virtual tour to aid learning disability patients who are attending hospital appointments to be placed on the Trusts web site. 7) Revise LD complaints and patient feedback systems. Switch

NCAPOP	Key successes, lessons learned and actions
	to 'Ask, Listen, Do', as favoured by NHSI/E. 8) TEPs and DNACPR Trust procedure and guidance for completion and decision making. 9) Develop a specific Trust forum on learning disabilities. 10) Implement Oliver McGowan training implementation.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE) - Core report: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20	Key successes: Trust conforms to 7/10 of the relevant national recommendations. Key actions: 1) To address the national recommendation of vulnerable and young women being overrepresented amongst those who have died from ectopic pregnancy, the team is currently reviewing its ectopic pregnancy guideline. This is in addition to existing measures of a detailed social and safeguarding history being taken at diagnosis and appropriate safety advice and phone numbers being given. Also, these patients are also put on the Trust's EPU database that is accessible to all doctors in the Hospital and personalised management plans discussed in multidisciplinary team meetings. 2) The thromboprophylaxis and termination of pregnancy guidelines are in the process of being reviewed. 3) The team is in the process of reviewing the antenatal care guideline to address the national recommendation of involving critical care teams in antenatal multidisciplinary team planning for women with serious morbidity who are anticipated to admission to intensive care postpartum.
MBRRACE perinatal mortality surveillance (Published September 2023)	Key successes: Funding received for placental histology at Addenbrookes (started Sept 2022), Aspirin for all women with a previous baby <10th centile (guideline updated 2022), management of jaundice – business case for more community bilirubinometers Key lessons learned: Documentation at the time IUD is diagnosed, Observations in triage at the time the IUD is diagnosed, Lab not processing Kleihauer, placental histology
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) Epilepsy (Published December 2022)	Key outocmes: Emergency department conforms to 4/11 (36%) of the relevant recommendations and the neurology department conforms to 9/11 (82%) of the national recommendations Neurology actions include • Nationwide portal to contact epilepsy specialists • To discuss with pathology the making all anti-seizure medication levels measured available • Develop a guideline for emergency staff to support the development of a core set of investigations for all patients who present with a seizure. • Develop a guideline/protocol for emergency staff that sets out the requirements for undertaking a CT scan of the

NCAPOP	Key successes, lessons learned and actions
	head of patients with known epilepsy. • Need to have EEG available at the Lister Hospital for patients with suspected or treated status epilepticus to confirm diagnosis and monitor the effects of treatment. Emergency medicine actions include: • Liaising with neurology department CD in relation to the arrangement of follow up plans before a patient is discharged from hospital following an admission due to seizure; ensuring there is specialist 24/7 neurology advice available for patients admitted with epilepsy; access to EEG for patients with suspected or treated status epilepticus to confirm diagnosis and monitor the effects of treatment; and having a system in place that enables emergency medicine or admitting clinicians to communicate with the patient's usual epilepsy clinical team • To add to the educational programme explaining to patients and their family members or carers the risks of sudden unexpected death in epilepsy, personalised risk reduction assessments; use all hospital presentations to reiterate the risks associated with epilepsy; documenting the discussions in case notes and discharge letters a; and provide resources to support these discussions

Local clinical audits

The Trust intends to continue improving the quality of healthcare by implementing actions from local clinical audit projects. Table 1 provides a sample of 17 the 100 completed local clinical audit projects with details of the key actions identified to improve the quality of the healthcare provided and table 2 provides the full list of completed projects reported during 2023-2024.

Table 1: Sample of projects completed during 2023-2024

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
Plastic and Reconstruction surgery	Audit and re-audit of LAOPS Safety checklist compliance *To prevent "Never Events" from happening in minor operations in plastic surgery, to improve patient care and outcomes* *(Audit n=75; Re-audit n=30)*	Key successes: Completion of lesion identification method section of the LAOPs checklist after the form's amendment increased from 97.3% to 100%, with at least one method selected Key lessons learned: The most frequent method of identifying lesions are drawing in patients notes and lesion identified by patients. WABA app was not used as a method of identification. Initially, LAOPS safety checklist compliance was not found to be 100%, but later it was modified and the compliance was found to 100% and no further zero events noted until

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
		now
	Animal bites management *Assess ENHT antimicrobial prescribing for the management of animal bites in accordance with NICE NG184 (n=36)*	Key successes: Antibiotics were known to be appropriately prescribed to the majority of patients (19 out of the 33 patients of known antibiotic outcome). Where known, the choice of antibiotic was in line with NICE/local prescribing guidelines, apart from 2 patients, possible influenced by case-specific factors. Patients on IV antibiotics were typically considered for switching to oral within 48 hours. Key lessons learned: Careful consideration of whether antibiotics need to be prescribed, helping to minimise resource use and reduce the risk of promoting antimicrobial resistance. Some patients may have received antibiotics against recommendations (though assessment of skin break and blood drawn was not always explicitly documented): 7 who did not have any broken skin or blood drawn: 1 dog bite patient who had broken skin but no blood drawn: 4 dog bite patients who had broken skin and blood drawn but did not meet the additional criteria necessary for recommending antibiotic.
Ear, Nose and Throat	**Re-audit of ENT Emergency clinic** *Assess patients booked per clinic to ENT compared to UK guidelines, review the suitability of patients referred to emergency clinic and the patients seen more than twice over 2-month period. (n=66)*	Key lessons learned: • Optimize appointment scheduling by redistributing bookings across sessions based on availability, ensuring efficient utilization of all available slots. • Prioritise appointment bookings according to clinical urgency, allowing flexibility to defer less urgent cases to accommodate more pressing ones, such as recurrent epistaxis. • Reserve Monday AM sessions for overbooked appointments, while appropriately allocating less congested sessions for routine cases. • Establish guidelines for determining the suitability of acute clinic visits, with a focus on conditions like OE, recurrent epistaxis, nasal fracture, Bell's palsy, SSNHL, and ear foreign bodies. • Exercise discretion and seek senior input for patients requiring more than two visits to the acute clinic to ensure comprehensive management and appropriate follow-up. Key actions: Educate the ENT team about how many patients should be booked and which conditions are appropriate.

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	Reducing ENT Follow-up appointments *Evaluate adherence to departmental follow-up guidelines, to reduce reduce unnecessary ENT follow-up appoitments (n=50)*	Key successes: Tonsillitis, hearing loss and post-op patients were followed up appropriately Key lessons learned: Some balance and non-polyp rhinitis patients were given unnecessary follow-ups. In person educational sessions about the types of patients to be offered follow up appointments and those suitable for patient initiated follow up delivered
Cancer Centre	CK1 and CK5: Skull and X-sight spine re-audit *Reassess compliance with the procedures laid down in Cyberknife Technique Documents CK1 and CK5 for treatment to various sites including 6D Skull Technique and X-sight Spine technique (n=3)*	Key successes: The Cyberknife team are 100% compliant with the procedures Key lessons learned: Cyberknife Radiographers are thorough with all treatment checks laid down in the Cyberknife techniques
	CK 4 - Synchrony re-audit *Reassess compliance with the procedures laid down in Cyberknife Technique Documents for treatment to various sites including 6D Skull Technique and X-sight Spine technique and Fiducial Synchrony (n=3)*	Key successes: Cyberknife team are compliant with the procedures laid down in Cyberknife Technique. Key lessons learned: Each team member independently performs checks.
Gynaecology	Ovulation induction audit *To assess the management of ovulation induction against local policy and national standard (n=20)*	Key successes: Practice conformed 100% to local Trust guideline. Key lessons learned: Letrozole is effective now as 'first line' management for ovulation induction although still off-label. Clomifene +metformin are effective for patients with PCOS and insulin resistance. No clinical benefit of Tamoxifen. We need local resources to conform to the national recommendation of performing ultrasound follicular tracking at least for the first cycle of ovulation induction.
	Management of urinary incontinence management	Key successes: There was an improvement in conformance to the following standards between the audit cycle in 2021 and

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	Re-audit to determine service conformance to NICE Guideline NG123 (June 2019). (n=20)	reaudit in 2023 1) All urinary incontinence to be categorised at initial assessment (2021 and 2023– 100%) 2) All women have a digital assessment of pelvic floor muscles before treatment (2021 and 2023 all women had examination at initial appointment and were discussed in MDT prior to surgery) 3) All urinary incontinent women with symptoms of significant prolapse are referred to a specialist (100%) 4) Undertake urine dipstick as part of assessment (2021 – 95%, 2023 -100%) First line management should involve a trial of supervised pelvic floor training of at least 3 months (2021-95% vs 2023-100%) and lifestyle modifications (2021 – 95% vs 2023-100%) Key lessons learned: Trust practice conforms to NICE recommendations Key actions: Quality of life questionnaire used to evaluate therapy to be analysed by the clinician every quarter and audited annually.
Trauma and Orthopaedics	Management of Traumatic Meniscal Tears (locked knees) *Assess conformance to local and national guidance, compare Trust outcomes with published outcomes.* (n=40)	Key lessons learned: The significance of urgent MRI for these cases could be shared with Radiologists as well as the importance of urgent surgery could be shared with trauma coordinators/managers and theatre staff. Key actions: To ensure MRI for locked knees can be performed urgently we need more statutory slots for MRI each week exclusively for these cases. To ensure bucket handle tears care operated on within 6 weeks of injury need knee specific trauma lists on alternate weeks
	Audit on follow-up for proper documentation on consent form 4 (demented patients) with neck of femur fractures. *Evaluate adherence to trust guidelines, regarding obtaining proper documentation of consent for demented patients, diagnosed with neck of femur fractures.*	Key lessons learned: Approx, 14% lacked procedure details, 68% only had dual healthcare professional sign, 23% lacked discussion with next of kin, and only 22.8% included Mental Capacity Assessment (MCA) forms. Key actions: 1. Improve awareness among the doctors/ junior doctors of filling consent form 4 by presenting the audit at a rolling half day meeting. Re-audit after 6 months to review improvement against the NICE guidelines.

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	This evaluation seeks to enhance both patient safety and the quality of care provided by ensuring that consent procedures align with established protocols. (n=22)	
	Audit on follow-up documentation of consent form 4 in neck of femur fractures patients- Re-audit and 2nd cycle. **Evaluate** the consent form process for patient lacking mental capacity with fractures of the neck of femur (NOF) and assess the compliance of completing the mental capacity (MCA) forms as part of the consent process.(**n**=31)	Key lessons learned: The department demonstrated enhanced compliance with RCA guidelines for consent Form 4. This was attributed to concurrent completion of the consent form in ED and preoperative checks by nurses in the ward. This led to improved MCA form completion and discussions with the next of kin. Key actions: The assessment encompassed the completion of Mental Capacity Assessment (MCA) forms, verification of signatures by healthcare professionals, engaging in discussions with the next of kin, and thorough documentation of procedure details.
Urology	Primary ureteroscopy at ENH *Assess Trust conformance to GIRFT guidelines for patients presenting ureteric calculi (n=32)*	Key findings: Of the non-infected obstructed system patients 4/23 (17.4%) received primary ureteroscopy and 0/9 (0%) of the infected obstructive system patients received ureteroscopy within 4 weeks.
Gastroenterology	**Large Non-Pedunculated Colorectal Polyps (LNPCP)** *Assess whether all complex polyps within ENH Bowel Cancer Screening Programme requiring endo-mucosal resection (EMR) Endoscopic Submucosal Resection (ESD) or surgical resection are managed in accordance with BSG guidance (34 polyp site checks carried*	Key lessons learned: • This audit remains ongoing, and data will be analysed year on year. • Within the local Endoscopy unit, a complex polyp MDT has been set up and is managed by the Bowel Cancer Screening Specialist Screening Practitioners and admin team. • This is held weekly and consists of all the Bowel Cancer Screening Accredited Gastro Consultants and a Colorectal surgeon. • This allows for any patients with large complex polyps to be discussed, and optimal management agreed. Key actions: Continue to monitor year on year via audit - all episodes of bleeding/perforation are reported to the

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	out)	screening quality assurance team and reviewd locally at RHD (Rolling Half Day)/team meetings
Obstetrics	Caesarean sections (CS) (n=32)	Key successes: 1) Resident Consultants and embedded practice has resulted in 100% conformance to the standard of CS being appropriately classified and 2) 91% conformance to standard of Consultant Obstetrician being involved in emergency CS decision making. 3) 100% conformance to the standards of offering prophylactic antibiotics and thromboprophylaxis 4) 83.3% (n=10/12) conformance to the standard of emergency CS performed in </=75mins 5) 100% conformance to the standard providing appropriate care to mothers 24h post surgery Key actions: • Need to improve documentation for causes of Cat 2 delays and ensure CTG are reviewed as needed. Need to improve post CS discussions and advice
Pathology	**Comparison of Uro17 biomarker with thin prep cytology to identify malignant cells in urine cytological samples.** *Evaluate the reproducibility of the reporting categories in Uro17 biomarker.* *To compare the atypia rates in the Paris system reporting with the equivocal category of Uro17 biomarker. (n=50)*	Key successes: (50%) negative and 10/12 cases (83%) positive categories were reported in the equivocal category. Key lessons learned: The criteria of 5 or more cells with 2+ staining to define a positive result in 31 cases showed a lack of unanimity in 12/31 cases (39% of cases); In 2/12 of these cases (16%), one of the participants (same participant) called N result. Key actions: The Paris system has been widely practised across the country and the continent. It merely requires the use of the prefix "U" to describe categories. Action will be to raise this with the requesting Urologists and discuss this in their forum.
Anaesthetics	Patient handover in the post anaesthetic care unit (PACU)- Re-audit *Evaluate the transfer of mandatory information and patient safety (n=23)*	Key lessons learned: Using the patient handover checklist is beneficial as it ensures a more organised and higher-quality handover process. Encourage all anaesthetists to consistently utilise it for handovers. Additionally, recover nurses will actively remind anaesthetist to employ the checklist for every handover. Key actions: As this was a re-audit, there no actions, audit showed full compliance.
Child Health	Audit of Peanut nut and tree nut allergy management	Key actions: To follow the BSACI guideline

	Project title, aim, objectives and sample size	Key successes, key lessons learned and key actions
	Assess primary and secondary care adherence to the BSACI guideline for the diagnosis and management of peanut and tree nut allergy. (n=264)	

Table 2: A list of 100 local clinical audit projects completed during 2023-2024 by specialty

Project title and reference	
Cervical Spine Fractures(17735)	Trauma and Orthopaedics
Osteoporotic vertebral thoracolumbar fractures at Lister hospital(18224)	
Analysis of rib fractures management and admission(18260)	
Completion rates of the Foot and Ankle Clinic Proforma(18263)	
An audit of post-operative prophylactic antibiotics following primary arthroplasty in the trauma and orthopaedics department in line with current trust guidelines of antibiotic prescription.(18297)	
Assessment of neurovascular status documentation of paediatric supracondylar humeral fractures in line with current British Orthopaedic Association Trauma Standards(18298)	
Compliance of elbow hemiarthroplasty for trauma with the BESS and GIRFT guidelines for Primary and Revision elbow Replacement – Re-audit of 18205.(18729)	
Audit of The Management of Shoulder Dislocations(18311)	
Re-audit - Evaluation of compliance of NJR policy and Trust policy of recording of data Reverse shoulder replacements performed for traumatic injuries(18712)	
Management of Traumatic Meniscal Tears (Locked Knees)(18746)	
Audit on follow-up for proper documentation on consent 4(demented patients) with Neck of femur fractures.(23/24_Trust_TandO_4)	
An audit on follow-up documentation of consent form 4 in neck of femur fractures patients- Re-audit and 2nd cycle.(23/24_Trust_TandO_5)	
Introduction of a New Protocol to Limit the Number of Cancelled Elective Orthopaedic Operations Due to Asymptomatic Bacteriuria (23/24_Trust_TandO_1)	
Audit to Improve Lister Hospital's Performance on National Hip Fracture Database (NHFD) in Regards to the Operative Management of Extracapsular Neck of Femur Fractures (23/24_Trust_TandO_6)	

Project title and reference	
Analgesic management of patients admitted with rib fractures.(18301)	Anaesthetics
Patient handover in the post anaesthetic care unit (PACU)- Re-audit of 18307(18709)	
Evaluating Intrathecal Bupivacaine's Impact on Unplanned Day Surgery Admissions(23/24_Anaesthetics_03)	
Post Delivery Neurological Injuries(23/24_Anaesthetics_04)	
Scaphoid referral sent to plastics department in Lister Hospital(18302)	Plastic and Reconstructive Surgery
Assessment of wound management in Trauma and Orthopaedics(18306)	
Audit and reaudit of compliance of LAOPS Safety checklist(18705)	
Animal Bites Management(18752)	
Audit on management of hypothyroidism in pregnancy(18708)	Obstetrics
Postnatal Audit inc Postpartum Bladder Care(18713)	
Waterbirth Audit. Re-audit of 17748(18715)	
Caesarean Sections(23/24_Trust_Obstetrics_02)	
Antenatal care(23/24_Trust_Obstetrics_03)	
Maternity Hypertension Audit(23/24_Trust_Obstetrics_01)	
Sequential Operative Vaginal Delivery.(23/24_Trust_ Obstetrics_08)	
Audit of obesity in pregnancy guideline.(23/24_Trust_Obstetrics_09)	
SBAR handover audit .(23/24_Trust_Obstetrics_11)	
Antenatal Optimisation for babies less than 34 weeks.(23/24_Trust_Obstetrics_10)	
Newborn observations in a low risk setting - NEWTT(23/24_Trust_Obstetrics_14)	
Fresh eyes audit 2023 (from guideline 4.1.2 Fetal Heart Rate Monitoring)(23/24_Trust_Obstetrics_13)	
Conservative Management of CIN 2(23/24_Trust_Obstetrics_12)	
Breech, malpresentation and ECV Audit.(23/24_Trust_Obstetrics_15)	
Molar Audit (Gestational Trophoblastic Disease)(23/24_Trust_Obstetrics_06)	
Fetal heart rate monitoring - intrapartum caution checklist compliance(23/24_Trust_Obstetrics_05)	
Women who decline blood products(23/24_Trust_Obstetrics_04)	
Stillbirth Audit July 2021 - June 2022(23/24_Trust_Obstetrics_07)	
Audit of epidural observations during labour (23/24_Trust_Obstetrics_17)	
Admission of pregnant women to the ED and non maternity wards (23-34_Trust_Obstetrics_16)	
Safe handover within urology department(18733)	Urology
Re-audit of 18305 - Management of radiological investigation reports within the Urology Department(18737)	
Primary Ureteroscopy at ENH(18747)	

Project title and reference	
Ureteric stones conservative management audit(23/24_Urology_02)	
Non-surgical acute scrotum patient's follow-up(23/24_Urology_03)	
Measuring serum calcium in adults with renal stones (NG118) 2ND CYCLE (re-audit of 18271)(23/24_Urology_04)	
Completion of Discharge Letters in Urology (23/24_Urology_05)	
Reaudit of 18283- Are patients presenting with urinary tract calculi routinely given dietary advice?(23/24_Urology_06)	
CK1 and CK 5 - Skull and X-Sight Spine (re-audit of 18213 and 18214)(18740)	Cancer Centre
CK 2 - Cyberknife Fiducial Tracking (re-audit of 17058)(18741)	
CK 4 - Synchrony (re-audit of 18215)(18742)	
EPA - MVCC Radiotherapy IR(ME)R Patient Identification Compliance Audit Part 2 –Treatment (23/24_Cancer Centre_02)	
EPC - MVCC Radiotherapy Audit IR(ME)R Procedures Consent, Communication of risk and benefit of radiation exposure and Enquiries of individuals to establish pregnancy and breastfeeding status - Treatment 2(23/24_Cancer Centre_03)	
EPK - Reduction of probability and magnitude of Radiation Incident(23/24_Cancer Centre_08)	
EP J - Clinical evaluation of Radiation doses in Radiotherapy_Cyberknife (23/24_Cancer Centre_05)	
EP J - Clinical evaluation of Radiation doses in Radiotherapy_LINAC(23/24_Cancer Centre_06)	
EP J - Clinical evaluation of Radiation doses in Radiotherapy_Pre-Treatment(23/24_Cancer Centre_07)	
EPA - MVCC Radiotherapy IR(ME)R Patient Identification Compliance Audit Part 1 – Pre-Treatment (23/24_Cancer Centre_01)	
EPE - IR(ME)R - Assessment of patient dose and administered activity in relation to patient records.(23/24_Cancer Centre_04)	
EPL - IR(ME)R Procedure Incident Reporting(23/24_Cancer Centre_09)	
EPB2 - IR(ME)R Procedure Practitioner(23/24_Cancer Centre_10)	
EP B1 - Procedure Operator Audit - Radiotherapy Department(23/24_Cancer Centre_12)	
EP B4 - IR(ME)R Procedure for Justification and Authorisation of concomitant exposures V1, for treatment purposes(23/24_Cancer Centre_13)	Cancer Centre
EP B.4 Justification and Authorisation of concomitant exposures V1 for pre-treatment(23/24_Cancer Centre_14)	
EP D1 - Radiotherapy Dept Policy Developing Standard Operating Procedure Documents(23/24_Cancer Centre_15)	
MVCC Radiotherapy IR(ME)R EP B.3 - Referral Form Audit (23/24_Cancer Centre_16)	
EP F - IR(ME)R Procedure for Diagnostic Reference Levels Audit (23/24_Cancer Centre_11)	
Re-audit of PT 21 – VSIM Care Path(23/24_Cancer Centre_19)	

Project title and reference	
Re-Audit of GP 12 pt3 Hygiene in the Radiotherapy Department December 2023(23/24_Cancer Centre_20)	
Re-AuditGP 12 pt 3 Hygiene in the Radiotherapy Department December 2023 (23/24_Cancer Centre_18)	
Reaudit of GP33 Encounters Audit(23/24_Cancer_Centre_21)	
Re-audit of RT 4 Head and Neck(23/24_Cancer_Centre_23)	
Re-audit of RT 14 - MVCC Radiotherapy RT 14 Adaptive Bladder Treatment Technique Audit Month/Year(23/24_Cancer_Centre_24)	
GP35 - PLAN PREPARATION(23/24_Cancer_Centre_22)	
Reaudit of RT 16 Real Time Position Management(23/24_Cancer_Centre_25)	
Reaudit of GP23- Carepath Tasks for Radiotherapy Patients Month/Year(23/24_Cancer_Centre_26)	
RT25 - Oesophagus Radiotherapy Technique(23/24_Cancer_Centre_27)	
Reaudit of PC15- Care of Patient during Radiotherpy Treatment Month/Year(23/24_Cancer_Centre_28)	
Reaudit of RT11- Radiotherapy Non-adaptive Gynae Technique(23/24_Cancer_Centre_29)	
RT 12 MVCC Radiotherapy RT12 Lung Treatment Technique Audit (23/24_Cancer_Centre_33)	
RT 13 MVCC Radiotherapy RT13 Adaptive Gynae Treatment Technique(23/24_Cancer_Centre_34)	
Reaudit of RT 02 SINGLE ISO Breast tumours OCTOBER 2023(23/24_Cancer_Centre_31)	
Reaudit of PT 11 - CT Scanning with IV contrast(23/24_Cancer_Centre_30)	
Reaudit of RT 03 Prostate October 2023(23/24_Cancer_Centre_32)	
EPB.1 Procedure Operator Audit(23/24_Cancer_Centre_35)	
30 day mortality rate of palliative patients from treatment to death(23/24_Cancer_Centre_36)	
Reaudit Discrepancies in Clinical Details for CT requests form the Emergency Department (re-audit of 17718)(18717)	Radiology
Audit of Peanut nut and tree nut allergy management(18703)	Child Health Acute
Comparison of Uro17 biomarker with thinprep cytology to identify malignant cells in urine cytological samples(18245)	Pathology
Departmental adherence to gastric biopsy protocols for dyspepsia and suspected H.pylori infection(23/24_Trust_Pathology_01)	
Audit into clinician knowledge of antiplatelet and anticoagulant medications (23/24_Vascular Surgery_01)	Vascular surgery
Audit of handwashing and PPE use on general surgery ward rounds(23/24_Trust_General Surgery_01)	General surgery
Large Non-Pedunculated Colorectal Polyps (LNPCP)(18735)	Gastroenterology
Ovulation induction audit(18743)	Gynaecology

Project title and reference	
Management of urinary incontinence(18744)	Gynaecology
ENT Emergency clinic audit(18704)	Ear, nose and throat
ENT Emergency clinic - Re-audit (of 18704)(18707)	
Reducing ENT Follow-up appointments(18736)	

Participation in Research and Development

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.

The number of patients receiving relevant health services, provided or sub-contracted by the ENHT in 2023/24 that were recruited during that period to participate in research approved by a research ethics committee was 4,380.

This number is likely to be an underestimate as it has been obtained from a national data system (the Clinical Research Network East of England Open Data Platform) made on 15 April 2024 and the full 2023/4 data set will not be available until 27 April 2024.

The research activity in 2023/4 relating to studies adopted to the NIHR Portfolio is summarised below with research participation by service area.

Service area	Research participation
Maternity	2,235
Renal (Kidney)	710
Cancer	476
Anaesthesia	391
Cardiovascular	185
Gastroenterology	118
Ear Nose Throat (ENT)	81
Surgery	48
Dementias and Neurodegeneration	42
Children	27
Health Services	24

Critical Care	15
Metabolic and Endocrine	13
Hepatology	9
Diabetes	3

Some examples of embedding research into practice for the benefit of patients

- **Developing new knowledge:** Anticoagulants (blood thinners) are used in some patients to reduce the risk of clots forming which can lead to stroke. However, these medications can significantly increase the risk of bleeding. Our cardiology team were the highest recruiters for two research studies which identified the optimum use of a new anticoagulant (Asundexian) in patients with atrial fibrillation (irregular and often abnormally fast heart rate).
- **Development of new treatments (e.g. for breast cancer):** Thanks to the oncology research team, Mount Vernon became the first cancer centre in the UK to treat a patient with Trodelvy, a new treatment for metastatic triple negative breast cancer. Cancer patient Carly Francis, said: "*I'm incredibly grateful to the team who acted so quickly to enable me early access to this new treatment*."
- **Enhancing the delivery of a service:** Patients whose kidneys do not work properly have a procedure known as dialysis to remove waste products and excess fluid from the blood. Our renal research team found that the amount of dialysis patients receive could be safely reduced for some people. This benefits patients because they have to spend less time in hospital. It also good for the environment because less dialysis means less patient travel and less electricity use.
- **Development of a new service:** Our gastroenterology team provide treatment to people with health issues of the digestive system including oesophagus, stomach and intestines). The team created a novel approach to detecting oesophageal cancer through the innovative Cytosponge approach - a 'sponge on a string' test that samples cells from the oesophagus without the need for gastroscopy (a tube into the stomach and previous standard of care). The use of Cytosponge can help with early detection and treatment of oesophageal cancer with improved health outcomes and cost savings.
- **Embedding research for all patients:** As a research active organisation we want to see research embedded as an expectation and we achieved this within our maternity services. Group B Streptococcus (GBS) is a bacterium present in the vagina of approximately 1 in 4 pregnant women. Giving women antibiotics in labour reduces the risk of their babies developing GBS infection but it is not routinely done. As part of a research study our maternity service offered GBS3 testing to every pregnant woman. A total of 3,610 women have taken up this offer, with 2,220 in 2023/4.

Update on Public involvement and research participation

We continually ask research participants about their experience using the standard National Institute for Health and Social care Research survey. During 2023/24 we had responses from 114 adults and their feedback is summarised below:

Questions	**Response**

1. The information that I received prepared me for my experience on the study	94% Agree or Strongly Agree
2. I feel I have been kept updated about the research	72% Agree or Strongly Agree
3. I know how I will receive the results of the research	74% Yes or Yes to some extent
4. I know how to contact the research team if I have any questions or concerns	92% Yes or Yes to some extent
5. The researchers have valued my taking part in the research	95% Yes or Yes to some extent
6. Research staff have always treated me with courtesy and respect	97% Yes or Yes to some extent
7. I would consider taking part in research again	90% Yes or Yes to some extent

The responses also provide data on ethnic group, summarised below:

Ethnic group (as described in the nationally designed survey questions)	**Responses (n)**	**Responses (%)**
White/English/Welsh/Scottish/Northern Irish/British	90	81.1%
White/Any other White background	7	6.3%
White/Irish	6	5.4%
Black / African / Caribbean / Black British/ African	3	2.7%
Asian/ Asian British/ Indian	2	1.8%
Asian/ Asian British/ Any other Asian background	2	1.8%
Black / African / Caribbean / Black British/ Caribbean	1	0.9%
Total (not all responded to this question)	**111**	**100.0%**

Although the information on the ethnic groups is based on a non-random sample of low overall number (i.e. 2.6% of the 2023/4 research participants) the ethnic composition of research participants is broadly similar to that of the populations served by the Trust.

Research participants also provided written comments, summarised below.

What was positive about your research experience?

- Welcoming and friendly practice nurse. The sense of being able to do something positive for the future healthcare of others.
- The research staff are excellent, caring and take the time to explain what is happening and are always available on the phone.
- Very grateful for my support and always thanked me for volunteering to take part in the study. I felt appreciated.
- Felt I was helping people in the future through my experience.

- Giving something back to help others in the future.

What would have made your research experience better?

- Access to a website about research programme.
- To have a newsletter (can be e-format to be kept updated about the programme note this might be available after completing the survey).
- Receive updates from the research team without me having to call every other day.
- That the research office was easier to find in the maze that is the Lister Hospital!
- Biscuits after the blood taking! No, in seriousness I don't know anything they could have done better.

Looking forward

We are tremendously proud of our research this year. The UK government has set out a vision to improve the lives of patients all over the UK and around the world by putting clinical research at the heart of patient care across the NHS, making participation as easy as possible and ensuring all health and care staff feel empowered to support research.

The Trust is committed to delivering on this compelling and ambitious vision which will unleash the true potential of clinical research right across the UK, to address long standing health inequalities and improve the lives of us all, both now and in the future.

Update on Commissioning for Quality and Innovation (CQUIN)

In line with national guidance for 2023/24, 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, indicative by value/performance only, as agreed by commissioners.

All providers in scope for CQUIN will be required to report their performance against all indicators to the relevant national bodies where they deliver the relevant services. The Trust's income in 2023/2024 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.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'requires improvement'. The CQC has not taken enforcement action against the Trust during 2023/24.

On 20 and 21 June 2023, the CQC carried out an unannounced inspection of acute services at the Lister hospital including urgent and emergency services, medical care, surgery and maternity services. This was followed by an announced 'Well Led' inspection which was carried out on 2 and 3 August 2023. The Trust submitted evidence of completion of 'must do actions' at the end of the year and are now focussing on the 'should do actions'.

In 2023/24 the inadequate rating for maternity services (previously rated inadequate in 2022) was lifted. The maternity service continued on the national improvement programme throughout 2023/24 and following the learning from the inspection, priority actions have been undertaken and delivered to address the identified must and should do actions.

The Trust has participated in other planned reviews by the CQC during 2023/24 relating to the following areas:

- IR(ME)R on 27 November 2023. CQC inspectors conducted a virtual announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the radiotherapy service at the Mount Vernon Cancer Centre.
- InHealth mobile van CT service on 7 August 2023.

During 2023/24 the Trust has continued to review the quality assurance framework. Actions to embed cultural change in good governance standards include the review of reporting requirements and reach of shared learning platforms where good practice is identified.

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 2023/2024 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 were as follows. The numbers in brackets represent the national average across the same period.

99.9% (99.7%) for admitted patient care
99.9% (99.7%) for outpatient care
99.4% (97.0%) for accident and emergency care

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

99.0% (99.7%) for admitted patient care
100.0% (99.5%) for outpatient care
100.0% (98.9%) for accident and emergency care

Update on data quality

The data quality team focusses on the quality of data captured on the Trust's patient administration system, Lorenzo, relating to patient information, activity recording and performance management. During 23/24, the team continued its focus on improving the quality of our performance data.

Good quality data feeds into all areas of the trust and the data quality team ensures that the Trust's data is accurate, valid and is recorded in a timely manner. Good quality data is essential for Trust reports, ensuring that the data supports the decisions that are made for the local community that we serve.

The team is taking the following actions in 24/25 to improve the quality of the Trust's data:

- Raising awareness of poor data quality, focussing attention on areas which need support through the monthly data quality steering group
- Reviewing the data quality KPI dashboard in line with the Trust objectives

Update on Information Governance Toolkit (IGT)/ Data security

All health and care organisations are expected to implement the 10 National Data Guardian (NDG) standards for data security. These standards are designed to protect sensitive data, and to also protect critical services which may be affected by a disruption to critical IT systems (such as in the event of a cyber-attack).

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that enables the Trust to measure their compliance against the NDG standards, and demonstrate and that sensitive information is protected from unauthorised access, loss, damage and destruction.

The DSPT 2022/23 submission achieved "approaching standards" status. In quarter 3 2023/24 a new cyber and information governance function was established in the Chief Information Officer's directorate led by a new role of Head of Information Governance and Cyber Security. A review of all DSPT assertions is underway to provide an improved level assurance for the 2023/24 DSPT cycle.

A baseline publication was made on March 7, 2024, and the outcome of an internal audit is pending but expected in advance of DSPT submission at the end of June 2024. The Information Governance Steering Group continues to monitor progress ahead of DSPT submission.

In the current DSPT year, 11 incidents have been reported on DSPT. Two of these incidents met the threshold for disclosure to the Information Commissioner's Office. The increase in incidents reported on the previous DSPT cycle, demonstrates improved awareness within the Trust regarding GDPR regulations to report personal data breaches and maintain data confidentiality, integrity and availability.

Update on clinical coding

The Trust undertakes annual and regular clinical coding data quality audits 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 are the results for the Admitted Patient Care (APC) audit.

	2023/24	Previous year (2022/23)	Standards Exceeded
Primary diagnosis	97.5%	95.5%	>=95%
Secondary diagnosis	97.0%	98.0%	>=90%
Primary procedure	97.1%	96.1%	>=95%
Secondary procedure	98.5%	98.5%	>=90%

Update on 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 seeking ways to continuously 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.

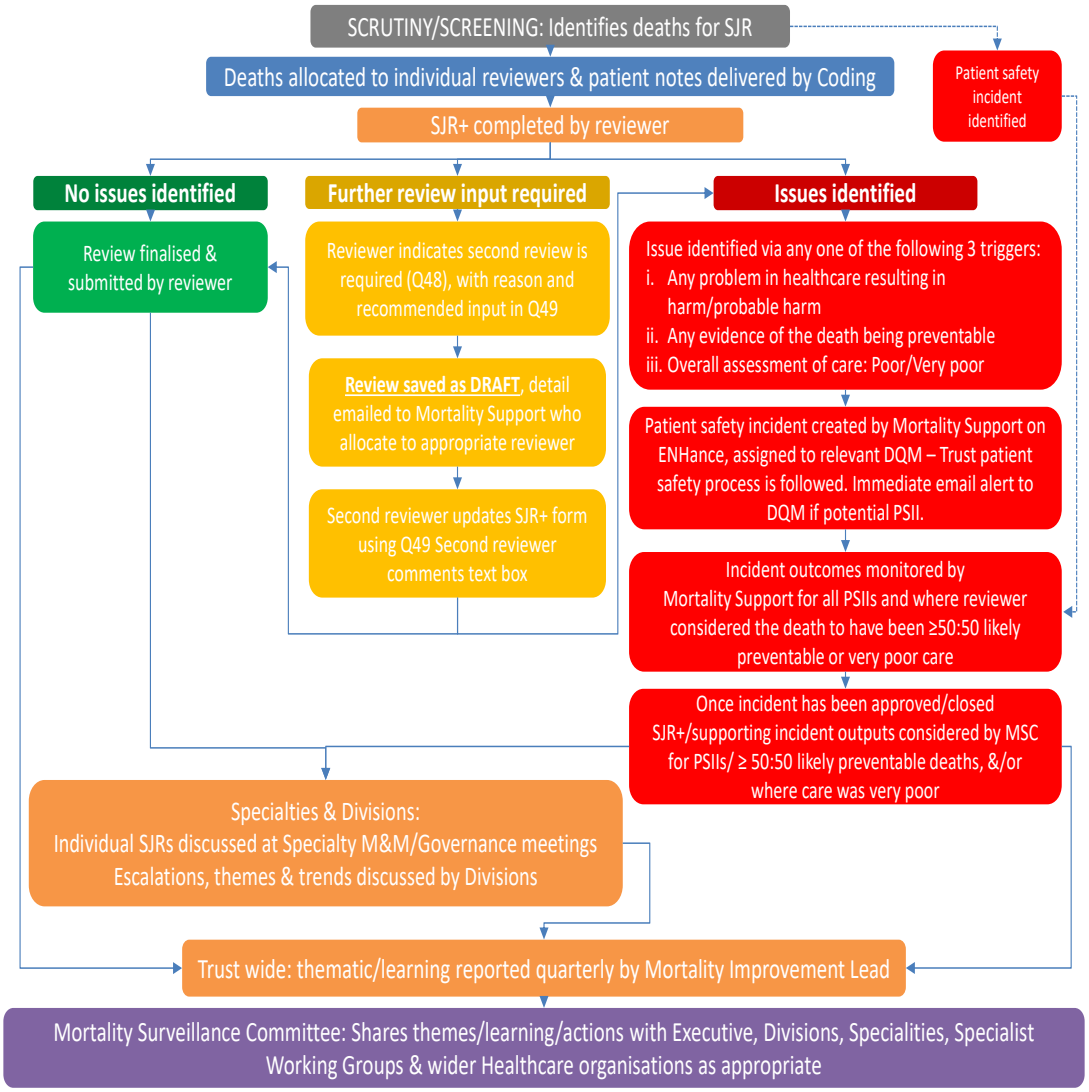
To learn from deaths and improve the quality of the care we provide; we recognise that it is vital that we have a robust process for reviewing the care received by our patients at the end of their life. In recent years we reviewed our processes and introduced several reforms which we believe have built 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 in July 2022 of the Structured Judgement Review Plus (SJR*Plus*) format for review, developed by the "Better Tomorrow" Aqua (Advancing Quality Alliance) team. This collaborative initiative was developed as part of the FutureNHS platform and has since transferred to Aqua. Its aim has remained the same, "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.

Currently learning from our mortality review process, whether specific cases or themes, is shared across the Trust with clinical staff via clinical governance and quality forums such as mortality and morbidity meetings, rolling half days and divisional quality and safety meetings. It may also be shared with relevant working groups such as those focussing on deteriorating patient and end of life care. Where appropriate, thematic review outcomes are also shared in the wider healthcare community, including with the ICB and community trust. We continue to seek ways 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 the Trust using the SJR*Plus* review format.



Some of the key themes identified in the course of our learning from deaths work are detailed below.

Themes and Current Issues Identified to Inform Future Improvement Planning
Findings from Thematic Reviews **Factors contributing to excellent care:** • early recognition of end of life • appropriate/timely communication with patient and family • patient and family involved in decision-making • creating a supportive environment • clear documentation of discussions • appropriate escalation and timely withdrawal of treatment

- excellent MDT and joined-up decision-making
- comfort for the patient
- compassion.

Factors contributing to poor/very poor care:

- issues with patient management; EoL care; errors and omissions; pathways, processes, policies; documentation including:
- patient cared for by wrong specialty
- multiple bed/consultant transfers
- unconscious bias
- failure to review test results prior to discharge
- pressures/overcrowding in ED
- insufficient specialist care for high numbers of MH patients in ED
- delay to acting on scan findings
- COVID pandemic
- appropriate drug to treat seizure not available on ward.

Learning from Deaths Strategy – Ongoing Objectives

- improvement against NHFD KPI target for #NOF patients to receive a nerve block and be admitted to an orthopaedic/orthogeriatric ward within 4 hours
- stroke: Improve the percentage of patients who are thrombolysed within 60 minutes of arrival
- reduce the number of inappropriate CPR attempts
- improve the conduct of Advanced Care Planning (ACP) discussions
- work with the ICS to reduce the number of in-patient deaths of medically optimised patients with delayed discharges
- improve case ascertainment for the national emergency laparotomy audit
- improve the delivery of ABX within 1 hour for In-patient and ED in those with septic shock or a high likelihood for sepsis.

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	2023-24 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 2023-24, 1379 of ENHT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 317 in the first quarter; 301 in the second quarter; 391 in the third quarter; 370 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	By 31 March 2024, 327 case record reviews and 3 investigations have been carried out in relation to 1379 of the deaths included in item 27.1. In 2 cases a death was subjected to both a case record review and an

	to the patient, including a quarterly breakdown of the annual figure.	investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 93 in the first quarter; 96 in the second quarter; 92 in the third quarter; 47 in the fourth quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	3 representing 0.22% 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: 1 representing 0.32% for the first quarter; 1 representing 0.33% for the second quarter; 1 representing 0.26% for the third quarter; 0 representing 0% for the fourth quarter. These numbers have been estimated using the Trust's Mortality Review process. Since 1 July 2022 the Trust has used the SJR*Plus* review format. Based heavily on the original Royal College of Physician's SJR model, this was developed by the 'Better Tomorrow' initiative, which was initially hosted on the Future NHS platform and has since transferred to Aqua (Advancing Quality Alliance). Included in the review, is an assessment by the reviewer of the preventability of death. It must be remembered that the question of the preventability of a death is the subjective assessment of an individual reviewer on the basis of a SJR desktop review. While not definitive, the assessment by them that the death was more likely than not due to a problem in healthcare (more than 50:50% preventable) triggers a patient safety incident, enabling further in-depth investigation of the case in line with current 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.	The skill mix within current stroke services required review and matching against skills required for a Hyperacute stroke. The reviewer concluded that if Nursing resource had been comparable to an High Dependency Unit, the some quality care standard may have been to a higher acuity level. In the second cases the reviewer could not find evidence of adequate VTE assessment and prophylaxis in the patient notes. This incident is now being investigated as a PSII under the new PSIRF regime. Final outputs and analysis awaited. In the third case, while there were no concerns relating to the final admission, the reviewer identified that in a prior ED attendance there was a failure to act on abnormal test results, with possible missed diagnosis, which potentially affected the patient's outcome.
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).	Case 1: The HASU staffing issue sits with the Chief Nurse and DNandQ Unplanned Division. A business case is in progress, with one of the areas being addressed being an increase in staffing levels for the HASU to align with the new Stroke Guidance. The matter has been reviewed as part of ongoing collaborative East of England Integrated Stroke Delivery Network initiative. Case 2: Final outputs and analysis awaited from the PSII incident investigation. Case 3: A Roundtable was considered the most appropriate learning event for this incident. At this it was agreed that ED consultants need to document ECG findings directly into NerveCentre and that Nursing Staff should be encouraged to document any findings noted by doctors regarding a patient's ECG onto this system.

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.	Insufficient time has elapsed to enable an assessment of the actions detailed above.
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.	76 case record reviews and 15 ACON investigations completed after 1 April 2023 which related to inpatient deaths which took place before the start of the reporting period.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	0 *[of the 76 case record reviews and 15 ACON investigations reported in 27.7 above]* representing 0% of the patient deaths before the reporting period *[ie 2022-23]* 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.	9 representing 0.65% of the patient deaths during 2022-23 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]*.

2.4 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 Trust's performance is reported together with the national average and the performance of the best and worst performing trusts, where applicable.

2.4.1. Mortality

Performance against national core indicators

The Summary Hospital-level Mortality Indicator (SHMI) is expressed as a ratio of observed to expected deaths so that a number smaller than '1' represents a 'better than expected' outcome. The Trust's SHMI for the 12 months to November 2023 is 0.9194, positioned within the 'as expected' Band 2 category. SHMI is generally available six months 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 21st out of all acute non-specialist trusts (119).

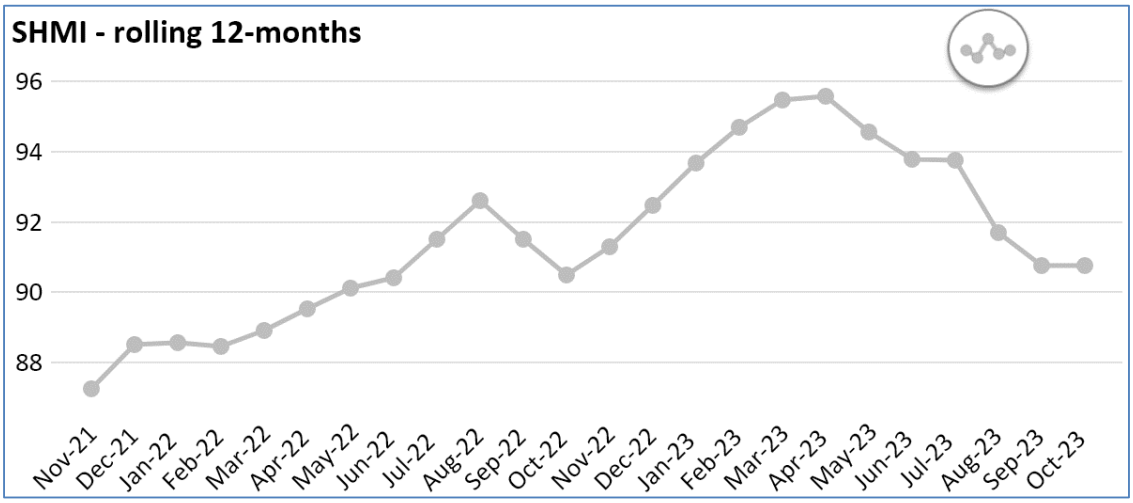
NHS Digital has excluded COVID-19 activity from the SHMI metric. Of note is that the fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture.

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	0.9194	Dec-22 to Nov-23	0.9113*	0.7195	1.2654	1.0
	Banding	2		2	3	1	-
% deaths with palliative care coding	Percentage	44.0		41.0	66.0	16.0	42.0

** Time period: December 2021-November 2022*

Rolling 12-month SHMI: December 2022 to November 2023

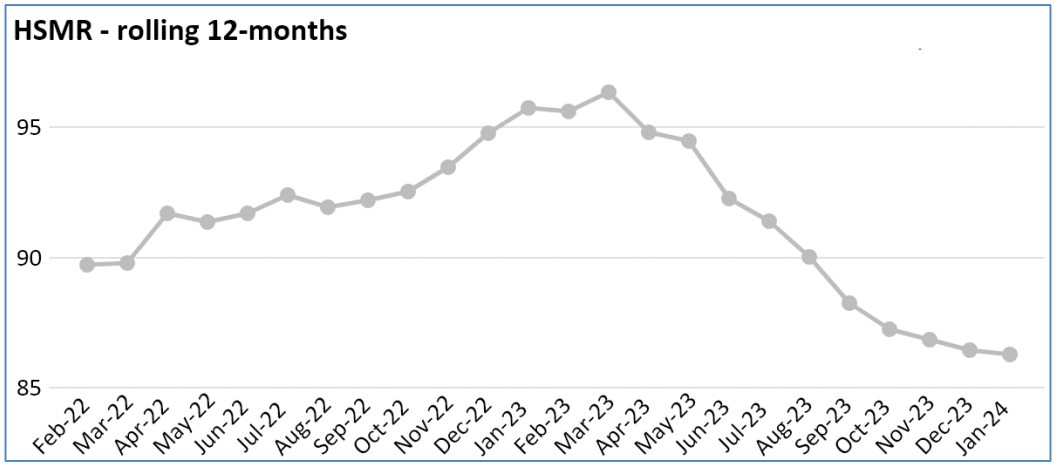


Note: In the chart above the observed to expected deaths have been multiplied by 100 (comparable to HSMR methodology) so that '100' and is comparable to the '1' as described above, where the number of observed deaths exactly matches the number of expected deaths.

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, for a basket of 56 diagnosis groups, which account for approximately 80% of all deaths.
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). Generally, this means that a figure below 100 indicates a 'lower than expected' number of deaths. However, unlike SHMI, our informatics provider CHKS, do not rebase the HSMR metric monthly. They currently rebase every one to two years. This should be borne in mind when assessing performance. Our performance is currently within the first quartile of acute trusts. HSMR is generally available 3 months in arrears and the latest HSMR for the rolling 12 months to January 2024 is 86.3 against a national average of 92.8.

Rolling 12-month HSMR: February 2023 to January 2024



The Trust 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 Trust 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.

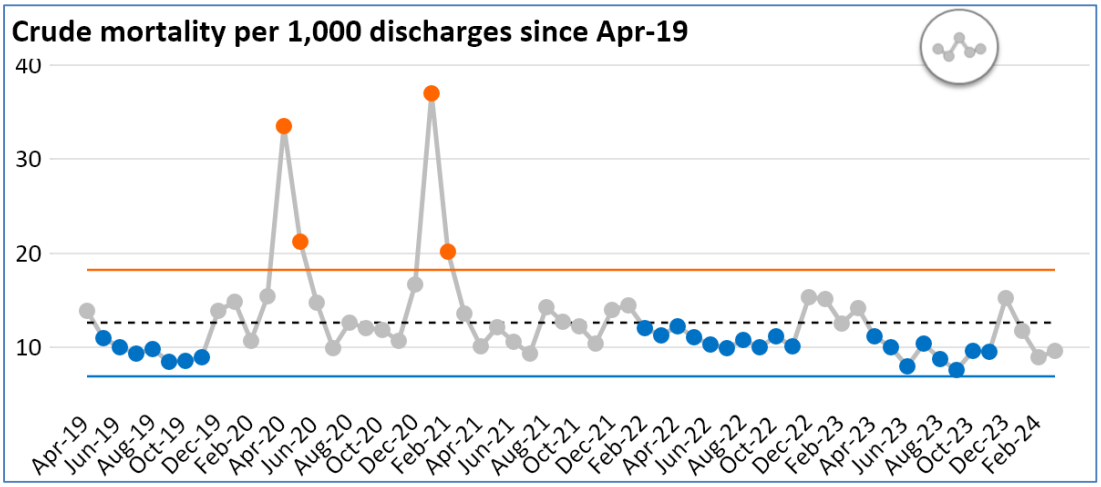
Crude mortality
Crude mortality is based upon the number of patients who die in the Trust whilst an inpatient. It is measured per 1,000 admissions.

This measure is available the day after the month end and is the factor with the most significant impact on HSMR.

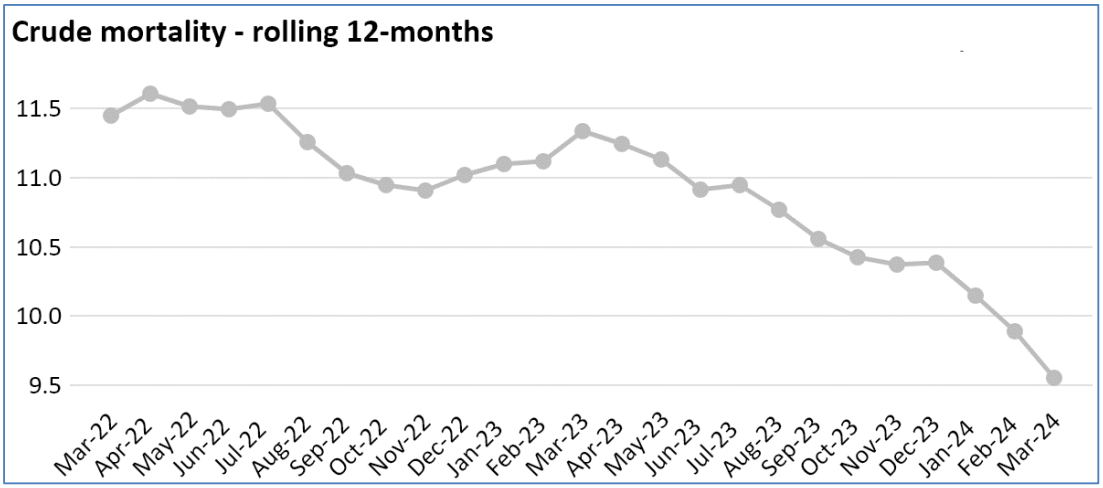
The general improvements in mortality over recent years have resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work, together with a continued drive to improve the quality of our coding.

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.

Crude Mortality per 1000 discharges since April 2019



Rolling 12-month Crude Mortality March 2022 to March 2024



2.4.2 Covid

The multi-layered effects of the Covid pandemic made meaningful analysis and comparisons regarding mortality data challenging. For example, in-patient numbers and case-mix have varied during the pandemic. While the WHO downgraded its status from an emergency to a threat in May 2023, signalling the end of the pandemic, the effects continue to impact data analysis, and Covid deaths will continue. The below chart provides the latest high-level detail covering most of the 2023-24 year.

Our reported number of deaths for the year 2023-24 are as follows:

Covid Deaths 1 Apr-23 to 31 Mar-24	Definition
105	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.
73	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.

2.4.3 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 2023/24, the Trust did not participate in PROM collections.

2.4.4. 30 Day/ Emergency readmissions

Readmissions data is only available until Jan 2024 and hence the data below is comparison of data from Apr - Jan period.

30 Day Readmissions	Apr 21 - Jan 22			Apr 22 - Jan 23			Apr 23 - Jan 24		
	0-15	16 and over	Total	0-15	16 and over	Total	0-15	16 and over	Total
Discharge	9377	84370	93747	10533	86496	97029	8544	95657	104201
30-day readmissions	1304	5326	6630	1317	4856	6173	894	5621	6515
30-day readmission rate	13.91%	6.31%	7.07%	12.50%	5.61%	6.36%	10.46%	5.88%	6.25%

*Data up to January 2024

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

2.4.5. 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	2022 -23			2023-24	
	A and E	Inpatient		A and E	Inpatient
Response rate	0.49%	21.75%		0.48%	18.19%
% would recommend	88.10%	96.37%		92.61%	96.45%

*data as at March 2024

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.

2.4.6. Venous Thromboembolism (VTE)

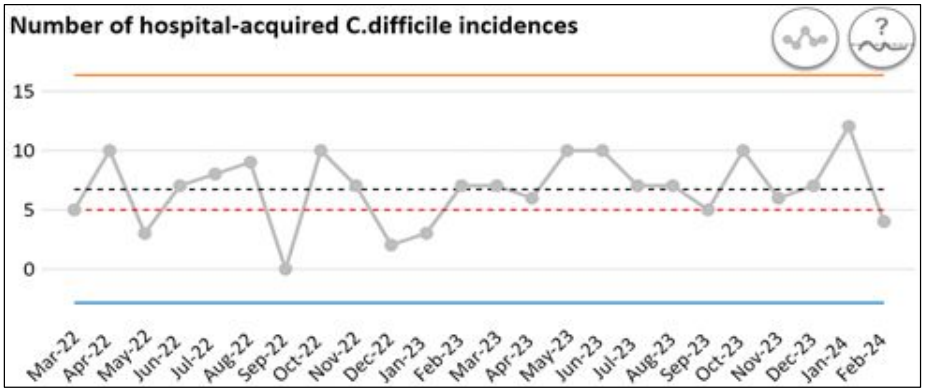
The national bench marking data collection has been reinstated for April 2024 with the first submission scheduled for July 2024. Since the quality improvement work began in July 2021 the following changes and improvements have been made:

- Reviewed and strengthened the VTE/HAT governance structure, this is in line with the Trust priority regarding VTE prevention.
- VTE training became essential training for relevant clinical staff
- 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.
- The successful appointment of a VTE lead practitioner
- The Trusts VTE policy was reviewed, updated and re-launched
- Established regular clinical engagement to share VTE data, improvement work and learning from HATs
- Reporting in real-time on the ‘patient safety at a glance’ (PSAAG) board to provide a ‘prompt’ as a visual reminder.
- Digital reporting at the ward, speciality and consultant level to support targeted improvement projects.
- 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.

2.4.7. Clostridioides difficile

Trust-allocated cases of *Clostridiodes difficile (C diff)* infections – 91 against the threshold of 58 for the financial year 2023/24. Post infection reviews remain the

process to ascertain timely learning, with the Infection Prevention and Control (IPC) team supporting education and training needs highlighted. The reviews have demonstrated that the intrinsic risk factors of our patient demographic increase the likelihood of certain patient groups developing *C diff* infection during their hospital stay or shortly after. The microbiology consultants and the IPC team worked with the pharmacy team, and relevant medical clinical leads to review the micro guide according to body systems, with the aim of providing appropriate treatment regimen and reducing C diffogenic antimicrobials, if clinically safe to do so. Regular IPC team engagement with the divisions to support timely sample taking and isolation in order to prevent cross transmission remains a focus.



The C.diff improvement programme started towards the end of 2022/23. The multidisciplinary approach in tackling the risk of developing C.diff was significantly recognised and focus on antimicrobial stewardship was strengthened. Recently, the programme has gained momentum having the Medical Director and Chief Nurse/DIPC inviting treating teams into a post infection review to identify where improvement can be made from the lessons learned. Progress on actions and improvements is monitored regularly.

Non-Covid related key infection control performance indicators for 2023/24

Month	***C.difficile* 23-24**	**MRSA BSI 23-24**	**MSSA 23-24**	***E.coli BSI* 23-24**	***Pseudomonas aeruginosa* BSI 23-24**	***Klebsiella spp BSI* 23-24**
April	6	1	1	1	2	0
May	10	0	1	3	2	2
June	10	0	3	6	0	3
July	7	0	2	6	0	0
August	7	0	2	7	0	2
September	5	0	1	2	0	1
October	10	0	5	6	1	4
November	6	1	1	4	1	3
December	7	0	3	7	0	0
January	12	0	2	3	1	2

February	4	0	2	8	0	2
March	7	0	2	3	4	1
	Total	**Total**	**Total**	**Total**	**Total**	**Total**
	91	2	25	56	11	20
	Threshold numbers 2023 -2024					
	58	0	N/A	44	10	18

Despite a significant increase of 10.7% in the number of patients who have had inpatient stays during 2023/24 compared to 2022/23, there is a reduction in Blood Stream Infection (BSI). MSSA and *Pseudomonas spp* incidences are lower compared to the previous financial year, and a slight increase of one case in MRSA BSI and two cases of *Klebsiella BSIs*. The IPC team have continued to support the Trust by delivering the '3Cs' (clean hands, clean equipment, clean environment) to all inpatient and outpatient areas, and renal satellite units, which emphasises aseptic technique principles as essential skills in preventing BSI. Fundamental IPC measures, based on the guidance from the National Infection Prevention and Control Manual (NIPCM), have been taught and re-emphasised Trust wide. Transmission based precautions have been widely encouraged to support patient care, following a return to pre-Covidpractices. Moreover, hand hygiene competency training continues to be delivered by the IPC team to all staff groups, both clinical and non-clinical. To date, well over 3,500 staff have completed the hand hygiene competency; significantly positively influencing patient safety throughout the organisation.

2.4.8. MRSA bacteraemia

The Trust reported a total of two healthcare associated MRSA bacteraemia (blood stream infections) which is above the threshold of zero. Both cases had intravascular indwelling devices. The first case was a renal dialysis patient in April 2023, who had shared care between our Trust and the neighbouring acute trust. The second case in November 2023 was an oncology patient, with numerous healthcare visits requiring repeated access to their intravascular line. Both patients were known to be colonised with MRSA from admission screening. Post infection reviews were held to ensure actions from the learning were carried out and sustained.

2.4.9 Patient safety incidents

In November, the Trust transitioned from investigating incidents under the Serious Incident (SI) Framework to the Patient Safety Incident Response Framework (PSIRF). The PSIRF is the national approach devised by NHS England to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and continuously improving. It replaces the SI framework and removes the classification of an SI.

The PSIRF embeds patient safety learning responses within a wider system of improvement and prompts a significant cultural shift towards systemic patient safety management. It focuses on proportionate responses being deployed to patient safety incidents with the focus being on learning and continuously improving whilst also engaging and involving those affected. The Trust developed a Patient Safety Incident Response policy and plan which were approved by the board on 5 July

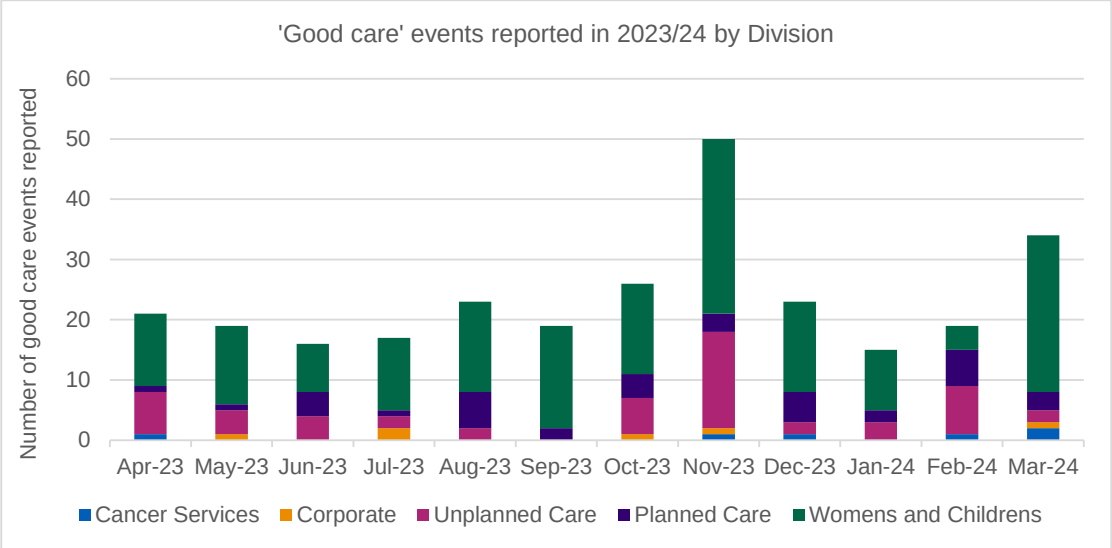
2023. Within our plan we identified our top local priority areas as communication, early recognition and management of deteriorating patients, reducing avoidable harms, recognition and management of challenging behaviours and reducing patient safety risks from long waiting times. There were defined more specifically in the table below which also details the planned learning / improvement response.

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

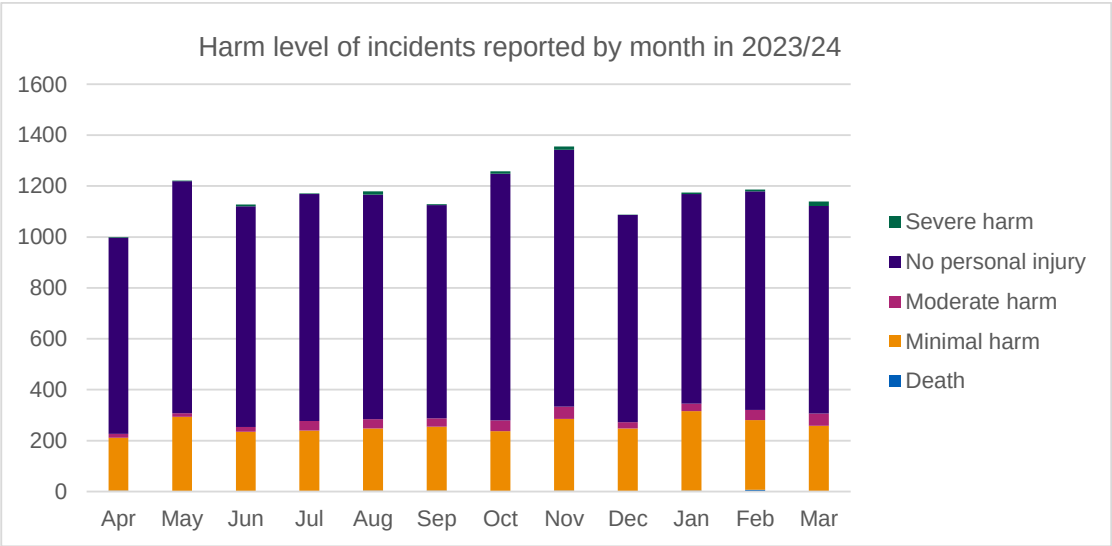
Learning From Patient Safety Events (LFPSE) – incidents and good care

The Trust encourages all healthcare professionals to report incidents on its electronic incident reporting system (ENHance) as soon as they occur, with timely reviews to support learning reflective of a positive safety culture. It also supports divisional oversight of incidents to ensure proportionate responses are being deployed alongside oversight of themes and trends (both existing and emerging).

Through our adoption of the new national NHS learning from patient safety events service (LFPSE), this allows central recording and analysis of patient safety events in healthcare across the country by NHS England. Under the LFPSE service the Trust now has functionality to record ‘good care’ events alongside reporting incidents. Recording good care allows us to both recognise individuals and teams’ positive impacts and in addition allows us to learn from excellence. The graph below shows the ‘good care’ events reported by month by each division. The Trust has recently revised our ‘good care’ reporting form to include further detail of the categories to allow for easier analysis of themes and trends.



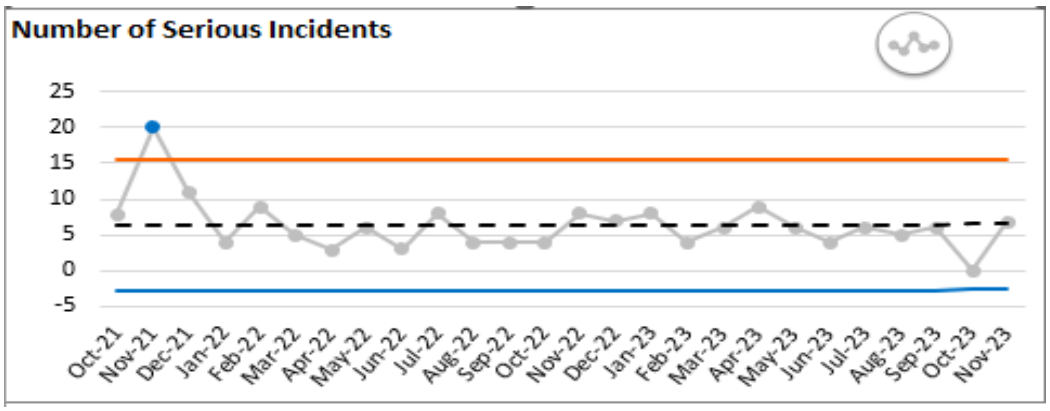
Between 1 April 2023 – 31 March 2024 there were 14,028 incidents reported. Of those, 96% reported resulted in no or minimum harm. Of the total incidents reported, 78% relate to patient safety incidents and 11% relate to staff. Within staffing incidents, the top themes are violence and aggression, staffing, communication and health and safety / security incidents.



As part of our transition to the PSIRF, local divisional incident review meetings have been established to co-ordinate weekly local incident reviews and support the deployment of proportionate learning responses. The Trust continues to hold serious incident review panels, chaired by either the Medical Director, Director of Quality, Associate Director of Patient Safety and/or Chief Nurse. The role of this panel is changing to reflect the organisation's journey into the PSIRF. Whilst it continues to review individual incidents of concern that have been escalated from divisions, it is also expanding into its oversight role to include themes and trends from divisional reviews and the associated learning. It also maintains oversight of the key milestones of the ongoing Patient Safety Incident Investigations (PSIIs).

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. The ENHance system provides greater oversight of incident data and management and will facilitate easier triangulation moving forward. It will also provide a standardised platform to enable oversight at care group, divisional and corporate level.

Serious Incidents (SI) / Patient Safety Incident Investigations (PSII)
Prior to our transition to the PSIRF, between April - November 2023, whilst operating under the SI framework, the Trust formally declared 43 Serious Incidents (SIs).



Of those SIs declared between April – November 2023, the top three themes were violence and aggression (8), treatment (8) and diagnosis (6). These were also common themes that were seen in SIs declared the previous year (2022-23). In 2022-23 the top theme of SIs declared was 'care'. When the Trust moved incident reporting system from Datix to ENHance in February 2023 the incident category of 'care' was consciously removed as it was considered too broad and non-specific. Thus it is not used in the 2023-24 data. Of the SIs undertaken between April – November 2023 there were two large thematic reviews; one focussed on paediatric audiology services and one focused on the management of patients with challenging behaviour / mental health concerns. It is of note that of the SIs declared between April – November 2023 there was only one obstetric related incident that met the criteria for HSIB investigation.

Paediatric Audiology Services
Following an NHSP (Neonatal Hearing Screening Programme) national peer review in March 2023, 799 patients were reviewed. From this review several concerns were raised regarding the service at East and North Hertfordshire.

Concerns related to quality of data submitted, processes for identification of risk and follow up arrangements. These concerns were escalated and reviewed through the Trust Serious Incident Review panel in March 2023. A serious incident investigation was commissioned, with systems sharing of the incident with external partners and regulators. Executive oversight and management of safety actions are reviewed weekly through an ENHT Paediatric Audiology improvement committee, chaired by the Trust Chief Nurse, and attended by ICB colleagues.

The Trust invited the United Kingdom Accreditation Service (UKAS) proactively to undertake an on-site assessment of ENHT Audiology service. These findings were published on 16 June 2023, and highlighted significant areas of concern for the quality and safety of the service, specifically the paediatric audiology service.

A risk-based approach was undertaken to pause the delivery of the paediatric audiology service due to concerns related to potential patient harm, however the service continued to receive paediatric referrals. (This decision was made collaboratively with the ICB and the Regional Chief Scientist)

Whilst the service is paused, the Trust has been reliant on mutual aid to carry out paediatric audiology services, with external providers working in the Trust, as well as accessing the independent sector. In some instances, families have had to travel to other Trusts. Mutual aid has been on a clinically prioritised basis and has been limited, due to the national shortage of available and accredited centres of expertise.

The service continues to require mutual aid across key pathways to deliver care safely, this has been escalated via the oversite committee. In July 2023, the Trust partnered with Guys and St Thomas's (GSTT) paediatric audiology service to benefit from their subject matter expertise, namely in the reviews of ENHT clinical pathways. The Trust improvement plans have six key organisation improvement drivers, with detailed actions and reporting oversight in progress. These priorities include:

1. Quality and safety
2. Environment and equipment
3. Digital
4. Operational
5. Workforce
6. Communications

Mount Vernon cancer centre (MVCC)
An incident occurred in Q2 23/24 and was investigated under the SI framework. A commissioned external peer review showed that ovarian patients treated at MVCC had a 30-day Systemic Anti-Cancer Therapy (SACT) associated mortality that is almost 3 standard deviations greater than the UK average. The final report concluded that immediate changes to the pathway were required to reduce the excess risk to patients and thereby reduce the 30-day SACT associated mortality.

Radiology
There were four patients with delay in formal reporting of chest x-rays, with harm associated. The index incident occurred in Q2 23/24 and was investigated under the SI framework. Following this incident, the unreported SDEC chest X-ray images were reviewed and reported. The subsequent cases were discussed and raised during the transition stage to PSIRF in Q3 23/24 and a round table discussion was agreed. An oversight group continues from divisional level, which reviews the ongoing management of radiology reporting.

Renal services
This incident was raised in Q4 23/24 under PSIRF. Several symptomatic patients presented with low haemoglobins, shortness of breath and fatigue, possibly due to changes in water quality. The dialysis unit was closed pending outcome of investigation, however, has now reopened. At the time patients were relocated to other dialysis units. A PSII is currently ongoing.

Update on Patient Safety Incident Response Framework (PSIRF)
Under the PSIRF a PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning and is aligned to both a national and local criteria. The aim of a PSII is to provide an understanding of how an organisation's systems and processes contributed to a patient safety incident. They examine systems factors and use human factors methodology to identify areas for improvement and systems learning.

Since adopting the PSIRF, between November 2023 and 31 March 2024 the Trust has commissioned five PSIIs.

Never Events
The Trust reported two Never Events between 1 April 2023 and 31 March 2024.

	2020/21	2021/22	2022/23	2023/24
Wrong site surgery	2	4	3	2
Total	2	4	3	2

It is of note that both of the Never Events were classified as minimal or no harm and occurred in different specialties and different areas of the hospital.

The first incident was a wrong site surgery/procedure involving a nerve block (local anaesthesia) in main theatres which occurred in Q1 23/24. This was reviewed under the SI framework and the findings informed a range of learning and actions including; reminder and refresh of 'stop before you block posters' and when the site of block insertion is away from site of surgery, additional marking (e.g. on the patient's back) to serve as visual reminder.

The second Never Event was an injection in the wrong eye in Ophthalmology. This occurred in Q3 23/24 and thus was investigated under PSIRF as a PSII. All Never Events are nationally mandated to be reviewed as a PSII. The learning review is being undertaken by a 'learning response team' comprising of a Patient Safety Manager, Divisional Quality Manager, Deputy Divisional Medical Director and Matron. The learning response is ongoing and is using SEIPS framework (Systems Engineering Initiative for Patient Safety) and also human factors methodology. In addition, the team have had discussions with staff, reviewed audits, undertaken observational work in the area and engaged with the patient affected to capture their insight. Whilst the review is still in progress, some early areas for improvement include lack of LoCSSIP, lack of site marking, and multiple interruptions in the clinical area. In addition, notable good practice has been identified including patient identifier checks including allergies, ease of documentation in paper records

regarding laterality and good pre-procedure laterality checks prior to the patient entering the treatment room.

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 2023-2024, the Trust's average falls rate per 1000 bed days is 4.1. This is an improvement from the previous year's rate of 4.3. The Trust's falls rate per 1000 bed days remains below the national average of 6.6 (NHSE).

In 2023-2024, we recorded 767 Inpatient fall. This is 3.8% lower than the previous year. Falls with serious harm were also lower this year (16) compared to the previous year (18).

We have seen an increase of inpatient falls resulting in a neck of femur (NOF) fracture. This will be the focus of quality improvement in the coming financial year.

Quality improvement remains the focus surrounding falls, targeting areas with the highest incidence. The digitisation of falls documentation was embraced by the Trust and yields a positive outcome where we have now a sustaining average of 92% completion, compared to 72% at the start of the digitisation program. We are also transitioning to the Patient Safety Incident Response Framework (PSIRF) and how apply a range of system-based approaches to learning from patient safety events. Reducing avoidable harm (including falls incidents) is one of the Trust's local priorities identified in our Patient Safety Incident Response plan. Our focus will be on sustaining current improvement workstreams and embedding effective change to reduce harm from falls.

Inpatient pressure ulcers (PUs)
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. HAPU identified by ward staff are reported to the Tissue Viability Team (TVT) via ENHance. These incident reports are then triaged by a Tissue Viability Nurse (TVN) and the skin damage is validated to ensure accurate reporting of harm and expert wound care planning to enable wound healing.

The Trust reported 146 HAPU for 2023-24.

	2021-22	2022-23	2023-24
Number of reportable HAPU	205	210	146

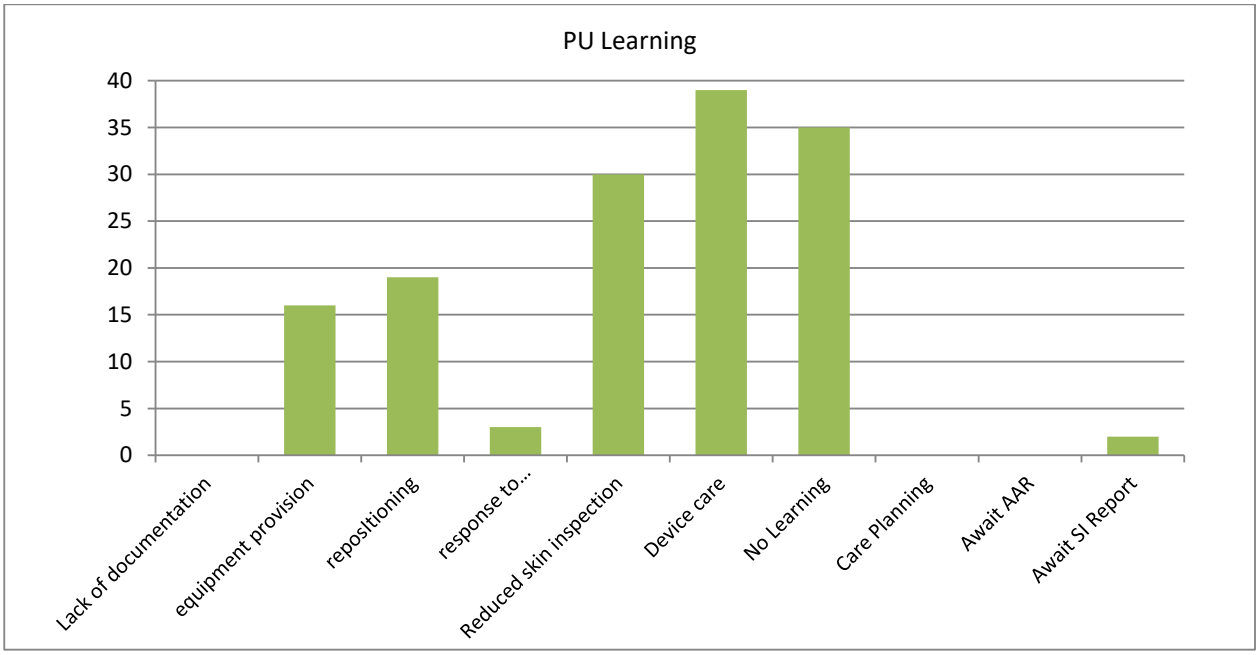
Due to the reporting changes introduced in 2018, the data for 2019-2022 shows more categories of damage were reported as compared to previous reporting periods. The TVT have supported the digital transformation of documentation and its impact has also been noted within the Trust's ongoing surveillance. Since April 2023, new National Wound Care Strategy Programme (NWCSP) recommendations were implemented which resulted in a decline of our PU reported numbers.

PU Categories
The most prevalent category for 2023-24 has been PU2 accounting for 61.6% of total reportable ulcers. 28% of these PU2 were directly related to the use of a medical device. There is a new rise in trend for PU3 and PU3 (device related) as the NWCSP recommendations have changed the way Suspected Deep Tissue Injury (SDTI) and unstageable PU are reported and validated as likely PU3, and all are documented under PU3.

PU RCA Themes
Every HAPU is investigated by a TVN to enable identification of gaps in care so that learning can be identified and improvements delivered, a Root Cause Analysis (RCA) is performed at the time of validation and outcomes are fed back directly to ward staff. The RCA is also attached to the incident reporting the skin damage to ensure transparency of cause of PU. All category 4 and significant PU3 (with considerations to the NWCSP recommendations), and any PU with significant gaps in care identified at RCA are escalated via the Serious Incident Review Panel for consideration and possible serious incident investigation. The chart below details the themes associated with this year's PU data. Our most prevalent themes are device care (26%), skin inspection (20.5%) and repositioning (13%).

Three PUs have been investigated as serious incidents this year and the TVT have been actively involved in the investigation and recommendations. The safeguarding team were involved in all three of the reviews of these incidents. The main care delivery problem (CDP) associated with each escalation is captured in the RCA theme data below.

In compliance with the NHSI PU recommendations the terms 'unavoidable' and 'avoidable' are no longer used in reporting, however, in 35 ulcers (23.9%) we were unable to determine any learning for ward staff as all care was delivered and documented as per Trust standards.



Transitioning to the Patient Safety Incident Response Framework (PSIRF) 2024/25

Reducing avoidable harm for pressure ulcers is one of the Trust's local priorities in our Patient Safety Incident Response Plan. HAPU Incidents are well understood and so it is necessary for the service to take an improvement approach. Quality Improvement (QI) programmes focusing on our three identified causes will be led by the service in collaboration with wards Trust wide. Improvement outcomes will be monitored by the Harm Free Care group.

QI methodology will be utilised to guide teams to identify and assess potential change ideas. Previous years HAPU data will be interrogated to identify which ward areas shall be the focus of initial improvement work. Successful programmes of change will be adopted and spread Trust wide.

Patient Experience

Complaints and Compliments

All complaints data is sourced from the Trust's internal quality management 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 2023/24 763 formal complaints were received across all services (from 746 in 2022/23) within the Trust, and 4657 informal PALS concerns (from 3496 PALS

2022/23) were received. The Trust has a current 28 day turn around on all non-urgent PALS enquiries.

Complaint themes were mainly around communication and medical care.

Indicator	21/22	22/23	23/24
Number of formal complaints	777	746	763
Number of PALS concerns	3614	3496	4657
Number of PALS concerns closed within 5 days/ % performance	2529 78%	1951 55%	2508 54%
Complaints – response within agreed timeframe	72%	50%	48%

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

Since starting to embed the PHSO standards framework, to ensure that we are offering early resolution meetings to complainants, we have seen an increase in the number of delays for complaints being responded to within the allocated timeframe. This is likely due to the time taken to arrange and hold meetings due to patient/carer and staff availability.

Plans for 2024/25:

- A pilot will take place within one of the Trust's divisions to try a new process within the formal complaints procedure, which will involve having independent investigators who have full ownership of the entire complaint and will gather the evidence around this. This will allow for a timelier investigation and conclusion.
- The Trust is introducing a new quality oversight framework which will clarify a group of core standards and governance arrangements across the Trust departments and services. This framework will be implemented over the next year and will require iterative testing and learning to sustain operational change.
- We will be providing new Trust wide PALS resolution training to train and empower staff to identify and resolve issues in real time.

Parliamentary and Health Service Ombudsman complaints

In the reporting year, nine were assessed by the Parliamentary and Health Service Ombudsman (PHSO). Three complaints were closed with no further investigation, four remain under investigation, one upheld and one with learning for the Trust.

The Trust received 295 formal compliments last year, and improvements have been made to the reporting functionalities of the Trust wide quality management system (ENHance), allowing day to day reporting of compliments and good care. All compliments are shared with the Chief Executive, divisional leads and the staff member in question.

2.5. Other Quality Information

2.5.1. Operational performance appraisal summary

In 2023/24 we welcomed 184,926 patient attendances to our emergency departments; we cared for 52,012 inpatients and saw 610,180 patients in our outpatient settings. Unfortunately, due to the high incidence of industrial action this year there were higher than average levels of cancellations and longer waits for elective care.

- The focus in 2023/24 has been on elective recovery and work towards the achievement of elective and non-elective operational performance targets. 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 this metric with the exception of community paediatrics. For this specialty the Trust is working with system and national leads to develop new community pathways with the aim of providing a more consistent and shortened pathway with particular reference to those with neurodiversity. During this year, the Trust delivered waiting times of 78 weeks from referral to treatment for the majority of patients, where the patient was available and fit for treatment with the exception of some Trauma and Orthopaedic patients.
- The Trust has continued to incrementally improve its performance against the four-hour non-elective wait time standard. Nationally the target was set at 76% for all patients by March 2024 and the Trust achieved 73.18%. Despite the underperformance this is 10% higher than the Trust's performance against the four-hour standard this time last year, against the backdrop of 13.5% more attendances to ED in-month. This has been delivered through a large Urgent Treatment Centre (UTC) improvement programme and significant investment to include operationalisation of an Urgent Treatment Centre, Surgical Assessment Unit and greater use of community models such as the virtual hospital.
- There has been a real and sustained improvement in ambulance handover times due to an acute focus reset, increased Same-Day Emergency Care (SDEC) direct admission and improved system working. By March 2024, the target was to not have any ambulance delays over 30 minutes. The Trust achieved 66.1%
- Delivery against the cancer targets has continued as a priority and remains a strong performer for the organisation. The Trust continues to focus on the reduction of the proportion of patients waiting over 62 days and working with system partners to reduce delays due to late referrals into the Trust. This year saw a change in focus of cancer operational standards away from two week waits and a focus on faster diagnosis. The Trust has been nationally recognised for its early adopter work on the timed pathway analyser which has enabled a sustained compliance against the faster diagnosis standard of 75%.
- Diagnostic turnaround times remain a challenge for the organisation across all modalities. Additional pressure has been experienced due to an increase in both cancer referrals and urgent and emergency care (UEC) demand requiring imaging. Detailed capacity and demand modelling has been

completed at Trust level which sees all modalities, except MRI, deliver DM01 compliance by March 2025. Community Diagnostic Centre (CDC) performance has been on track with agreed trajectories for 2023/24 across all the radiology areas of CDC. Cardiology CDC fell below trajectories as a result of poor GP uptake, workforce pressures and delays in commencement of the service.

- Stroke performance nationally is monitored on the calendar year rather than the financial year. The Trust has improved on its performance and is now at a B rating due to the amount of work and attention to detail by the teams. The Trust will continue to work on actions with the aspiration to achieve an A rating.

2.5.2. Performance Analysis: In-depth performance review

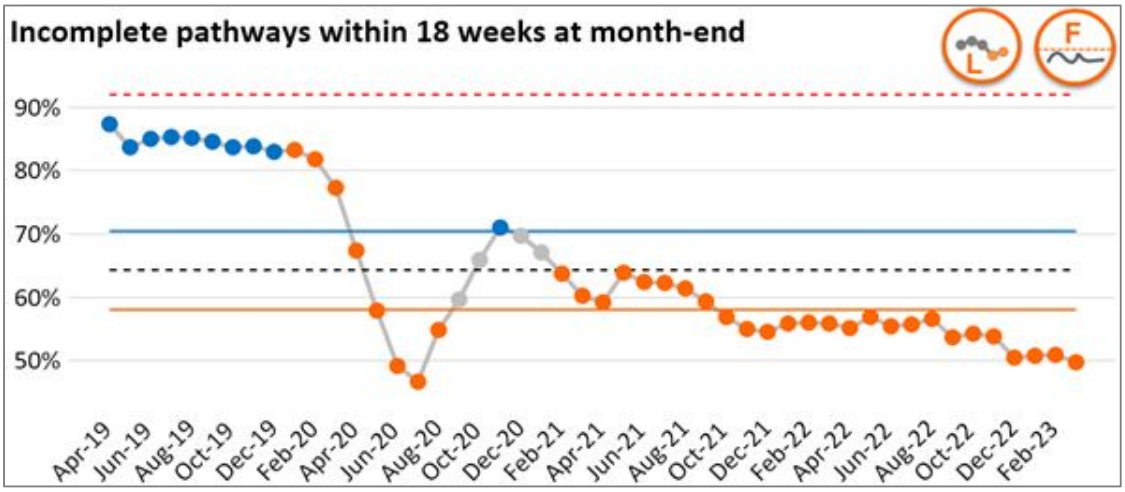
Operational Performance

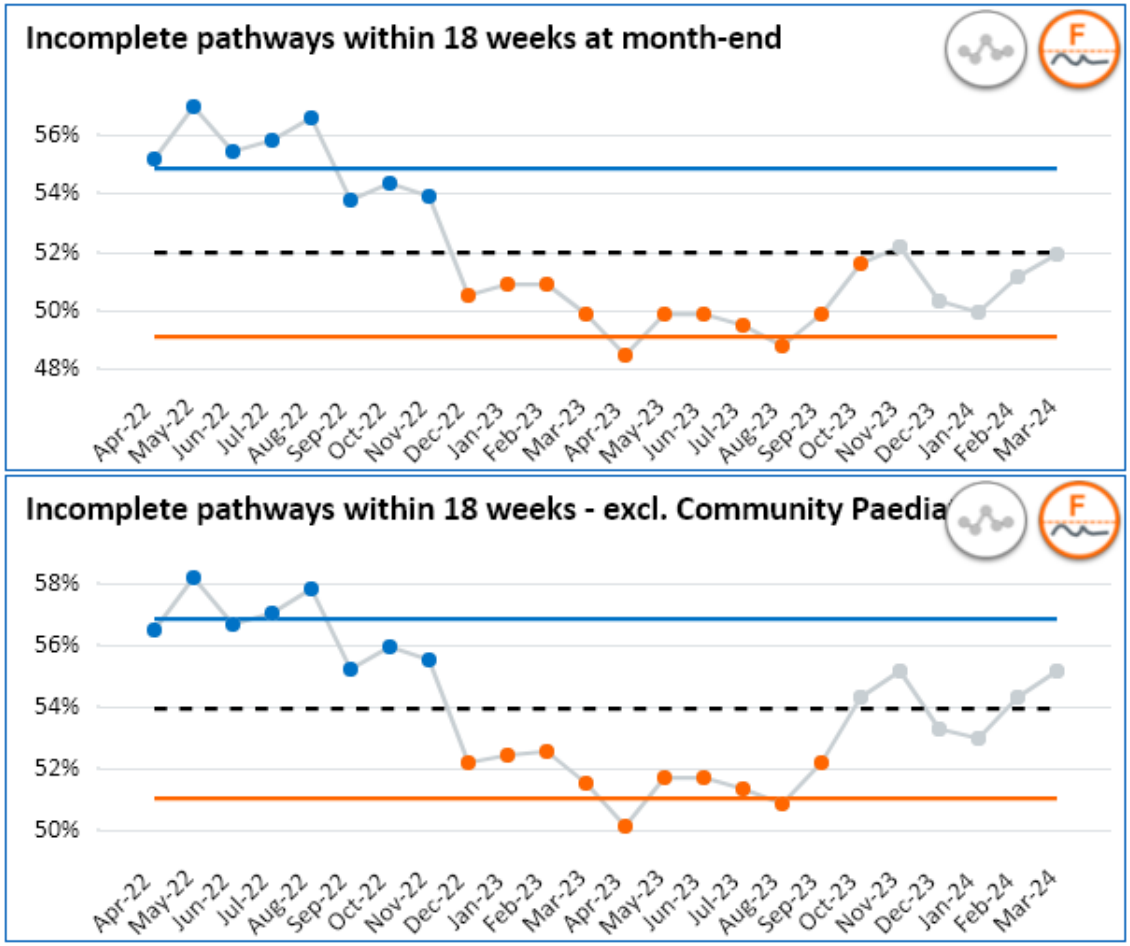
A summary of performance against the key metrics is provided below:

Referral To Treatment (RTT)

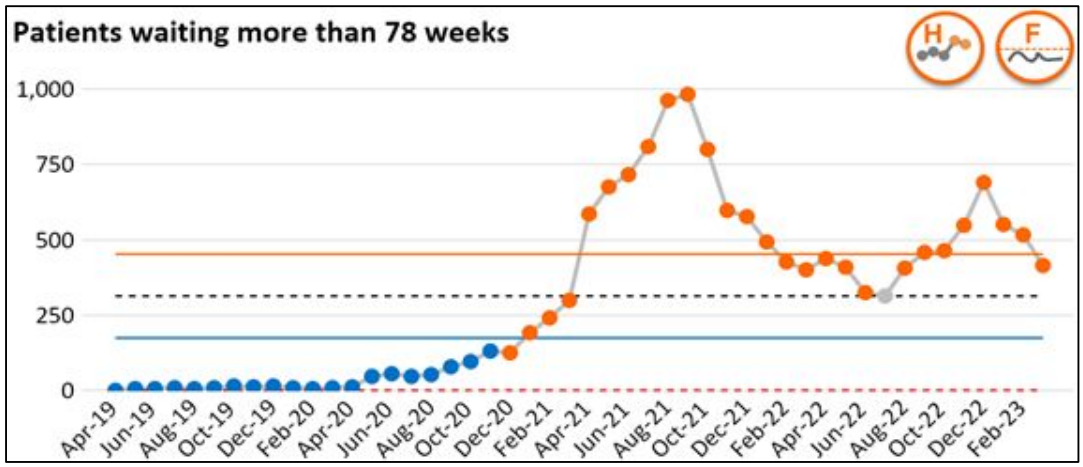
Nationally the drive was to eradicate any patient waiting over 78 weeks with a push to getting waiting times below 65 weeks. The Trust through a variety of actions including recruitment, efficiency gains, additional waiting lists, contact, validation and robust waiting list management has seen a dramatic improvement in waiting times.

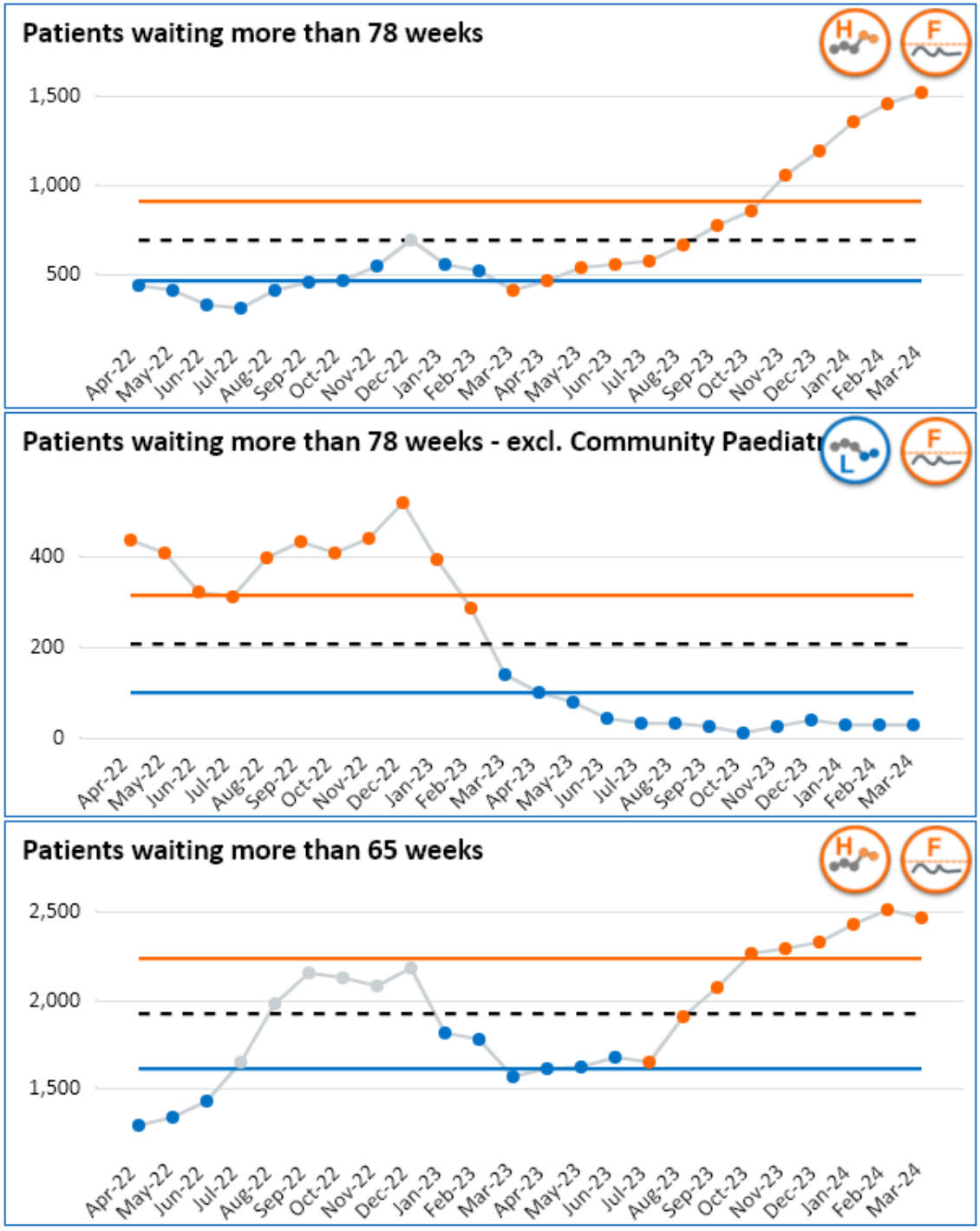
Community paediatric waiting times has nationally remained a concern with a clear gap between demand and capacity. The Trust has been working closely with system partners to really understand the demand and the reason for the increase, impact of covid and streamline the pathways to ensure equitable access for all children within the region.

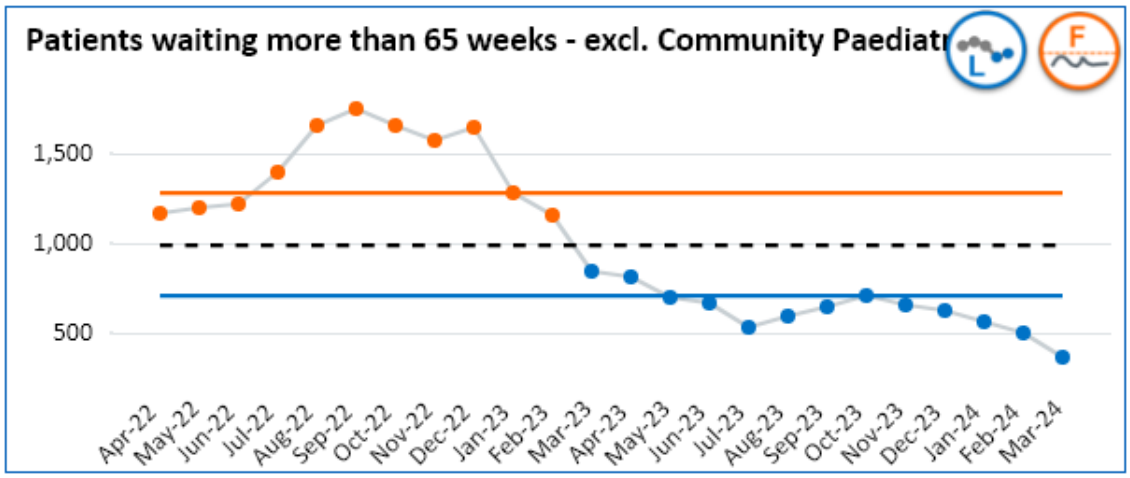




The Trust ended the year with 29 patients (of which 22 were in Trauma and Orthopaedics) waiting over 78 weeks due to patient choice, complexity or capacity.




Patients waiting more than 78 weeks
H
F
1,500
1,000
500
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Patients waiting more than 78 weeks - excl. Community Paediatr
L
F
400
200
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Patients waiting more than 65 weeks
H
F
2,500
2,000
1,500
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24



With the exception of Community Paediatrics and T and O, the Trust managed to treat the majority of patients within 78 weeks unless the patient chose to delay their treatment, or their treatment was delayed due to a clinical condition. Trauma and orthopaedic capacity has been challenged due to a combination of industrial action, clinically urgent patients taking priority and sub specialisation capacity pressures.

At the end of the 2023/24 financial year, the majority of services were able to meet the new target waiting time of 65 weeks. However, capacity remains challenging in trauma and orthopaedics, gastroenterology, pain management, ophthalmology, oral surgery and urology and there is agreement to be compliant with the 65-week target from the beginning of September 2024 for these services.

To support the delivery of the contact and validation target of 90% of patients waiting over 12 weeks who have not had an appointment in the last 12 weeks and don't have an appointment booked in the next four weeks, 72,500 text messages were sent asking if patients wanted to remain on the waiting list. The response rate was 75% with almost 5,000 patients requesting discharge (6.8%).

In addition, as part of national patient choice requirements, 3,069 patients who were waiting more than 40 weeks for treatment and who did not have a future booking were invited to sign up to the national Patient Initiated Digital Mutual Aid System (PIDMAS) in October 2023. The Trust received 125 responses (4.1%) confirming they would be happy to potentially go elsewhere for treatment. However, 90 of these patients had treatment at the Trust before they could be offered an appointment elsewhere, 22 were not suitable for PIDMAS, and the ICB could not find suitable capacity within the region for the other 13 patients.

Urgent Care Pathways

To improve performance against the four-hour standard, the Trust embarked on a multi-project programme to develop a new emergency care model.

The national four-hour standard still remains at 95% with a recovery trajectory set at 76% of patients arriving at the Emergency Department (ED) to be admitted to hospital, transferred to a more appropriate care setting, or discharged home within four hours by the end of March. In April 2023 the Trust's 4-hour performance was 64.2% and the Trust achieved 73.8% in April 2024

The ambition of the programme was to transform emergency care pathways to provide alternative(s) to the ED where appropriate, thereby reducing the volume of patients in ED and improving patient flow and experience.

With the support of Hertfordshire and West Essex Integrated Care Board (HWE ICB) funding, a new Adult Urgent Treatment Centre (UTC) opened in January 2024 on the Lister Hospital site. The service is open from 8am to 10pm 7 days per week and can treat a range of minor illnesses and minor injuries for adults aged 16 years and over that would otherwise have gone to ED. In the first seven weeks of opening, the UTC treated more than 2500 patients, with the average time from arrival to discharge of 1 hour 43 minutes. Plans are in development to expand the service to include children (under 16 years) which will enable the Lister UTC to fully mirror the successful model at the New QEII Hospital.

Medical SDEC opening hours were also extended until 10pm to provide additional capacity for patients who had either been directed to the medical team by their GP, or who were identified as requiring medical team intervention by the ED.

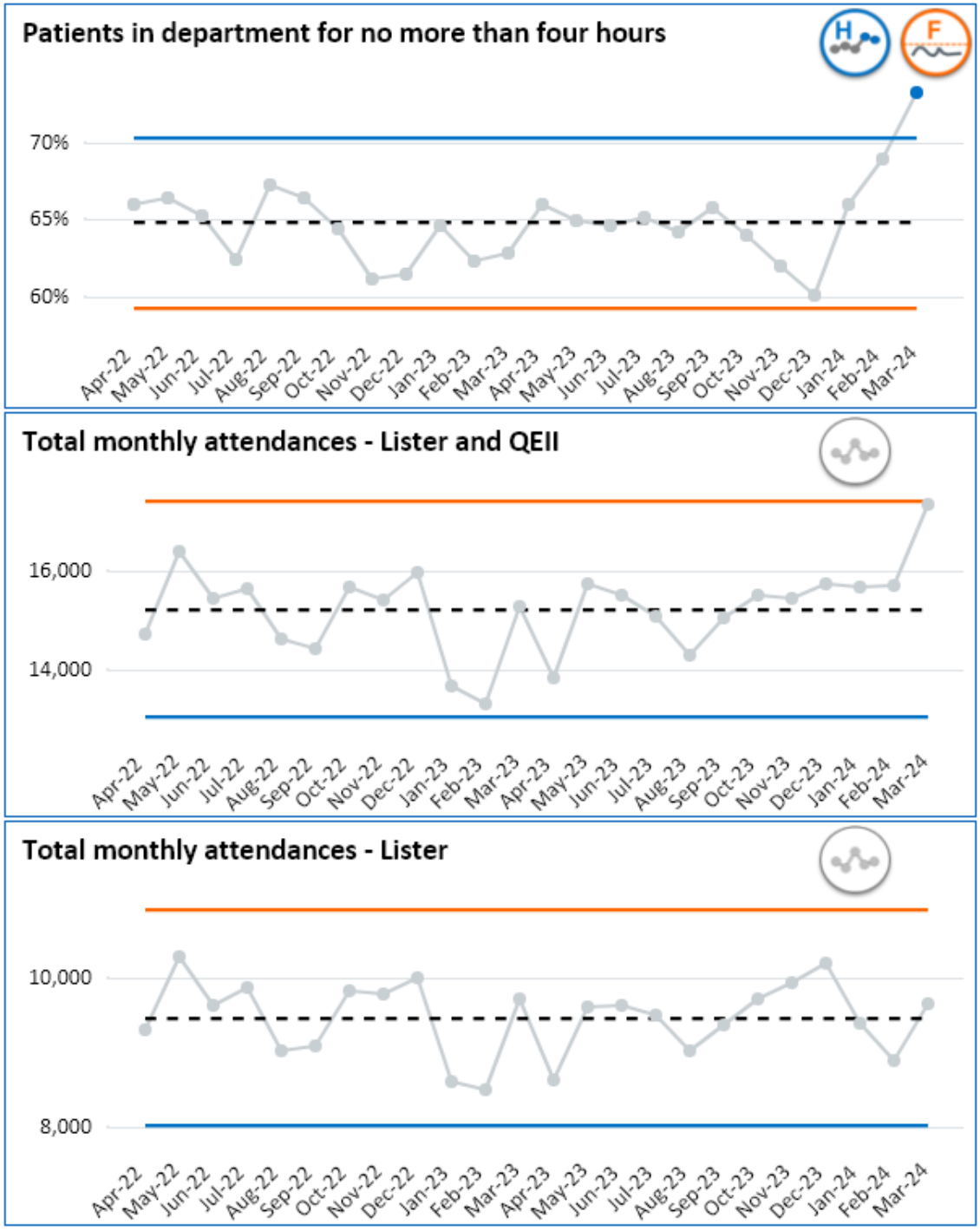
A Surgical Assessment Unit (SAU) was formally re-established in January 2024 having been stood down during the COVID-19 pandemic. This is a dedicated service for the assessment of emergency surgical patients who may be referred directly by their GP or who have presented to the ED and referred to surgical specialties for further assessment and possible inpatient admission. Since opening the SAU has cared for over 1000 patients. The service also supports a Surgical SDEC which will continue to expand its capacity in line with recruitment of workforce.

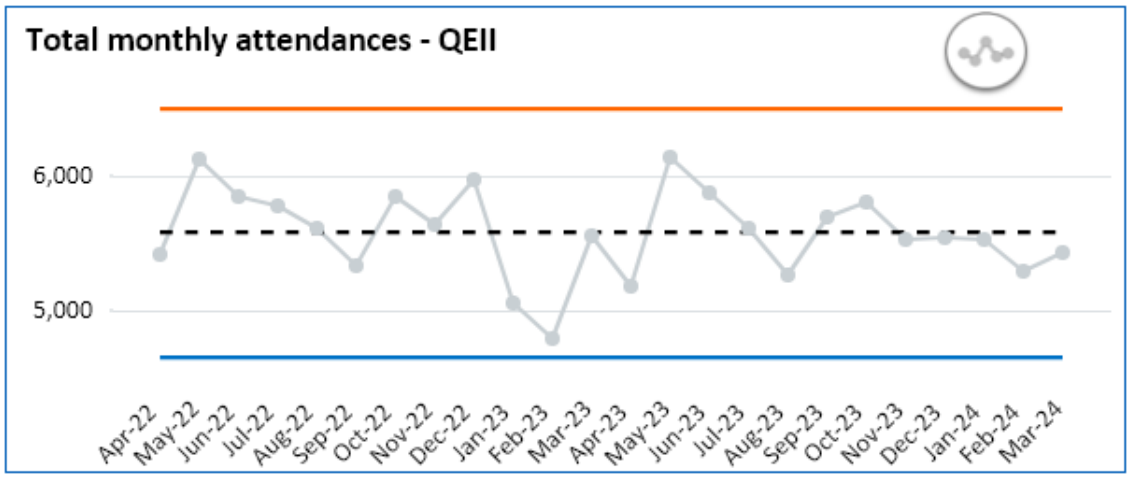
In addition to alternative services, the ED has revised nursing and medical workforce rosters to ensure the staffing model aligns with expected peak times in patient arrivals to the department. The new rosters came into effect in January 2024 and continue to be embedded across all staffing groups, providing more support during peak hours. Work is also ongoing to increase diagnostic capacity with an additional CT machine expected to open for ED patients and inpatients from April 2024.

Paediatric ED has also been part of the ED improvement programme and further focus on new space for time to triage during peak times, development of the CDU and redesign of the medical workforce to align with expected peak demand is forecast to improve paediatrics ED four-hour performance further in 2024/25.

All Urgent and Emergency Care (UEC) services are operating under a model of continuous improvement with processes constantly reviewed to identify areas of opportunity. The ED has reviewed and refined their streaming and triage models to ensure patients are directed to the most appropriate service at the earliest opportunity. Further areas of development and improvement will be identified and driven in 2024/25.

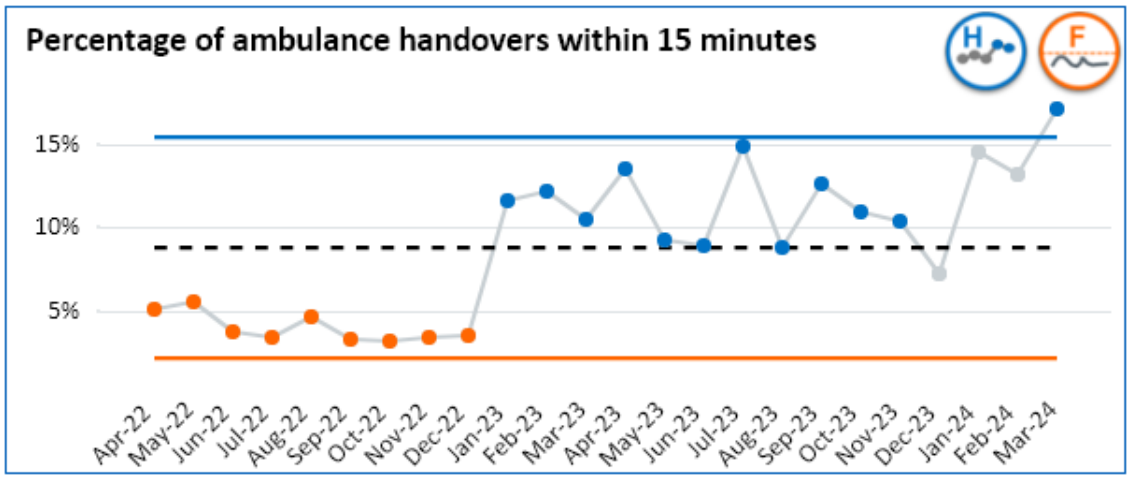
In March 2024, the Trust's four-hour performance standard increased to 73.18%. Many of the improvement initiatives did not commence until January 2024 therefore it is anticipated that as new pathways and services embed performance will continue to improve in this area in-line with the target of 78% for 2024/25 but will remain under close observation.

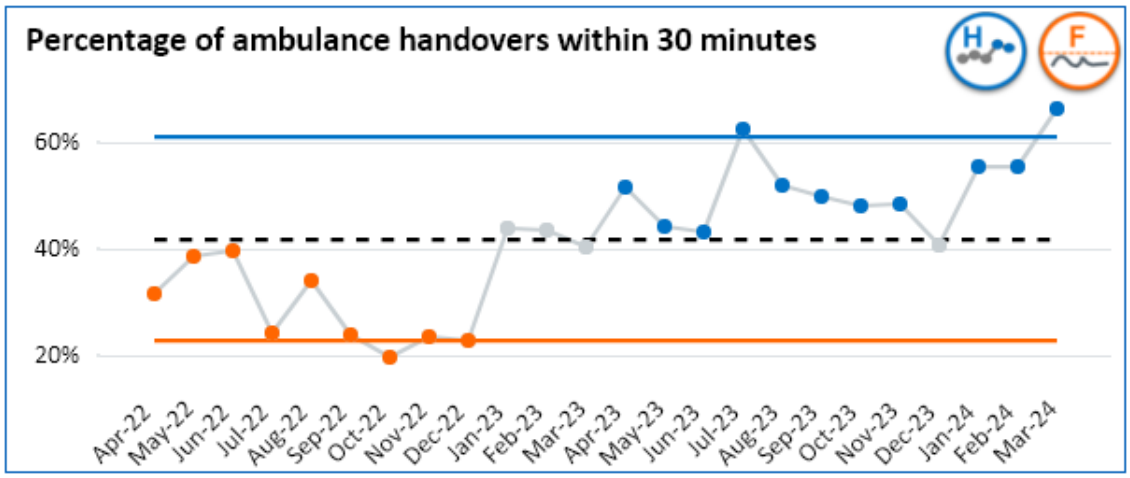

Patients in department for no more than four hours
H
F
70%
65%
60%
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Total monthly attendances - Lister and QEII
16,000
14,000
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Total monthly attendances - Lister
10,000
8,000
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24



Ambulance handover

The Trust with the East of England Ambulance Service NHS Trust (EEAST) and other partners such as Hertfordshire Community Trust and the other acute providers, worked hard to significantly reduce handover time for those patients bought to the department by ambulance. Despite the number of conveyances, the Trust through its actions and work on the urgent care pathways, has significantly improved handover time therefore enabling ambulances to get back out into the community and patients arriving to the department getting the care they require in a quicker timeframe.





Cancer performance

In the 2023/24 financial year, the national Cancer Waiting Times standards were streamlined from eight separate to three combined standards. These new standards are:

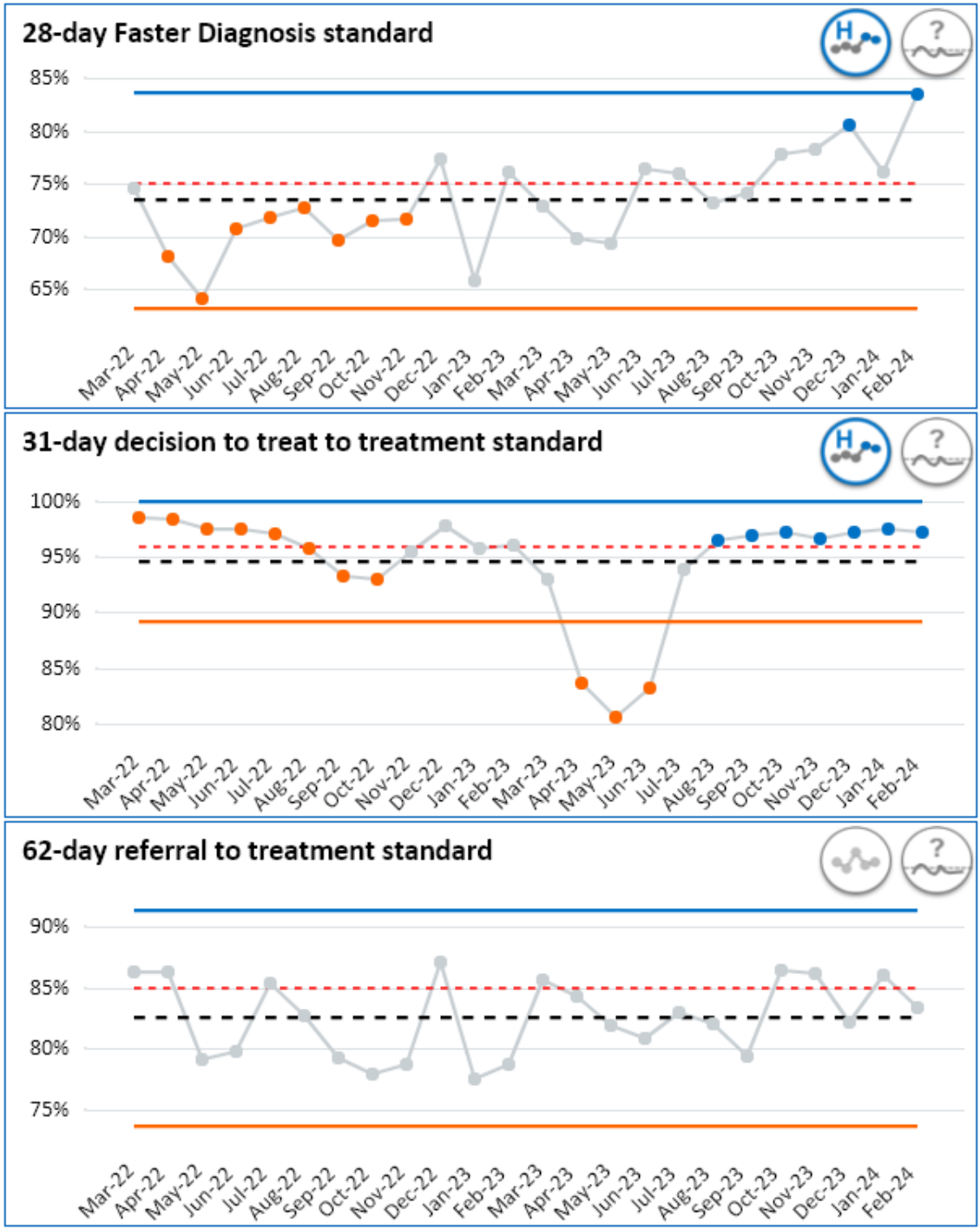
- the 28-day faster diagnosis standard,
- the 31-day decision to treat to treatment standard,
- the 62-day referral to treatment standard.

Whilst cancer performance was not sustained fully over the course of the first 6 month for 2023/24, the 62-day cancer target was achieved for three out of six 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 three of the eight standards and within 1.0% of achieving the 62-day standard. Factors for this underperformance include high numbers of two week wait referrals putting substantial pressure on the Trust capacity in endoscopy, radiology and histopathology, late referrals from other local providers, patient choice and industrial actions have caused delays in the cancer pathways; these all have remedial plans in place to prioritise all cancer pathways to avoid delays in 2024/25.

31-day subsequent performance for chemotherapy and radiotherapy was consistently sustained for the year, despite a few months' dip in performance for radiotherapy as a result of increased downtime from aging linacs, coupled with workforce shortages. The new machines have now been replaced with new Ethos technology and staffing is fully established.

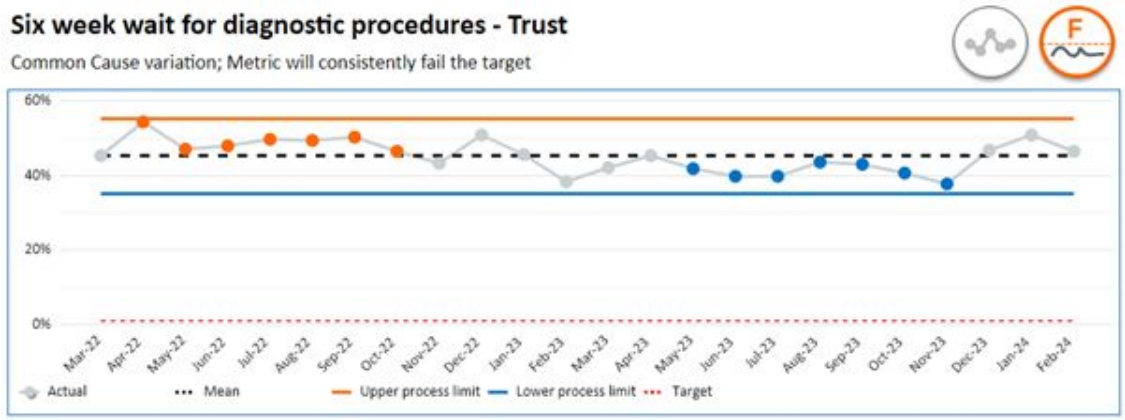
The Trust's 28-day faster diagnosis standard has remained consistently high during 2023/24. The Elective Intensive Support Team has supported pathway analysis for all tumour sites so the Trust can clearly identify delays and make changes to improve the end-to-end pathway. The Trust's early adoption of the pathway analyser work has been recognised nationally and the cancer team has been asked to share good practice with other trusts.

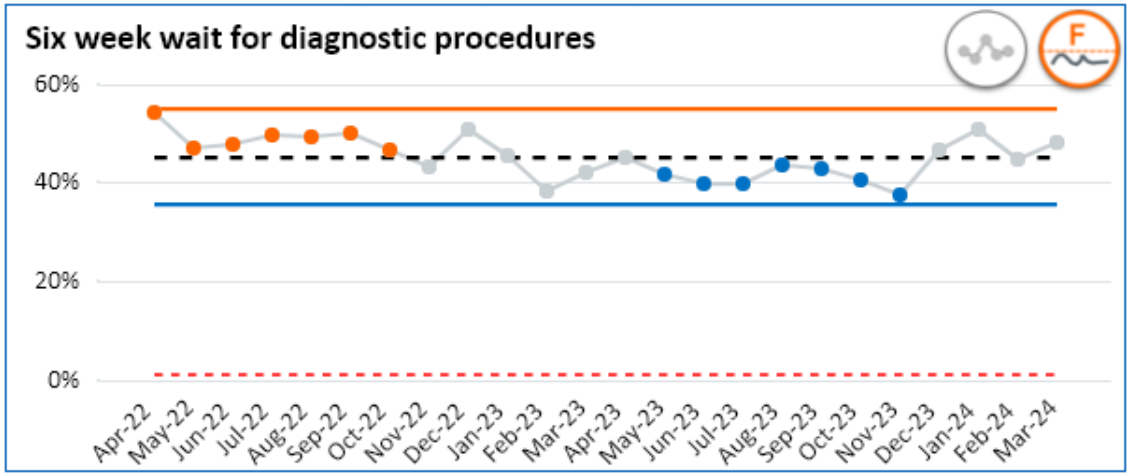
Cancer performance for the three new standards was sustained fully over the course of the first six months for 2023/24. The 62-day cancer target was achieved for four months out of six months, and our performance against this standard remains one of the best regionally.

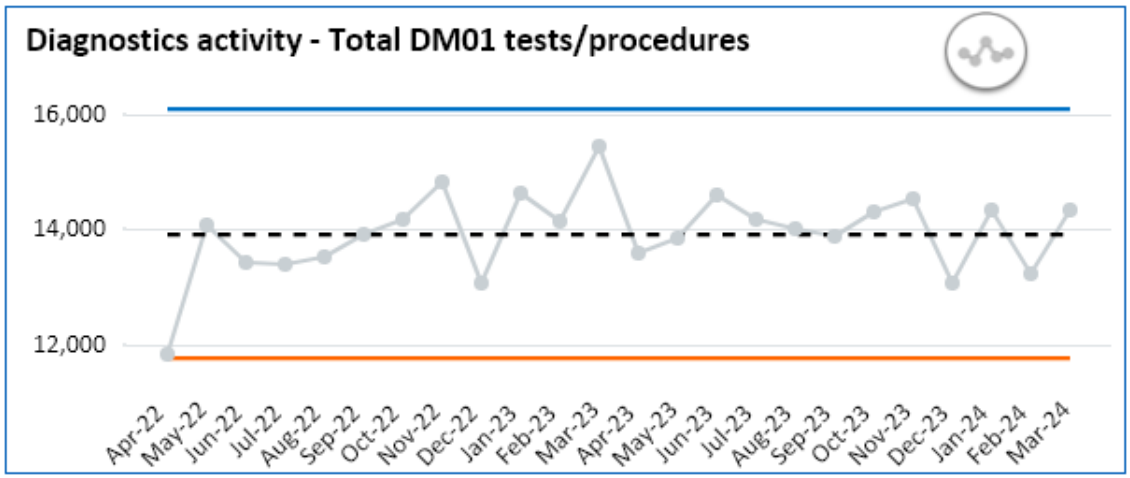


Diagnostics (DM01) (less than 1% of patients should wait 6 weeks or more for a diagnostics test)

As mentioned previously in the report, the demand on services has exceeded capacity plans for the majority of 2023/24 as a result of urgent and cancer referrals. This has resulted in an inability to meet DM01 performance this year. The Trust has undertaken detailed capacity and demand modelling with recovery trajectories that will deliver DM01 compliance for all modalities other than MRI by March 2025 as agreed.







Stroke performance

The Trust's performance continues to improve and is now at level B for the second consecutive quarter. Stroke cases continue to increase over the average baseline set on SSNAP of 63. Most recently in Feb 2024 we saw 91 confirmed strokes. A high number of patients are requiring care at Addenbrookes and Charing Cross – these patients make up a high number of our breach reasons alongside winter pressures such as stroke beds being occupied by medical patients which reduces flow through the pathway.

Further work is required to protect dedicated stroke beds during peak times in ED and manage repatriation of out of area referrals.

There have been improvements in the provision of both occupational therapists and physiotherapists in this area, but further Trust investment is needed to sustain level B for the organisation and progress to level A. A business case has been submitted with this in mind.

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 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.

SSNAP Scoring Summary	Team Type	Routinely admitting team			
	ISDN	East of England (South)			
	Trust	East and North Hertfordshire NHS Trust			
	Team	Lister Hospital			
	Time Period	Jan-Mar 2023	Apr-Jun 2023	Jul-Sep 2023	Oct-Dec 2023
	SSNAP level	D	C	B	B
	SSNAP Score	57.0	65.0	70.3	75.0
	Case ascertainment band	A	A	A	A
	Audit compliance band	A	A	B	A
	Combined total key indicator level	D	C	B	B
	Combined total key indicator score	57.0	65.0	74.0	73.0
Number of records completed:	Team-centred post-72h all teams cohort	204	206	215	252

Other positive developments to note

- Thrombolysis in Acute Stroke Collaborative (TASC) project underway from January 2024 in partnership with NHS Elect, to support improvement in thrombolysis performance rate to 14% and additional benefits in supporting overall flow within the stroke wards, due to positive impact on simple discharges.

- Stroke video triage pilot; positive feedback on the benefits to the clinical pathways.
- Digital Nerve Centre project is ongoing to support MDT working and goal setting to improve SSNAP data collection.
- Radiology is consistently meeting targets set against scanning patients within 1-hour of clock start. However, progression to achieve scanning under 15 minutes will enable thrombolysis with a median time of less than 40 mins, which is currently a challenge.

Seven Day Service
The national Seven Day Hospital Services (7DS) Programme is a quality improvement initiative providing acute provider organisations with a framework to work to reduce variation in outcomes for patients admitted to hospitals in an emergency and at the weekend across NHS trusts in England. There are four priority standards:

Standard 1: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of admission. An audit undertaken in 2023 identified that approximately 66% of patients were reviewed within 14 hours of admission by a consultant.

The table below details the schedule for on-site consultant cover for our acute specialties:-

Specialty	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 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 compliance regarding 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		Yes	
Stroke Thrombolysis	Yes		
Stroke thrombectomy		Yes	
PCU for MI	Yes		
Cardiac pacing	Yes		

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. An audit during 2023 identified that approximately 60% of a sample of patients were reviewed within 14 hours of admission.

The nationally recommended board assurance framework for 7-day standards will be used when reporting to the Trust's Quality and Safety Committee during 2024/5.

Rota Gaps

We recognise that increased number of vacancies, resulting in rota gaps, puts increased pressure on doctors in training (DiT), locally employed (LED) and SAS doctors also working on the rota. Whilst all attempts have been made to recruit to these gaps, recruitment can be delayed and at times unsuccessful. Acknowledging this, the following action plan is in place to alleviate pressure created by rota gaps.

As part of the annual review, all departments are requested to review their rotas for resident doctors, ensuring they meet both requirements of the service and the requirements for all doctors in training, outlined by their terms and conditions, and educational requirements outlined by Health Education England. The review of rotas ensures that where there are changes to numbers of doctors on the rotas, the rotas are amended, to avoid unnecessary rota gaps.

Table 1

Month	Total vacant trainee posts	Number filled with SCF/JCF	% of vacancy gap Filled
Jan-24	22	9	41%
Feb-24	22	9	41%
Mar-24	21	9	43%

As soon as vacancies that create rota gaps are identified, the recruitment process is started to ensure that the vacancy is filled as soon as possible. As indicated in table 1 above, this recruitment is not always successful. We are therefore looking at ways to make these roles, particularly Senior Clinical Fellow roles, more attractive. Currently, a paper is being written with the focus of LED's being employed on the 2016 terms and conditions, rather than the 2002 terms and conditions that they currently are. The principle behind this is to create parity between DiT and LEDs, with a focus on rota commitments and educational opportunities. The idea being that offering greater educational opportunities will aid recruitment to these roles. There is also a focus on providing full and thorough inductions for these doctors, enabling them to join the full rota sooner.

The Trust has recently undergone a restructure, with a focus on leadership. The restructure in leadership allows for greater ownership of the service, therefore ensuring the identified rota gaps are filled.

With regard to improving short term rota gaps, the Trust's management, in liaison with the junior doctor forum, have been working to finalise a new process for out of hours to fill rota gaps. The new process, which is yet to be implemented, as discussion is ongoing, will highlight responsibilities of each party, and at what point escalation is required. It also highlights the need to prepare for options other than bank and agency fill, to mitigate risk and pressure on the resident doctors present for the specific shift.

Staff/ National staff survey
For 2023/24, we will focus primarily on themes around the following and continue work in other areas:

- We are compassionate and inclusive
- 'Morale'
- 'Voice that counts'

Our overall scores shown below indicate improvements in all categories:

People Promise elements	2022 score	2023 score	Statistically significant change?
We are compassionate and inclusive	7.07	7.13	Not significant
We are recognised and rewarded	5.67	5.83	Significantly higher
We each have a voice that counts	6.51	6.56	Not significant
We are safe and healthy	5.78	5.99	Significantly higher
We are always learning	5.14	5.55	Significantly higher
We work flexibly	5.97	6.17	Significantly higher
We are a team	6.55	6.65	Not significant

Themes			
Staff Engagement	6.71	6.80	Not significant
Morale	5.58	5.78	Significantly higher

The key survey areas of focus include 'morale', 'voice that counts' and 'compassionate and inclusive'. The survey results show improvement in people being clear about their objectives in work, with this helping them improve doing their job and we can see more staff progressing their careers, through undertaking learning activities and staff taking advantage of flexible working opportunities. Increases are also seen in the percentage of staff recommending the Trust as a place to work.

We have developed and launched our EDI strategy and our EDI commitments and actions are informed by our survey results with areas such as the development of mentoring and coaching, supporting staff with disabilities and long term conditions, including supporting our staff networks to facilitate change.

The Trust continues with consistent approaches to improve culture including embedding our refreshed values and development of staff values charters. We continue to support interventions that encourage safer and more inclusive environments for our staff, including improvements to our onboarding processes to ensure they are values driven.

Veterans covenant

The Trust has committed to the Veterans' Covenant Healthcare Alliance (VCHA) which is an organisation for healthcare providers aiming to provide the best standards of care for the armed forces community. The aim is for veterans not to experience disadvantage as a result of their service compared to other citizens. This includes ensuring family members retain their place on NHS waiting lists if moved around the country and that veterans receive priority treatment for a service related health condition/injury, subject to need.

As part of our inclusion agenda, we will be establishing a staff network for service personnel.

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.

The Trust has 1.0 WTE freedom to speak up guardian who supports staff with speaking up five days/ week. The executive lead for freedom to speak up is Theresa Murphy, Chief Nurse and the non-executive lead is Val Moore. Governance is

provided by the People Committee, providing assurance in relation to process and clear connectivity to the People Priorities and People Promise.

40 speak up champions across all staff groups, specialities and sites support the freedom to speak up function by addressing barriers to speaking up, signposting staff and influencing positive culture within their department.

In line with the Trust values (Include, Respect and Improve), all staff are encouraged and supported with speaking up. Both confidential and anonymous speaking up is welcomed with several avenues available to our people.

Speaking up confidentially: Staff can speak up to their line managers, divisional directors, Trust executives (including ask.adam email to raise concerns directly with CEO), and the freedom to speak up guardian.

Speaking up anonymously: Staff can speak up anonymously via Work in Confidence (external service provider) or our incident reporting system (ENHance).

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.

Assessment of issues
Total number of concerns raised this year (2023/24): **270**

	Q1 2023/24	**Q2 2023/24**	**Q3 2023/24**	**Q4 2023/24**	**Total**
Total Cases	54	69	68	79	270

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

Themes	**Number**	**Percentage**
1. Worker Safety or Wellbeing	93	34%
2. Patient Safety/ Quality	49	18%
3. Bullying and Harassment	13	5%
4. Inappropriate attitudes or behaviours	115	43%
5. Disadvantageous or demeaning treatment because of Speaking Up	0	0%
Total	270	100%

Achievements
A new speak up policy, in line with NHS England policy, was approved by the board and introduced in September 2023

A five- year speak up strategy was discussed and approved at the board seminar in October 2023

The speak up guardian regularly visits all sites to provide cross- site cover.

Freedom to speak up and support for speaking up is a standing agenda item for all inductions including corporate induction, junior doctors' induction, and student inductions.

NHS Staff survey: 3 percentage point increase in staff reporting that if they spoke up, they have confidence that the organisation would address their concern.

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.

Speak up cases are reviewed through the lens of learning and improving, ensuring meaningful actions and sustained improvement.

Part 3: Other information

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

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 2023/2024.

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 (ENHT) Quality Account for 2023/24. The ICB would like to thank ENHT for preparing this Quality Account, developing future quality priorities, and acknowledging the importance of quality at a time when they continue 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 ENHT. During the year the ICB has been working closely with ENHT in 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 Quality Account has been reviewed and checked against data sources, where this is available, and we confirm this to be accurate and fairly interpreted to the best of our knowledge.

During 2023/24 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, for example regarding paediatric audiology services. The ICB worked in partnership with the Trust to undertake Partnership Quality Visits obtaining assurances regarding the quality of care provided, and where identified improvements were highlighted, provided relevant support to embed the changes required.

The Trust's Care Quality Commission (CQC) rating has remained as 'Requires Improvement'. The Trust has provided a transparent account of the CQC inspections they have had in year, including the CQC improved grading for the Maternity Service to Requires Improvement and the removal of the Section 29A notice. The Trust continues to focus on their CQC Improvement Plan and progress is regularly reported to the ICB as well as the Trust Board and CQC.
During 2023/24 ENHT achieved a range of results in 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.

The ICB notes the sepsis pathway compliance continues to be an improvement priority and will continue to seek assurance that this, alongside venous thromboembolism (VTE) risk assessments, continues to move in the required direction and that related performance is sustained.
The 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 two MRSA bacteraemia cases for 2023/24 with post infection reviews held to ensure actions from the learning were carried out and sustained. Cases of Clostridium difficile have been above the annual ceiling and all cases have undergone a review, to support learning and improvement, and the aligned work undertaken by the IPC team in providing education, training and support is also noted. The ICB will continue to have oversight and seek assurance regarding Clostridium difficile cases for 2024/25.

During 2023/24 the Trust reported 2 Never Events; a decrease from the three reported the previous year. The ICB are pleased to note the ongoing actions and identified learning related to these incidents to prevent similar incidents in future. The ICB would like to recognise ENHT for their readiness and successful implementation of the Patient Safety Incident Response Framework (PSIRF), which sets out a shift in approach for how the NHS responds to patient safety incidents for the purpose of learning, improving patient safety and outcomes for our population. The ICB looks forward to working in partnership with ENHT and across the system as we collectively take forward PSIRF and the National Patient Safety Strategy.

The timeliness of complaint responses has seen a decrease in performance during 2023/24. The ICB acknowledges the added pressures that have impacted on this, and the work planned by the Trust in 2024/25. The ICB looks forward to seeing continued 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 2024/25 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.

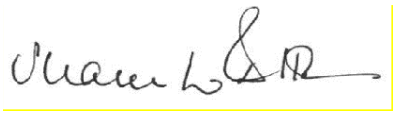
In 2023/24 the national cancer waiting times standards were consolidated into three combined standards. For the 28-day faster diagnosis standard, the Trust has met the target threshold of 75% every month since October 2023 and for the 31-day treatment standard the Trust has also met the target threshold of 96% every month

since October 2023. For the 62-day treatment standard, the Trust met the target threshold of 85% for three out of the six months between October 2023 and March 2024, and the Trust's performance against this standard remains one of the best regionally. The ICB is pleased to see that improvements continue to be made in this area and would encourage the Trust to sustain a strong commitment and focus in this area.

The Trust has embarked on a multi-project programme to develop a new emergency care model. In March 2024 the Trust's four-hour performance standard increased to 73.2%. The Trust's Urgent and Emergency Care services are operating under a model of continuous improvement and further areas of development will be identified in 2024/25.

The 2023 annual national staff survey results for the Trust showed areas of progress as well as those requiring action for improvements and the ICB recognises the ongoing work and commitment within the Trust in progressing these.

During the year the ICB have been working closely with ENHT gaining regular assurance on the quality and safety of provision to ensure a positive patient experience. Looking forward to 2024/25, the ICB supports ENHT's quality priorities and we look forward to a continued collaborative working relationship, including through building on existing successes and collectively taking forward needed improvements to deliver high-quality services for this year and thereafter.



Sharn Elton
Place Director, East and North Hertfordshire
Hertfordshire and West Essex ICB

Healthwatch Hertfordshire values the relationship with East and North Hertfordshire NHS Trust and has welcomed the regular updates on quality improvements, in particular to maternity services and urgent and emergency care.

The Trust has also been very supportive in arranging for us to meet with their internationally recruited midwives to understand their experiences. Retaining and supporting staff to provide high quality care is crucial to ensuring patient safety and a good patient experience and we look forward to sharing the outcomes from this research with them.

We look forward to continuing to work closely with the Trust to help enhance opportunities for patient voices to be heard and services to be improved including supporting the quality priorities outlined in this Quality Account.

Neil Tester, Chair Healthwatch Hertfordshire
May 2024

Statement from Social Care Health and Housing Overview and Scrutiny Committee

Central Bedfordshire Council's Social Care Health and Housing Overview and Scrutiny Committee holds decision-makers to account for improving outcomes and services for the residents of Central Bedfordshire. As a critical friend to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Account for East and North Hertfordshire NHS Trust.

We would like to start by acknowledging the many highlights and achievements delivered by the Trust during the last year.

We make specific reference to the 'respect our patient's time' priority within the patient experience quality domain – this focus on the patient experience is welcomed. We also welcome the focus on improving discharge within this priority, although we note the slight decline in midday discharges compared to last year and the work undertaken to focus on tackling delayed discharges.

Waiting times at AandE services are often raised as a concern of residents and so it is encouraging to see that the Trust's performance against the national 4 hour wait target has improved and we hope to see further improvement on this in the coming year in order to meet the recovery trajectory.

We highlight the following area of concern and for improvement;

- the lack of awareness amongst the public about the new Urgent Treatment Centre (UTC) at the Lister Hospital. We would like to see this more widely publicised so that residents are aware that they can use this facility rather than having to travel further afield to other health facilities.

We note that only 48% of complaints to the Trust received a response within the agreed timeframe, in comparison to the Trust KPI of 80%. We are concerned that the business case submitted for Patient Advisory and Liaison Service (PALS) and Complaints department may not come to fruition given financial challenges and wish to see a clear plan for improving response times to complaints.

In conclusion we welcome the opportunity to consider and comment on the report and we look forward to working constructively with the Trust to support the scrutiny process and our residents.

Cllr Emma Holland-Lindsay, Chair, Central Bedfordshire, Social Care Health and Housing Overview and Scrutiny Committee

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

28 June 2024 Date Chair

28 June 2024 Date Chief Executive

Glossary

Acronym	Meaning
AKI	Acute Kidney Injury
AMS	Antimicrobial Stewardship
C-DIFF	Clostridium difficile
CLD	Criteria-led discharge
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSW	Care Support Worker
DSPT	Data Security and Protection Toolkit
Enhance	Trust's Risk and Incident Management System
ENHT	East and North Hertfordshire NHS Trust
ENH PS	East and North Herts Production System
ED	Emergency Department
ePMA	Electronic Prescribing Medicines Management
EOLC	End of Life Care
FFT	Friends and Family Test
GDPR	General data protection regulation
GP	General Practitioner
H@H	Hospital at Home
HAT	Hospital acquired thrombosis
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPI	Key Performance Indicator
LocSIPPs	Local Safety Standards for Invasive Procedures
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
SDEC	Same day Emergency Care
SHMI	Summary Hospital Level Mortality Indicator
SJR	Structured Judgement Review
SJRPlus	Structured Judgement Review Plus
StEIS	Strategic Executive Information System

SUS	Secondary Uses service
TOCH	Transfer of care hub
UTC	Urgent treatment centre
VTE	Venous thromboembolism
WHO	World Health Organisation
WMTY	What Matters To You

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	11
Report title	Complaints, PALS and Patient Experience Annual Report 23/24			**Meeting Date**	11 September 2024
Presenter	Chief Nurse				
Author	Complaints, PALS and Patient and Carers Lead				
Responsible Director	Chief Nurse			**Approval Date**	
Purpose (*tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

To inform the Board of the Trust's annual position with regards to patient experience feedback, complaints and PALS activity, alongside the work of the Volunteers, Admiral Nurse and Carers work.

The report highlight's themes from patient feedback and Friends and Family Test (FFT) surveys, alongside complaints, Patient Advice and Liaison Service (PALS) and compliments, highlighting any areas of best practice and concern.

Key points:

- Significant rise in PALS concerns received
- 21 day turn around to respond to PALS concerns
- Success in early resolution meetings within complaints
- Exciting new additions to carers support

Impact: where significant implication(s) need highlighting

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

CQC domains: Caring, Effective, Responsiveness

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

Team capacity still remains on the risk register for the Complaints Department and PALS department

Report previously considered by & date(s):

Recommendation	The Board is asked to discuss the report

To be trusted to provide consistently outstanding care and exemplary service

Introduction

This annual report provides high level assurance that service users and their families are effectively listened to, and staff are supported to respond to feedback in a timely, effective manner. 2022-2023 has seen a continuation of the strengthening and improvement of the arrangements in place within the Trust to respond to feedback and engage and involve people who access our all services provided by the Trust.

1. Volunteers supporting improvements in patient and carer experience

Over the last year, Voluntary Services' focus was establishing regular volunteering roles across the Trust – ensuring that they spanned a range of different areas and departments, types of tasks and those volunteers continued to support staff and improve patient care and experience. East and North Hertfordshire NHS Trust are proud to now have over 360 active volunteers across the hospital sites.

Within the last year, Voluntary Services implemented a new online application form to further streamline the registration process and increase accuracy of volunteer records. In addition to this, the Voluntary Services team also introduced a new e-learning training programme as part of the updated registration process. This new process continues to improve the accessibility and flexibility of the on boarding process for applicants. It also ensures all volunteers receive mandatory training in accordance with national standards.

There were also improvements in the training provided to Trust staff regarding volunteers. In order to ensure that staff help patients get the most out of volunteers, Voluntary Services now feature on the Trust's induction training. This means all new staff will get a better understanding of the volunteers, their different roles and how the volunteers can support them to improve patient experience.

Projects

Wheelchairs for patients
The hospital has a supply of wheelchairs for patients to use when they are on site. Patients sometimes require a wheelchair to transport them to their appointments, so it is very important to have a supply ready at waiting at the main reception. Our hospital guide volunteers at Lister Hospital raised concerns that there are not always wheelchairs available for patients and this can cause delay and anxiety for patients getting to their appointments. The Voluntary Services team ran audits to identify the number of wheelchairs available across the Lister Hospital site. The team started working with the portering team and Estates department to identify whether there are wheelchairs that can be repaired in order to increase the numbers available for patients. Voluntary Services also developed a 'Wheelchair Warden' volunteer role to support the portering team in collecting unused wheelchairs from across the site and returning them to the main reception. The team have also been deploying Response Volunteers to support with this task when they have availability. The team will continue to support the volunteers in having a better supply of wheelchairs available for visiting patients.

The introduction of 27 new wheelchairs (kindly funded by The Friends of Lister charity) has been a welcome addition and has improved waiting times in locating and supplying wheelchairs for our patients.

Speech and Language Therapy (SALT) volunteers
The Speech and Language Therapy (SALT) Team support our stroke patients to help them regain their communication skills following a stroke. Voluntary Services worked with our SALT Team to develop a new SALT volunteer role to help patients practice their speech exercises, communication activities, and conversations. This is a very valuable role; expanding their team of

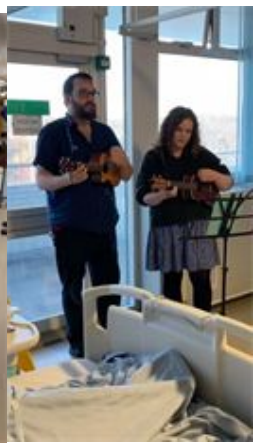
support volunteers means the SALT team have been able to introduce a weekly communication group for patients to benefit from. Alongside the (SALT) volunteer role, the Response Volunteers have also been assisting the SALT team with ad hoc befriending requests. Response Volunteers will visit patients who have experienced a stroke and who have been identified by the SALT team as being in need of conversation and companionship.

Friends and Family Test Questionnaires

Voluntary Services were enlisted to help improve the Friends and Family Test completion rates. The volunteers now provide the Outpatients Department and Swift Ward with support on a regular, weekly basis to obtain completed Friends and Family Test questionnaires from their patients. This provides patients with the opportunity to give feedback about their experiences in a timely way and for the areas to implement improvements in response to this. This has helped improve response rates within many of the outpatient areas.

Musician Visits

Within the last year, the Voluntary Services team reinstated the musicians that we previously had visiting the wards. The team continue to expand on the number of musicians invited in to perform for our patients and visitors – including weekly visits from music students (St John Henry Newman School) to the wards, as well as Christmas performances in the main corridor from choirs and hand bell ringers.



Therapy Animals

Voluntary Services revised and updated the Animals in Hospital Policy this year. It now allows animals to visit more areas within the hospital and there have since been regular visits to ACU and the Chemotherapy Suite, which have received very positive feedback from patients and staff. The Voluntary Services team also increased the number of therapy dogs within the team, helping to satisfy the ever-increasing demand for visits across the hospital. Voluntary Services are now able to provide regular visits for the 20 wards and clinical areas who are requesting them.

The therapy ponies continue to visit once every 3 weeks and are enthusiastically received by staff and patients. One of our volunteers has, with guidance from the Hospitals Charity, set up a small consortium of businesses he works with, to continue to sponsor the pony visits from February 2024 to February 2025.

Community Groups

May 2023 marked the 10th anniversary of the Lister's Sew Dementia Group, a wonderful group of local ladies who meet twice a month to make dementia fiddle blankets and aprons, toys, syringe driver bags, cannula and PICC line covers for patients, and cushions for frail patients. Over the past 10 years the group has produced thousands of items for the hospital, all of which have helped to improve the quality of our patients' experience with us, and their generosity and support has been invaluable. Tea and cake were enjoyed by all, and we look forward to continuing such a worthwhile and valuable partnership in the future.

3. Admiral Nurse

The Admiral Nurse, the Forget me Not Dementia Volunteer Service Coordinator and the Elderly Care Consultant Clinician for dementia and delirium collectively lead the dementia service for the Trust. A wide range of support is available to people living with dementia and their families during a hospital stay. This includes direct patient and carer contact with the team, advice, training, role modelling best practice and continual dementia awareness raising for staff in all roles.

Forget – Me – Not Dementia Volunteer service

This award-winning service commenced in April 2023. Led by Molly Shepherd, the service coordinator, this is a specialist team made up of 23 (and growing). Our volunteers are from diverse backgrounds with ages spanning between 17-75 years. This inclusive approach has enriched the volunteer pool and facilitated intergenerational interactions, fostering of shared

experience, respect, awareness and understanding of people living with dementia. “Thank you for your efforts to support all the people with dementia in the Lister. My Mother was delighted to receive a visit from the "Forget Me Not girls” (hope that’s correct!), describing them as great fun and she was really buzzing after they visited her. It really does make a difference!”

The service has received funding donations from 2 local Rotary Clubs enabling the provision of resources to use with people with dementia improving their overall experience.
The service was awarded the ENHT Time to Shine award in the Here to Help category and volunteer Chris Goward was awarded the Pride of Stevenage award for his dementia volunteering work.

Training
A comprehensive training programme is available for staff delivered by the dementia team at Lister and Mount Vernon Cancer Care. In this reporting time frame, the Dementia team have delivered 45 training sessions which includes Tier 2 and Dementia Interpreter – a highly interactive session which provides a simulated experience of what it may be like to live with dementia, Bespoke teaching to Emergency Department Staff and theatre staff, Monthly CSW Induction, training to the FY1 and FY2 doctors and ward team time sessions.

Staff have fed back how they will apply their learning in their clinical practice:
More understanding about communication with people living with dementia such as allowing more time to process information and checking understanding, using tools for enabling delivery of person-centred care, looking out for unmet needs and ensuring family are involved and communicated with. “Thank you for an excellent course”.

Dementia Champions
All areas have a dementia champion who promotes best practice dementia care. A conference was provided in July bringing together acute and community services to develop stakeholder relationships and share experience and resources.

Dementia Champions Conference, Ruth and Molly with Ashwell ward sister Gemma Smith, one of their dementia champions.

Dementia Champions Conference June 2023

Hertford Shires Rotary Club, Forget Me Not Volunteers, new resources

The team are always on the look out for best practice and regularly provide awards. AMU were recognised for compassionate end of life care involving the family at every step.

Governance
The dementia steering group meets bimonthly, providing updates on progress of the dementia strategy action plan. Bimonthly updates are presented at the PACE committee. A presentation was made to the Trust management Group reporting on Quality Improvement work to improve communication with family members during an inpatient stay. The National Audit of Dementia results have been presented at the Quality and Safety Committee and actions required for improvement identified. This includes provision of finger foods in all areas, reporting of incidents of falls, pressure ulcers, violence and aggression and readmission within 30 days capturing if the person has dementia with subsequent action plan.


Volunteers receiving training/ Registered Nurse Angela Brady who works in the Surgical Assessment Unit receiving a dementia best practice award for enabling person centred care.

4. Carers

Over the past year, our commitment to enhancing carer engagement has yielded significant progress and valuable outcomes. We are excited to share the highlights of our carer-focused initiatives for this year.

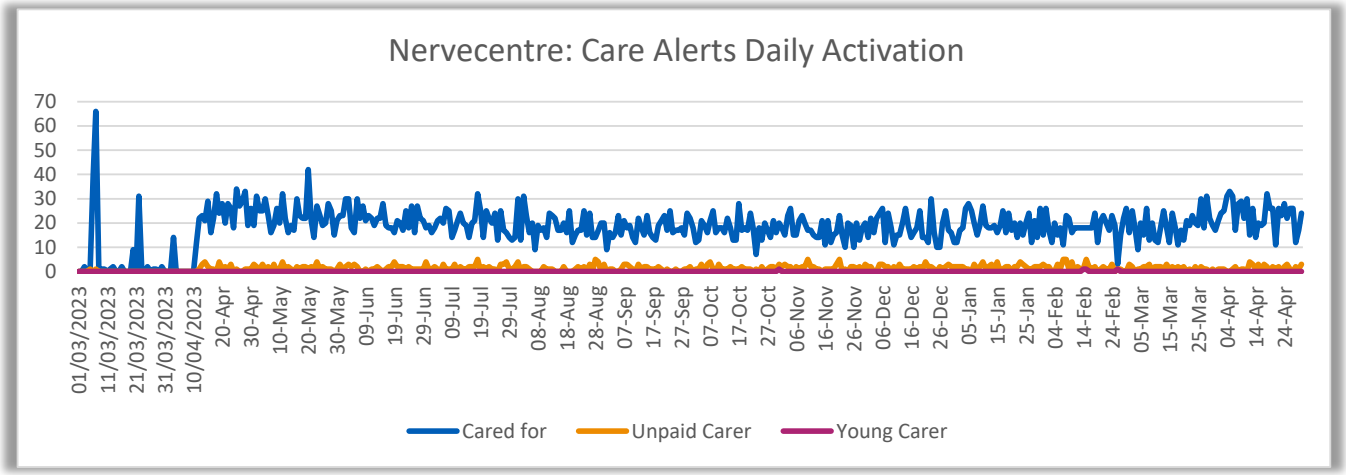
Carer Awareness training:

Our teaching programme has evolved significantly, transitioning from initial bitesize local sessions to a comprehensive, structured curriculum. We now deliver this training at various levels, including preceptorship and care support worker (CSW) induction.

In October 2023, we launched this enhanced training programme through the East and North Hertfordshire (ENH) Academy, enabling our colleagues to access this valuable e-learning more readily. This structured approach ensures that all staff are well-equipped with the necessary knowledge and skills to support carers effectively, enhancing patient care and wellbeing across our facilities.

Nervecentre: Care alerts

Since launching our system in March 2022, we have successfully sustained the daily activation of carer alerts within our healthcare facilities. On average, we identify 20-30 new patients with carers each day. Additionally, 5-10 patients who are unpaid carers themselves are admitted daily, ensuring they receive the necessary support and resources. While less frequent, we also occasionally encounter situations where a young carer is admitted, and our systems are equipped to provide the appropriate care and support in these cases.



This initiative was shortlisted for the Fab Award in late 2023 and won the Highly Commended Tiny Noticeable Thing Award in November 2023, further highlighting the impact, success and uniqueness of our work.

Carer Experience Volunteers

This year we have expanded our Carer Experience Team to include four main volunteer roles, enhancing our ability to support and engage with carers. These roles include:

Carer Support Volunteer: Visits the wards to offer out local support and to complete carers passports for families during visit.

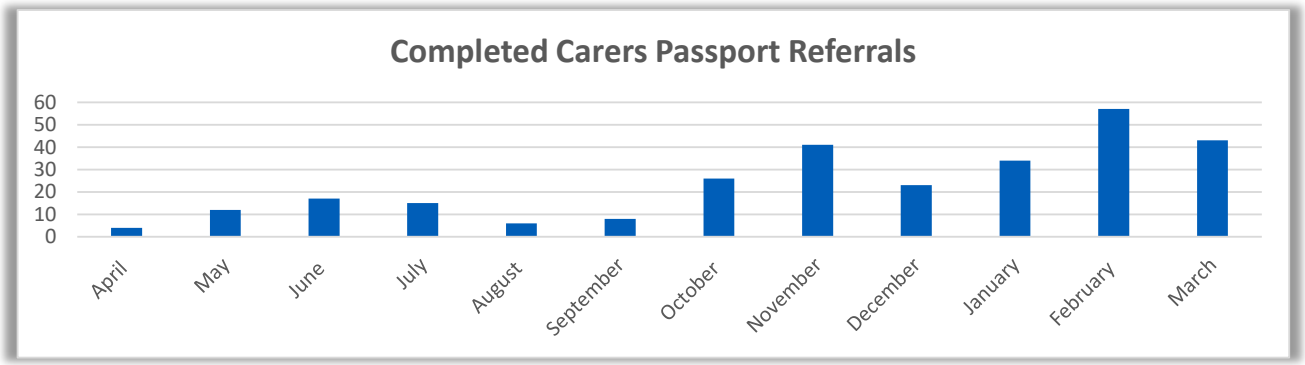
Carer In-Reach Volunteer: Call families that we couldn't capture on the ward visits and complete carers passport over the phone.

Carer Admin Volunteer: Manages stocks of our leaflets at our public "carers corner" and leaflets at the wards. Also supports with information stalls to raise awareness

Carer Companion Volunteer: Visit the carers that are admitted to hospital to offer company whether its just to have a chat or to play some games together.

The most impactful role has been the **Carer In-Reach Volunteers.** This role has dramatically increased our team's carer passport referrals, ensuring that carers are systematically identified and supported within our healthcare facilities.

These roles have significantly strengthened our capacity to meet the diverse needs of carers, ensuring they receive comprehensive support and recognition for their vital contributions to patient care.



Launch of Carer Charity Branding:

With the support of our hospital charity, we launched our own carer charity branding November 2023, further solidifying our commitment to supporting carers. We are now striving to increase fundraising activities to enhance the support we offer to our carers.

East & North Hertfordshire Hospitals' Charity
Supporting carers

Carers Forum

Since the successful carer forum in February 2023, we have significantly increased our engagement with carers by conducting quarterly forums. These regular meetings have facilitated valuable input from carers about the services they are interested in exploring.

One notable outcome was the creation of our new patient information leaflet, which carers helped develop when the service started. After a year, carers reviewed the leaflet again, providing feedback that led to revisions for greater clarity on which information is most relevant to specific carers and which site it pertains to. Previously, carer support was primarily available at Lister, but now it is also provided at QEII and Hertford, with plans to include Mount Vernon Cancer Centre in the future.

New Carers Leaflets 2023/2024

Next Steps for 2024-2025

1. **Strengthen Carer Champions in Clinical Areas:** Enhance the role and presence of Carer Champions to ensure robust support across all clinical areas.
2. **Carer Lanyards for Physical Identification:** Introduce carer lanyards to provide a visual prompt for colleagues, making it easier to identify and support carers of patients.
3. **Increase Volunteer Recruitment:** Expand our volunteer base, with a dedicated uniform to clearly highlight the presence of our voluntary service.
4. **Launch of the Carer Survey:** Implement a new carer survey with a target of achieving a minimum of 10 survey responses per clinical area.
5. **Launch of the New Carer Policy:** Introduce a comprehensive carer policy to further support and guide our commitment to carers.

5. Compliments

352 compliments were raised over the last year, a rise compared to previous year of 260.

Compliments continue to be promoted within governance meetings, divisional updates to PACE and reported to the staff member involved and reporting manager to ensure that praise is given.

6. Complaint and PALS annual overview

This report provides a summary of formal complaints received in 2023-24 in accordance with the NHS Complaints Regulations (2009).

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

The Patient Advice and Liaison Service (PALS) provide ‘on the spot advice and support’ with the aim of timely resolution. In the event that this has not been achieved, PALS discuss with patients and relatives how their concerns can be appropriately resolved and where appropriate, provide advice to them on the formal complaints process. The PALS role has unfortunately not met the expectation of the service provision due to capacity issues within the team. As such, there is a 21 day turn around on non-urgent concerns.

On closure of complaints, any action plans are now logged and tracked on ENHance to ensure that continuous improvements are happening within the Trust. This also helps identify areas that that are still having the same consistent concerns raised in their areas.

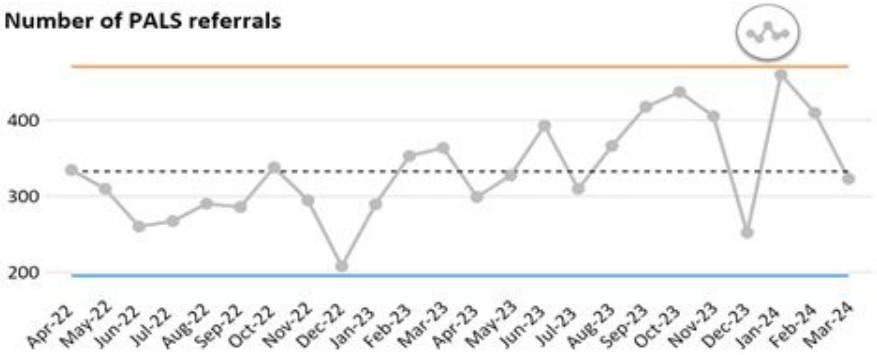
Formal complaints training is also conducted by the Complaints Department twice a month via Microsoft Teams. This has been very successful and due to this, staff are now able to book online to attend so that we are able to keep a log of all that have been trained.

During 23/24 the Complaints Department also set up a triage system for complaints that should be offered face to face meetings prior to any investigation. The criteria for these types of cases would include loss of a loved one; complaints over 15 points long and complex complaints. This has worked extremely well with many of the people raising concerns taking up the offer of an initial meeting and has reduced the time taken for them be provided with a response; they felt listened to and it was ensured that compassionate conversations were taking place.

PALS Enquiries – Concerns

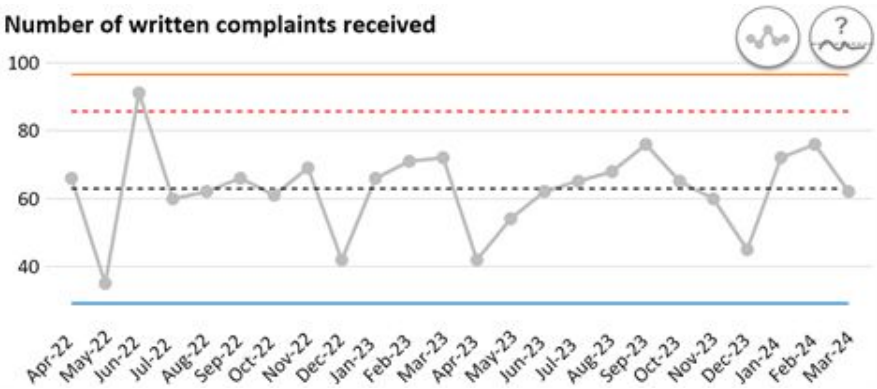
There was a total of 4657 PALS enquiries received in 2023/24, a significant increase from 3499 the previous year.

Key themes from our Patient Advisory Liaison Service (PALS) are related to delays in appointments, poor communication and delayed/poor care/treatment.

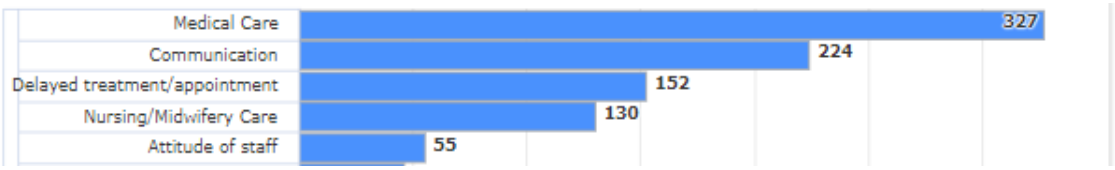


Formal complaints activity

In 2023/24, 763 formal complaints were received across all services, a slight increase since 2022/23 whereby 750 received.



Below are the top five categories that complaints have related to within hospital. Medical care and communication remain the highest categories in line with previous years. Communication this year pertains to the communication around care, family being updated, appointments and waiting times.



Unplanned Care have received the highest number of complaints during 23/24, in line with the previous annual report. The Emergency Department receives the most complaints per month and as such falls under this division increasing the number of complaints received in this division.

There are continuous improvement works within the Emergency Department, such as redeveloping the departments environment and also reviewing shift patterns for staff to cover the higher numbers of people within the waiting area.

Top 5 five services receiving highest number of complaints

7. Acknowledgement of formal complaints

There is a mandatory requirement to acknowledge all formal complaints within three working days of receipt. In 2023/24 97% of complaints were acknowledged within this timeframe. This has increased from the 95% the previous year. The team continue to strive towards 100% compliant in 24/25. The current Trust target is set at 90% and as such we have been exceeding this target.

8. Outcomes of formal complaints

During 2022/23, 757 formal complaints were closed. Of those closed, 128 were upheld, 437 partially upheld and 192 were not upheld.

7. Parliamentary and Health Service Ombudsman Outcomes

Q1 2023-2024

The Parliamentary and Health Service Ombudsman (PHSO) advised that they were investigating two cases in Q1, April – June 2023. They requested information to demonstrate learning and improvement regarding a formal complaint before deciding if they would proceed to investigate the case. This information was shared with the PHSO.

1. The PHSO provided a final report and made recommendations that a letter of apology should be written to the family and awarded £600 recompense. The Trust did not prescribe pain relief as it should when it discharged the patient. It is likely that this failing contributed to the patient being in pain for over 24 hours.

2. The Trust lost handwritten records on a patient's admission on 16 October 2018 and failed to report the lost notes on the incident reporting system, or do a risk assessment, in line with GDPR regulations.

   The PHSO did not find that the missing records impacted on the patient's treatment, however this failing caused the patient's daughter, and the complainant distress. The Trust did not give the patient nutritional supplement drinks as it should have. The PHSO have not found this had an impact on the patient's ability to recover, but the PHSO found the failure caused the patient's daughter, the complainant distress and worry.

Q2 2023-2024

The PHSO requested two sets of patients records and complaints files in Q2, July – September 2023.

The PHSO had four cases under investigation in Q2. No additional information was requested. No outcomes of investigations were provided.

Q3 2023 -2024

The PHSO did not request any medical records during Q3, October – December 2023.

The PHSO provided an update on a formal complaint. They had reviewed the concerns raised and the medical records and information they had requested from the Trust. The Trust was advised that the PHSO would not be investigating this case and had closed the file.

The PHSO did not request any additional information for the three cases they were investigating.

The PHSO shared a final report with the Trust. This complaint was in relation to the medical care provided. The PHSO partly upheld the complaint in relation to the management of intravenous fluids, lack of a capacity assessment and observation omissions. The PHSO recommended that the Trust write to the family and acknowledge the worry, anxiety and uncertainty they suffered and pay them £300 in view of this. These recommendations were actioned, and the family received a letter of apology and recompense from the Trust.

Q4 2023-2024

The Parliamentary and Health Service Ombudsman did not request any medical records during Q4, January – March 2024.

The PHSO shared their findings with the Trust about concerns raised by a family who's relative was under the care of the Cancer Services. The family had sought a second opinion privately and requested recompense from the Trust for the cost of private scans. The PHSO did not uphold this part of the complaint but recommended that the Trust write to the family and apologise for the communication. Cancer Services undertook to write a policy concerning patients who are outpatients and wishing to seek a second opinion. A letter of apology was written alongside the policy being shared with the family.

8. Local Surveys

The Trust continually monitors feedback from patients and uses this feedback to make changes and improvements to the services it provides. An electronic patient survey system is in place called 'ENHance'.

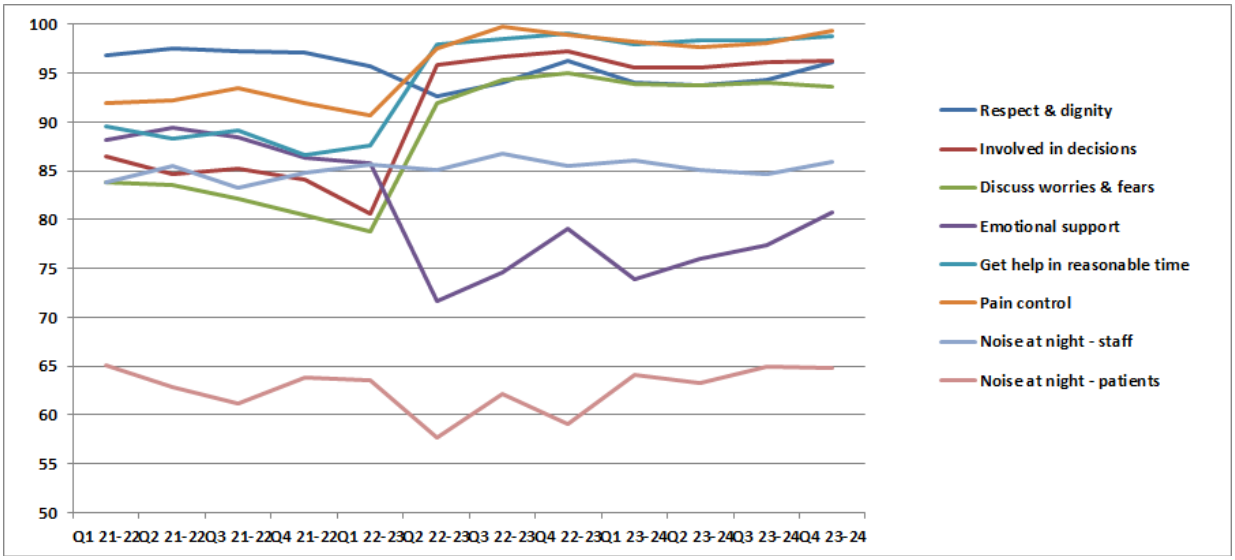
In 2023-24, 12,972 patient experience surveys were completed compared to 10,012 surveys in 2022-23 (this excludes the single question Friends and Family Test survey).

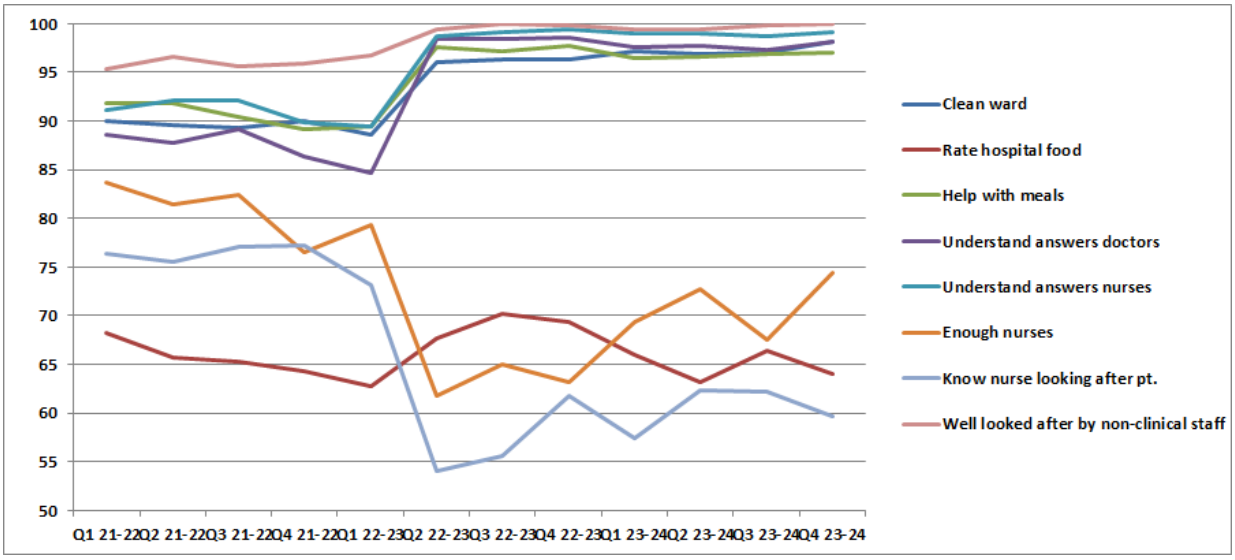
ENHance Local Patient Experience Surveys	No of responses 2021-22	No of responses 2022-23	No of responses 2023-24
Day Case	610	498	569
Critical Care	28	67	169
Emergency Department / UCC	514	191	457
Discharge	3	N/A	N/A
Renal Dialysis	937	908	1027
Outpatient Department	2139	3241	4692
Neonatal	154	169	116
Maternity	1307	330	247
Inpatient	4928	4207	5412
Assessment Area	1	109	69
Community Respiratory	104	204	163
Experience of EoL Care	30	11	48
Bramble safeguarding	0	N/A	N/A
Renal Tele-clinic	1	0	N/A
Keeping in Touch	128	13	N/A
What matters to you	1649	64	3
Total	**12,533**	**10,012**	**12,972**

The compliance scoring for the Inpatient Survey questions was reviewed and updated earlier this year. This has had an impact on the historical data since the Inphase platform ENHance has been used in the Trust (July 2022).

Divisional action plans on findings continue to be presented during the monthly PACE Group which provides ongoing evidence of what is being done about the consistent themes raised within the FFT surveys.

The charts below show a comparison of the inpatient survey results between April 2021 - March 2024.





Friends and Family Test

The Friends and Family Test (FFT) asks **'Overall, how was your experience of our service?'** There are six response options ranging from 'very good' to 'very poor'.
We continue to collect feedback from patients completing a survey on their own device via displayed QR codes, by using a ward iPad or completing a paper survey whilst they are in the hospital. The FFT surveys are also available on the Trust website, and we carry out post-discharge telephone calls to patients asking for feedback regarding their experience of their most recent visit to hospital.

An easy read version of the FFT survey is offered to people (with appropriate support if needed) who have dementia, learning disability, are profoundly deaf, deafblind, blind/vision loss, have little or no English or low levels of literacy. Guidance is available for staff offering the FFT survey to patients with dementia or a learning disability.

The response numbers have increased in each of the past three years since the pandemic but are still reduced in comparison to the pre-Covid period.

Summary of Trust FFT results and response rates (2023-24):

In 2023-24, 23,144 patients responded to the Friends and Family Test (FFT) question (compared to 22,363 in the previous year).

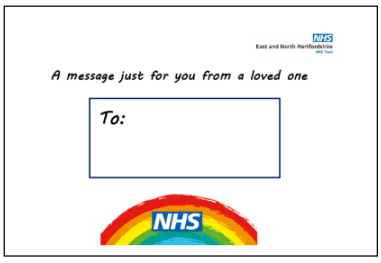
	Inpatients/ Day Case	ED-UCC	Outpatients	Maternity				TOTAL
				Antenatal	Birth	Postnatal	Community	
Q1 2023-24	2428	318	2638	101	93	186	0	**5764**
Q2 2023-24	2525	348	2671	95	85	174	5	**5903**
Q3 2023-24	2136	181	2694	73	44	167	44	**5339**
Q4 2023-24	2501	249	2895	193	51	187	62	**6138**
Total	**9590**	**1096**	**10898**	**462**	**273**	**714**	**111**	**23144**

Supporting family and friends to Stay in Touch with patients

The ‘stay in touch’ service is still available through the Trust website for friends and family of inpatients staying at Lister Hospital or Mount Vernon Cancer Centre, where messages are received by email and then printed and delivered to patients.

This service was well received by patients and their family and friends during the pandemic, but use of this service has continued to decline. In 2023-24, there were 50 messages with a total of 34 photographs delivered to patients. This compares to 228 messages and 211 photographs/pictures/crossword puzzles the previous year.

The service will be promoted more frequently via posters, staff briefings and on social media (Facebook) to encourage use, as it has been found to benefit patients, families, carers and friends who, for whatever reason, are unable to visit their loved ones in person.



Patient receiving ‘stay in touch’ message

NHS
East and North Hertfordshire
NHS Trust

Integrated Performance Report

Month 04 | 2024-25

	P	?	F
H, L	1	10	10
	8	40	9
H, L	1	4	1

Data correct as at 27/08/2024

Performance Highlights

East and North Hertfordshire NHS Trust

Quality

- *C difficile (C diff.)* - There has been an increase in the number of cases this month compared to the previous month by 57% (4 cases). Although this remains above the monthly threshold.
- MRSA BSI - There were zero MRSA BSI in the month of July'24 with an annual threshold of 0.
- Friends and Family Test (FFT) - Positive feedback on the Trust's inpatient facilities is consistently passing the target; Emergency and Outpatient department remains mixed.
- Proportion of complaints acknowledged within three working days is consistently passing the target.
- The rolling 12-month crude mortality rate continued to decrease in Jul-24, HSMR remained below 100 and SHMI has also seen a decrease in their latest respective publications.

Operations

- Urgent and Emergency Care - The monthly attendances saw further increases with the continued presentation of high acuity reducing the performance to 69.73% in July.
- Cancer Waiting Times - The Trust achieved the 28-day Faster Diagnosis and 31-day decision to treat to treatment in June-24, but not the 62-day referral to treatment standards. All three are statistically likely to have mixed performance (passing and failing) from month to month.
- Referral To Treatment (RTT) 18 weeks - Numbers of patients waiting over 65, 78 and 104 weeks for treatment (excluding Community Paediatrics) continued to show Improving trends in-month.
- Diagnostics - The proportion of patients waiting more than six weeks for diagnostic tests remains higher than the target, and has started to decrease in the recent months.

Finance

- The Trust submitted a revised 2024/25 plan in June of £1m surplus. This plan assumes the delivery of a £33.8m (5%) cost improvement programme.
- At Month 4 year to date, there was a planned deficit of £1.0m, and an actual position of £2.1m. The £1.1m adverse variance is entirely due to the impact of a 7 day junior doctor strike during June/July.
- ERF delivery was behind plan on month due to delays in recruitment to new posts and this will be reported in further detail in the ERF and Productivity report.
- Pay was £0.4m adverse to plan in month, excluding industrial action and non recurrent reserves. High levels of Waiting list initiative payments, high locum usage for medical staff within the ED department and midwifery continue to be the main pay hotspots and actions are being undertaken to mitigate in future months.

People

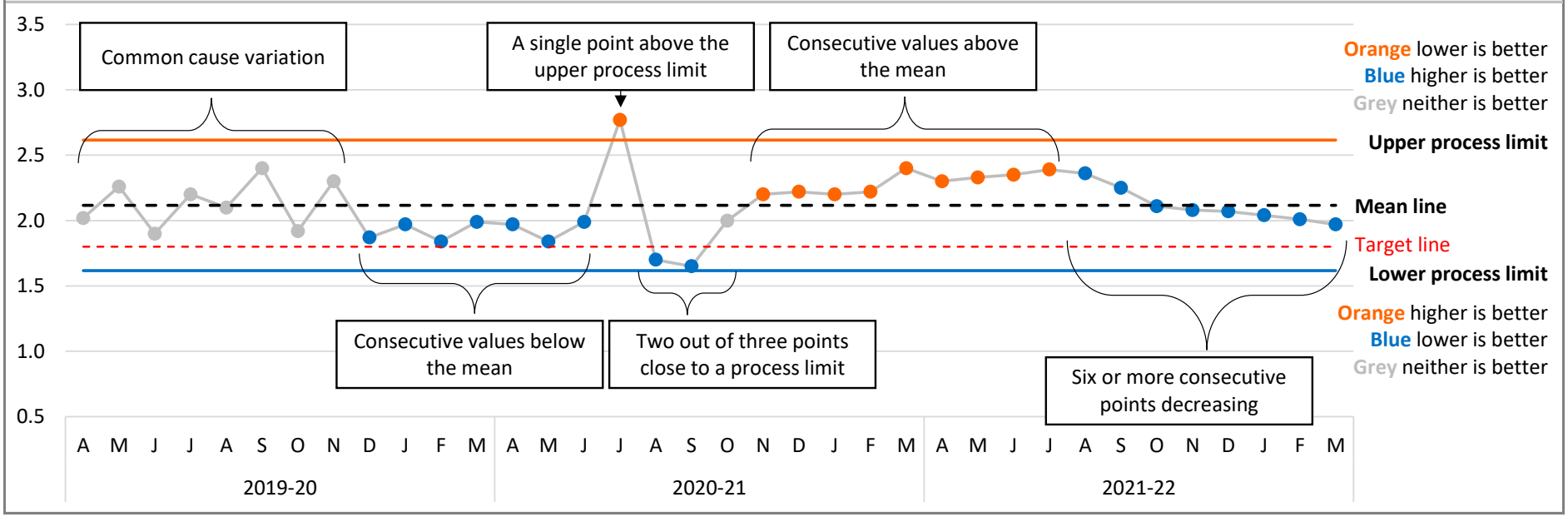
- The vacancy rate decreased to 9.2% (622 vacancies). Recruitable establishment increased by 18 WTE. There are 107 more staff in post than a year ago.
- 'Grow Together review (GTR)' compliance this month has remained the same. The Trust is in the last month of the 24/25 GTR window, however compliance remains low, particularly for staff in bands 6 and below. A weekly Trust news reminder cascade is in place throughout August.
- Mandatory training shows a slight improvemnet compared to the previous month, though the 90% target is not being met.
- Continued focus on management of short and long term sickness absence results in more consistent reductions supported through regular divisional board review and occupational health supporting work and early advice is making a consistent positive difference.

Month 04 | 2024-25

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



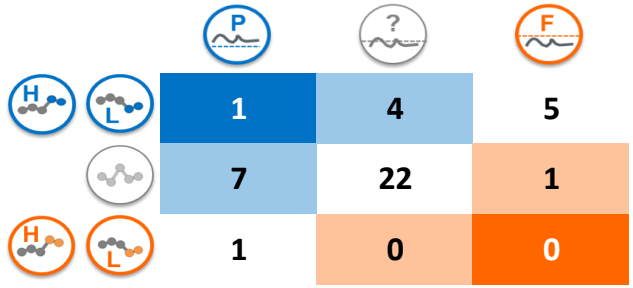
Variation	
H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

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

NHS
East and North Hertfordshire
NHS Trust

Quality

Month 04 | 2024-25



Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Jul-24	n/a	1,386			Common cause variation No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Jul-24	0	0	L	?	8 points below the mean Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Jul-24	0	11		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Jul-24	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Jul-24	0	5		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Jul-24	0	5		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Jul-24	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Jul-24	0	0	L	?	22 points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Jul-24	80%	94.0%	H	P	9 points above the mean Metric will consistently pass the target
Safer Staffing	Overall fill rate	Jul-24	n/a	84.7%	H		10 points above the mean No target
	Staff shortage incidents	Jul-24	n/a	25			Common cause variation No target

Month 04 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Jul-24	n/a	0.84			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Jul-24	n/a	0.63			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Jul-24	95%	73.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Jul-24	95%	57.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Jul-24	95%	90.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Jul-24	95%	73.6%		F	Common cause variation Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Jul-24	85%	88.3%	H	F	5 points above the upper process limit Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	Jul-24	n/a	120			8 points above the mean No target
	Number of HAT RCAs completed	Jul-24	n/a	13			Common cause variation No target
	HATs confirmed potentially preventable	Jul-24	n/a	3			Common cause variation No target
PU	Pressure ulcers All category ≥2	Jul-24	0	16		?	Common cause variation Metric will inconsistently pass and fail the target

Month 04 | 2024-25

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Jul-24	n/a	5.7			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Jul-24	n/a	1.1%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Jun-24	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Feb-23	6.0%	5.8%			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	Jul-24	95%	96.8%		P	Common cause variation Metric will consistently pass the target
	A&E positive feedback	Jul-24	90%	84.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Jul-24	93%	96.3%	H	F	6 points above the upper process limit Metric will consistently fail the target
	Maternity Birth positive feedback	Jul-24	93%	100.0%	H	F	3 point above the upper process limit Metric will consistently fail the target
	Maternity Postnatal positive feedback	Jul-24	93%	97.4%	H	F	16 points above the upper process limit Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Jul-24	93%	100.0%	H	F	11 points above the upper process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	Jul-24	95.0%	95.7%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Jul-24	n/a	484	H	-	7 points above the mean No target

Month 04 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Jul-24	n/a	64		-	Common cause variation No target
	Number of complaints closed in-month	Jul-24	n/a	102		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Jul-24	75%	98.4%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Jul-24	80%	54.2%		?	Common cause variation Metric will inconsistently pass and fail the target
Maternity Safety Metrics	Caesarean section rate Total rate from Robson Groups 1, 2 and 5 combined	Jul-24	60 - 70%	70.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Jul-24	3.3%	2.0%	H	P	9 points above the mean Metric will consistenly pass the target
	3rd and 4th degree tear vaginal	Jul-24	2.5%	2.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Jul-24	4.5%	0.6%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear instrumental	Jul-24	6.3%	3.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Jul-24	6.0%	7.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Jul-24	0.7	1		?	Common cause variation Metric will inconsistently pass and fail the target

Month 04 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Jul-24	12.5%	6.1%		P	Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Jul-24	2.3%	4.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Jul-24	50.5%	75.5%		P	Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Jul-24	72.7%	73.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Number of serious incidents	Jul-24	0.5	0	L	?	9 points below the mean Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Jul-24	12.8	7.6		?	common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Jul-24	12.8	9.1			Rolling 12-months - unsuitable for SPC
	HSMR In-month	May-24	100	89.0		?	Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	May-24	100	81.9			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Feb-24	100	80.0		?	Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Feb-24	100	92.0			Rolling 12-months - unsuitable for SPC

Month 04 | 2024-25

Quality

Summary

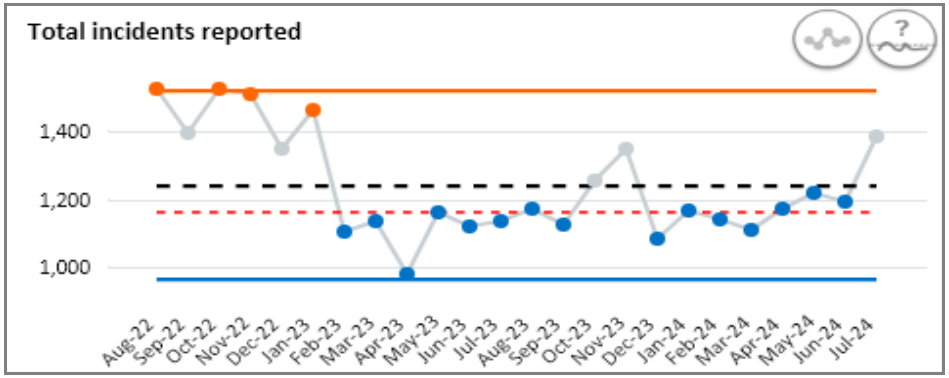
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	May-24	n/a	786	H		3 points close to upper process limit No target
	Rate of emergency re-admissions within 30 days of discharge	May-24	9.0%	6.5%		P	Common cause variation Metric will consistently pass the target
Length of Stay	Average elective length of stay	Jul-24	2.8	2.3		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	Jul-24	4.6	4.1	L	?	1 point below the lower process limit Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Jul-24	n/a	84.6%			Common cause variation No target
	Individualised care pathways	Jul-24	n/a	32			Common cause variation No target

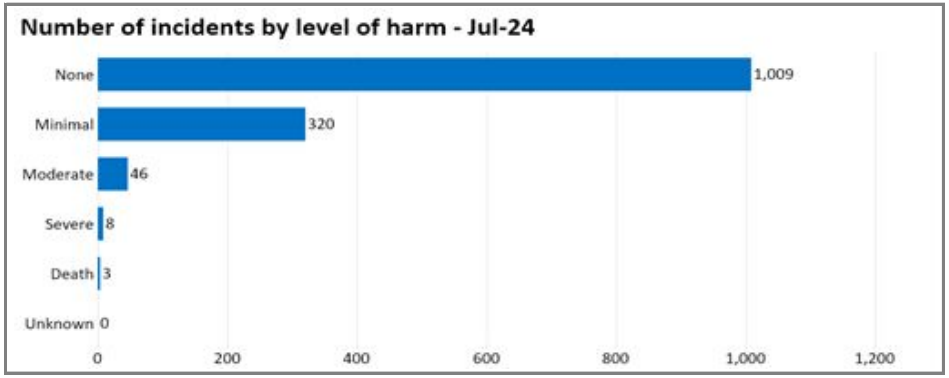
Month 04 | 2024-25

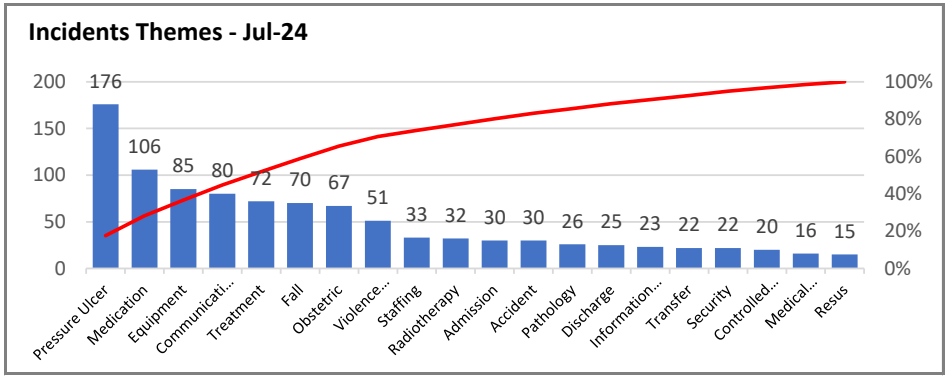
Quality

Patient Safety Incidents

East and North Hertfordshire NHS Trust

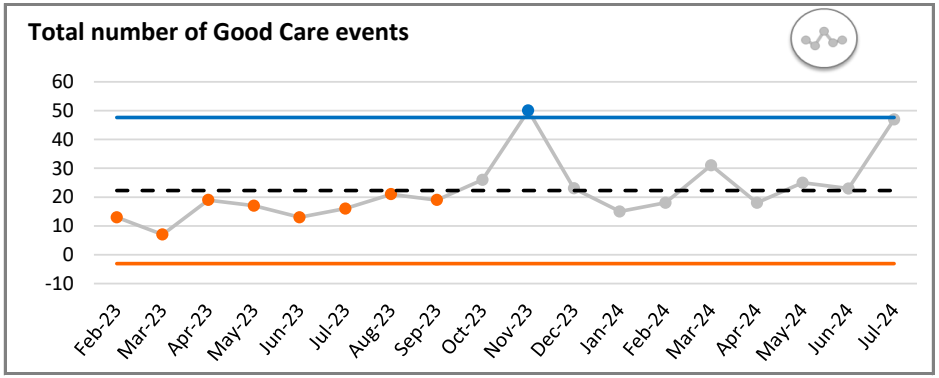






Key Issues and Executive Response

- Increase in incidents reported in July - specifically noted in Planned Care and W&C. No obvious themes or clusters identified in Planned care but remains under review by Divisional team. In W&C, increase in incidents is in response to positive promotion of incident reporting. Also noted they have implemented new EPR system which has impacted on staffing (combined with holiday period) lead to an increase in staffing incidents reported. There has been a cluster of maternity safeguarding incidents reported and there is an ongoing QI project.
- The number of open accumulated open incidents remains an improvement priority. Oversight meetings remain are in place to support improvement within Unplanned Care.
- Four serious incidents remain open, all relate to Paediatric Audiology review.
- No new PSII commissioned in July.
- Successful transition to bi-weekly oversight patient safety event review panel (PSERP) providing forum for oversight of themes and trends in incident reporting and learning
- Divisional teams progressing with daily incident review huddles advocating more proactive incident management (deployed in W&C and Planned Care).

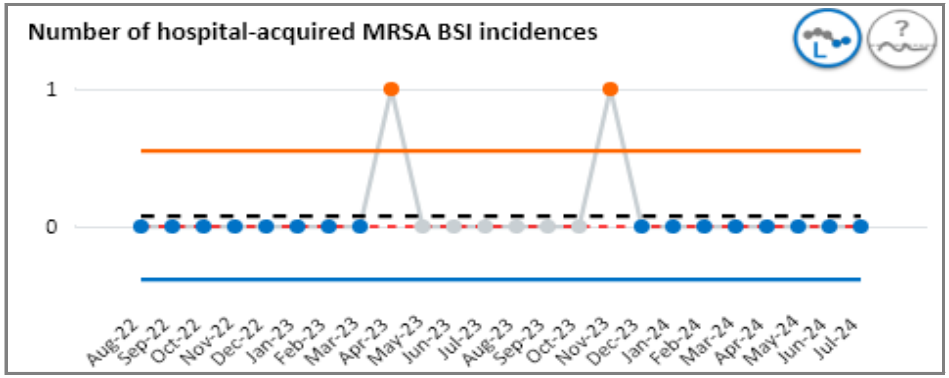


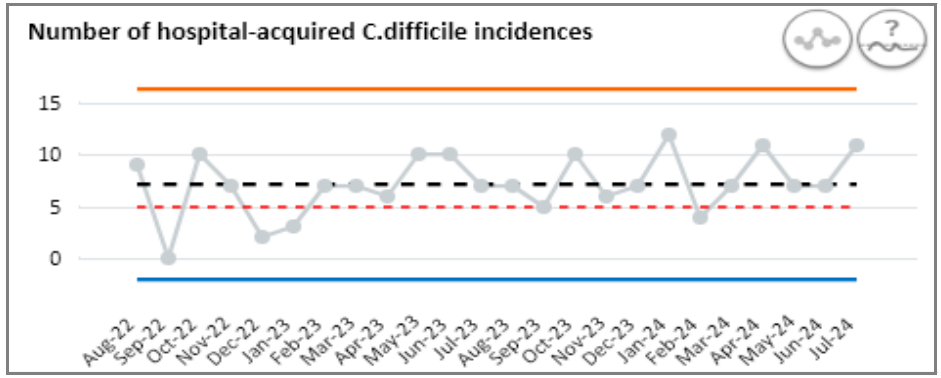
Month 04 | 2024-25

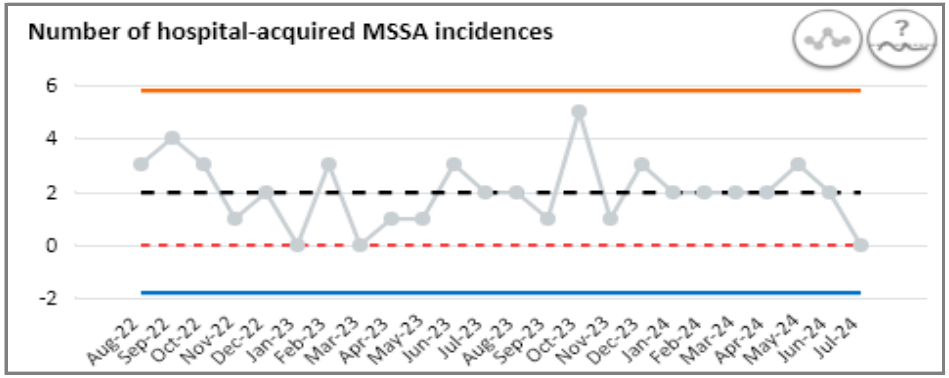
Quality

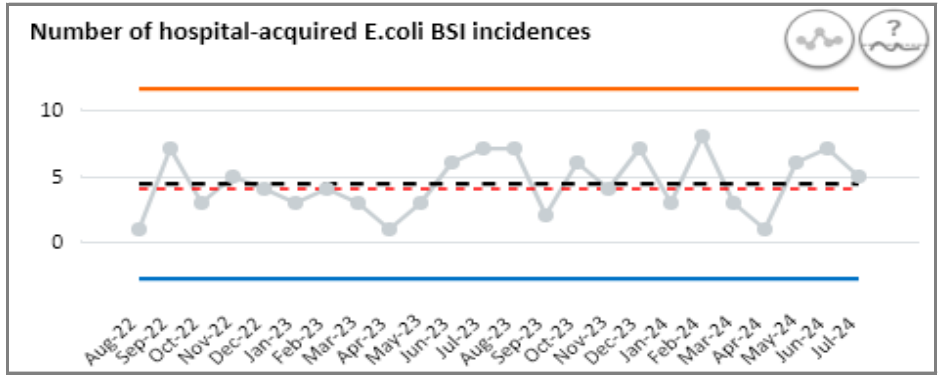
Infection Prevention and Control

East and North Hertfordshire NHS Trust









- *C difficile (C diff.)* infection (CDI) - the number of CDI cases from April 2024 to July 2024 is slightly higher than the number of cases compared to the same period in 2023 by three cases. The weekly *C.diff* Multidisciplinary team continues to meet to discuss the treatment and management all *C.diff* cases. This meeting continues to be well attended by the clinicians, facilitating helpful conversations about patient safety.
- The study day that took place in the month of July was successful with over fifty participants. The teaching and presentations supported safe practise areas such as aseptic technique and CDI.

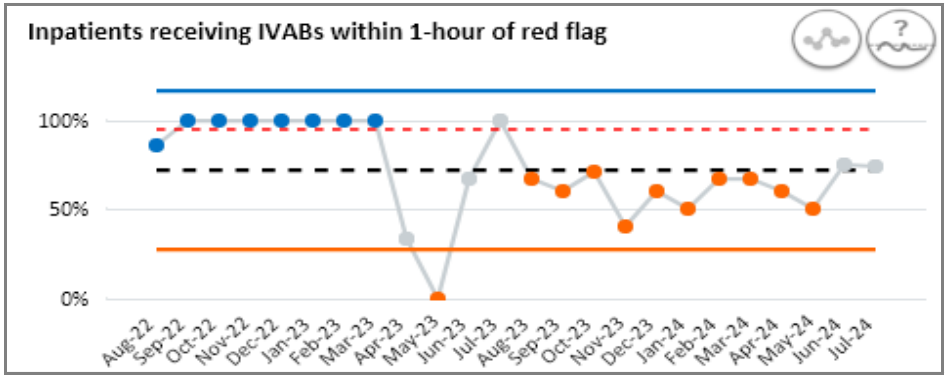
- MRSA BSI - there were zero MRSA BSI in the month of July 2024. There have been no MRSA BSIs this financial year to date.
- MSSA BSI - there were zero cases in July 2024 compared to in July 2023.
- *E.coli BSI* - as of July 2024, the number of E.coli BSIs is one above the total of the same period in 2023.

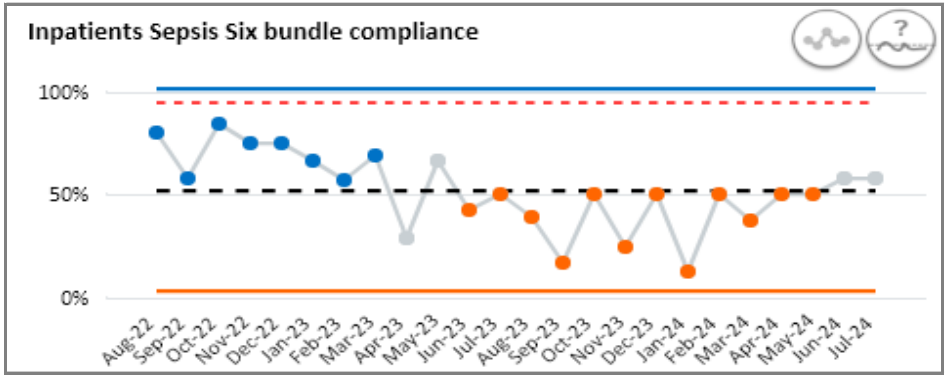
Month 04 | 2024-25

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust





Themes

Sepsis IP	2023-24								2024-25			
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	80%	64%	83%	75%	78%	57%	100%	63%	78%	88%	75%	95%
IV antibiotics	67%	60%	71%	60%	60%	50%	75%	67%	60%	50%	75%	74%
IV fluids	55%	57%	56%	71%	83%	57%	100%	100%	67%	71%	67%	77%
Lactate	65%	64%	83%	57%	60%	25%	86%	63%	89%	100%	75%	89%
Urine measure	59%	42%	83%	71%	60%	50%	57%	75%	89%	88%	92%	74%

Key Issues and Executive Response

Themes

- Overall compliance shows gradual improvement at 63%. There are consistency and improvements across 5/6 aspects of the sepsis six, with fluid balance dropping compliance levels in July.
- Blood cultures and Lactate have been encouraging with improvements across July. The focus now is to maintain this level.
- Urine measurement dropped to 74%, highlighting the continued need for education and a focused drive on its importance.
- Upon recommendation from the Sepsis Task and Finish Group, average time to antibiotics is no longer being taken into account as can prove to be unreliable when there are significant outliers. Patients who are already receiving appropriate anti-microbial therapy prior to deterioration are also being counted in compliance figures as a pass.

Response

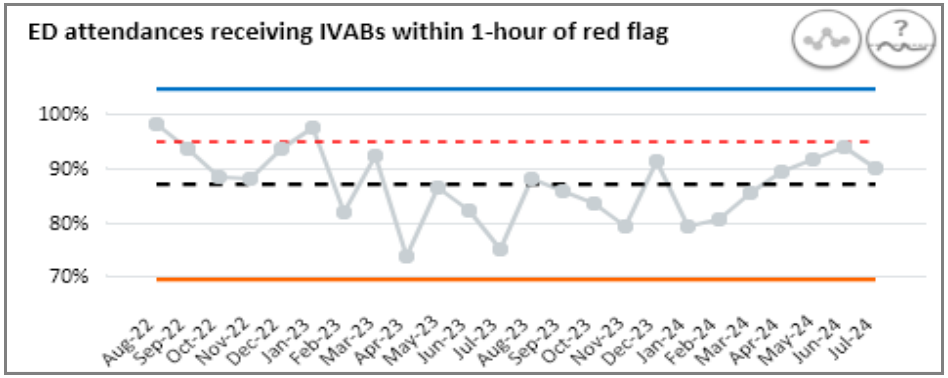
- 4/7 IP fails occurred out of hours, highlighting the pressures of the on call teams, impacting prompt assessment and implementation of sepsis treatment.
- 4/5 of the delays in antibiotic administration were found to be due to a delayed prescribing of antibiotics falling outside the hour, with one highlighting a delay in administration. In one instance there was a delay in prescribing and a further delay in administration once prescribed. All instances have been ENHanced and shared with the teams and anti-microbial pharmacist for local learning.
- The pilot of 'sepsis grab boxes' on 11A, has been extremely successful and will be rolled out to other wards starting at the end of August.
- The Sepsis Team continue to be a visible presence in inpatient settings assisting with recognition and management of septic patients.

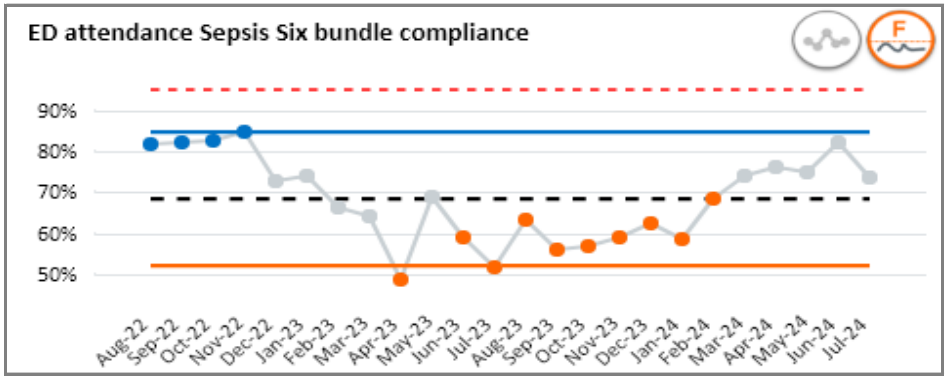
Month 04 | 2024-25

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust





Themes

Sepsis ED	2023-24								2024-25			
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Oxygen	94%	100%	98%	100%	100%	100%	96%	100%	100%	100%	100%	100%
Blood cultures	89%	88%	87%	93%	91%	92%	100%	97%	97%	91%	100%	99%
IV antibiotics	88%	86%	84%	79%	91%	79%	80%	85%	89%	92%	94%	90%
IV fluids	83%	89%	88%	87%	92%	82%	85%	84%	91%	92%	94%	92%
Lactate	96%	100%	97%	93%	95%	98%	100%	98%	100%	100%	100%	100%
Urine measure	72%	64%	63%	64%	67%	66%	78%	86%	79%	83%	86%	74%

Key Issues and Executive Response

Themes

- Overall compliance dips slightly compared to June, with fluid balance being the main protagonist letting compliance down. Individual elements of sepsis compliance show consistent improvements with 5/6 sitting at 90% and above for the third successive month.
- Lactate and Blood culture compliance sit above trust target.
- Fluid balance compliance dipped slightly, remaining the lowest aspect. Awareness of when to start a fluid balance remains a running theme, showing a continuing need for further education. The sepsis team is liaising with the ED to facilitate this.
- IVF compliance remains consistent sitting at 92%. IVABX sits at 90%, 64/71 patients received within the hour. Of the 7 delays in antibiotics, 5 fell outside by less than 43 minutes and can be attributed to clinical pressures, demand on staff and patient prioritisation.

Response

- No serious harms were reported in June
- There was one instance in July of a patient receiving delayed antibiotics, due to being extremely unwell and peripherally shutdown. In these instances whereby the delay has a clearly documented reason, we audit it as a N/A and it will not contribute to compliance figures. This is why 71/72 patients have been audited for antibiotic compliance.
- The Sepsis Team continue to provide bedside education to staff, often attending patients in ED and going through the Sepsis Screening Tool in real time.
- ENHance reports are submitted to ED matrons for non-compliance to be reviewed and set a plan for continuous improvement.
- ED resus project to create a sepsis drawer is in progress.
- Mandatory e-learning is being updated to include a detailed video showing how to use the digital screening tool.

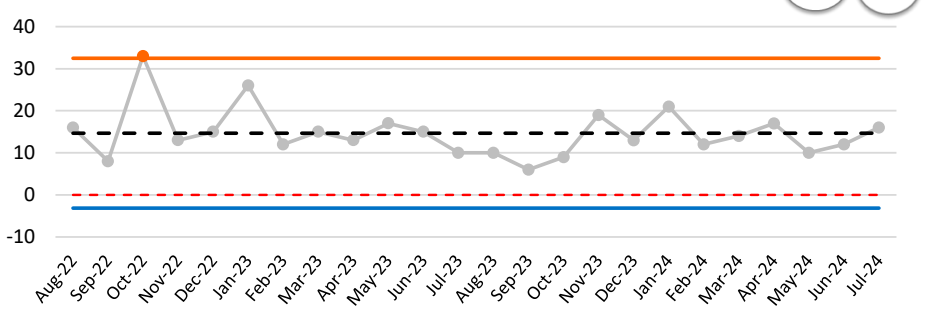
Month 04 | 2024-25

Quality

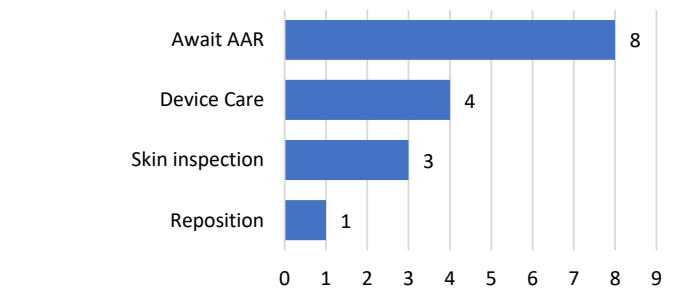
Pressure Ulcers | VTE

East and North Hertfordshire NHS Trust

Number of hospital-acquired pressure ulcers



Themes - Jul-24

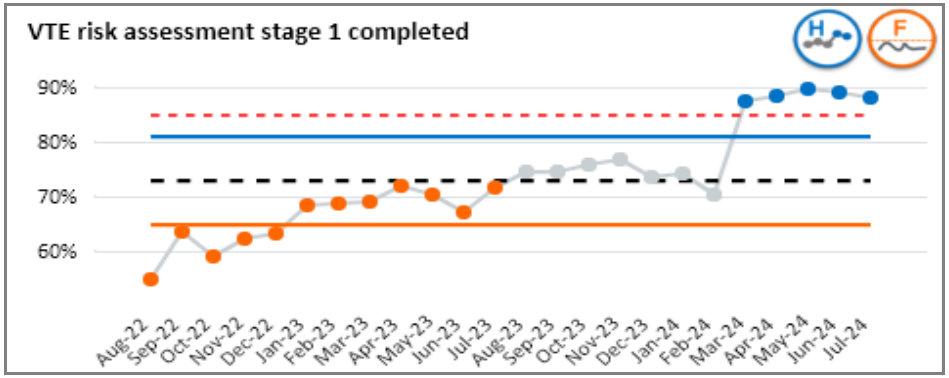


405

days since last category 4

as at 23/08/2024

VTE risk assessment stage 1 completed



Key Issues and Executive Response

Pressure Ulcers

- Ward 10B have started sharing their QI project Learning with Trust colleagues, using meetings as platform of sharing.
- Annual Link Nurse Study day was held on the 1st of July with a very good turnout. Link Nurses have agreed to continue with PU Audits in line with CQUIN just ended National audit, aiming to increase our compliance to 85%.
- Heel PUs continue to lead the PU numbers. Some of the new Care Groups are focusing of the reduction of these, ensuring that ward managers are ordering enough supply of Heel protection equipment.
- TVT Actions FOR 2023/24:
  - Risk assessment and pressure ulcer prevention care planning improvement project within CDU in ED; (Paused as requiring more support)
  - Implementation of new National Wound Care Strategy Programme (NWCSP) PU recommendations in progress;
  - Convert PU risk assessment tool to PURPOSE-T to align with the new NWCSP recommendations. (Awaiting approval from digital to start)

VTE

- Auditing parameters reviewed in February in preparation for NHSE audit relaunch in July 2024 and adjustments implemented to mimic VTE exemplar centres - resulting in improved compliance rates
- Continue sustained improvement in local QI projects.
- Reports are continuously being analysed to provide focused data-driven quality improvement projects in specific areas and specific teams.
- Quarterly VTE and Anticoagulation Newsletter distributed in April to feedback ward and specialist data.
- Ongoing pilot of digital 'welcome pack' in certain areas to improve patient awareness of VTE, VTE risk assessment and VTE prevention.

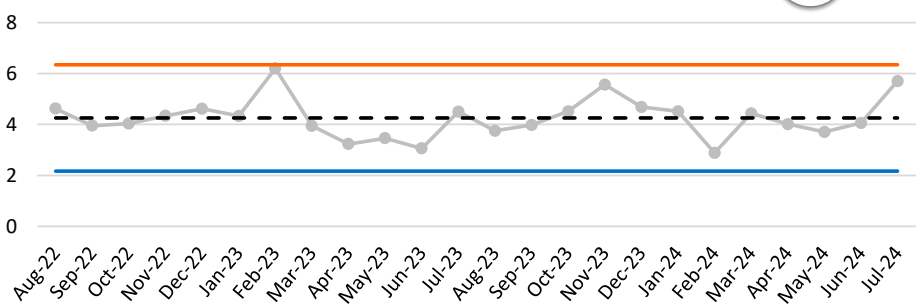
Month 04 | 2024-25

Quality

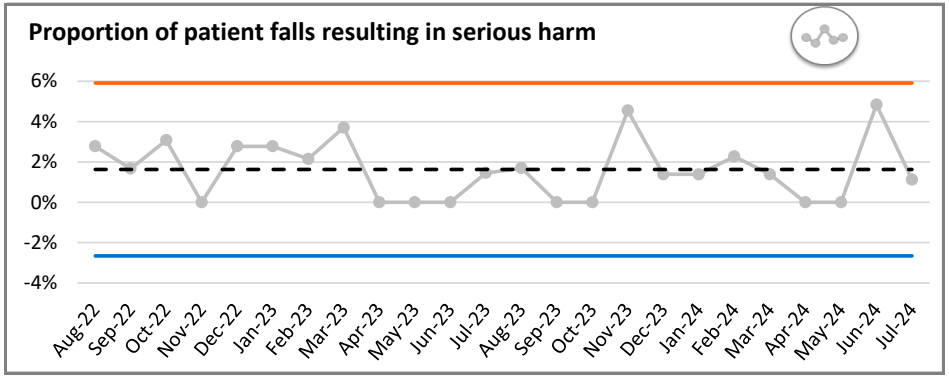
Patient Falls

East and North Hertfordshire NHS Trust

Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm



Key Issues and Executive Response

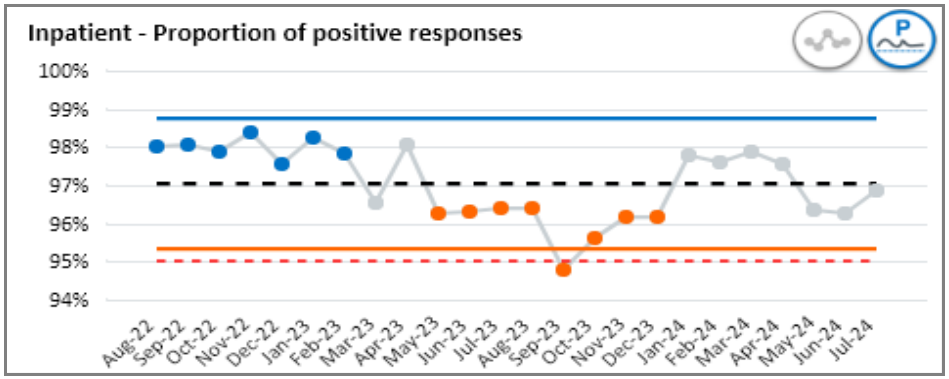
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- We have seen an increase of inpatient falls for the month of July compared to the previous months. This has been communicated to heads of nursing and team leads and suggested a review of their teams compliance in post fall documentation and recommendation.
- x1 inpatient fall with serious harm recorded for the month of July as patient deteriorated following the fall. There's an incidental findings that could have caused the deterioration rather than the fall itself. This is being reviewed at the divisional level and will make a decision whether to downgrade or keep the harm.
- Falls risk assessment compliance now available on QlikView. This has been shared to the divisions so they can actively look at the data and share this with their teams to either celebrate success or to unpick learnings.

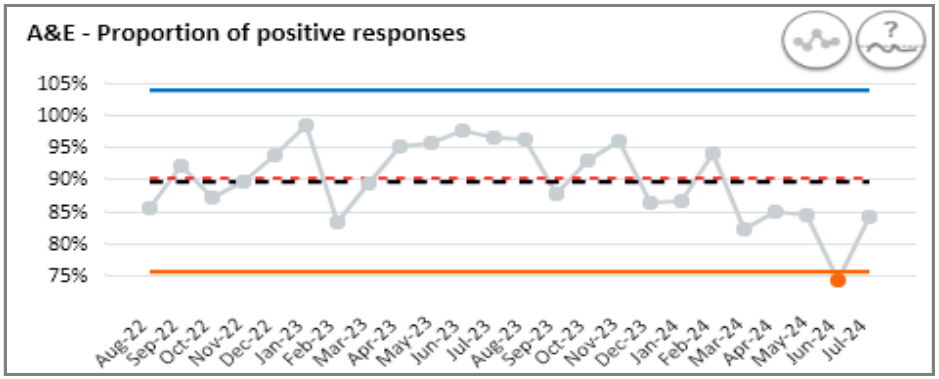
Month 04 | 2024-25

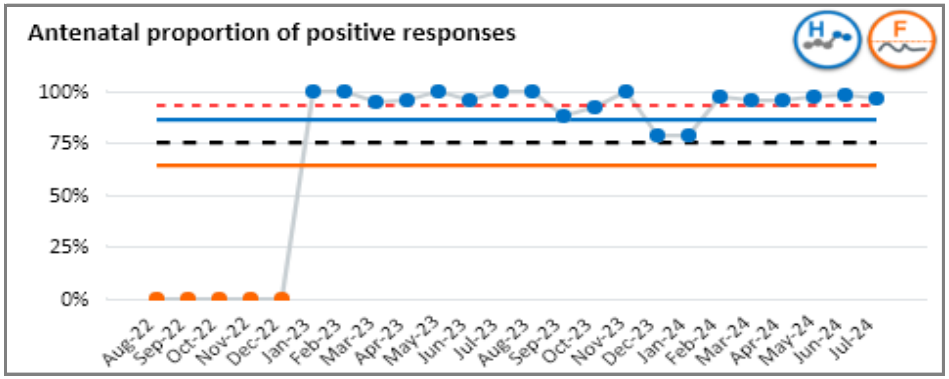
Quality

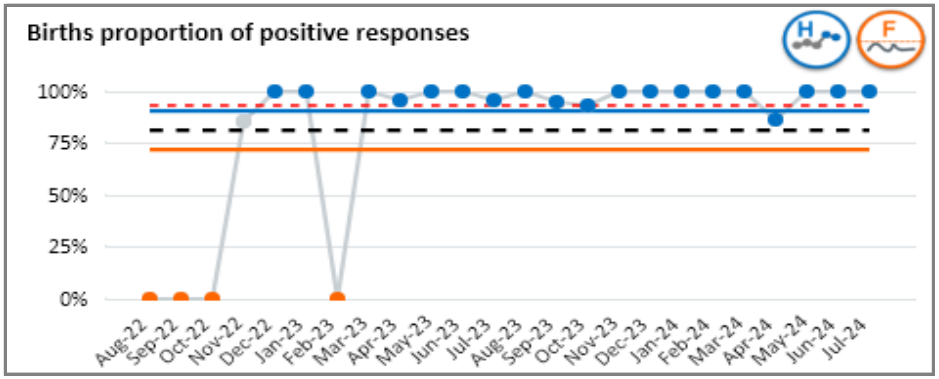
Friends and Family Test

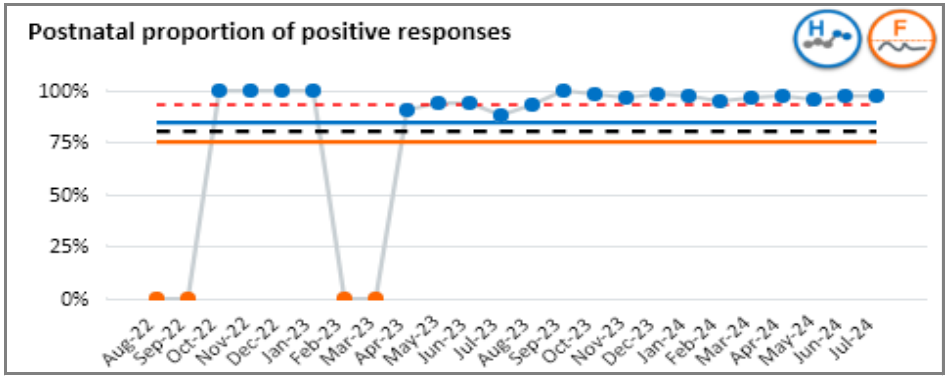
East and North Hertfordshire NHS Trust

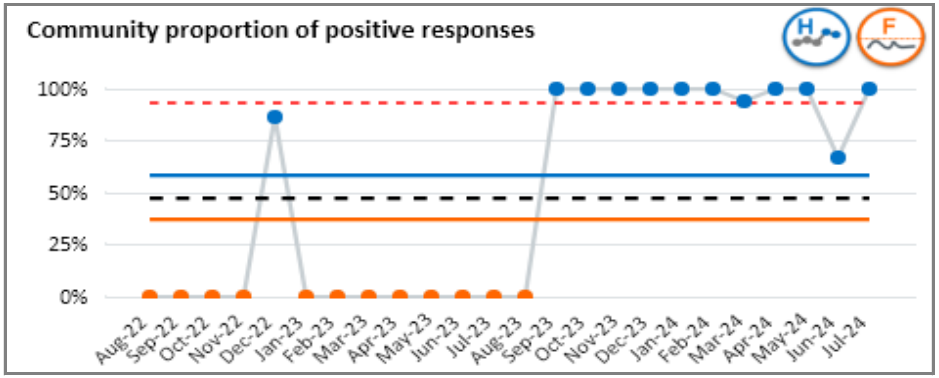










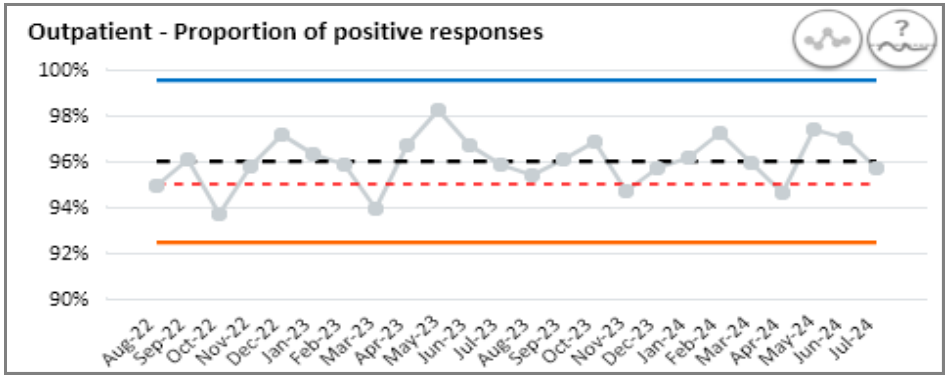


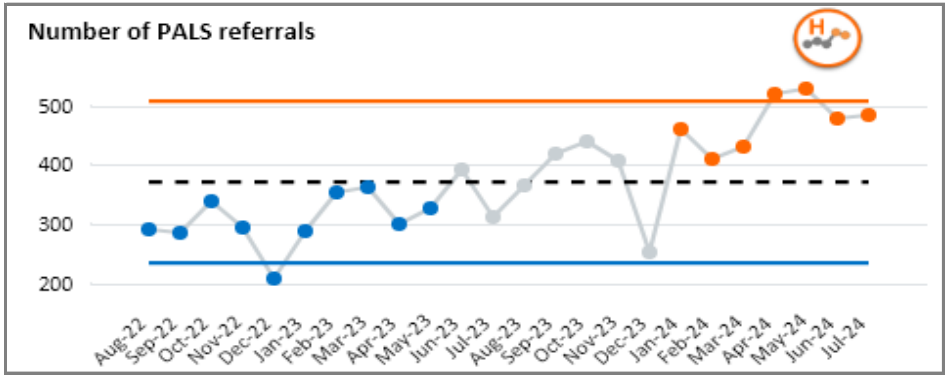
Month 04 | 2024-25

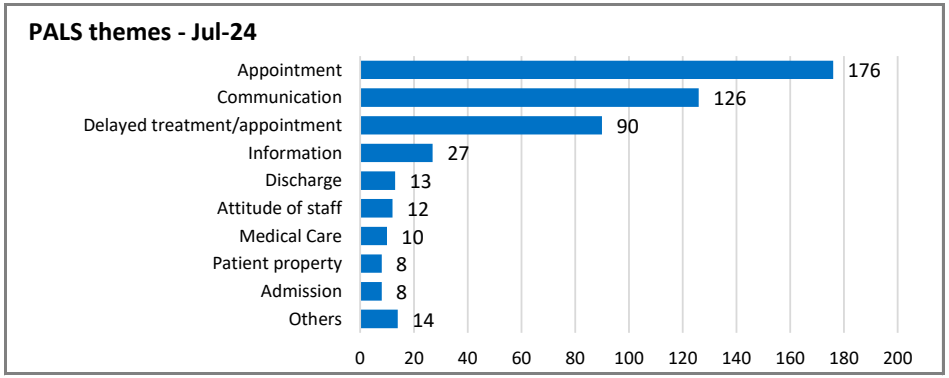
Quality

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

- Inpatient responses saw an improvement based on recent months. The drop in ED satisfaction results seen in June has resumed to those seen in previous months. The overall number of responses for July has increased in comparison with those seen in June. Themes within the comments remain consistent related to waiting times, lack of information regarding waiting times, lack of communication, and staff attitudes. These comments have all been highlighted to the senior nursing teams.

Patient Advice Liaison Service

- PALS continues to receive a high volume of emails and phone calls. Despite considerable efforts and a reduction in the turnaround time for enquiries to within a 2 week response timeframe, the team inbox is sitting around 80 emails due to the number of enquiries coming in each week.
- All enquires are screened each day so those of priority receive a quicker response.
- Audiology remains a concern with lack of response from the service in responding the concerns which has been escalated to service leads.
- Lack of staff on the hospital main reception continues to impact on the volume of walk ins that the PALS department receives at there is no one to provide information.
- Trauma and Orthopaedic concerns have risen in regards to appointments in the plaster room which has also been escalated.

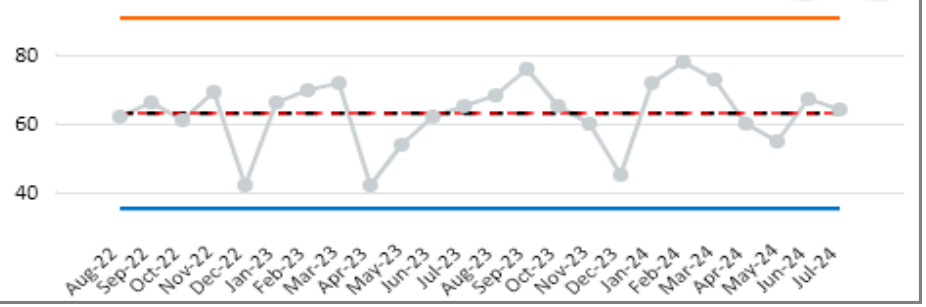
Month 04 | 2024-25

Quality

Complaints

East and North Hertfordshire NHS Trust

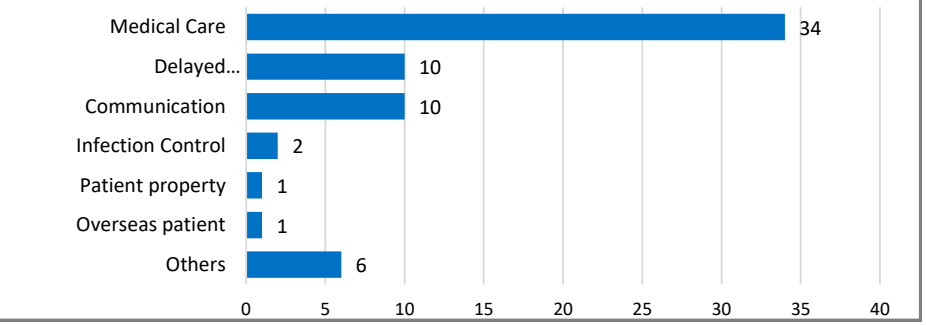
Number of written complaints received



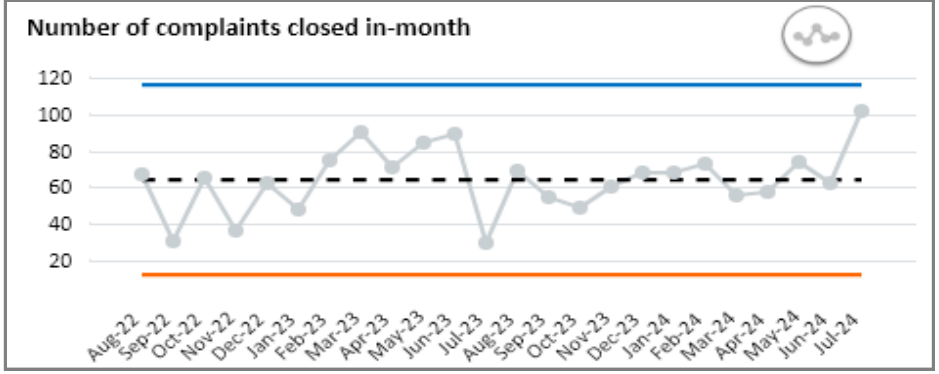
Key Issues and Executive Response

- At the time of writing, the Trust has 168 open complaints, with 19 complaints awaiting for scope confirmation.
- The team have been working hard with the divisions to close down the oldest complaints currently open due to the length and complexity, and as such the amount of complaints closed in the month has increased significantly.

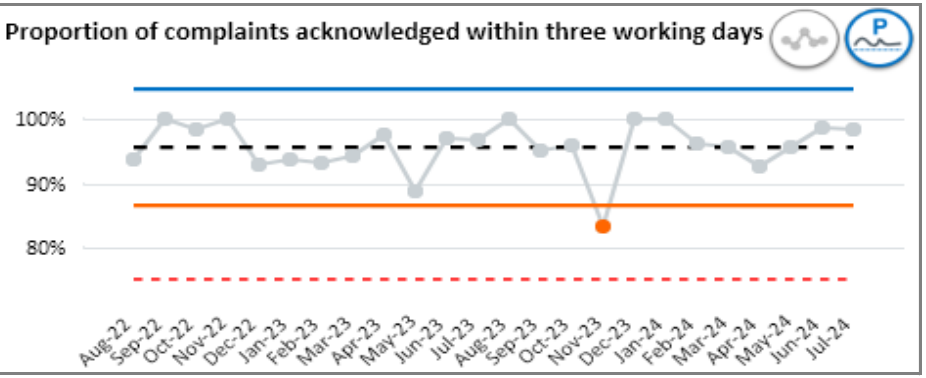
Complaints themes - Jul-24



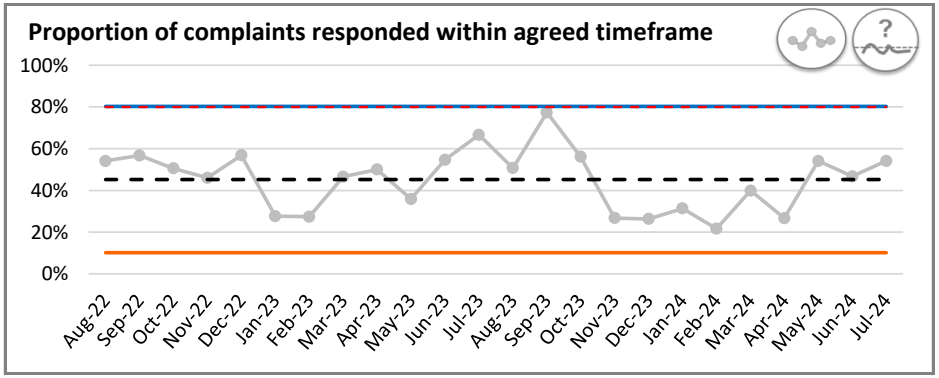
Number of complaints closed in-month



Proportion of complaints acknowledged within three working days



Proportion of complaints responded within agreed timeframe

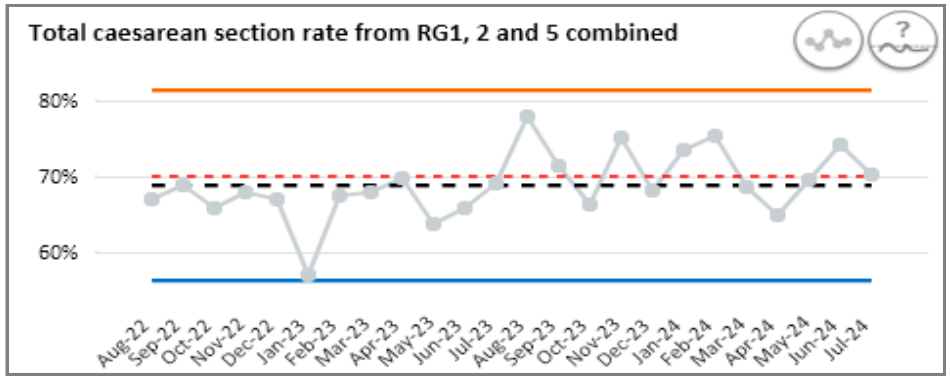


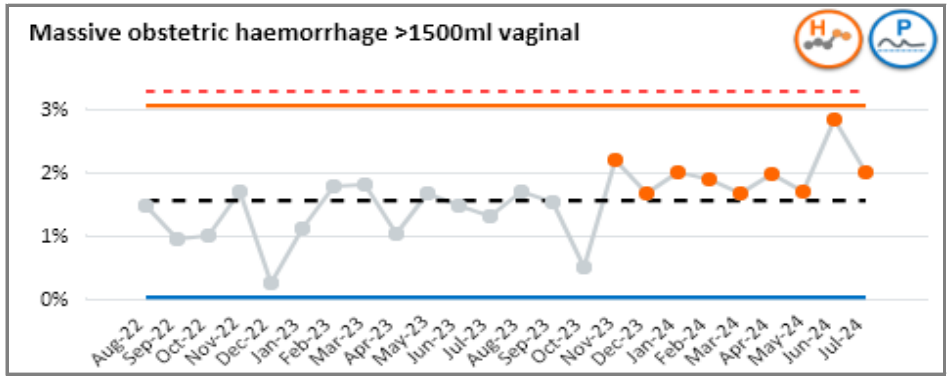
Month 04 | 2024-25

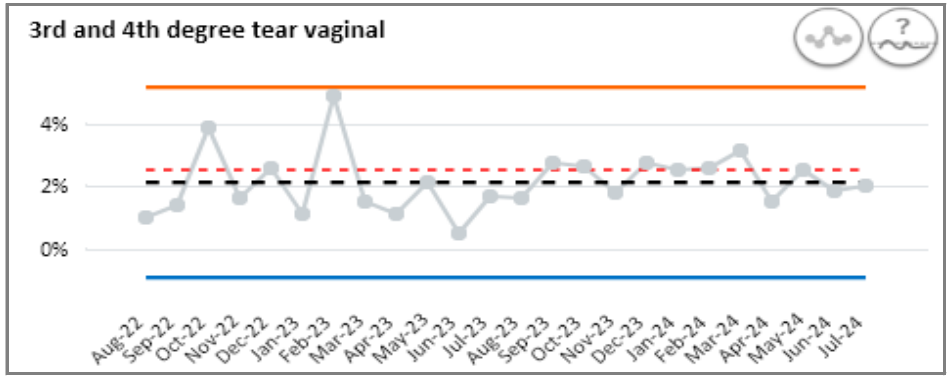
Quality

Maternity | Safety Metrics

East and North Hertfordshire NHS Trust







Key issues and executive response

- No PSII declared between January and July 2024.
- 3rd / 4th degree tears - normal variation noted. Rates consistently below national expectation. Monthly obstetric review and audit continues. Working party in place to implement the OASI 2 care bundle in line with national recommendation. Training package produced - integration as on MMD annual training, planned launch Autumn 2024.
- Normal variation continues at LSCS and reduction to tolerable rates noted for MOH > 1500mls at vaginal deliveries. Rate of MOH > 2000 mls remains significantly low against red flags. Thematic review by Labour Ward Lead to establish trends and/or special cause variation. Increased trajectory examined by LMNS and co-production of guidance.
- Breast Feeding initiation and discharge rates reduced and within normal variation. Includes donor milk, EBM and breastmilk in line with NMPA.
- Term admissions to the Neonatal unit at a rate above goal limits (<6%) now at 7.08% and increase on previous months noted. Weekly ATAIN reviews continue. x3 avoidable obstetric cases for long labours (escalation and delivery could have occurred earlier) and x1 avoidable neonatal case (could have been transferred to TC to avoid separation).

Robson Group Criteria

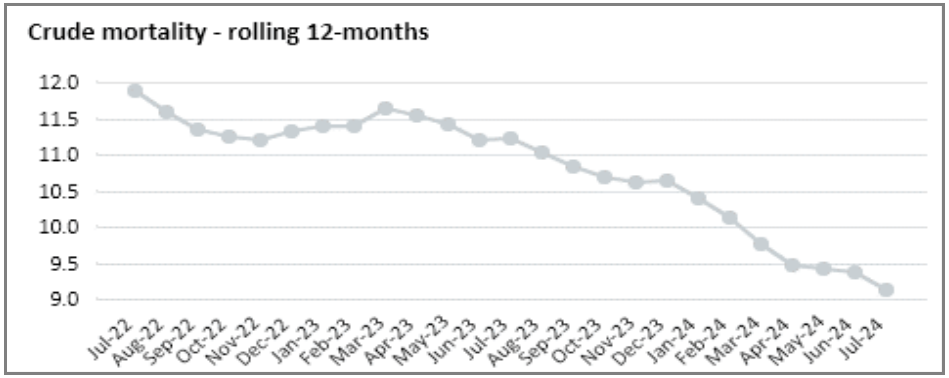
- Considers obstetric variables to enable classification into one of 10 groups. Categorisation assists in understanding reasons for trends:
  - **Robson group 1:** Nulliparous singleton pregnancy > 37 weeks with spontaneous labour onset.
  - **Robson group 2:** Nulliparous singleton pregnancy > 37 weeks delivered before labour onset or where labour induced.
  - **Robson group 5:** Multiparous women, singleton pregnancy >37 weeks with at least one previous uterine scar.
- These 3 groups combined normally contribute to two thirds of all CS performed in most hospitals. For month 04 the combined rate is 71%.

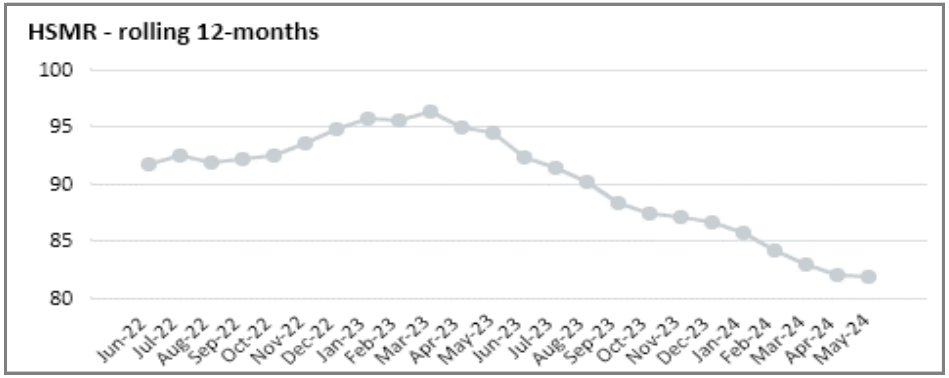
Month 04 | 2024-25

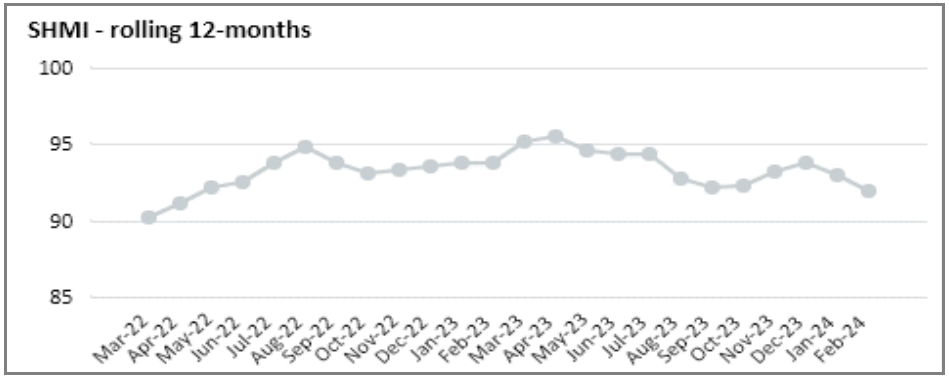
Quality

Mortality

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

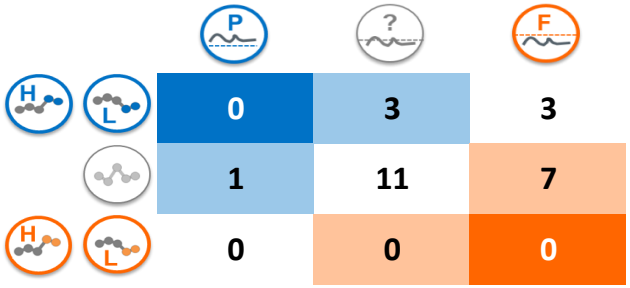
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues.
- The general improvements in mortality (excluding the COVID-19 period) have resulted from corporate level initiatives such as the learning from deaths process and focussed clinical improvement work. Of particular importance has been the continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average.
- Following a six month gradual upward trend in rolling 12-month HSMR, it has now been on a downward trend since March 2023.
- The latest rolling 12-month HSMR to May-24, reported by CHKS, stands at 81.9. While this positions us in the first quartile of trusts nationally, it should also be noted that national peer currently stands well below 100 at 91.9. CHKS has confirmed that their HSMR is due to rebase in the coming months.
- There are currently no 3SD outlier diagnosis groups.
- Latest NHSD published rolling 12-month SHMI available to March 2024, shows a marginal decrease from 91.96 to 91.41. This positions us in the first quartile of trusts nationally.
- Following the Dec-23 in-month spike of 103.1, the latest in-month figure provided by CHKS for Feb-24 stands at 79.7, well below the national average.
- For the period to Feb-24, CHKS reported 8 3SD outlier alerts.

Month 04 | 2024-25

East and North Hertfordshire NHS Trust

Operations

Month 04 | 2024-25



Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Jul-24	95%	69.7%	H	F	7 points above the mean Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Jul-24	2%	5.3%	L	F	2 points below the lower process limit Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	Jul-24	65%	15.8%	H	F	7 points above the mean Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Jul-24	80%	50.7%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Jul-24	240	196.0	L	?	2 points close to lower process limit Metric will inconsistently pass and fail the target
	Average (mean) time in department - admitted patients	Jul-24	tbc	494.0			Common cause variation No target
	Average minutes from clinically ready to proceed to departure	Jul-24	tbc	208	L		2 points below the lower process limit No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Jul-24	92%	54.8%		F	Common cause variation Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Jul-24	0%	57.7%		F	Common cause variation Metric will consistently fail the target

Month 04 | 2024-25

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Jun-24	85%	82.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-day decision to treat to treatment standard	Jun-24	96%	97.3%	H	?	11 points above the mean Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Jun-24	75%	78.7%	H	?	9 points above the mean Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Jun-24	7%	14.1%		F	Common cause variation Metric will consistently fail the target
	Number of cancer PTL waiting more than 104 days	Jun-24	16	97		F	Common cause variation Metric will inconsistently pass and fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Jun-24	0	13		?	Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for suspected cancer	Jun-24	93%	88.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Jun-24	93%	95.2%		?	Common cause variation Metric will inconsistently pass and fail the target

Month 04 | 2024-25

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

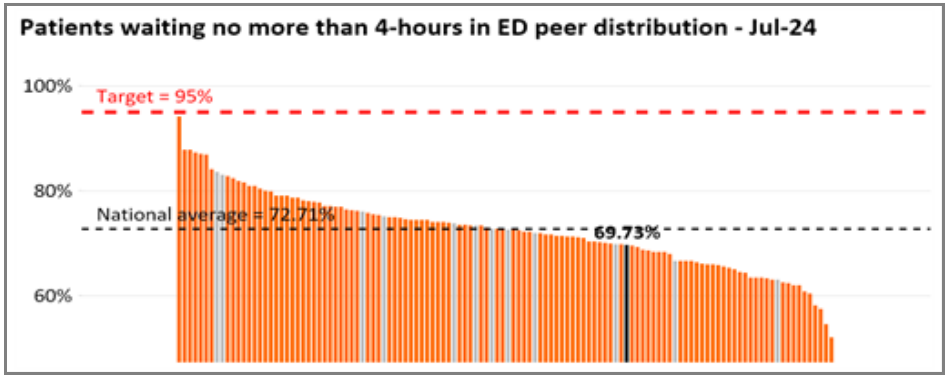
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q4 2023-24	A	B			
	4-hours direct to Stroke unit from ED	Jul-24	63%	34.2%		F	Common cause variation Metric will consistently fail the target
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Jul-24	80%	100.0%		P	Common cause variation Metric will consistently pass the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Jul-24	63%	35.1%		F	Common cause variation Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Jul-24	n/a	86			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Jul-24	80%	85.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Jul-24	50%	60.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Scanned within 12-hours - all Strokes	Jul-24	100%	95.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	% of all stroke patients who receive thrombolysis	Jul-24	11%	7.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	Jul-24	70%	50.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with JCP	Jul-24	80%	95.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Jul-24	50%	55.4%		?	Common cause variation Metric will inconsistently pass and fail the target

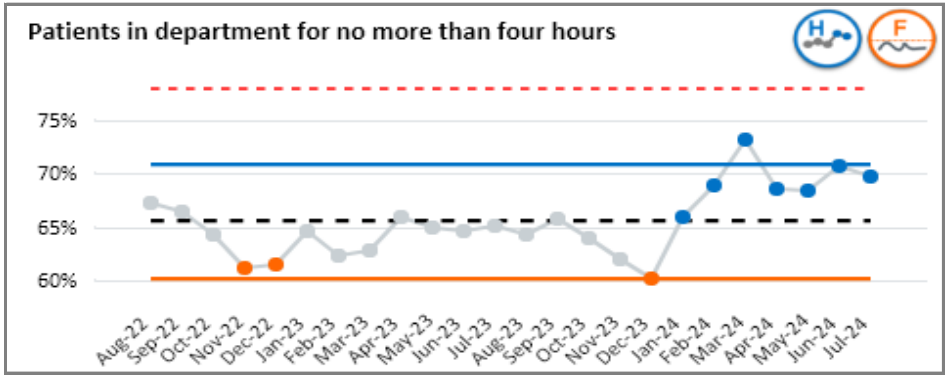
Month 04 | 2024-25

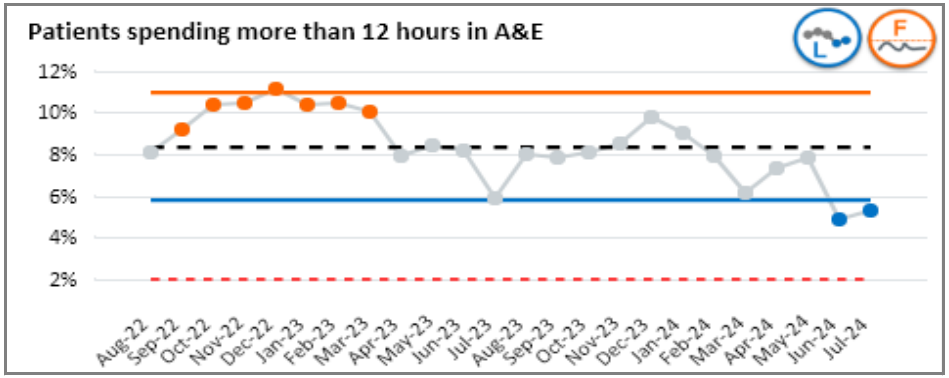
Operations

Urgent and Emergency Care

East and North Hertfordshire NHS Trust

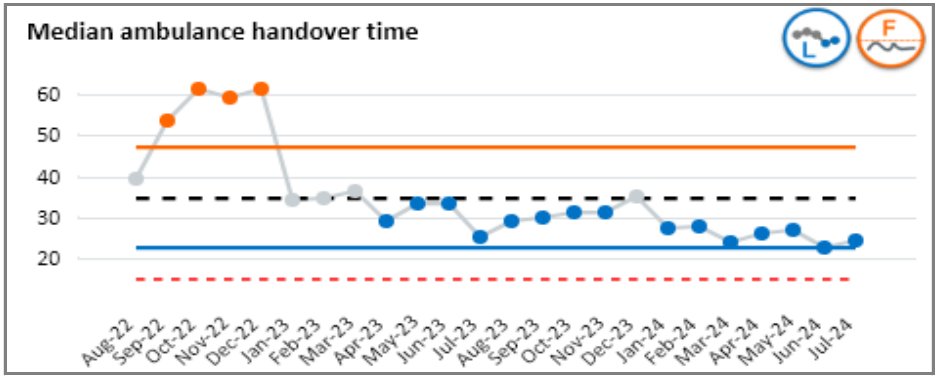






Key Issues and Executive Response

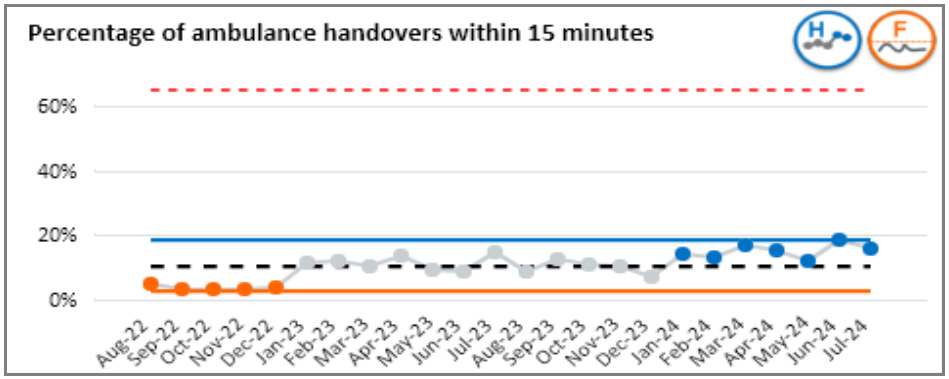
- ED monthly attendances were within normal variation; acuity remains high, with increasing trend.
- 4HR performance in July reduced very slightly from June, impacted by IT critical incident and recovery period.
- 12 hour LOS in ED remained within normal variation.
- The reduction in ambulance handover delays was sustained despite ongoing increase in arrivals. Median on target at approx 23 minutes.
- Continued month on month increase in Medical SDEC activity.
- Average time from clinically ready to proceed to departure has stabilised with further initiatives identified to reduce.
- Acceleration of plans and initiatives in August within UEC demonstrate performance improvements.

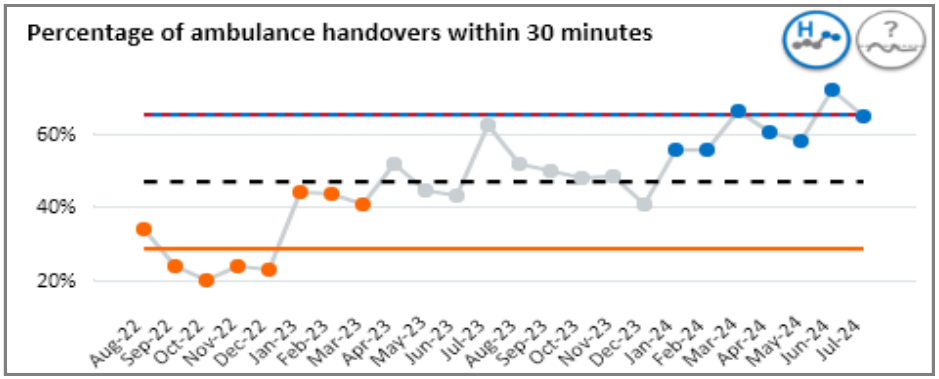


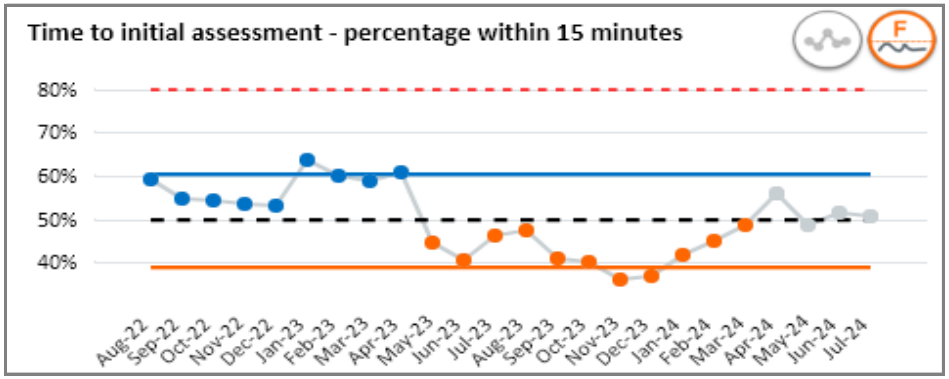
Month 04 | 2024-25

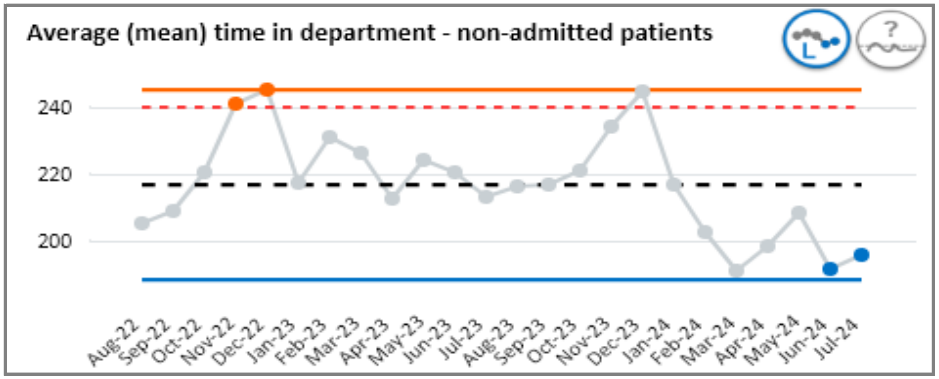
Operations

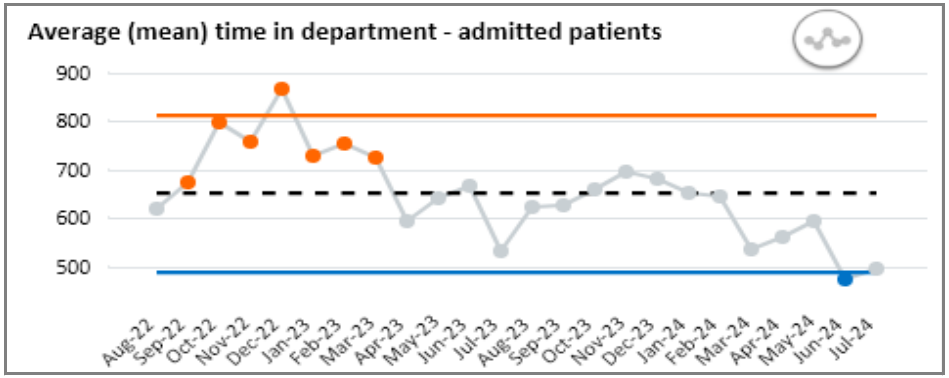
Urgent and Emergency Care New Standards

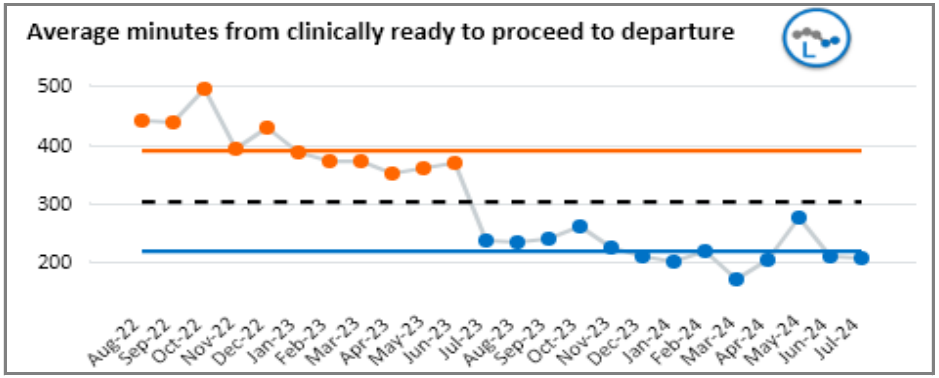










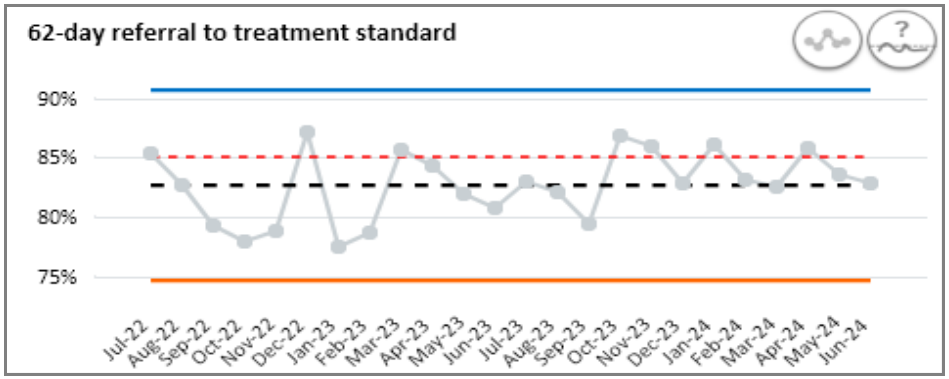


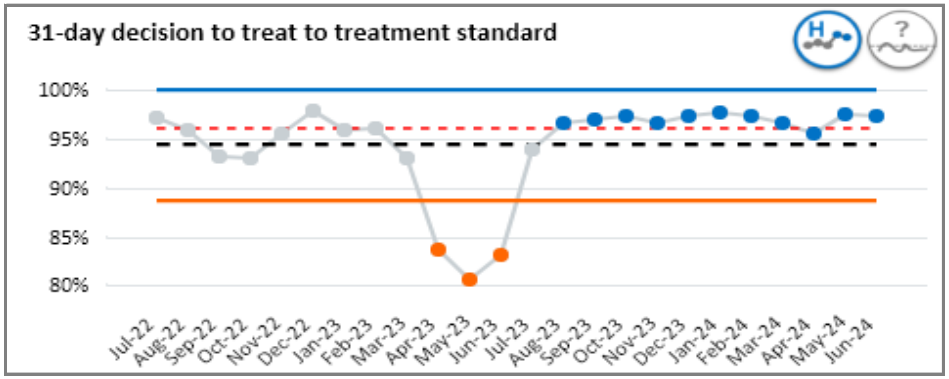
Month 04 | 2024-25

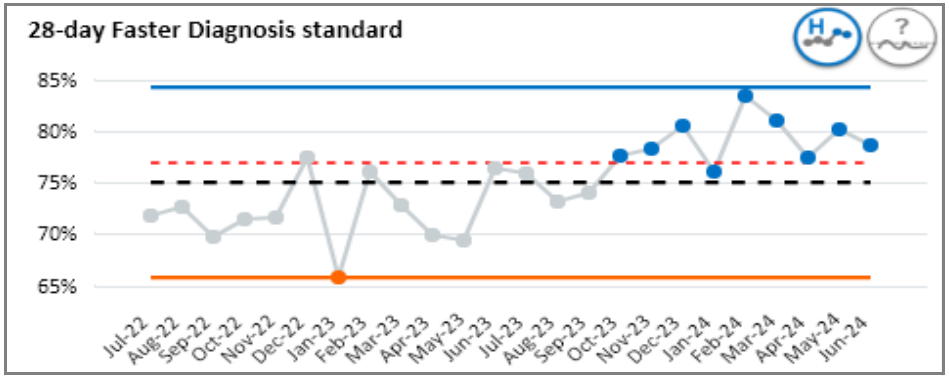
Operations

Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- The 62-day backlog decreased in June. Services continue to work to clear the backlog and new trajectories have been set for 24/25.
- We achieved 2 of the 3 national targets in June 24 with compliance in the 28 General Faster Diagnosis Standard (FDS), 31-Day General treatment standard, and missed compliance in the 62-Day general treatment standard.
- The 62 day General treatment standard performance is non compliant at 82.8% vs 85% target due to colonoscopy capacity issues in lower GI (partly mitigated with WLI and use of private sector colonoscopy), MRI capacity (mitigated with mobile MRI at Lister), patient choice delay in urology diagnostics and complex investigation pathways including upper GI and haematology.
- Work continues with the operational teams to sustain and improve CWT performance for the Trust.
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning.
- The Trust has reported on the new CWT standards but still monitors the previous 9 standards.

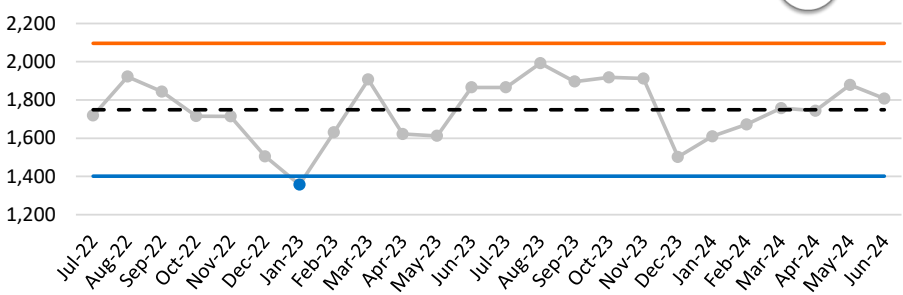
Month 04 | 2024-25

Operations

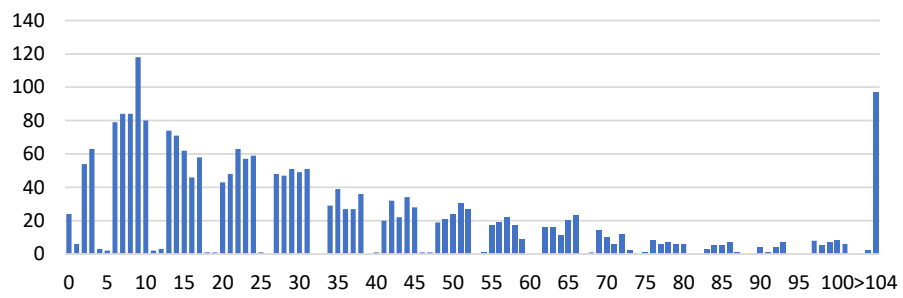
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

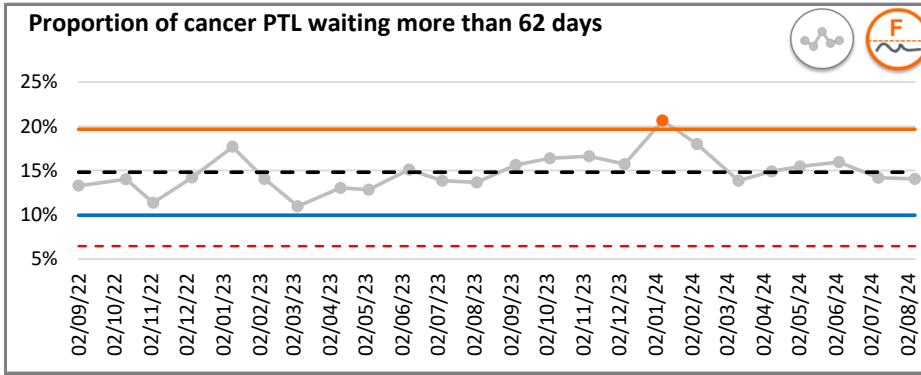
Suspected cancer referrals



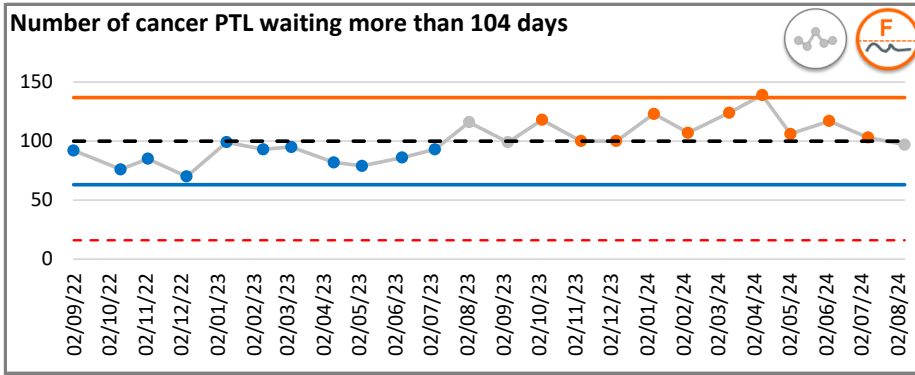
62-day PTL as at 08/08/2024



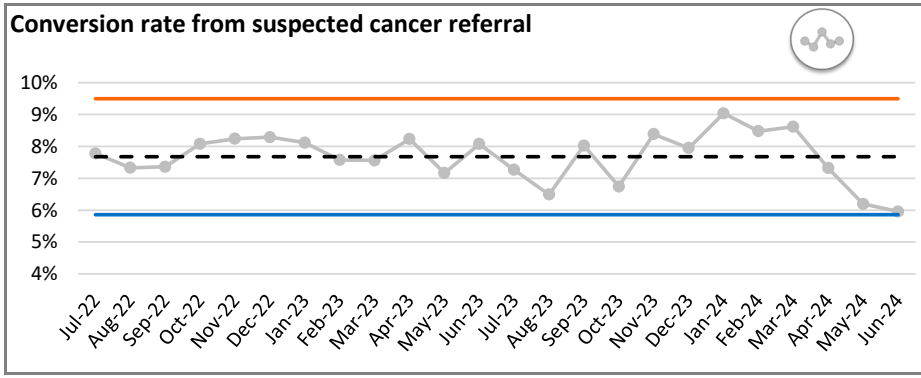
Proportion of cancer PTL waiting more than 62 days



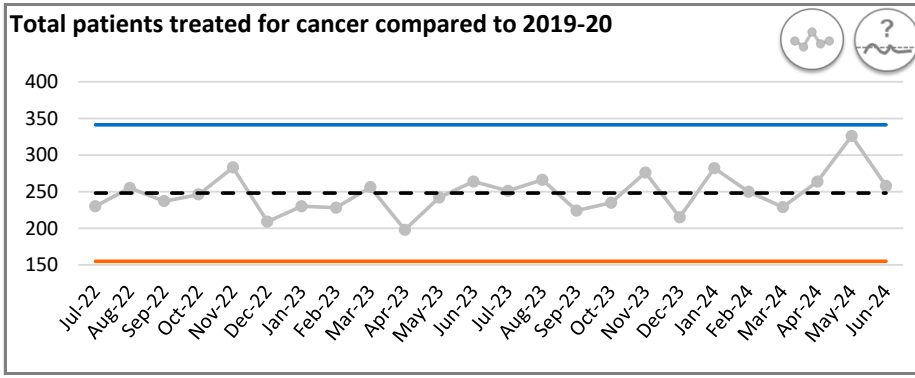
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



Total patients treated for cancer compared to 2019-20

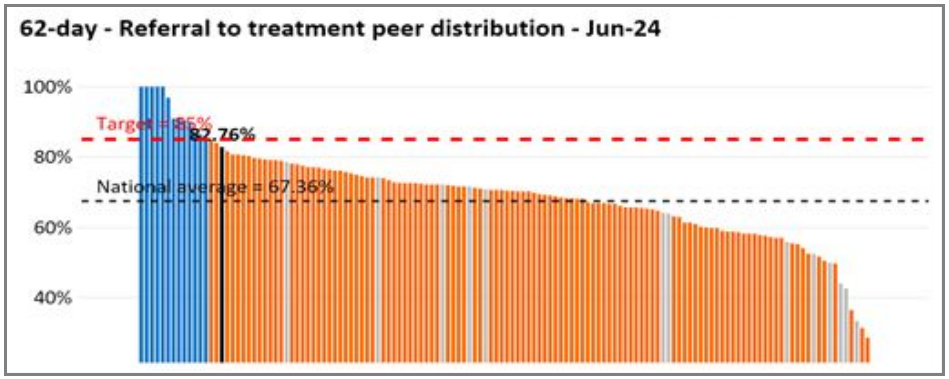


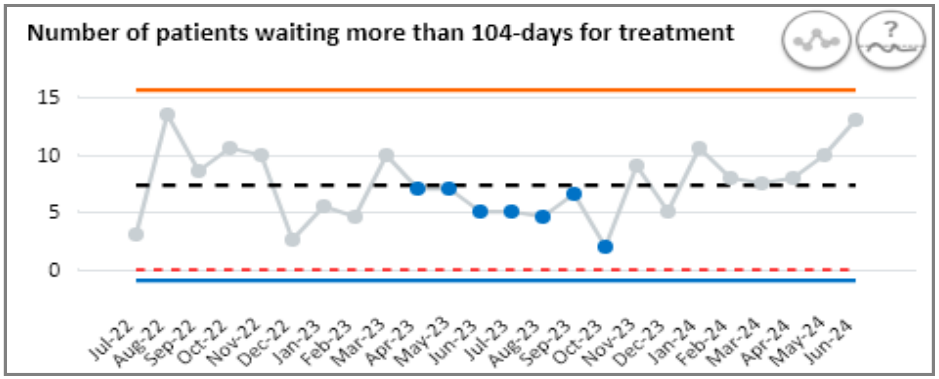
Month 04 | 2024-25

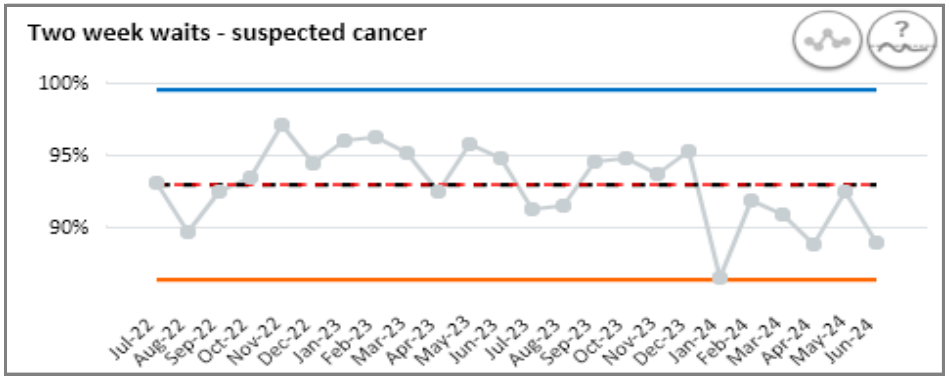
Operations

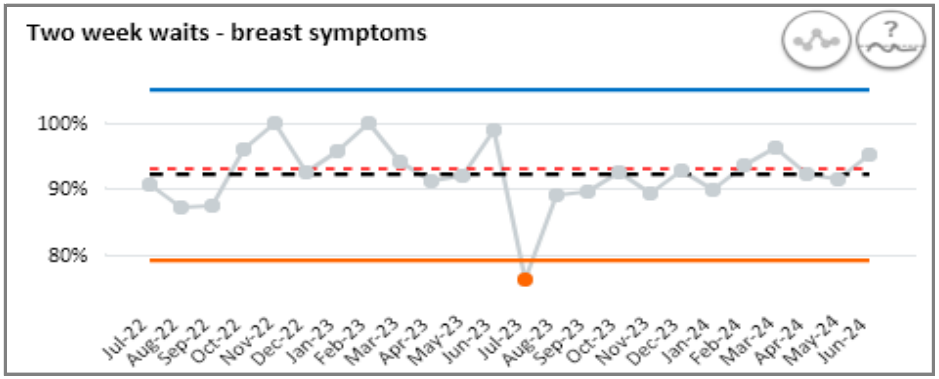
Cancer Waiting Times | Supporting Metrics

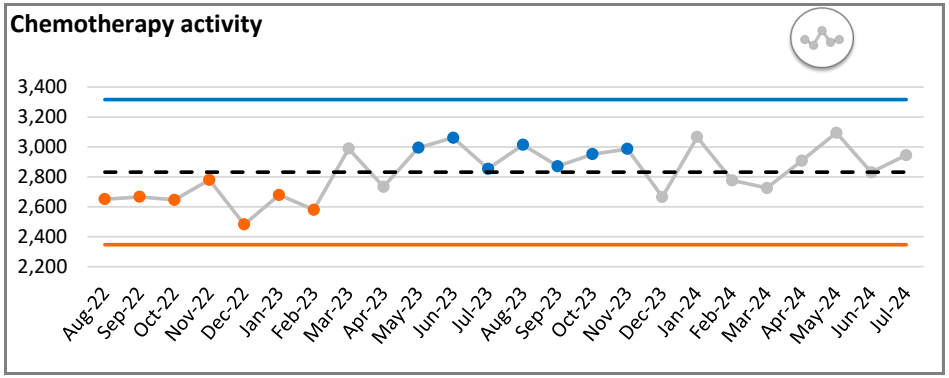
East and North Hertfordshire NHS Trust

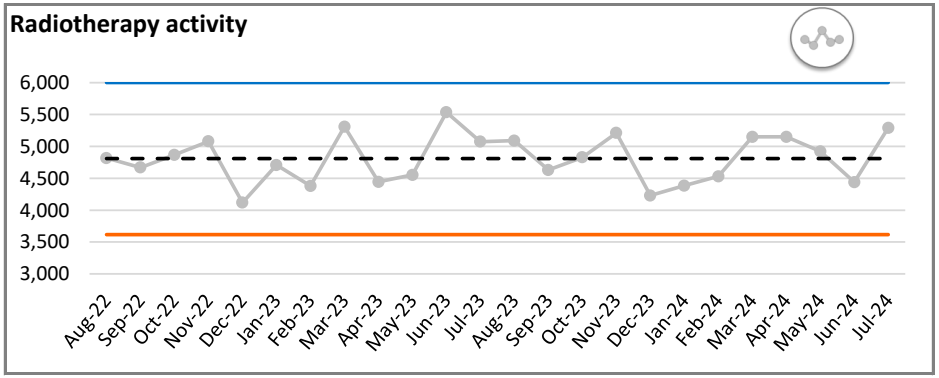










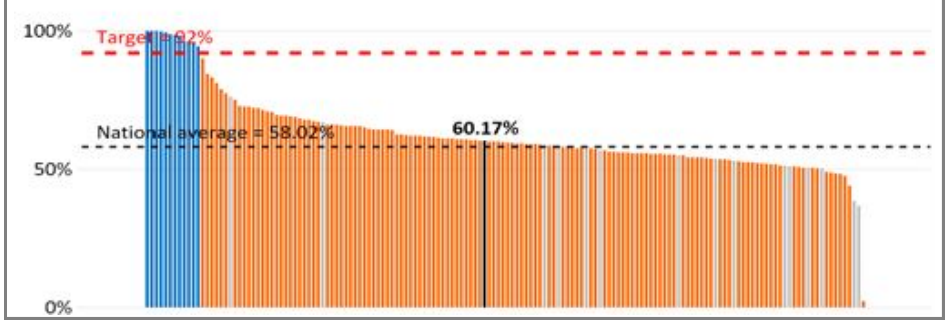


Month 04 | 2024-25

Operations

RTT 18 Weeks

East and North Hertfordshire NHS Trust



Key Issues and Executive Response

Community Paediatrics

- **104 Weeks** - There were 824 x Community Paediatric patients waiting over 104 weeks at the end of July. Due to known capacity issues in the service, this will continue to increase.
- **78 Weeks** - There were 1,927 patients waiting over 78 weeks at the end of July, compared to 1,832 the previous month, an increase of 95 patients.
- **65 Weeks** - There were 2,654 patients waiting over 65 weeks.
- Community Paediatrics is now reported via the Community Data Set.
- The waiting list continues to increase, driven by referrals for neuro diversity which is reflected in the increase in over 18 week wait.
- Transformation work is ongoing to change pathways both internal to E&N Herts and as part of the system transformation work
- This includes a standardised system-wide referral form and a single point of administrative triage. Improved reporting through developing a Community Services reporting and coding dashboard.

Key Issues and Executive Response

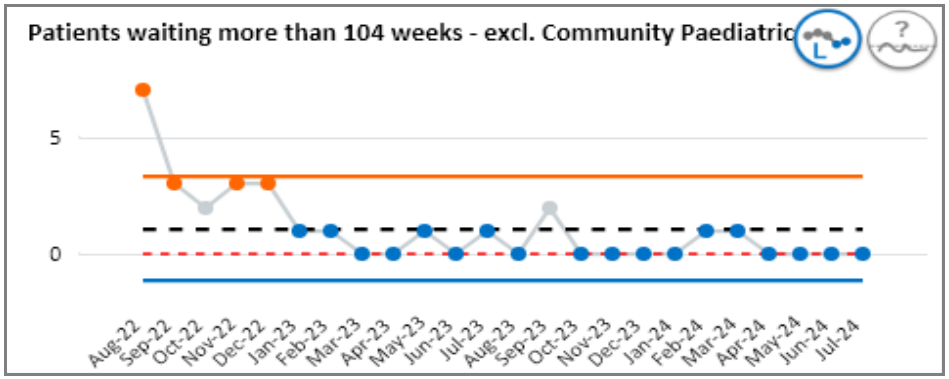
Excluding Community Paediatrics

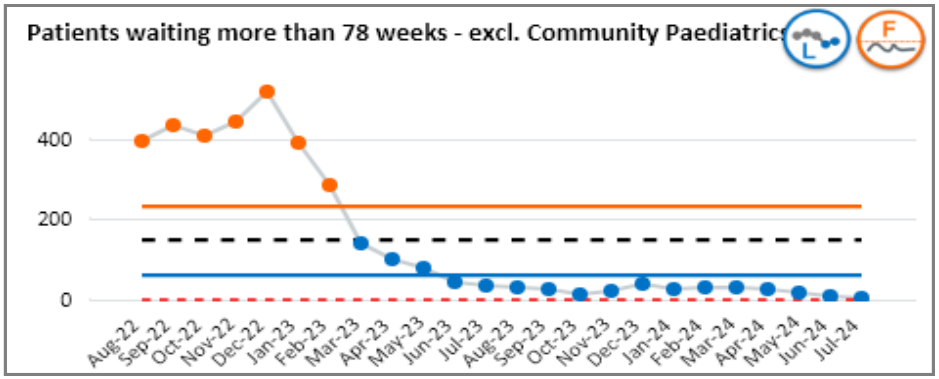
- The Trust will be reporting a performance of 58.7% of patients treated within 18 weeks.
- **78 Weeks** - There were 5 patients waiting over 78 weeks at the end of July, due to patient choice, national delays with prosthesis delivery, equipment failure and patient unwell. This accounts for 0.008% of the incomplete waiting list.
- All five patients have been treated in August.
- **65 Weeks** - There were 240 patients waiting over 65 weeks at the end of July. This has decreased by 128 patients in month and accounts for 0.4% of the incomplete waiting list.
- The Trust has submitted a revised plan to be compliant with this target from the end of September 2024.
- Many services are already compliant, however there will be phased compliance for the more challenged services :-
- Services behind their recovery trajectory who should have been compliant in July were:- Pain (22 breaches), Endocrine & Diabetes (10 breaches), Ophthalmology (7 breaches), Urology (4 breaches), ENT (3 breaches), Plastic Surgery (3 breaches)
- Services with future compliance dates:
    - August 2024 -- Gastro, Oral
    - September 2024 -- T&O
- **52 Weeks** – There were 2048 patients waiting over 52 weeks. This has reduced by 235 patients in month.
- The number of patients waiting more than 52 weeks reduced for the 5th month in a row.

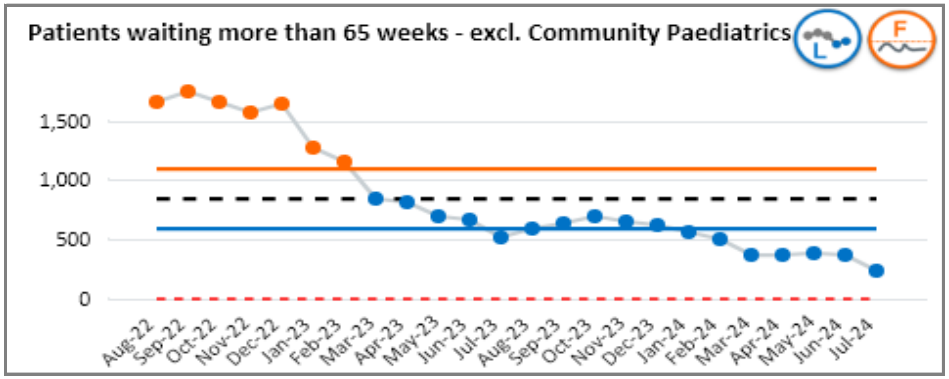
Operations

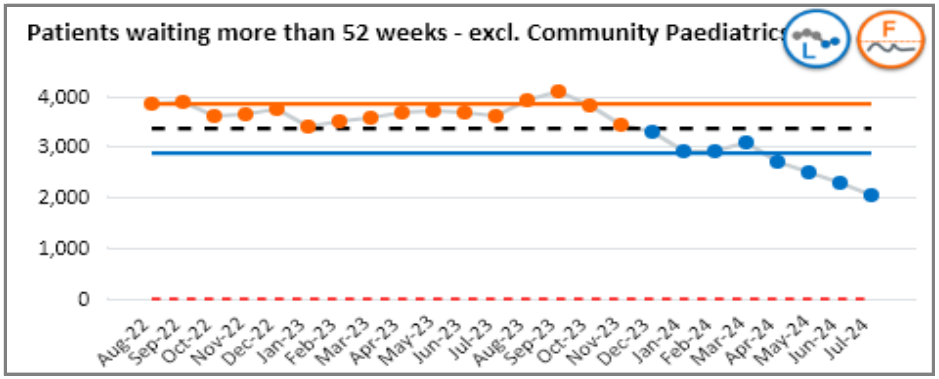
RTT 18 Weeks

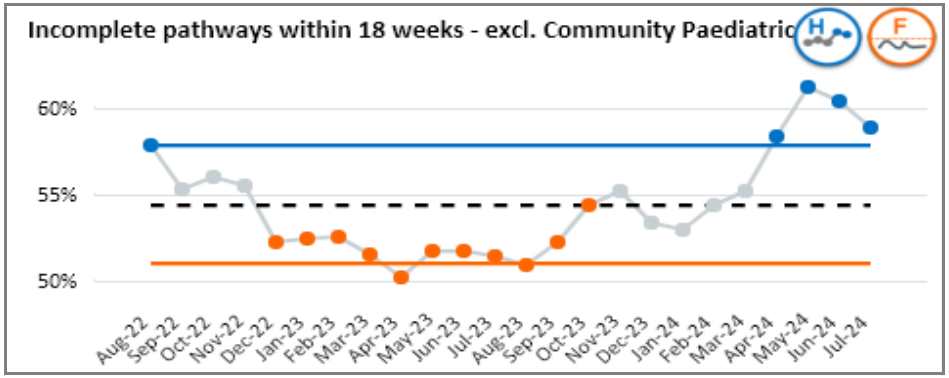
East and North Hertfordshire NHS Trust

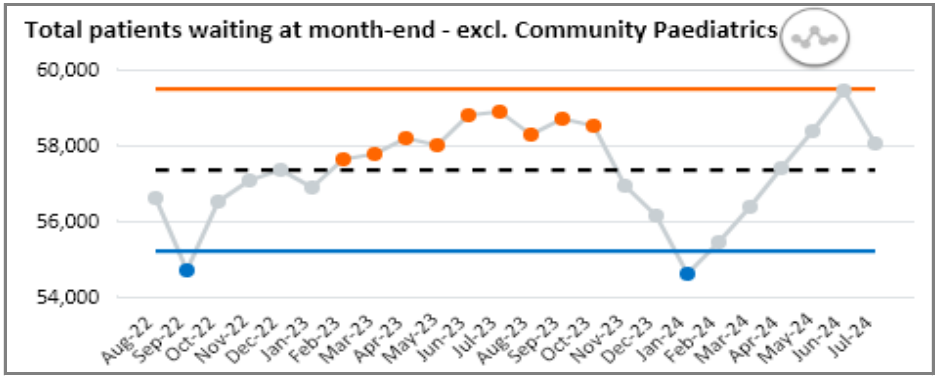










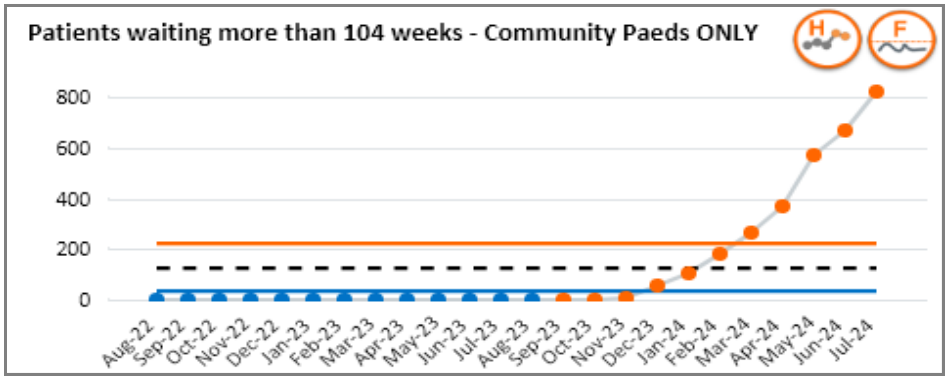


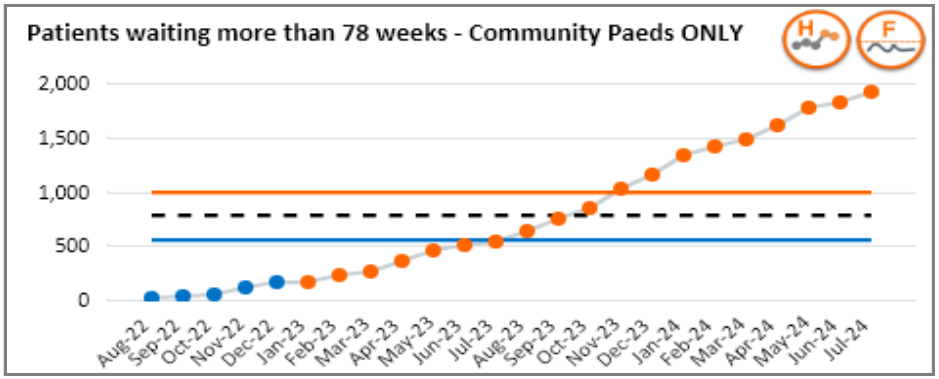
Month 04 | 2024-25

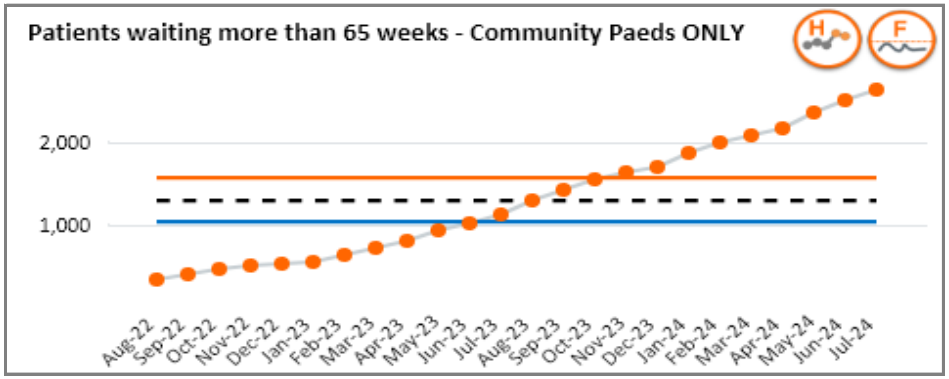
Operations

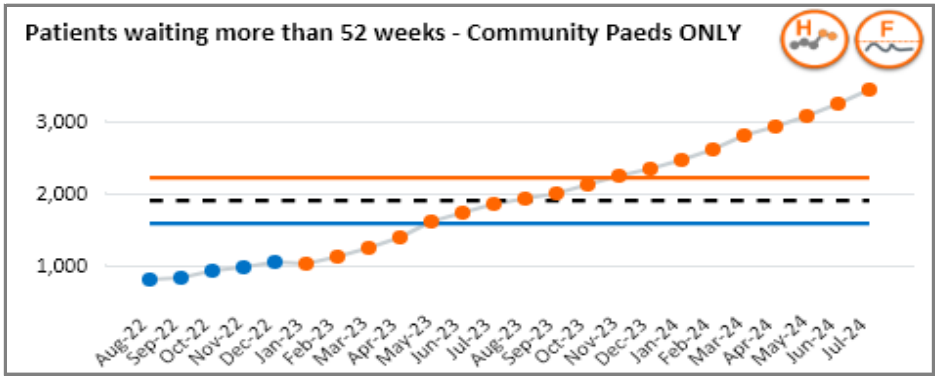
RTT 18 Weeks

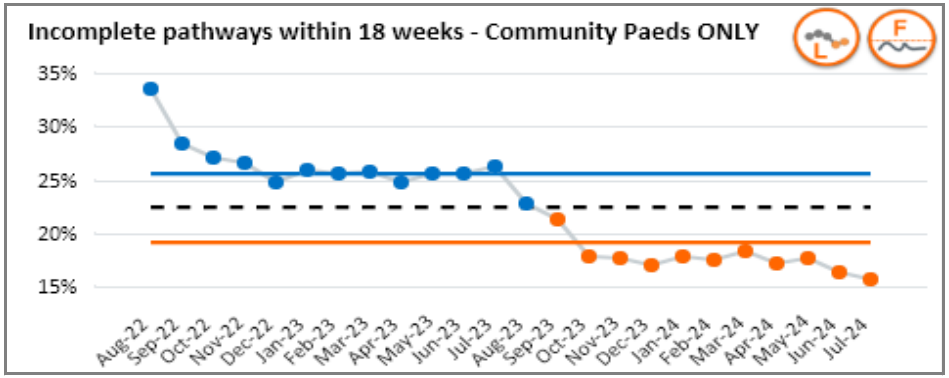
East and North Hertfordshire NHS Trust

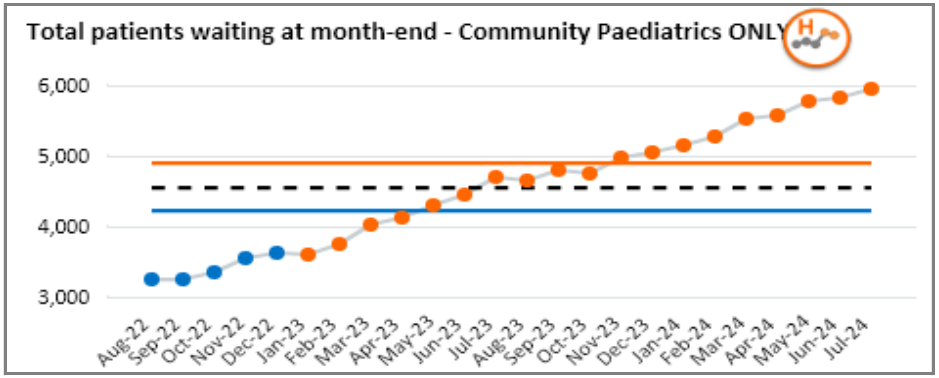










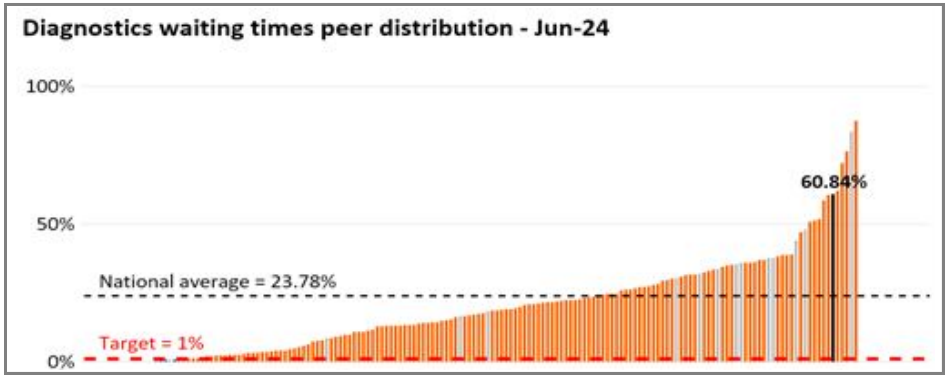


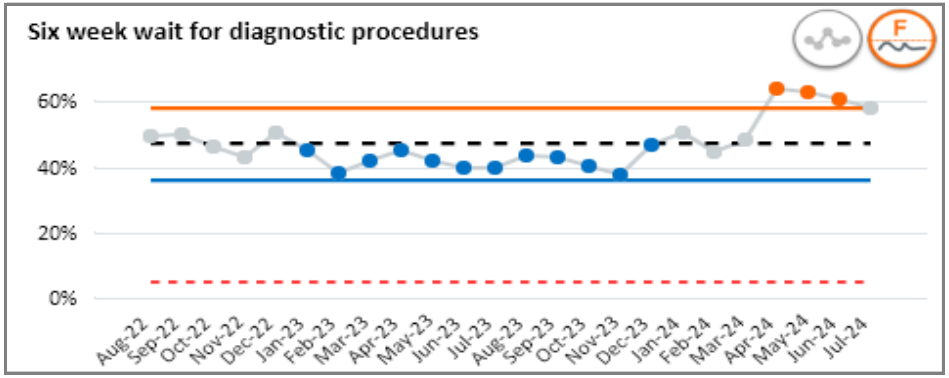
Month 04 | 2024-25

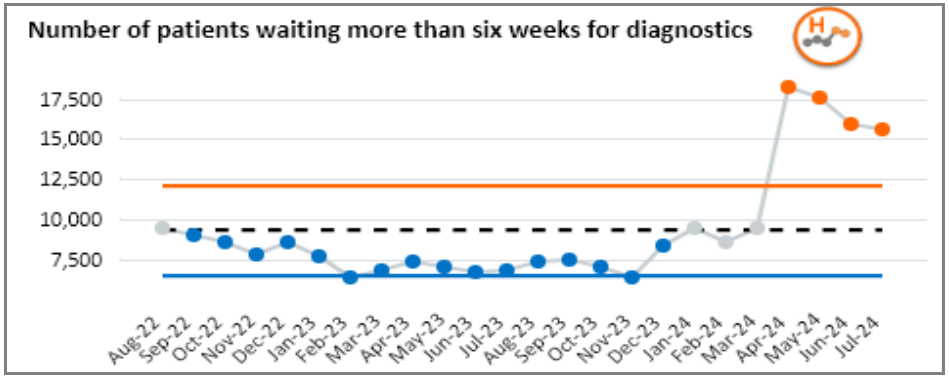
Operations

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Forward look:

- **July DM01 performance has improved inclusive of audiology from 60.84% to 57.66%.**
- **Excluding audiology, the overall DM01 trajectory is on track to deliver performance by March 2025.**

Challenges / Actions

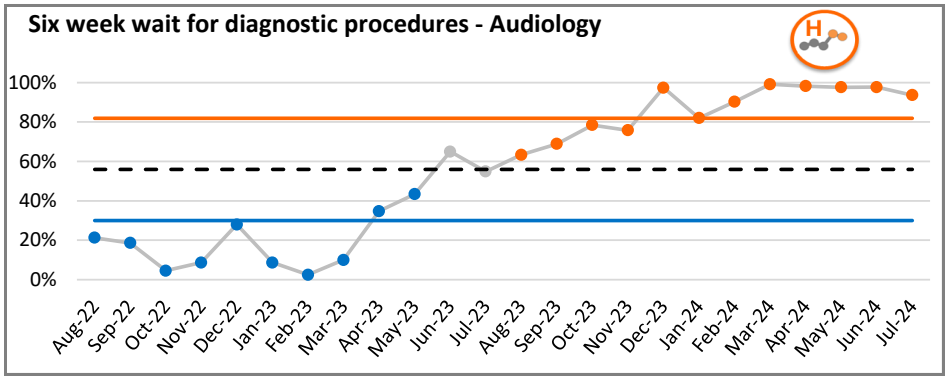
- Significant MRI capacity gap in house to meet service demand and DM01 compliance by March 2025. T&O long waiters being outsourced to Pinehill. Cancer demand has increased and is being addressed through additional MRI van time per month on the Lister site.
- Audiology now reporting, which prompted large increase in both volume and proportion of diagnostic waits over 6 and 13 weeks. Further PTL validation currently underway; Audiology capacity and demand modelling commenced in August. Developing clear recovery trajectories, using outsourcing where possible. New Audiology clinical manager starts 23/9. Paeds audiology remains highly challenged, with very little mutual aid possible. Exec involvement with recovery plan and system / regional approaches.
- Increase of referrals for Sleep studies has caused capacity gap; plan to arrange additional insourced capacity.
- CT and DEXA position has improved with continuation of lists OOH.
- Specialist MSK and cardiology scans remain a challenge for capacity.
- Focussed transformational work with Imaging service planned.
- Weekly DM01 PTL meetings continue tracking delivery against DM01 recovery trajectories by modality and to ensure access in chronological order.
- Refreshed capacity and demand modelling for MRI underway.
- Work with partners to promote GP uptake of community diagnostic capacity.

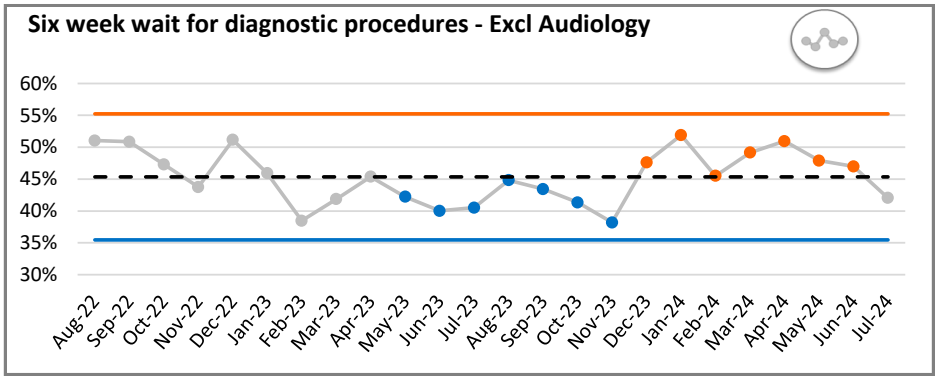
Month 04 | 2024-25

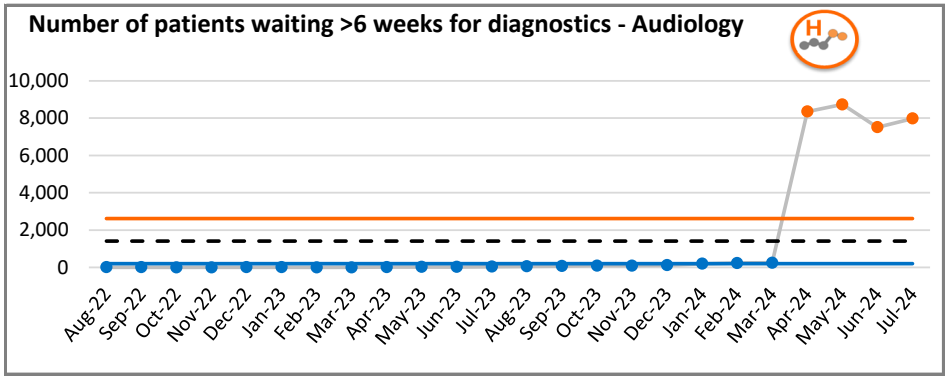
Operations

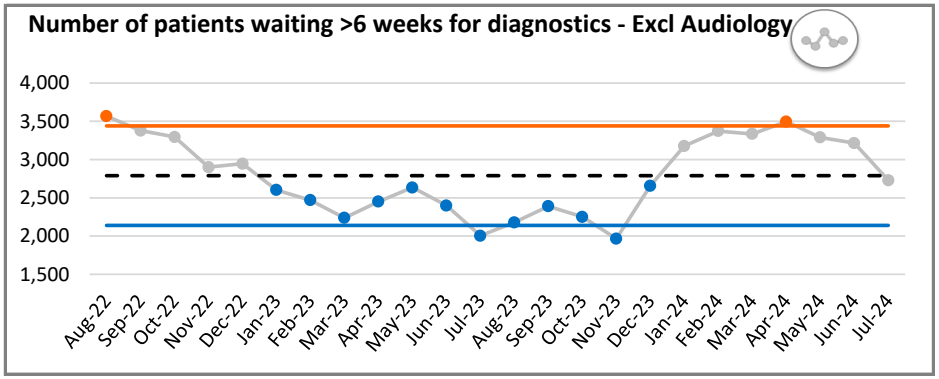
Diagnostics Waiting Times - Audiology

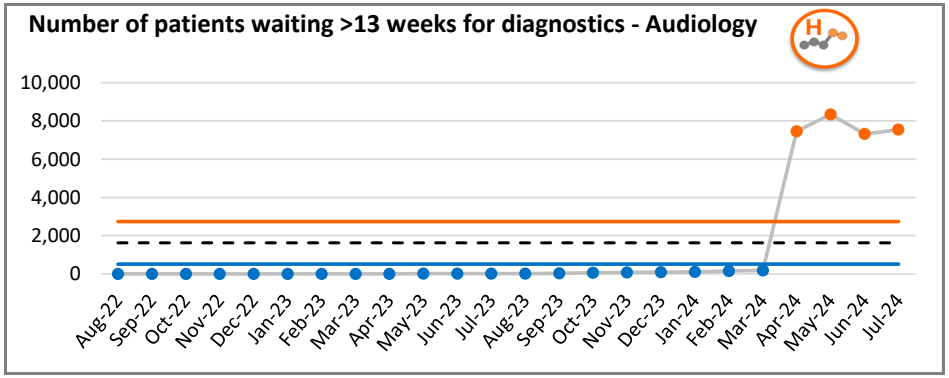
East and North Hertfordshire NHS Trust

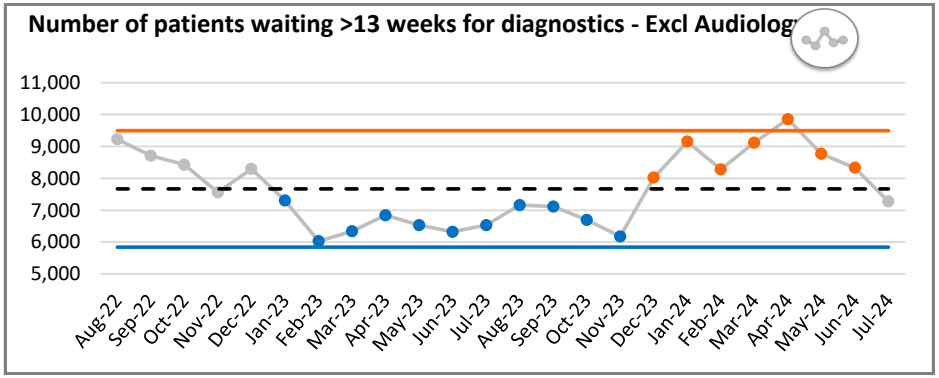










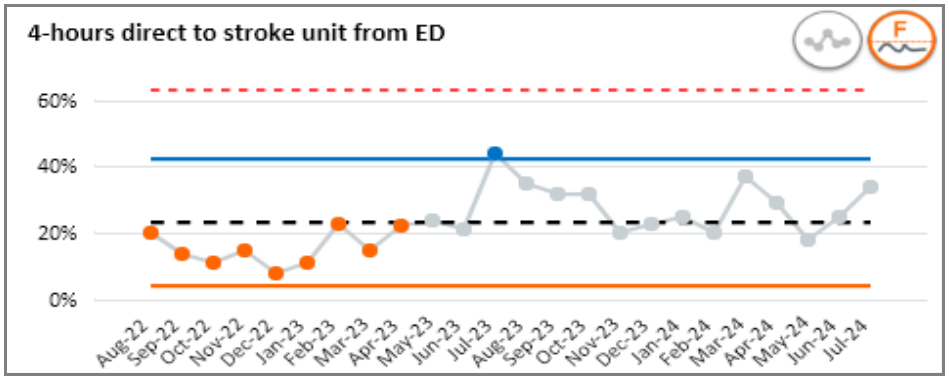


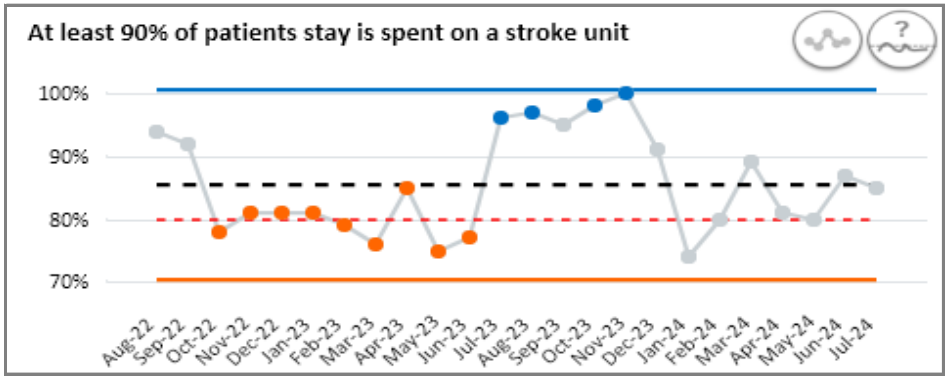
Month 04 | 2024-25

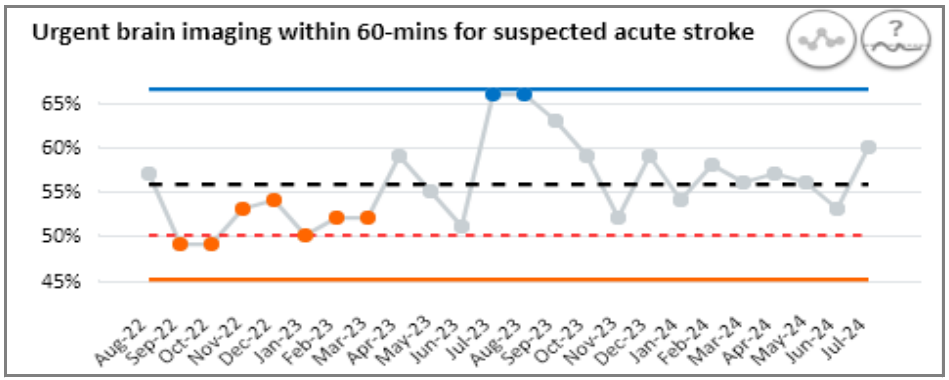
Operations

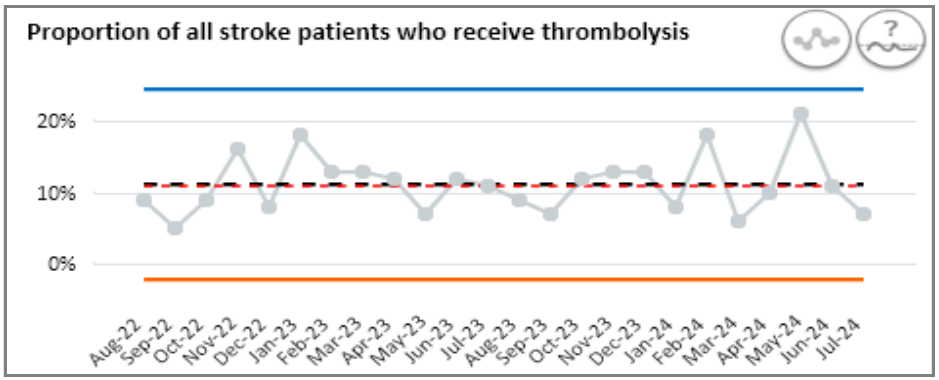
Stroke Services Supporting Metrics

East and North Hertfordshire NHS Trust









Key Issues and Executive Response

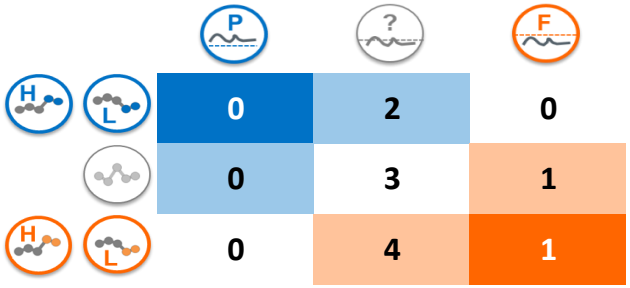
- The SSNAP rating for Q4 (January - March) remained at a B. For Q1 we are predicting to retain this B rating. Planned changes to the SSNAP dataset have been postponed until October 2024. These are expected to negatively impact performance, with stricter key performance indicators. This will also increase workload, particularly within the SLT and data team due to data recording changes.
- Thrombolysis in Acute Stroke Collaborative (TASC) project underway to support improvement in Thrombolysis performance rate to 14%. Thrombolysis is on the border of an increase from a D to a C with an average forecast of 12.5% (not published).
- Improvement in proportion of patients given thrombolysis due to education ongoing with clinical team surrounding thrombolysis eligibility.
- Ongoing challenges out of hours to support 4 hour direct to stroke target. Stroke Unit appears to have declined again this quarter 24% to SU(from 28% Q4) and 7hrs 30mins(from 6hrs 55mins Q4). Swallow in 4hr(CNS) and 72hr(SLT) have also declined. Focus groups ongoing to improve this. Approval for additional Speciality Doctors to provide a 08:00 - 22:00 7 days a week cover to improve performance and patient pathway.

Month 04 | 2024-25

NHS
East and North Hertfordshire
NHS Trust

Finance

Month 04 | 2024-25



Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Jul-24	-2.4	0.85			Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Jul-24	1,245	2,321			Common cause variation No target
	Cash balance	Jul-24	77.9	43.9	L	F	3 points below the lower process limit Metric will inconsistently pass and fail the target
Key Financial Drivers	Income earned	Jul-24	45.3	56.0	H		7 points above the mean Metric will inconsistently pass and fail the target
	Pay costs	Jul-24	29.5	34.0	H		8 points above the mean Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	Jul-24	15.5	21.2	H		7 points above the mean Metric will inconsistently pass and fail the target

Month 04 | 2024-25

Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Jul-24	24.9	29.6	H	?	7 points above the mean Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	Jul-24	0.9	5.0		F	Common cause variation Metric will consistently fail the target
	Agency costs	Jul-24		1.1			Common cause variation No target
	Unit cost of agency staff	Jul-24		12.7			Common cause variation No target
	Bank costs	Jul-24	3.7	3.3		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Jul-24	0.5	3.3	H	?	14 points above the mean Metric will inconsistently pass and fail the target
Other Financial Metrics	Private patients income earned	Jul-24	0.4	0.6	H	?	10 points above the mean Metric will inconsistently pass and fail the target
	Drugs and consumable spend	Jul-24	2.8	3.7		?	Common cause variation Metric will inconsistently pass and fail the target

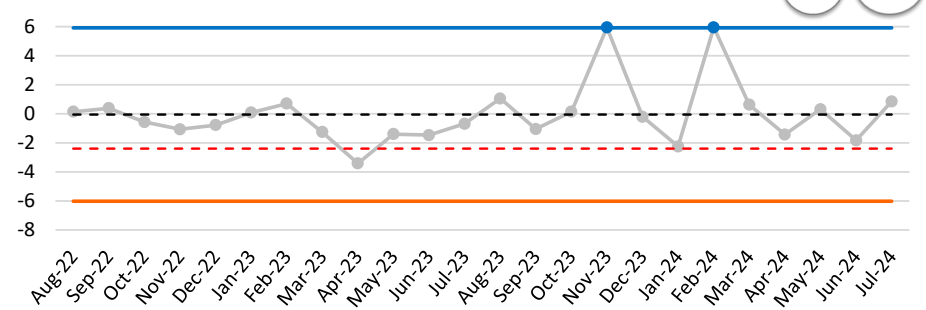
Month 04 | 2024-25

Finance

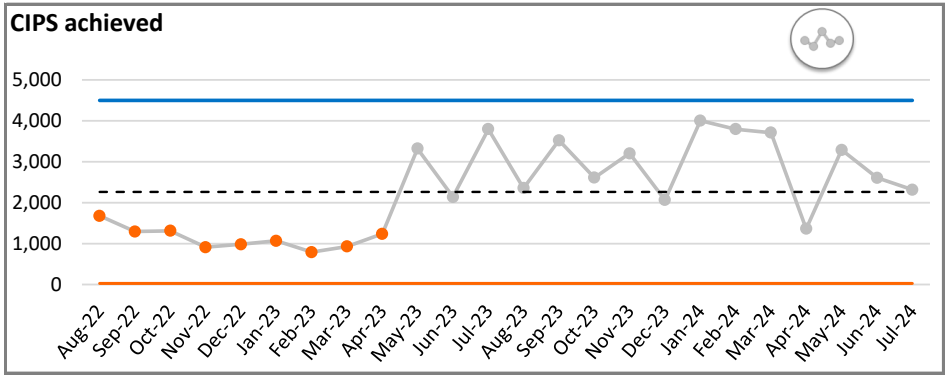
Summary Financial Position

East and North Hertfordshire NHS Trust

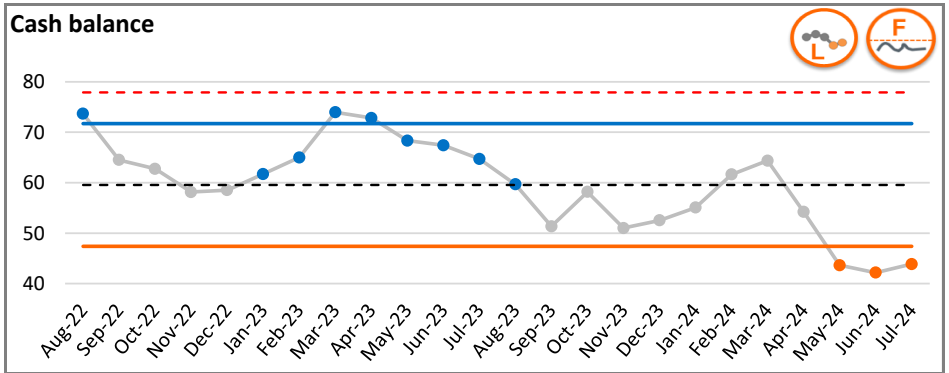
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- In June the Trust submitted a surplus plan of £1.0m for 24/25. This plan assumes that both a £33.8m cost improvement programme will be delivered, and ERF performance of 138% will be achieved.
- At Month 4, the Trust has reported an actual deficit of £2.1m. This is adverse to plan by £1.1m. This gaps relates to additional costs and lost income resulting from Industrial Action.
- The YTD position reports a material shortfall in elective activity delivery compared with plan. Daycase and Inpatient Elective gaps were of particular concern, and reflects a delay in mobilising additional capacity.
- Pay budgets report a YTD overspend of £1.5m. A number of hotspots of concern have also emerged in respect of management of medical, nursing and admin spend staffing spend.
- CIP savings are to date in line with plan expectations, although a series of non recurrent benefits have offset the impact of shortfalls in elective activity delivery.

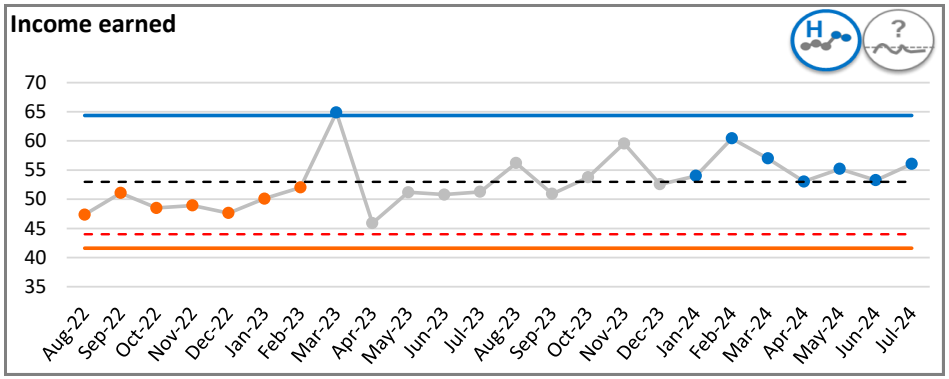
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	656.0	217.3	217.5	0.2
Pay	-407.0	-135.5	-137.0	-1.5
Non Pay	-214.2	-71.5	-71.6	-0.2
EBITDA	**34.8**	**10.3**	**8.9**	**-1.4**
Financing Costs	-33.8	-11.3	-11.0	0.3
Surplus / Deficit (excl Fin Adj's)	**1.0**	**-1.0**	**-2.1**	**-1.1**

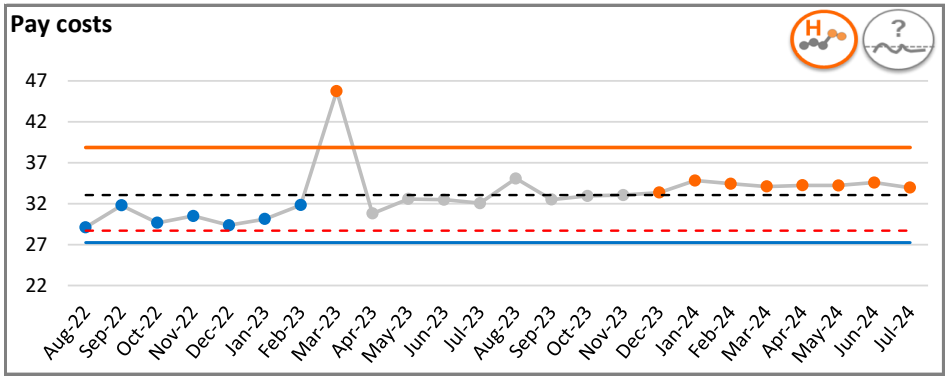
Month 04 | 2024-25

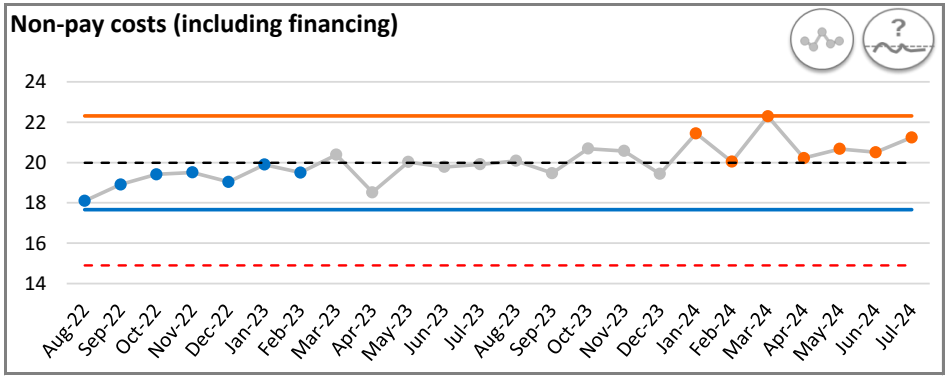
Finance

Key Financial Drivers

East and North Hertfordshire NHS Trust







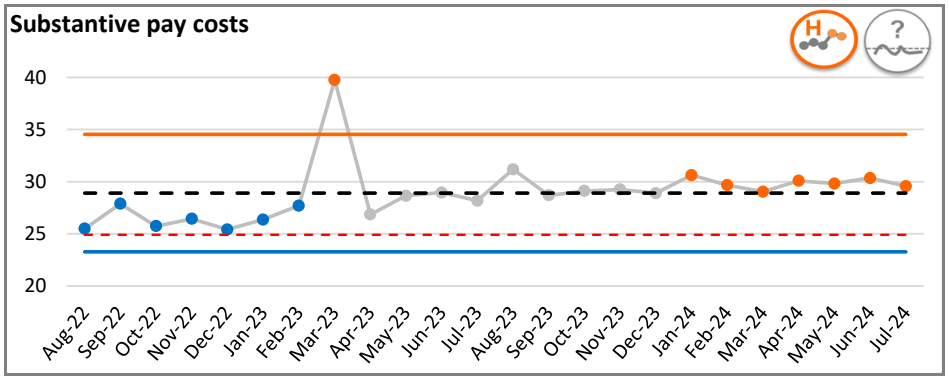
- The Trust submitted a revised 2024/25 plan in June of £1m surplus. This plan assumes the delivery of a £33.8m (5%) cost improvement programme.
- At Month 4 year to date, there was a planned deficit of £1.0m, and an actual position of £2.1m. The £1.1m adverse variance is entirely due to the impact of a 7 day junior doctor strike during June/July.
- In month, the Trust delivered a £0.8m surplus, which was £0.6m adverse from plan.
- The in month position includes the impact of a 2 day junior doctor strike in July. This has resulted in a £0.1m increase in pay expenditure to reflect cover arrangements and £0.1m of lost ERF activity/income.
- Excluding the impact of industrial action, the year to date position is in line with plan, however, this includes the utilisation of significant non recurrent reserves. The current run rate and activity delivery is not sustainable and would not allow the Trust to achieve its £1m surplus if this were to continue. Divisions have developed recovery plans
- ERF delivery was behind plan on month due to delays in recruitment to new posts and this will be reported in further detail in the ERF and Productivity report.
- Pay was £0.4m adverse to plan in month, excluding industrial action and non recurrent reserves. High levels of Waiting list initiative payments, high locum usage for medical staff within the ED department and high midwifery usage continue to be the main pay hotspots and actions are being undertaken to mitigate in future months.
- Agency expenditure had slightly increased in month and was to 3.3% of pay expenditure and year to date is now 3.2%, which is in line with the 3.2% target set by NHSE and where further central controls will be applied by the 'triple lock' process.
- There continues to be significant non pay cost pressures within the Pathology department due to pathology tests charged from other Trusts as well as under delivery of CIP schemes.
- The Trust has a challenging CIP target of £33.8m this year. To date the Trust has delivered £9.6m savings against a £9.9m plan, however, much of the delivery is through non recurrent schemes. A detailed analysis of the CIP position will be presented in a specific CIP paper to FPPC.

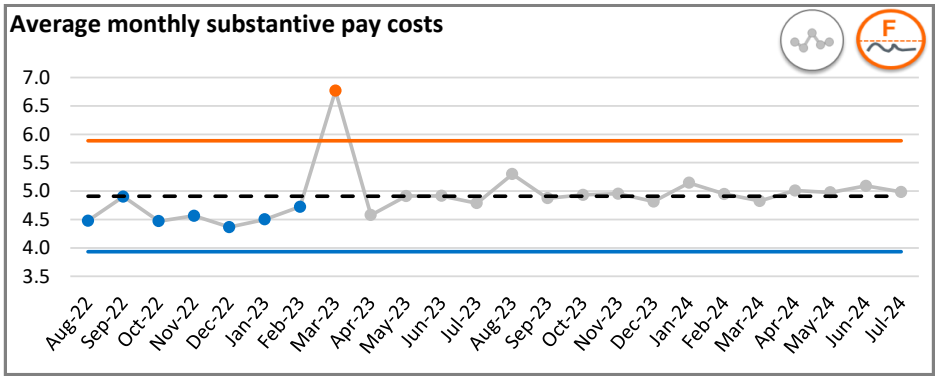
Month 04 | 2024-25

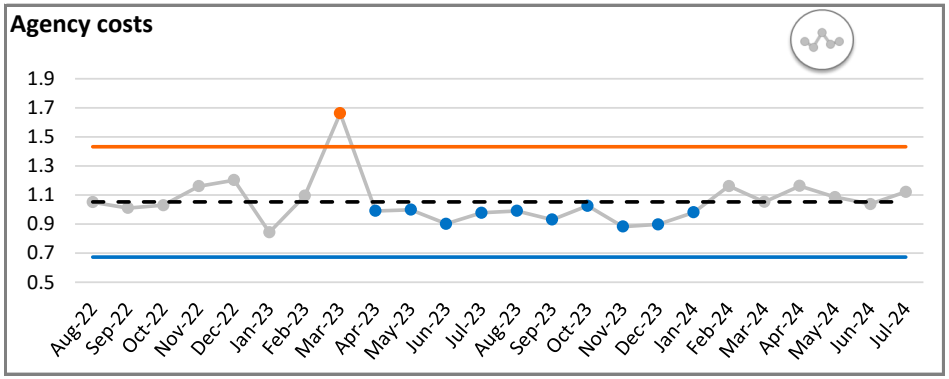
Finance

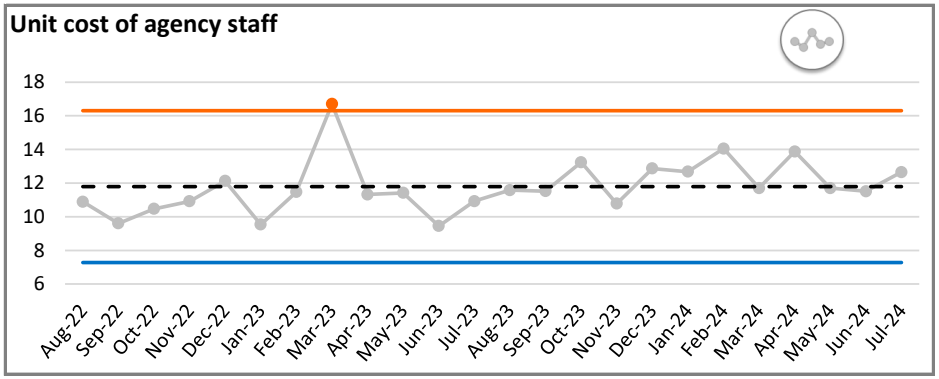
Other Financial Indicators

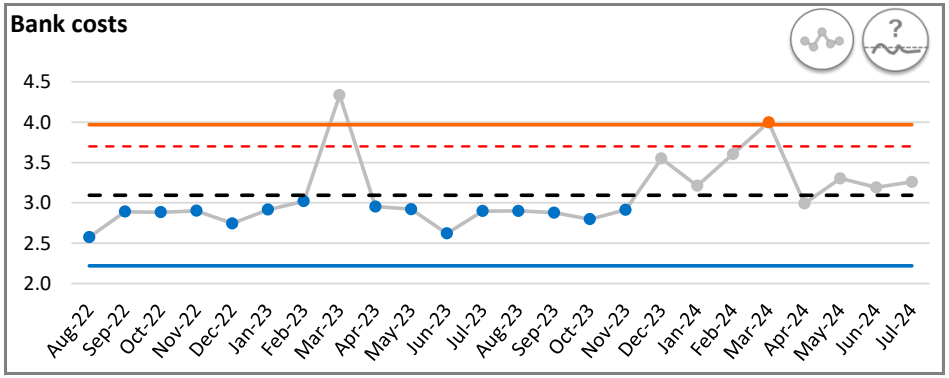
East and North Hertfordshire NHS Trust

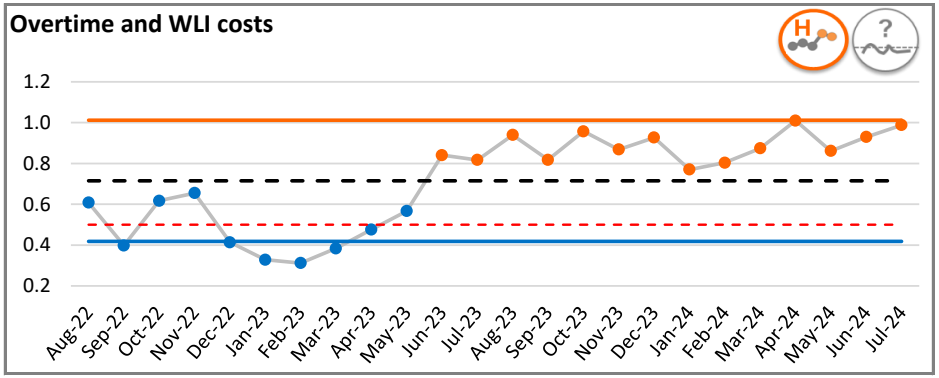










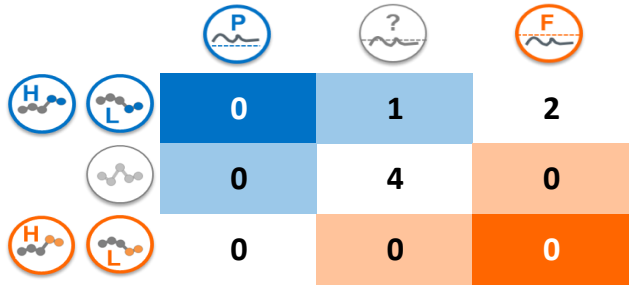


Month 04 | 2024-25

NHS
East and North Hertfordshire
NHS Trust

People

Month 04 | 2024-25



People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Jul-24	5%	9.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Jul-24	5%	9.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	Jul-24	3%	3.3%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Jul-24	90%	89.6%	H	F	13 points above the mean Metric will consistently fail the target
	Appraisal rate	Jul-24	90%	77.9%	H	F	11 points above the upper process limit Metric will consistently fail the target
Thrive	Turnover rate	Jul-24	11%	9.6%	L	?	9 points below the lower process limit Metric will inconsistently pass and fail the target
Care	Sickness rate	Jul-24	3.8%	4.7%		?	Common cause variation Metric will inconsistently pass and fail the target

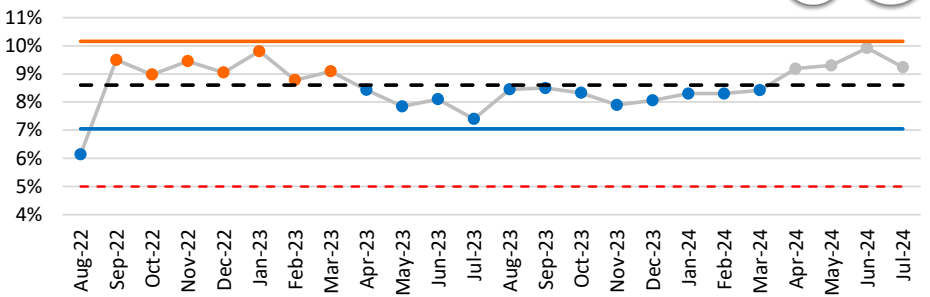
Month 04 | 2024-25

People

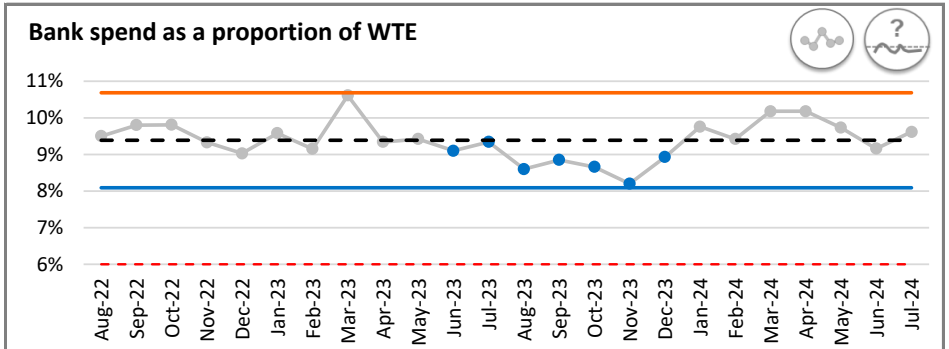
Work Together

East and North Hertfordshire NHS Trust

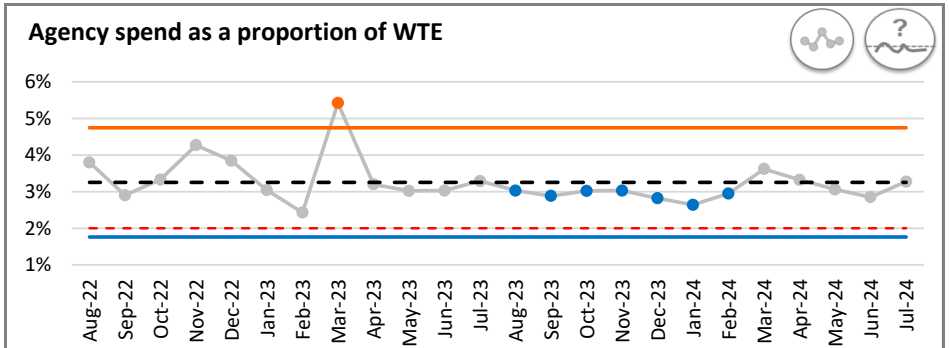
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- The vacancy rate decreased to 9.2% (622 vacancies). Recruitable establishment increased by 18 WTE. There are 107 more staff in post than a year ago.
- Nursing & Midwifery vacancy rate increased to 11.5%, 9 experienced RN's started in July.77 Band 5 nurses in the pipeline.
- Hotspot areas include Renal, CRM (Highly Specialised Physiologist), ED and Audiology. Talent acquisition lead is working in partnership to run targeted recruitment campaigns for substantive appointments.
- There are 56 vacancies currently out to advert.
- 42 newly qualified nurses started in M4, 13 still to be assigned. 25 newly qualified midwives going through pre employment checks.
- 7 CSW started in month, with a further 23 in the pipeline.
- There are 412 candidates in the resourcing pipeline.
- The recruitment experience has shown a downward trend over the last three months. All candidates invited to interview, whether successful or not, are invited to complete a survey about their experience. This feedback may sometimes reflect frustration from not being offered the job, but it is carefully considered and used to drive future improvements linked to our RPIW and improvements.
- Medical vacancy rate decreased to 1.5% - supported with 323 trainee rotations in August and 81 for September
- 'Great for 8%' temporary staffing pay bill increased to 12.9%- proactive actions remain underway between Resourcing, Temporary Staffing and Finance triangulation to improve metrics against the 8% target, including a reset on the ToR and metrics/focused actions.
- 'Triple Lock' control remains in place - ENH falls into the 'light touch' scrutiny i.e. only newly created posts are subject to ICB/NHSE review/approval. M4 workforce tracker submitted to the ICB.
- 91% of clinical staff are on eRoster. ENT Audiology now live. Radiology and RDA implementation will restarted in M4 (145 clinical and 57 admin staff).

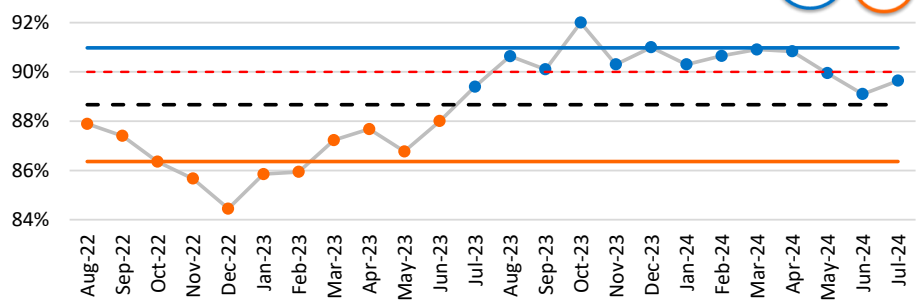
Month 04 | 2024-25

People

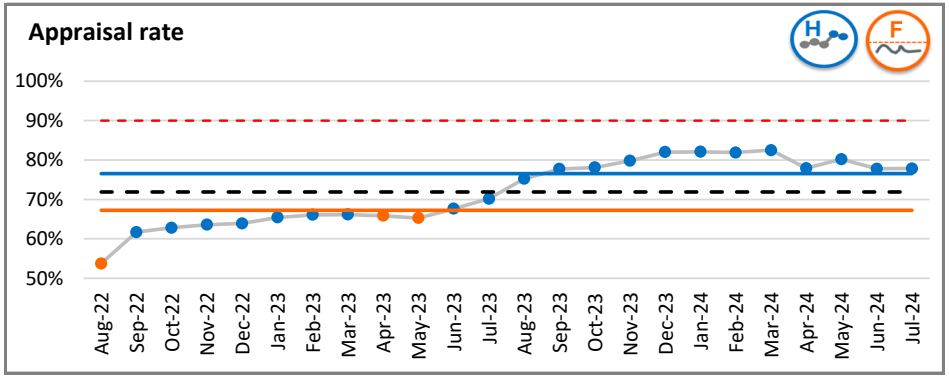
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- 'Grow Together review (GTR)' compliance this month has remained the same.
- The Trust is in the last month of the 24/25 GTR window, however compliance remains low, particularly for staff in bands 6 and below. Reminders continue to be sent to relevant services and leads, including People Partners to support improvements in their divisions. A weekly Trust news reminder cascade is in place throughout August.
- Mandatory training shows a slight improvement this month, though the 90% target is not being met. The recent decant of training teams and training provision from the Old School of Nursing to alternative sites, has had some impact on delivery, where some training had to be stood down. We anticipate we will see the impact of this in August data.
- Work continues, to improve on face-to-face mandatory training compliance, with a recent review undertaken in conjunction with the medical director, of the audience required to undertake Moving and Handling Level 2. This audience review should reduce the numbers requiring training and support with improving compliance.
- In addition to the statutory mandatory courses, the Trust continues to support staff to achieve compliance with the recently introduced Oliver McGowan training, which replaced our Learning disability and Autism training late last year, supported by the ICB. 76% of our staff have completed the E learning modules and another 11% have completed Tier 1 and 2% Tier 2. While this is low additional training dates are being made available, provided by Herts Care Partnership on behalf of the ICS.
- The other role essential course introduced last year in line with our Patient Safety Incident Response Framework (PSIRF) , however is showing really good uptake with 90% achieved for Level 1 Patient Safety compliance.

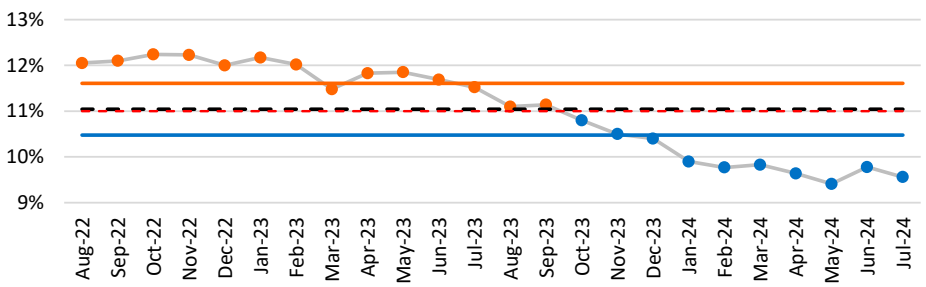
Month 04 | 2024-25

People

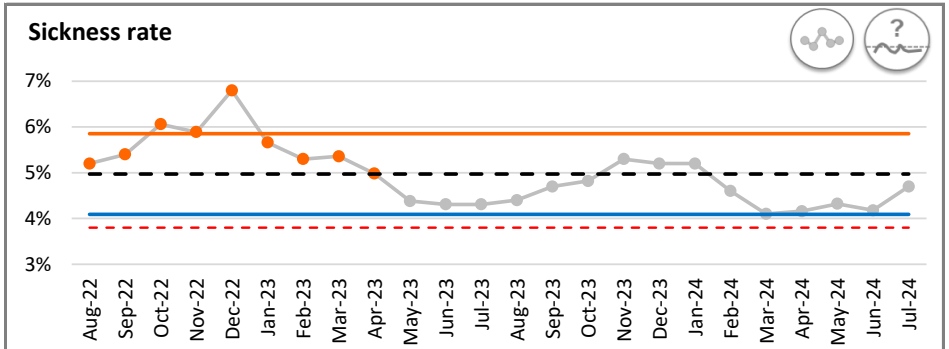
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

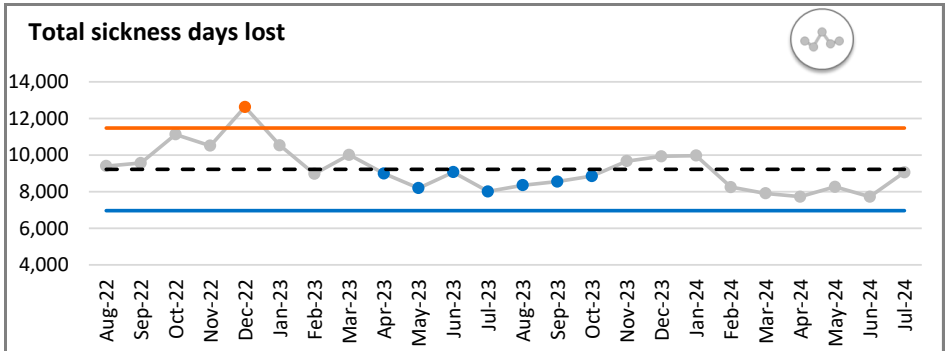
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Time to resolve Grievance is at an average of 60 days and for a disciplinary remains under 60 days for the 4th consecutive month
- Staff are speaking up more and we are resolving many cases informally and through early engagement and coaching with the line manager.
- The upcoming People Committee will receive a report on health and wellbeing reflecting the range of interventions and current work programme supporting our staff.
- The staff community shop and hub has now closed and we move to pop up events in the staff hub in Lister corridor as required.

Care Together

- Sickness absence rates continue to remain steady and are our target of 3.8% focus on supporting manager to manage absence and staff to return to work continues.
- Plans for the winter flu vaccination programme are well underway and plans will come to TMG in September for support and approval
- Our Pulse staff survey from July shows recommending the organisation as a place to work has improved by just under 6% and a 19% improvement in Care of patients/service users being the organisation's top priority and a 5% improvement in "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"
- three key themes emerging are Lack of communication around changes; HCSW Band 2 work was highlighted in comments as was Staff well-being support (update on Vivup) - plans in place to share structure charts wider, work well underway with HCSW and unions and a promotional campaign will feature for widening knowledge of Vivup for the Autumn.

Month 04 | 2024-25

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	13
Report title	Assurance report detailing readiness to exit NHS England and Improvement Maternity Safety Support Programme (MSSP).			**Meeting Date**	11 September 2024
Presenter	Director of Midwifery				
Author	Director of Midwifery				
Responsible Director	Chief Nurse			**Approval Date**	
Purpose (*tick one box only)* [See note 8]	**For information only**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Executive Summary:

East and North Hertfordshire NHS Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of ENH maternity services on 4th and 5th October 2022 and the issuing of a 29a warning notice on 18th October 2022.

Following a further CQC unannounced inspection on the 20th and 21st June 2023, the CQC improved ratings in the Well-led and Safe domains for maternity improving the overall rating from inadequate to requires improvement.

CQC commended the Trust on the progress made since the previous inspection. They found that the divisional triumvirate were aligned on the challenges to quality and sustainability within the service and had assurance that progress was being monitored through a maternity improvement plan with strengthened governance in place to ensure oversight at divisional and executive level.

The introduction of the Director of operations for women's and children's position to complete the triumvirate has strengthened divisional leadership structure, improving the stability and effectiveness of the leadership of the service. However, while early indications were positive, changes and improvements within the service needed to be sustained and embedded before the full impact and effectiveness could be assured.

The Trust are currently in the improvement phase of the MSSP with actions in quality and safety improvement being addressed through a sustainability action plan. Our Maternity Improvement Advisors (MIA) have maintained periodic site visits as well as virtual support and attendance at key governance meetings to maintain oversight of progress.

This report identifies the supporting evidence for improvements as well as ongoing work to continue to improve the quality and safety of maternity services to facilitate the Trust to exit the MSSP.

Key points outlined in this report are:

- The process for entering and exiting the MSSP.
- Progress with implementation of the sustainability action
- Improvements to workforce structure and sustainability
- Changes and improvements to systems and processes

Next Steps
The Maternity Services will continue to provide evidence to the Trust Board, NHS England, and other external partners to support their continued commitment to quality and safety and progress towards a sustained improvement in key aspects of care and services.

Introduction:

East and North Herts NHS Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of maternity services on 3rd and 4th November 2022 with a 29a warning notice being issued on 18th October 2022.
The Trust formally entered the MSSP in April 2023 and since this time have been working through the three key workstreams identified in the sustainability action plan.

Both a senior midwife and an Obstetric consultant were assigned to the Trust as Maternity Improvement Advisors (MIA's). Their role is to work with the divisional leadership and executive teams to support the delivery outcomes identified in the CQC Report and section 29a Improvement notice.

The sustainability action plan in response to the CQC findings has been focused on three key workstreams:

- Leadership and staffing
- Culture and diversity
- Policy and processes

Following the CQC unannounced inspection on 20th and 21st June 2023 and submission of evidence to support improvements, the CQC revised ratings for maternity services at ENH to requires improvement.

In May 2024, NHS England (NHSE) supported by ICS and Maternity Improvement Advisors reviewed the service and progress against the sustainability action plan. Whilst they acknowledged significant progress has been made there were four key actions that needed to be addressed to support the organisation in exiting the MSSP, as outlined below.

- Failure to comply with Birth rate plus, midwifery staffing due to reliance on this workforce to staff obstetric elective and emergency theatres including safety concerns relating to the Association for Perioperative Practice (AfPP) standards.
- Lack of sufficient recruitable headroom to support required training.
- Community midwifery caseloads exceed birthrate plus and national recommendations.
- Assurance of sustained changes to support repair and replacement of equipment and maintenance of estates and environment.

The service can now evidence significant progress against all of these actions.

MSSP exit criteria:
To exit the MSSP the service need to demonstrate sustained improvement in response to identified actions from the diagnostic phase of the MSSP. This has been achieved with external recognition of the significant progress made evidenced by the improved CQC rating.

A re-set meeting is planned for 16th October 2024 which will be attended by the divisional triumvirate, MIA, regional chief midwife, LMNS and service user reps and the medical and midwifery MSSP programme leads. The purpose of the re-set meeting is to allow all stakeholders to review progress made of the services improvement journey and confirm readiness to exit the programme.

Ahead of the re-set meeting this report seeks to give assurance of progress made and assurance of readiness to exit the MSSP.

Supporting evidence to exit MSSP.

Several reviews and self-assessments have taken place as part of the Trust's support programme and assurance processes. The key results, recommendations, actions, and progress reports are included as a summary below:

The East and North Hertfordshire Maternity Services CQC Inspection 2022 Maternity Improvement Plan.
An overarching maternity improvement plan was developed in response to the CQC's section 29a warning notice issued on 22nd October 2022. This was monitored via a strengthened governance framework which included a weekly maternity Improvement committee and a monthly maternity senate chaired by the Chief Nurse.

Ahead of the CQC unannounced visit on the 20th / 21st June the Trust had submitted evidence required to meet must do actions in response to the section 29a notice and following a positive inspection confirmation was received from CQC that the improvement notice had been closed.

Outstanding CQC actions continue to be progressed and monitored via internal governance processes. It should be noted that these actions are part of the overall maternity improvement plan.

Exit criteria workstream updates:

1. **Leadership and staffing**

a) Governance Structure and Framework

The roles and responsibilities for staff working within the governance framework have been reviewed. Medical and midwifery staff with specific roles within governance are clearly defined with job plans and PA's reflecting the commitment to improve through organisational change and learning.

A new perinatal governance and quality strategy has been developed and was approved by the Divisional board in July 2023. This replaced the previous maternity risk strategy to ensure that all the elements of clinical governance are included. This outlines the structure, processes and people involved in promoting quality and safety through learning.

Patient Safety Incident Response Framework (PSIRF) is now in place across the Trust including maternity, gynaecology, and neonatal services. The incident management pathways follow PSIRF principles, identifying when a Patient Safety Incident Investigation (PSII) is required.

The Trust governance and reporting processes have been reviewed and the maternity and neonatal framework is reflective of the Trust PSIRF plan and maintains the need for reporting to external bodies such as Mothers and Babies Reducing Risk through Audit and Confidential Enquiries across the UK (MBRRACE-UK), Maternity and Newborn Safety Investigations programme (MNSI) and NHS Resolution (NHSR) Early Notification (EN) when indicated.

The Director of Midwifery is now a member of the Trust Quality and Safety committee with a maternity assurance report being presented to the committee monthly and an exception report presented bi-monthly to the Public Trust Board.
The Local Maternity and Neonatal System (LMNS) serious incident panel monthly meetings provide external scrutiny and oversight through a multidisciplinary panel with representation across the system. Learning is also shared at the LMNS quality and safety forums, at maternity MNSI quarterly meetings with assurance to the LMNS partnership board.

National reports and recommendations from National Institute of Clinical Excellence (NICE), MBRRACE, MNSI and other organisations are reviewed within the Trust and

where a gap analysis identifies areas where improvements are required. Necessary actions are included within the maternity improvement plan.

Several strategies are used to support shared learning which include a 'Message of the week, daily safety huddles, governance information boards, the newly established daily patient safety triage, team forums and rolling half day audit meetings.

b) Leadership Structure and sustainability

Over the last year the divisional leadership has been strengthened to ensure there is sustainability with succession plans in place. A new clinical care group lead has been appointed for women's services and there is now a quadrumvirate leadership structure for women's and children's following the appointment into the new Divisional Director of Nursing for children and young people position (a structural chart can be found in appendix 1).

Following an operational restructure, neonatal services are now part of the women's services care group and is aligned with the maternity management structures rather than being directly managed by paediatrics.

The Chief Nurse and a Non-Executive Director are the Maternity Board Level Safety Champions and enhance the Trust oversight of maternity services. The Chief Nurse has continued to provide significant, consistent, and essential support to maternity and neonatal services.

c) Workforce Structure and sustainability

The Risk and Governance, Quality and Safety team has been strengthened through some changes to Job titles and banding alongside the introduction of new roles including a lead midwife for perinatal quality improvement, additional resource to support guideline and audit compliance and a patient safety midwife (structure chart can be found in appendix 2).

Following approval of two additional substantive obstetric consultants both roles have been successfully recruited into. These positions include additional leadership for postnatal services and have allowed for changes within Job plans with allocation of additional PAs to strengthen governance and quality improvement. A new internal appointment into Clinical Director for Obstetrics has been made following the appointment of the previous CD as the new care group lead for women's services.

The Practice Education Team has a new lead who reports directly to the lead midwife for governance ensuring that our training needs analysis is supported by learning from local incidents and themes from complaints. Training is delivered in line with a comprehensive training needs analysis aligning to the national core competency framework.

A multi-disciplinary faculty are responsible for delivery of core skills and practical training including **PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining days (PROMPT), fetal monitoring and surveillance, and a recently revised saving babies lives care bundle study day. There is dedicated support in place within the team for students, preceptors and Internationally educated Midwives.

The operational team for the division has been further enhanced within the last year by updating the roles and responsibilities and appointment of personnel into new posts to support the processes required to demonstrate effective management of the services.

All aspects of the clinical workforce are continuously reviewed as part of the Maternity Incentive Scheme (MIS), Ockenden and against the professional standards from the governing bodies, Birthrate plus® and professional bodies such as British Association of Perinatal Medicine (BAPM). The service successfully met the evidential requirements for all safety standards in year five of MIS which includes obstetric, anaesthetic, neonatal medical, and nursing workforce (safety action 4) and Midwifery staffing (safety action 5).

All business cases to support enhancement of staffing levels are submitted through the Trust processes for approval prior to advertisement and appointment to posts.

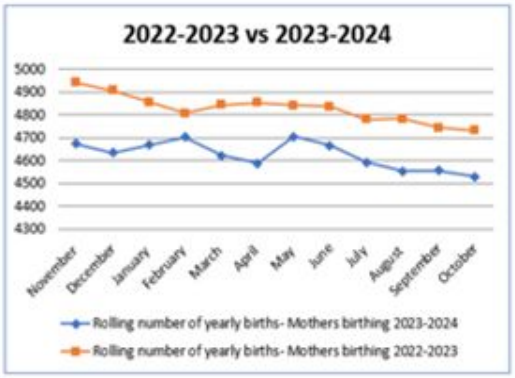
d) Safe midwifery staffing

A systematic midwifery workforce review was undertaken in June 2023 utilising Birthrate plus®. Birthrate plus® is NICE, RCOG and RCM endorsed workforce tool for assessing midwifery staffing needs for women throughout pregnancy, labour, and the post-natal period, in both hospital and community settings. This method uses available activity and acuity data to calculate and recommend the number and skill-mix of midwives and unqualified staff to meet current standards and models of care. The recommendations were based on case-mix data from April 22 – March 2023 and reflected the previous 12 months total births of 4907.

Since the Birthrate plus® review the service has seen a decline in the annual birth rate. The table below shows comparison data of the rolling rate of mothers birthing for year 22/23 and years 23/24 (table 1). Numbers highlighted in red depict the predicted birth numbers based on number of women reaching 20 weeks of pregnancy between March and June 2024.

Table 1. Rolling number of yearly births- Mothers birthing 2023-2024

	Rolling number of yearly births- Mothers birthing 2023-2024	Rolling number of yearly births- Mothers birthing 2022-2023
November	4673	4941
December	4635	4907
January	4669	4855
February	4703	4807
March	4623	4844
April	4589	4853
May	4705	4842
June	4666	4837
July	4594	4781
August	4555	4783
September	4557	4744
October	4530	4731



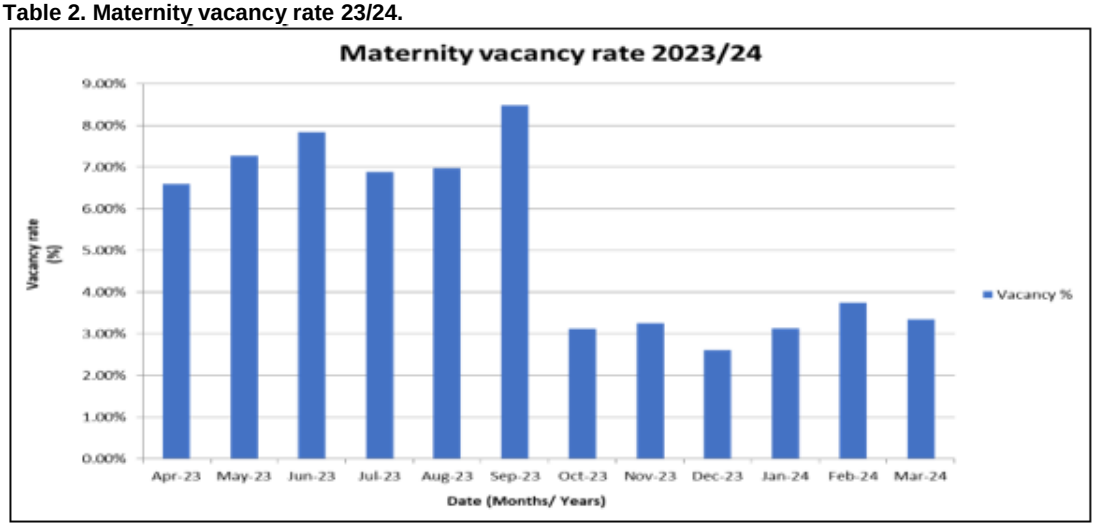
Booking data for April, May and June suggests that predicted birth rate for year 24/25 will continue to decline to closer to 4300 births. The staffing requirements have therefore been adjusted based on predicted deliveries for 24/25 of 4300 births. Maternity shift plans that align with this recommendation were approved by the Trust Management Group (TMG) on 25th July 2024 and will go live on 20th October 2024.

TMG agreed with the recommendation from the Director of Midwifery that a further Birthrate plus® establishment review is commissioned at the end of 2024 to review birth numbers, activity, and acuity within the unit and that this information is used to inform any further adjustments needed to staffing and shift plans.

Maternity Vacancy rates:

The service has significantly improved the vacancy position across maternity in financial year 23/24 and sustained those improvements with a 0% vacancy reported for registered midwives in July 2024 (Table 2 below shows the declining vacancy rate for financial year 23/24.).

Table 2. Maternity vacancy rate 23/24.



Community midwifery care provision:
Birthrate plus® recommends an average caseload ratio of 1:116 for community midwives based on activity and acuity. Currently 4 of the 5 community teams are operating on higher caseloads than this. This is because while some in-patient areas are over established community remains a hard to recruit to area due to current vacancy against funded establishment in community (currently 20%). In addition, all community antenatal appointments are currently 15 minutes long. 20 mins is the minimum recommended appointment time. The current pressure of 15 minute appointments is likely to be heightened by the transition to digital electronic patient records.

The current funded establishment for community has been reviewed against Birthrate plus® and the current birth rate of **4300 births.** This demonstrates that if community was fully established the average caseload would be 1:112 which gives assurance that the community establishment is correct for the current caseload and birthing numbers and that it would be possible to increase appointment times to align with other Trusts and improve quality of care. As a current vacancy hotspot community will be a focus area within our recruitment and retention strategy for 2024/25.

Midwifery Headroom:
Birthrate plus® suggests a minimum of 22% recruitable headroom is applied to the clinical establishment with many trusts now increasing headroom beyond 22% in response to increasing training requirements identified in response to publications of reports such as Ockenden (2021) and Kirkup (2023). The training needs analysis for the service identifies that 63 training hours are required per midwife per year to meet the national and local training requirements for midwives.

A business case presented to the Trust Management Group on 25th July agreed an uplift in the recruitable headroom in maternity from 17% to 25% which has been applied to the revised shift plans.

Uplifting the headroom to 25% allows the service to meet the shift plan requirements aligned to 4300 births per year and achieves the required uplift to support training with a contingency to support maternity leave cover. The proposed breakdown of headroom allocation is shown in table 3 below.

Table 3. Headroom allowance	**Uplift**
Annual leave	15%
Sickness	4%
Study Leave	3.7%
Maternity leave cover	2.3%
Total	**25%**

Staffing maternity theatres and recovery:
Currently the staffing model for maternity requires midwives to regularly undertake the scrub nurse role taking them away from midwifery roles and responsibilities. The analysis and recommendations of Birthrate Plus® do not include any additional provision for midwives to undertake scrub and recovery nursing. Therefore, the staffing model and provision for theatres and recovery sits outside of Birthrate Plus®.

CQC inspections undertaken in October 2022 and June 2023 highlighted concerns about the reliance on midwives to undertake scrub duties in theatre.

"The practice of midwives scrubbing in obstetric theatres is still not in line with best practice guidance around the national staffing of obstetric guidance consensus statement (May 2009)."

The reliance on midwives to undertake scrub duties in theatre impacts on available midwives and the training and annual competency assessment required in line with AfPP standards are not consistent which poses a safety risk.

The agreed changes to the maternity funded establishment and recruitable headroom represent a cost saving of £325,000 through reduction in bank usage (which is higher in cost) as the headroom is now fully recruitable. This cost saving means that the staffing model required for maternity theatres and recovery can be delivered without incurring an additional cost pressure. This was presented in a business case to TMG on 25th July and approved along with a revised shift plan. The divisional leadership team are working with the divisional leadership team on a phased implementation plan and withdraw of midwives from theatre and recovery.

Currently the teams are working towards a target date of 1st April 2025 for completion with management of maternity theatres and recovery planned to move to the planned care division. However, Our MIA's are keen that the Trust challenges itself to deliver this change by the second week of January 2025. This has been shared with the working party to discuss what support would be needed to meet a revised trajectory.

2. Culture and diversity
The CQC report, following the short notice inspection on October 2022, highlighted concerns about culture within the service with some staff reporting experience of bullying and discrimination. These concerns had been raised to the CQC and through internal forums.

Between December 2023 and March 2024, the service received a number of anonymous whistleblowing concerns raised directly to the CQC. Themes of concern included:

- Leadership and culture including low staff morale.
- Negative staff experience including unhappiness at work.
- Patient safety concerns due to staffing levels and the impact of discrimination and inconsistent levels of service user advocacy.

The service has responded to the concerns in a number of ways as outlined below:

- The divisional leadership team held a series of listening events with staff to better understand the experiences of staff. The output from these events was used to identify and action quick wins and to inform our recruitment and retention strategy for 2024/25.
- An independent assessment of culture in maternity was commissioned by the chief nurse and the Director of people and culture. The report made a number of recommendations which have informed a cultural improvement action plan.

- The divisional triumvirate established an Equity, Diversity, and Inclusion (EDI) Board with identified workstreams, and governance pathways as outlined in the organogram in appendix 3.
- The Trust have commissioned a number of external partners to undertake focused work to support cultural improvement including:
  - Senior midwifery coaching and development programme
  - Professional conversations multi-disciplinary workshops
  - Kindness into action masterclasses
- Quadrumvirate participation in the NHS England Perinatal leadership and development programme including a staff culture survey which has informed our improvement plan.

Evidence of cultural improvement:

The service was able to demonstrate improvements across all domains in the NHS national staff survey for 2023 compared to the 2022 survey (see table 4).

Table 4. Themes from National Staff Survey 2023 – Obstetrics

BD 1	Obstetrics	
Year	2022	2023
Question	Score	Score
PP1 We are compassionate and inclusive	6.63	6.72
PP2 We are recognised and rewarded	4.88	5.23
PP3 We each have a voice that counts	6.18	6.27
PP4 We are safe and healthy	4.84	5.28
PP5 We are always learning	3.91	5.11
PP6 We work flexibly	5.21	5.62
PP7 We are a team	5.84	5.99
E Staff engagement	6.26	6.60
M Morale	4.73	5.13

In addition, there has been a reduction in sickness rates across midwifery and medical workforce as seen in table 5 and 6 below.

Table 5. Maternity sickness episodes.

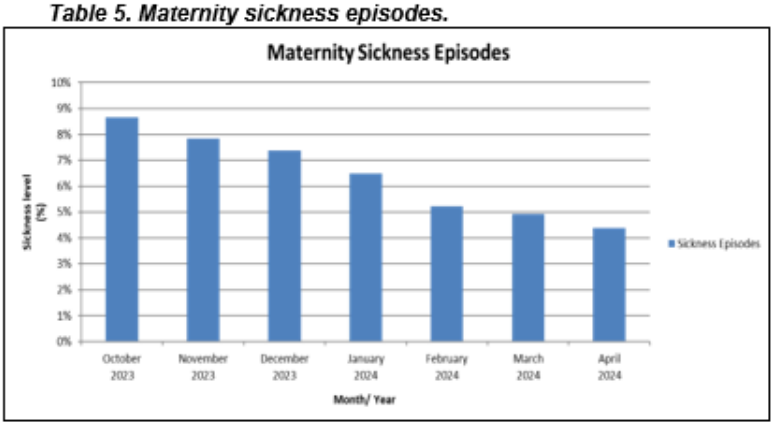
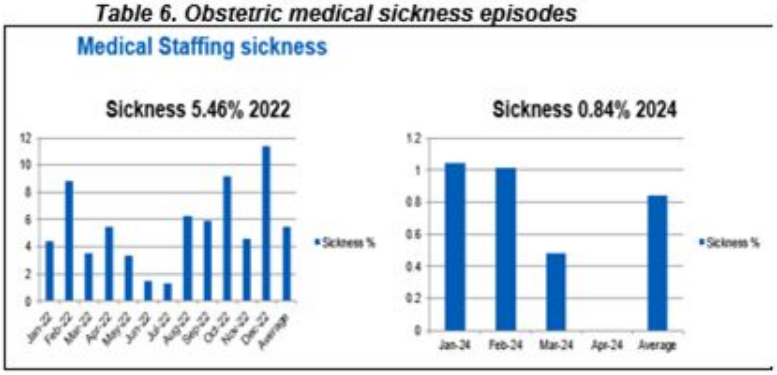


Table 6. Obstetric medical sickness episodes



Trainee Feedback

A local survey undertaken with trainees ending their placement in March 2024, undertaken by the college tutor, gave assurance that trainees felt able to escalate if needed. The College tutor provides a monthly report to Consultant meetings which includes escalation of any cultural / EDI issues. No escalations were received in May, June, or July. Responses from the most recent local survey were reassuring with none of the respondents reporting facing cultural issues during their placement. However, a third of respondents did report that they observed others facing cultural Issues. This feedback supported the decision to offer the professional conversations cultural workshops supported by Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) which commence in September 2024.

The Trust have been sending regular progress reports to the NHS England Workforce, Training and Education directorate in response to concerns raised by midwifery and obstetric trainees in October 2021 and March 2023 which led to an improvement plan. Following the latest progress submission in July 2024 NHS England WTE Education Quality acknowledged the progress and positive efforts made by the Trust and were satisfied that the ongoing actions will result in the necessary embedded and sustained changes. They therefore confirmed that no further updates to the improvement plan were required and were happy for any next steps to be self-managed by the Trust.

3. Policy and processes.

Following the CQC inspection in October 2023 and the section 29a notice, the improvement plan tracked progress on actions to improve the availability of equipment and investment in estates to ensure the creation of a suitable environment for birthing families. The sustainability action plan seeks assurance of policy and processes that will maintain a proactive versus reactive approach.

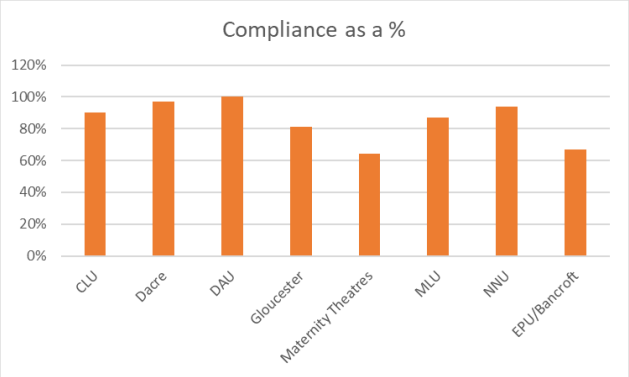
Progress and sustainability.

- The service has been working closely with the newly appointed lead for Electrical and Biomedical Engineering (EBME) to create a service schedule for maternity services.
- Line management of the equipment coordinator for maternity will transfer to EBME to ensure a coordinated approach with clear escalation pathways.
- Bi-monthly estates and equipment meetings led by the safety and quality manager have an action log and strengthened reporting and escalation pathways and processes to ensure timely resolution of concerns.
- A new estates and facilities strategy will support a proactive process for scheduling and planning maintenance and estates upgrades across the organisation.
- Significant progress has been made with servicing compliance since the NHSE peer review undertaken in May with 4 of the 8 areas now exceeding 90% compliance as evidenced in table 7 below.
- An action plan is being progressed through the estates and equipment meetings that includes introduction of a trust wide servicing schedule, further

improvements to the management process for equipment and servicing requirements, and coordination of internal engineers and external contractors to work through the remaining servicing backlog.

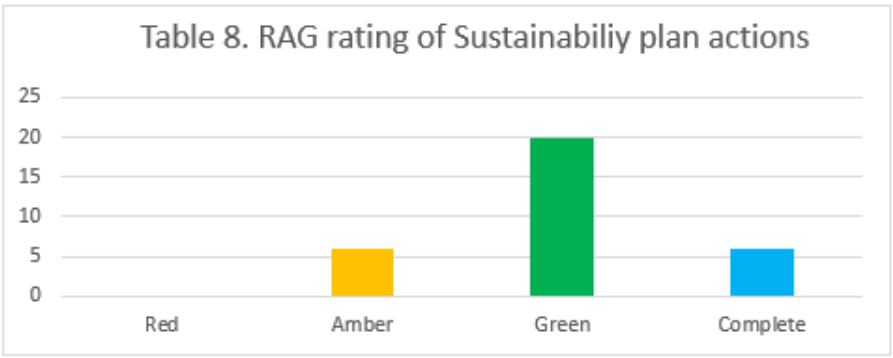
- A sustainability plan is needed to ensure that the environment in maternity remains fit for purpose and is adequately maintained. The divisional leadership will work with Estates colleagues on a robust estates plan for maternity.

Table 7. Servicing compliance by location



Sustainability Action Plan Progress and Next Steps:
The sustainability action plan has been reviewed at touchpoints throughout the improvement journey by the Maternity Improvement Advisors and the regional chief midwife. Of the 32 actions within the plan, 6 are fully completed with no red rag rated actions meaning that there is no serious risk to evidence delivery against any of the actions within the improvement plan (see table 8 below).

The maternity quality and safety team continue to collate evidence to support progress against all open actions ahead of the stakeholder re-set meeting planned for 16th October 2024.



Next steps:
Following the re-set meeting in October, a progress update and the sustainability action plan (SAP) will be presented to Trust Board in November. The Board will be asked to approve the SAP and support the steps outlined that are needed to deliver sustainable improvements across the service.

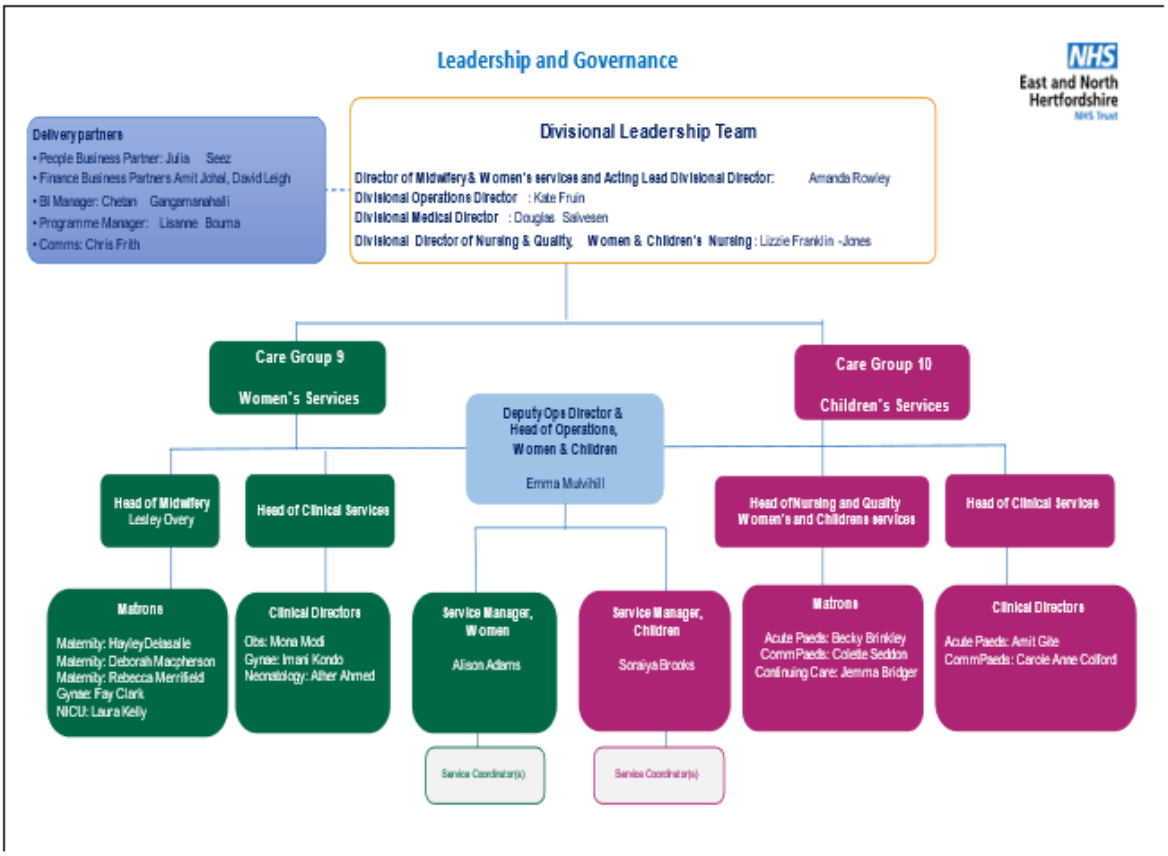
Impact: tick box if there is any significant impact (positive or negative):											
Equality (patients or staff)	☒	**Patients**	☒	**Finance/ Resourcing**	☒	**System/ Partners**	☒	**Legal/ Regulatory**	☒	**Green/ Sustain-ability**	☐
Sustainability of improvements made have and will continue to benefit staff, service users and families. Sustaining improvements will assure external regulators and internal and external stakeholders.											

Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:							
Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒
Identified Risk: *Please specify any links to the BAF or Risk Register*							
Report previously considered by & date(s):							
N/A							
Recommendation	The Board/Committee is asked to: • Note the progress made to meet the exit requirements of the maternity safety support programme. • Support the recommendation that the service is now ready to commence steps required to exit the programme. • Note that a progress update and the sustainability action plan will be presented for approval at the November Trust Board.						

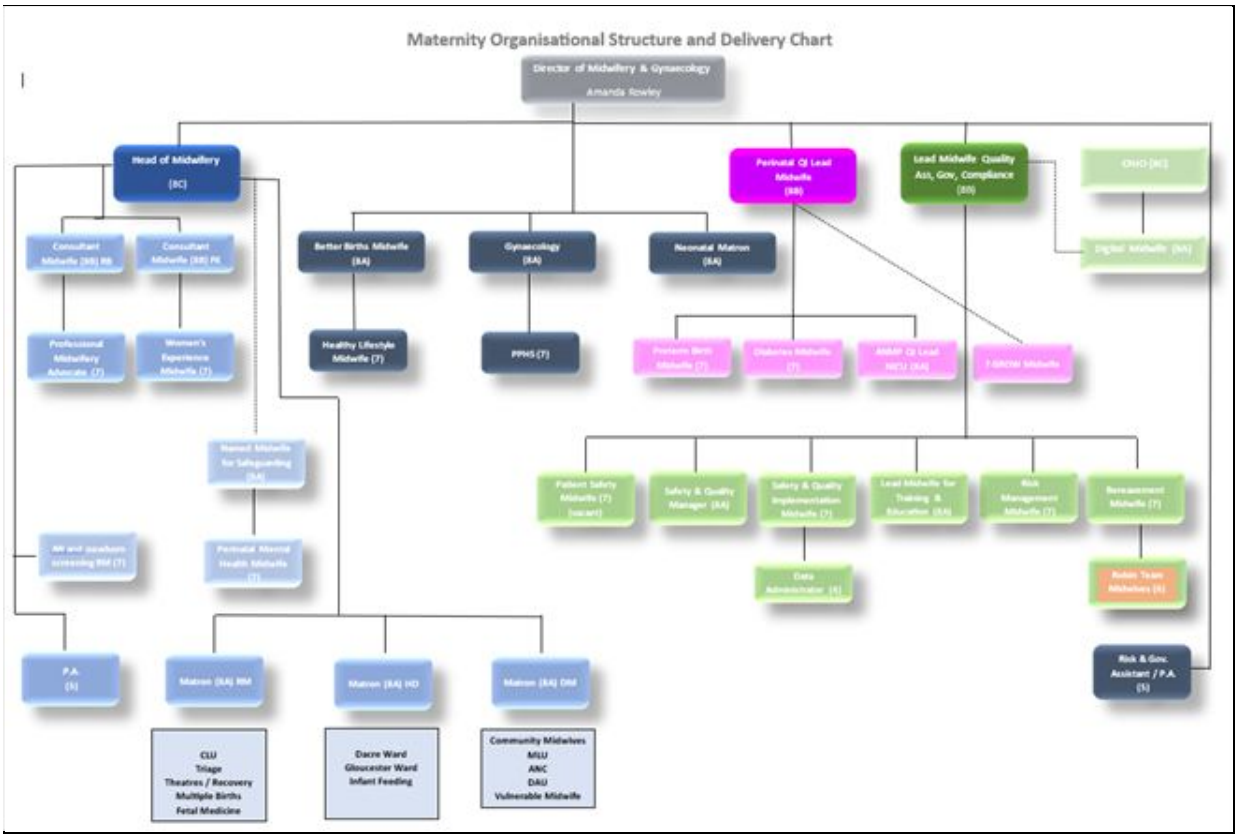
To be trusted to provide consistently outstanding care and exemplary service

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

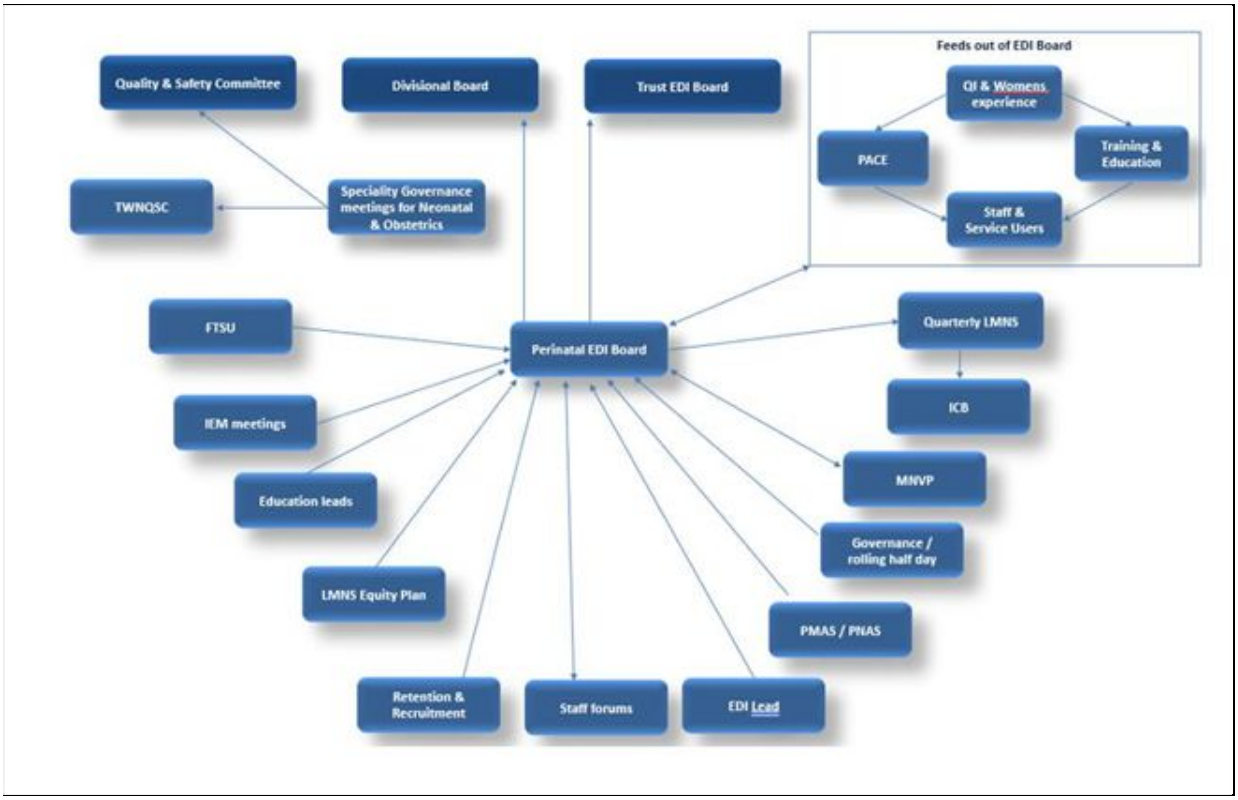
Appendix 1. Divisional Structure Chart for Women's and children's



Appendix 2. Midwifery leadership and governance structure



Appendix 3. EDI Board workstreams and reporting pathways


Quality & Safety Committee
Divisional Board
Trust EDI Board
Feeds out of EDI Board
QI & Womens experience
PACE
Training & Education
Staff & Service Users
TWNQSC
Speciality Governance meetings for Neonatal & Obstetrics
FTSU
Perinatal EDI Board
Quarterly LMNS
ICB
IEM meetings
MNVP
Education leads
Governance / rolling half day
LMNS Equity Plan
PMAS / PNAS
Retention & Recruitment
Staff forums
EDI Lead

Hertfordshire and West Essex Integrated Care System

HWE ICS Performance Report

July 2024

Working together
for a healthier future

Executive Summary – KPI Risk Summary

Highest Risk	Programme
CHC Assessments < 28 Days	Community
Community Waits (Children)	Community

High Risk	Programme
% of <14 day GP Appointments	Primary Care
% in ED > 12 Hours	UEC
NHS 111 Calls Abandoned	UEC
Ambulance Response Times	UEC
4 Hour Stroke Unit	Stroke
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
Community MH - Adult Waits for 2nd Appt	Mental Health
Learning Disabilities - Time to 1st Assessment	Mental Health
6 Week Waits	Diagnostics
62 Day Standard	Cancer
RTT 78 Week Waits	Elective
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective
Theatre Utilisation	Elective
Autism Spectrum Disorder (ASD)	Community
Attention Deficit Hyperactivity Disorder (ADHD)	Community

Lowest Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
CHC Assessments in Acute	Community

Low Risk	Programme
2 Hour UCR	UEC
90% Stroke Unit	Stroke
Adult Crisis 4 Hour	Mental Health
Transformed Community MH Pathways	Mental Health
Community Perinatal MH	Mental Health
28 Day Faster Diagnosis	Cancer
Community Waits (Adults)	Community

Variable Risk	Programme
% of on the day GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
ED 4 Hour Standard	UEC
No Criteria to Reside (NCTR)	UEC
Ambulance Handovers	UEC
Thrombolysed < 1 Hour	Stroke
Out of Area Placements	Mental Health
CYP Eating Disorders	Mental Health
HPFT Early Memory Diagnosis (EMDASS)	Mental Health
Talking Therapies	Mental Health
Severe Mental Illness (SMI) Health Checks	Mental Health
31 Day Standard	Cancer
62 Day Backlog	Cancer

Moved to lower risk category | Moved to higher risk category | No change to risk category | New KPI added this month

Hertfordshire and West Essex Integrated Care System

Executive summary

URGENT CARE, Slides 8-13	**4 Hour Performance**	**Region: HWE worse than average**	**National: HWE worse than average**

- Hours lost to handover >15mins reduced to 2,085 hours in May. Whilst higher than in March, this is the second-best performance since April 23
- Performance against the 4-hour ED standard was unchanged at 73.5%. Whilst not achieving the 78% ambition for 24/25, this was the third best performance since August 21
- NHS 111 abandoned calls reduced significantly in April and May to 5.6%. This is the best performance since September 23
- Category 2 ambulance response times were largely unchanged at 44 minutes in May. HWE responses remain the highest in East of England

PLANNED CARE, Slides 14-15	**18 Week RTT**	**Region: HWE better than average**	**National: HWE worse than average**

- Following a 6-month trend of reduction, the overall elective PTL grew slightly in both April and May
- HWE reported 83 x 78-week breaches at the end of April. There were 40 patients at ENHT & PAH, with a further 43 in the Independent Sector. WHTH have cleared all 78-week waiters
- The 65-week backlog increased in April and is not meeting plan. Trusts continue to forecast achievement of the zero end of September national ambition, but ongoing Industrial Action is a significant risk

DIAGNOSTICS, Slide 16	**6 Week Waits**	**Region: HWE better than average**	**National: HWE worse than average**

- 6 week wait performance fell at each acute Trust in April, and across the ICS by 1.8%. Imaging, and specifically Non-Obstetric Ultrasound (NOUS), are the biggest drivers of under-performance

CANCER, Slides 18-19	**28 Day FDS / 31 Day / 62 Day**	**Region: HWE better than average**	**National: HWE better than average**

- 28 Day Faster Diagnosis Standard (FDS) performance has fallen by 5.7% in the last two months, but continues to achieve the 75% standard
- 62-day performance betters the national and regional averages and is meeting the 70% ambition for this year. 31-day cancer performance continues to fluctuate just short of the national 96% standard

MENTAL HEALTH / LD, Slides 21-35	**Community MH (1st appt)**	**National: HWE better than average (Adult)**	**LDAHC**	**Regional: HWE best in EOE**

- Learning Disability Annual Health Checks (LDAHC) – 75% standard was achieved across the ICS and in each Place. HWE achievement was the highest in East of England
- Out of Area Placements (OAPs) are up over the last 2-3 months. Improvement forecast in WE from May; Hertfordshire remains challenged due closure of Aston Ward at The Lister. Scheduled to reopen early July
- Community Adult MH waits for a 2nd contact reduced in March to 73 days. This remains notably above the historic mean, but significantly better than the national average of 118 days

CHILDREN, Slides 36-41	**Various**	**Community 18 Week %: HWE worse than national**	**Community MH 2nd Appts: HWE better than national**

- The total number of children on community waiting lists remains very high but has plateaued over the last 12 months. Longest waits have increased further to 117 weeks, compared to 61 weeks for adults
- 18 week % for children's community waits is c.44%, compared to the national average of 56.9%. Pressures are predominantly in Community Paediatrics, as well as therapies and Audiology services
- Autism Spectrum Disorder (ASD) waiting lists and times continue to grow as 24/25 funding / investment remains unresolved. ADHD services are also high risk due to rising demand and waiting lists
- Reversing a period of long-term improvement, CAMHS caseloads have increased since December and are back to historic mean levels. The 28-day access standard in Hertfordshire has not been achieved since 2021
- Children's waits for a Community MH 1st appointment are better than the national average. However median waits are 119 days, compared to 73 days for a 2nd contact in adult services

COMMUNITY (Adults), Slides 42-47	**% <18 Weeks**	**National: HWE better than average**	**Adult waiting times better than CYP**

- The % of adults waiting <18 weeks remains strong at c.93% compared to the national average of 83.8%

PRIMARY CARE & CHC, Slides 48-51	**Appointments <14 Days**	**National: HWE in line with national average**

- Total number of GP appointments are variable but remain higher than pre-pandemic levels. Appointments in 2023 were the highest since 2019
- The % of appointments seen on the same day has been within common cause variation for the last four months. The % seen within 14 days of booking is marginally below this year's plan of c.89%
- CHC assessments within 28 days have deteriorated further. April performance at 40%, has halved from 80% in June 23. The service in South & West Hertfordshire is particularly challenged

Executive Summary – Performance Overview (1)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	May 24	73.5%	78.0%			68.8%	63.8%	73.8%
A&E - % spending more than 12 Hours in Dept	May 24	10.1%	-			10.3%	7.6%	13.0%
A&E - ED Attendances	May 24	49697	-			44120	37593	50647
Trolley Waits	May 24	199	-			180	-31	390
2 Hour Community Response	May 24	83.0%	70.0%			80.8%	73.6%	87.9%
14 day LOS	May 24	24.1%	-			25.2%	21.9%	28.5%
Ambulance - Handover >60 Mins	May 24	717	-			970	548	1392
EEAST: Cat 1 - Mean (<7min)	May 24	00:09:20	00:07:00			00:09:29	00:08:03	00:10:54
EEAST: Cat 2 - Mean (<30 Mins)	May 24	00:44:35	00:30:00			00:52:08	00:21:36	01:22:40
CHC - Decision within 28 days	Apr 24	39.6%	80.0%			66.2%	48.1%	84.3%
CHC - Assessments in Acute	Apr 24	0.0%	0.0%			0.1%	-0.6%	0.9%
111 - Calls received by telephony system	May 24	40547	-			52122	31234	73011
111 - Calls answered within 60 seconds	May 24	72.0%	100.0%			47.8%	14.8%	80.9%
Access to stack - average patients accepted per day	May 24	17.5	-			12.9	6.0	19.9

Hertfordshire and West Essex Integrated Care System

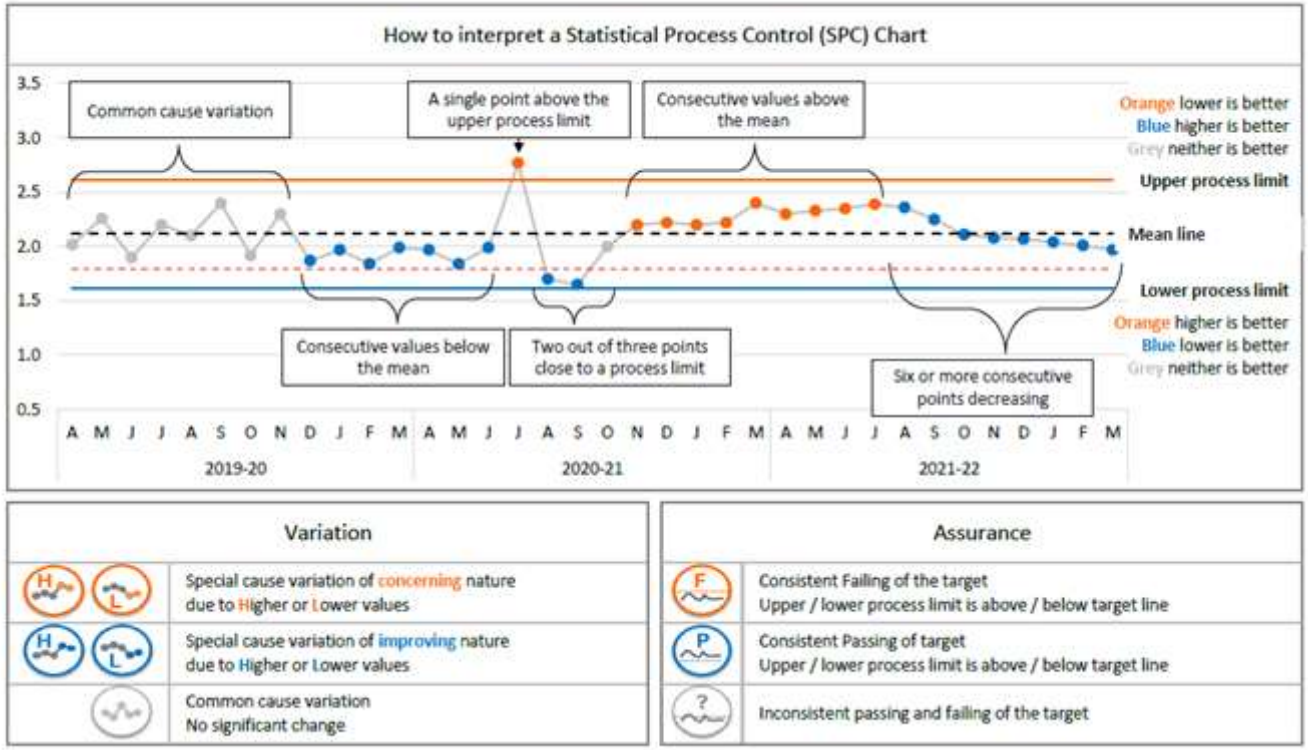
Executive Summary – Performance Overview (2)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT - 18 Weeks	Apr 24	54.7%	92.0%			55.3%	52.4%	58.3%
RTT - 52 Week Waits	Apr 24	7063	-			8157	6617	9696
RTT - PTL Size	Apr 24	142264	-			131696	124677	138715
RTT - 78 weeks	Apr 24	54	0			876	468	1283
RTT - 65+ weeks	Apr 24	1198	-			2874	2183	3565
Cancer - 2 Week Wait Referrals	Apr 24	8815	-			7079	3446	10712
Cancer - 62 Day Standard	Apr 24	71.3%	70.0%			72.2%	63.4%	81.0%
Cancer - 62 Day Total Waiting	May 24	433	-			556	383	730
Cancer - 104 Day Total Waiting	May 24	146	-			156	108	204
Cancer - 28 Day Faster Diagnosis Standard	Apr 24	75.4%	75.0%			71.7%	62.2%	81.1%
Cancer - 31 Day Standard	Apr 24	93.7%	96.0%			95.1%	90.9%	99.3%
Diagnostics - 6 Week Wait	Apr 24	63.9%	95.0%			64.9%	57.1%	72.8%
Diagnostics - PTL Size	Apr 24	28222	-			25412	20532	30292
Primary Care - Booked Appointments	Apr 24	698881	-			662159	494106	830212
Primary Care - Routine Referrals	Apr 24	29296	-			25051	12186	37916
Primary Care - Urgent Referrals	Apr 24	7743	-			5542	2728	8356
Primary Care - Same day appointments	Apr 24	46.1%	-			45.8%	40.7%	50.9%
Primary Care - 14 day appointments	Apr 24	82.1%	-			85.0%	81.2%	88.8%
Mental Health - Out of area Placements (End of month	Apr 24	34	-			34	#N/A	#N/A
Mental Health - Recorded >65s Dementia Diagnosis	Apr 24	64.4%	66.6%			62.5%	61.8%	63.2%
Mental Health - IAPT Entering Treatment	Mar 24	2309	-			2390	1317	3463
Early Intervention in Psychosis	Apr 24	75.9%	60.0%			81.7%	59.2%	104.1%
Planned Care - Day Case Rate (% of Day Case of All Inp	Apr 24	92.6%	85.0%			91.9%	90.3%	93.5%

A Dashboard including Place and Trust based performance is included within Appendix A of this report

Hertfordshire and West Essex Integrated Care System

Statistical Process Control (SPC)

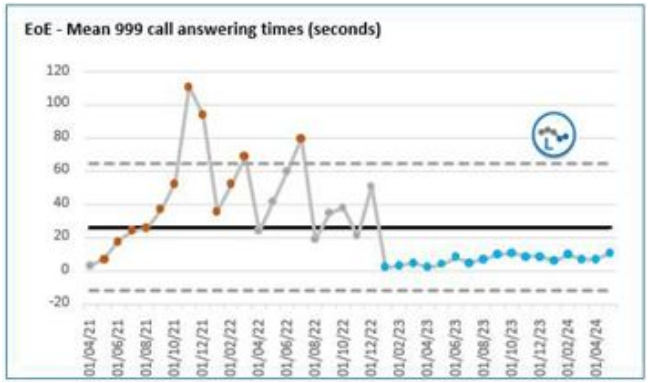


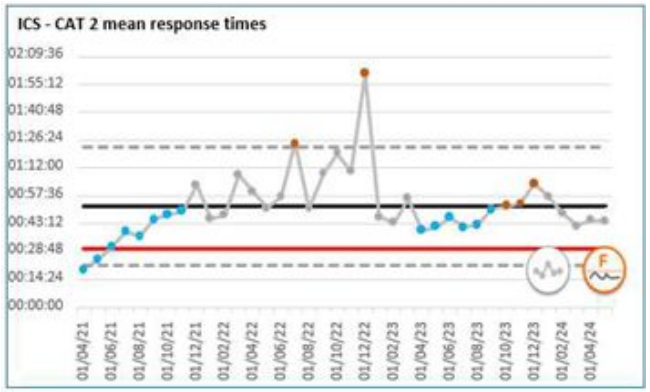
Hertfordshire and West Essex Integrated Care System

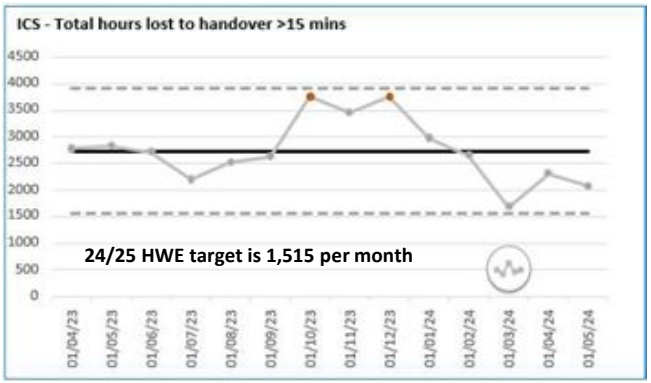
Performance by work programme

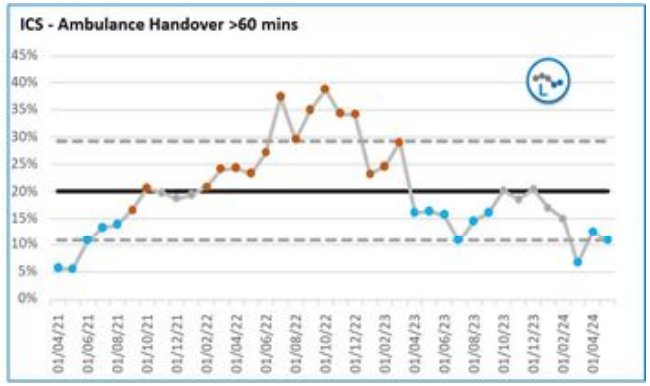
Hertfordshire and West Essex Integrated Care System

UEC - Ambulance Response and Handover



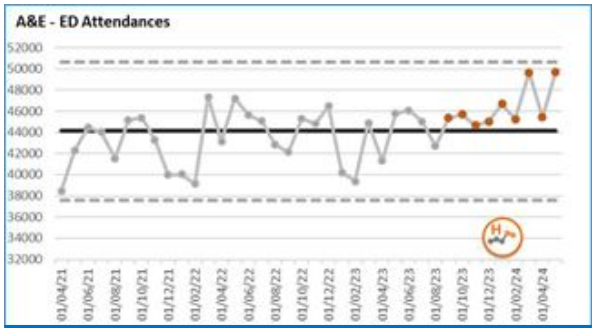


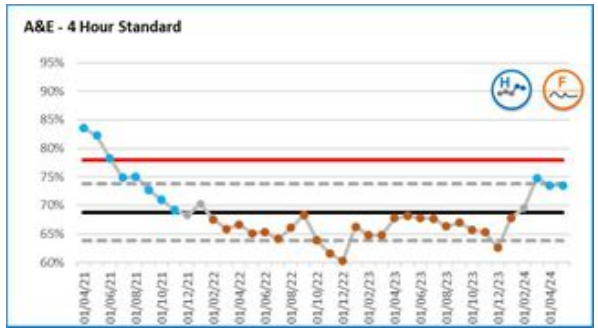


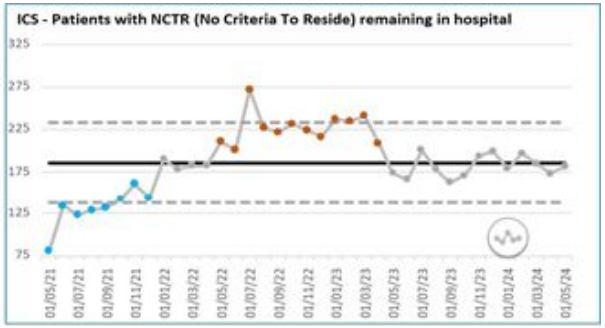


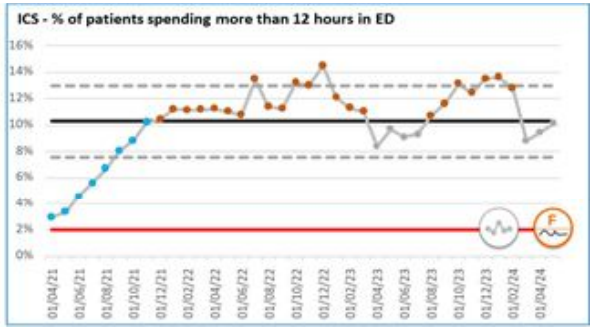
Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC)







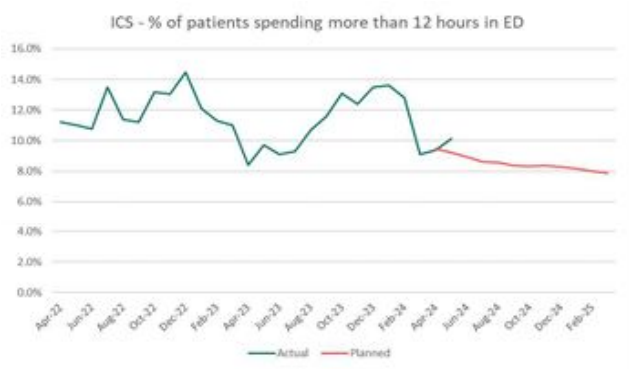


Hertfordshire and West Essex Integrated Care System

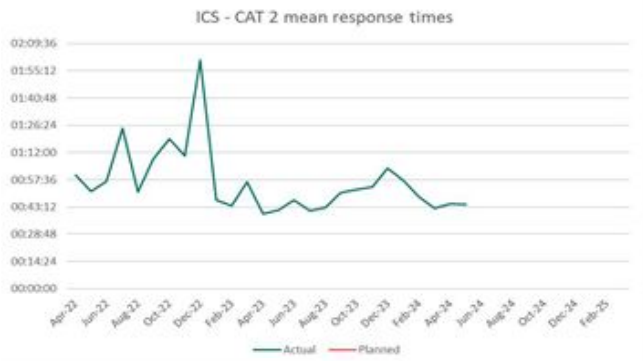
Urgent & Emergency Care (UEC) Improvement Trajectories

4 Hour Standard

% of Patients Spending > 12 Hours in ED



Ambulance Category 2 Mean Response Times



Hours Lost to Handover

Category 2 Ambulance Response and Hours Lost to Handover trajectories are currently in discussion

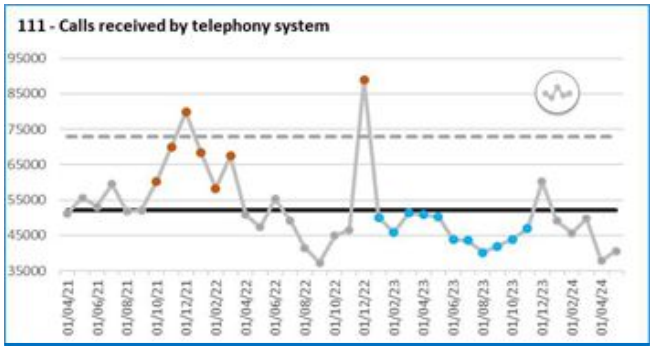
Urgent & Emergency Care (UEC)

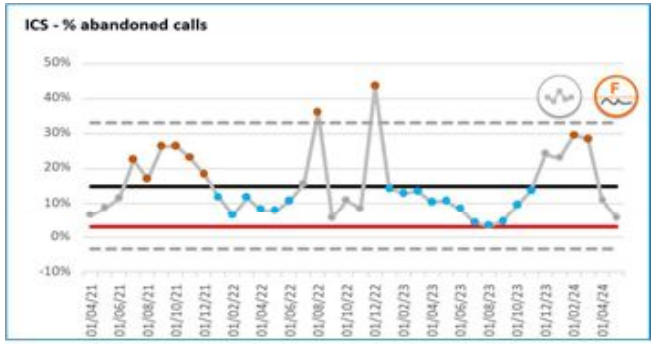
ICB Area	What the charts tell us	Issues	Actions

ICB	• 4-hour ED performance at a system level has been maintained at 73.5% in May. This is the third month in a row where the ED performance has been above / close to the upper process limit
	• Performance maintained despite high volumes of ED attendances across HWE – e.g. attendances in May-24 were 9% higher than in May-23
	• There remains variation at place level. In May:
	  ○ SWH 79.8%
	  ○ ENH 72.0%
	  ○ WE 67.0%
	• 999 call answering times remain low with an average of 11 seconds in May
	• The mean Category 2 ambulance response time was 44 mins in May. This is an improvement compared to Dec-23 (63 mins), but remains adrift of the national 30-minute standard, and is consistently longer than other systems in the region
	• Hours lost to handover >15mins reduced to 2,085 hours in May. This is the second-best performance since Apr-23. Note that regional reporting for this metric has changed from hours lost >30mins, to hours lost >15mins
	• Average patients per day with NCTR remaining in hospital has been relatively steady of the last few months. May's performance of 182 was better than the planning submission target of 193
		• Continued high demand and high acuity of patients. ED attendances across the system were 9% higher in May-24 than they were in May-23
		• Ambulance incidents were 8% higher in May-24 compared to May-23
		• However, 111 call volumes were 20% lower in May-24 compared to May-23
		• Mental Health (MH)presentations at ED remain high, coupled with a shortage of beds / assessment space. Analysis suggests that MH patients are more likely to wait >12 hours in ED
		• Hospital flow remains challenging with high occupancy rates, especially at PAH where average bed occupancy in May was 97%
		• Significant number of vacancies at EEAST
			System – June / July actions:
			• Demand management workshop taking place in July
			• ICB wide working groups being established
			
			East and North Herts – June / July actions:
			• Medical SDEC opening hours extending to 10pm
			• ED triage training drive
			• ED wait-to-be-seen-by-doctor workshops
			• Made Week – plan to involve all system partners available, focusing on the front door flow
			
			West Essex – June actions:
			• Monitor PTS activity and trial EEAST management of additional vehicles
			• PAH reviewing the patient contacts identified at front door audit
			• Funding approved and letter of intent sent for recruitment of Head of ToCH
			• Establish system review of Failed Discharges
			• Urgent review and update of SDEC DOS underway to improve visibility and use of direct access pathways for primary care to SDEC
			• Establish highlight reporting feed from UCPB and In and Out programme into LDB
			• New SystmOne unit for IUATC being sought to fully capture ECDS data
			• IUATC Phase 1 stocktake and review to be started
			
			South and West Herts – June actions
			• Establish what proportion of NCA could be treated in SWH under new proposal
			• Complete 'returns' audit
			• Assessment of system impact of A2S
			• Complete ToCH manager gap analysis
			• Stand up CHC dedicated resource if agreed for funding
			• Meeting with CHC and ENH rep to discuss aligning process

Hertfordshire and West Essex Integrated Care System

NHS 111

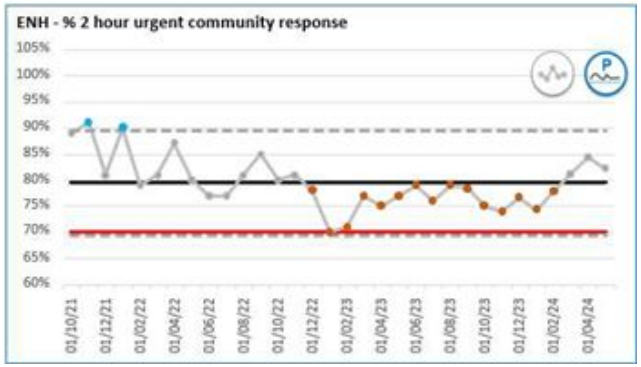


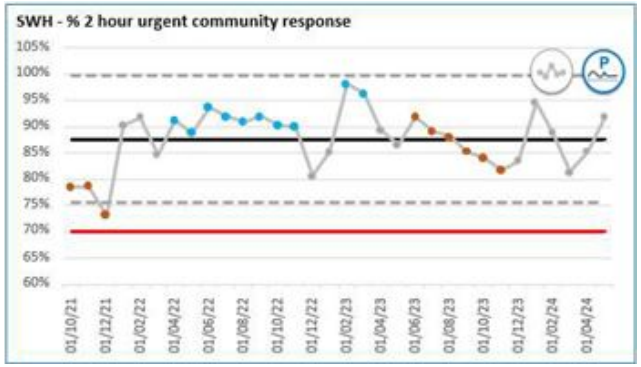


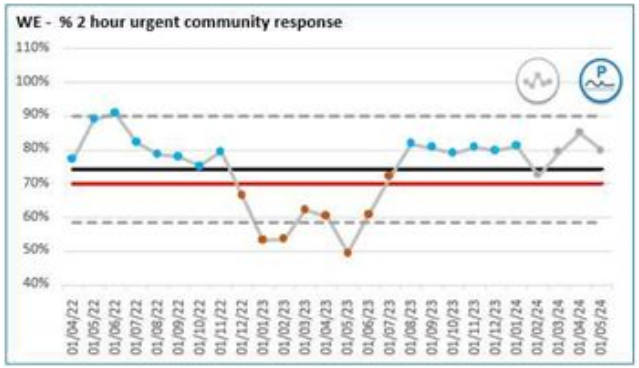
ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have been consistently trending below the historic mean for the last 15 months, other than a spike in December when more than 10,000 additional calls were received • Significant improvement in abandoned call rates from the yearly highs seen in February and March	• Overall rota fill impacted by hours lost by coaches supporting new starters • 25% of Health Advisors on probation requiring additional support with pathways and DOS queries • Recruitment continues to be challenging. Hopeful that the increase in the national living wage will increase applications over the next 3 months	• NHSE National Resilience agreed for part of 24/25 - dedicated workforce to pick up an agreed % of HUC calls. NHSE employed remote staff • Weekly Recruitment Assessment Centres and strategic plan in place for the next 3 months • Home working capacity increased by 6 – now 32 Health Advisors overall • Continued use of Non-Clinical Floorwalker (NCFW) to reduce the volume of calls passed to Clinical Advisors. Also, trial of remote NCFW during peak periods • Continued staff support with MH and wellbeing • Staff awards and year end appraisals completed to celebrate improvement in performance and to address overall concerns

Hertfordshire and West Essex Integrated Care System

UEC - Urgent 2 Hour Community Response (UCR)







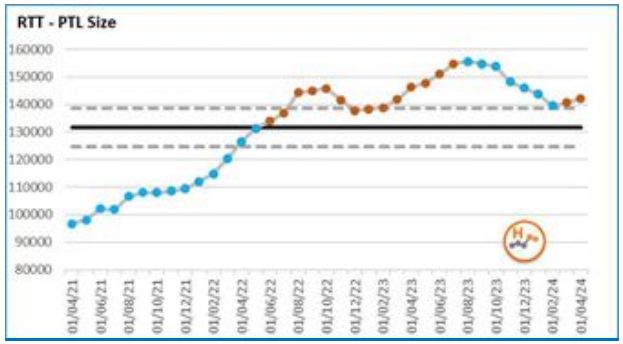
Activity	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
West Essex	257	324	330	394	399	453	344	301	313	317	412	397	412
East & North Herts	545	545	641	649	693	643	631	650	709	568	707	736	691
South & West Herts	222	196	232	159	175	180	158	157	213	212	209	237	217

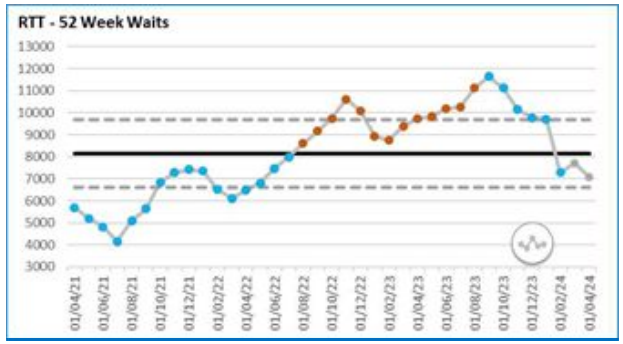
ICB Issues, escalation and next steps

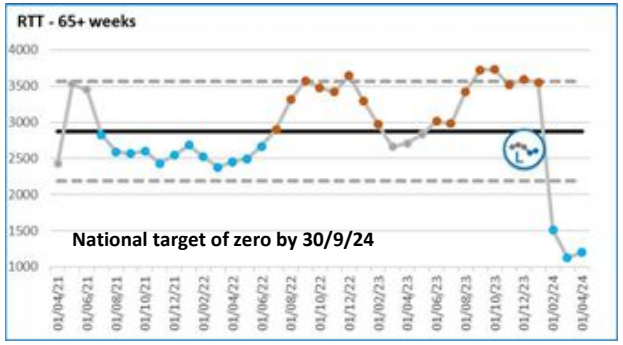
- The ICS and all 3 Places continue to achieve the 70% standard
- Work continues in SWH to ensure recording practices are correct and to improve referrals to the service, which is reflected in the improved response times. However, further work continues to ensure that all patients are included in reporting. Service also experienced annual leave / sickness within the team which impacted on overall numbers
- CLCH Business Team are developing bespoke training material and guidelines to be rolled out in line with national guidance

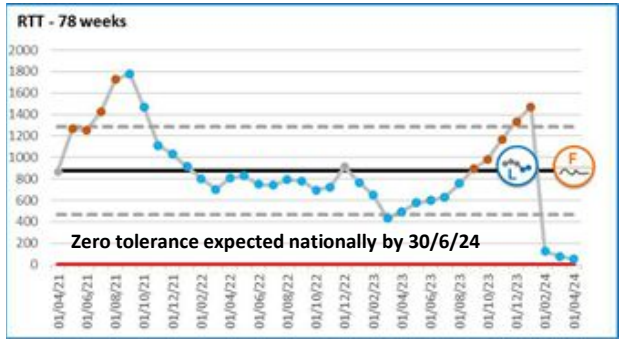
Hertfordshire and West Essex Integrated Care System

Planned Care – PTL Size and Long Waits









Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

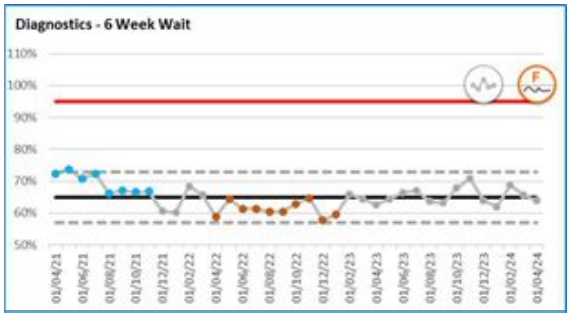
Planned Care – PTL Size and Long Waits

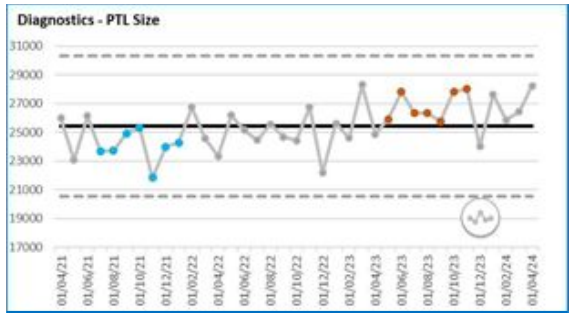
ICB Area	What the charts tell us	Issues	Actions

HWE	• Due to the change in national guidance, Community Paediatrics patients have been excluded from RTT reporting from February 2024. Waiting lists therefore show significant reductions from February 2024. These waits are included within the Community section of this report
	• The overall PTL size remains high. There was an uptick in the overall PTL in the last two months, following a seven-month period of reduction
	• April saw a decrease in 78ww long wait breaches
	• The number of patients waiting >65 weeks was beginning to reduce, but April saw the number of breaches increase by 71
	• Excluding Community Paediatrics, the number of patients waiting >52 weeks has shown a decreasing trend over the last seven months
		• Trauma and Orthopaedics (T&O) remains the main specialty under pressure, with ENT also a notable risk
		• Staffing remains a challenge, particularly in Anaesthetics
		• There were 83 x 78-week breaches in the system at the end of April
		  ○ 25 at ENHT
		  ○ 15 at PAH
		  ○ 43 in the independent sector (transferred from PAH)
		  ○ Zero at WHTH
		• The latest 78ww June forecast (as of 19/6) for the system is 23
		  ○ 8 at ENHT
		  ○ 0 at PAH
		  ○ 15 in the independent sector (transferred from PAH)
		  ○ Zero at WHTH
		• The 65ww risk cohort is on trajectory in Hertfordshire, but not meeting plan at PAH
		• 65ww actuals are behind planned trajectory overall for the system. The target is to reach zero by end of September
			• Princess Alexandra Hospital is in Tier 2 of the national oversight and support infrastructure for Elective (including Diagnostics) recovery. Fortnightly tiering meetings with the NHSE EOE regional team commenced on 9th May
			
			Management of waiting lists
			• System focus on reducing number of patients waiting >78 weeks and >65 weeks, with regional and national oversight
			• Demand, capacity & recovery plans are in place to monitor 78 & 65 weeks
			• Weekly KLOEs in place with NHSE to track 104/78/65-week positions
			• Fortnightly performance meetings with each of the three acute Trusts are in place with NHSE support
			• Validation and robust PTL management in place
			• The 65ww target to zero breaches has been extended to September 2024 with each of the three trusts submitting plans to meet that target
			
			Increasing capacity and improving productivity
			• Pro-active identification of pressured specialties with mutual aid sought via local, regional & national processes
			• Outpatients has a full programme of work to increase productivity including PIFU (patient initiated follow up), reducing follow ups including discharging where appropriate, and increasing take up of advice & guidance
			• Maximising use of ISP capacity and WLIs where possible
			• Theatre Utilisation Programmes in place including an ICB wide programme
			• Anaesthetist recruitment

Hertfordshire and West Essex Integrated Care System

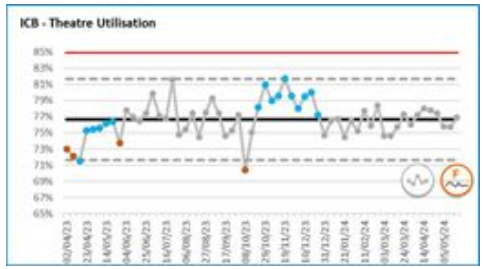
Planned Care – Diagnostics

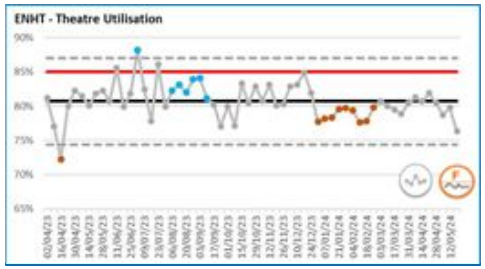


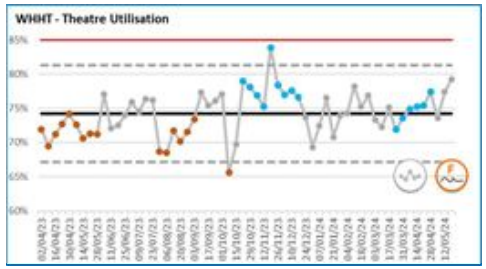


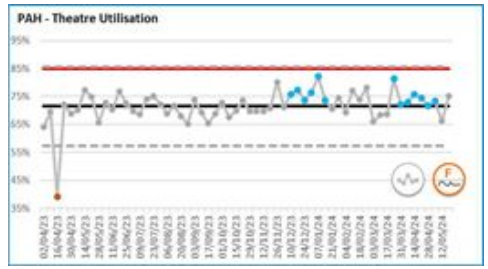
ICB Area	What the charts tell us	Issues	Actions
HWEICB	• 6-week wait performance across the ICS fell by 1.8% in April • Performance fell by 1.1% at PAH; 1.2% at ENHT; 2.3% at WHTH • The overall PTL continues to fluctuate within expected common cause variation limits	• Significant variation in Trust performance: o ENHT – 50.5% o WHTH – 86.0% o PAH – 70.7% **ENHT** • Imaging remains the biggest risk to delivery, most notably in NOUS which has seen a 22.5% drop in performance since last year • Imaging >6-week backlogs: 9,591 Total; MRI 2,921; CT 1,327; DEXA 1,521; NOUS 3,822 **PAH** • Non-Obstetric Ultrasound (NOUS), Echocardiography, Cystoscopy and Audiology are the key challenges at PAH • There has been notable improvement in Endoscopy performance compared to last year **WHTH** • NOUS presents the greatest risk to 6 week wait performance • There has been a substantial improvement in Echocardiography and DEXA investigations	• Imaging Network workforce lead and DEXA Practice Educator now in post **ENHT** • DEXA capacity will also increase from 24/06/24 following the appointment of two new members of staff and ability to fully operate two machines. Also investigating mutual aid • NOUS – specific issues in April due to sickness and annual leave have normalised. Two new Sonographers now in post and performance has improved through May / June to date • CT – main areas of pressure are for Cardiac and colon scans. latest local data shows that waits have significantly improved to just over 6 weeks • MRI – main issue is staffing. Waiting List Initiatives undertaken at QE2 throughout May / June to date, with outsourcing also in place to Pinehill. Further ISP outsourcing under discussion **PAH** • PAH CDC is live for MRI, X-Ray and US Extended Access through insourcing and existing facilities • Significant slippage with St Margarets CDC build. PAH, ICB, and NHSE regional / national teams working together to resolve • NOUS weekend insourcing in place • Paediatric Audiology funding request submitted to NHSE **WHTH** • DEXA position significantly improved, working with E&NHT to offer mutual aid • Working with Cardiology to share improvement across the ICS and network • Working on CDC and Endoscopy Unit mobilisation • CDC activity reprofiled until 30/6/24 (SACH) and 7/07/24 HHH

Planned Care – Theatre Utilisation / Productivity





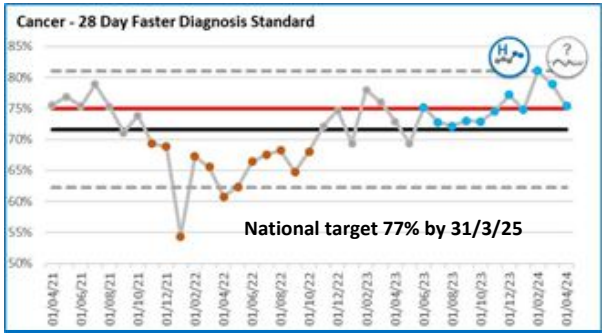


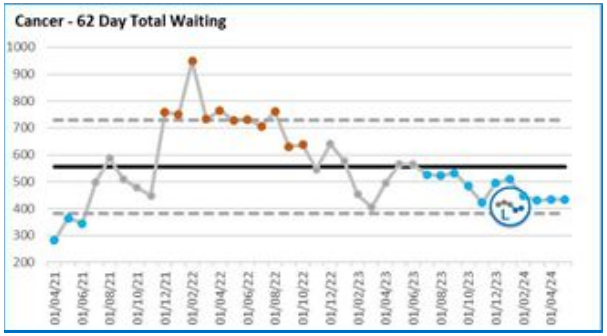


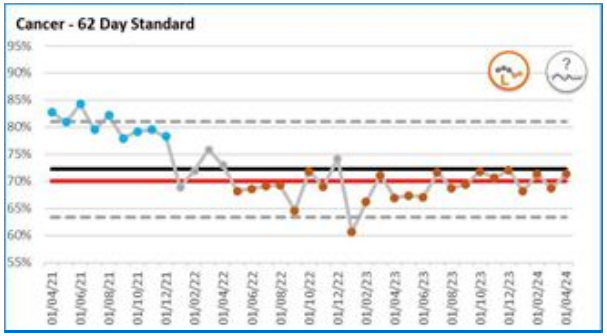
ICB Area	What the charts tell us	Issues	Actions
HWEICB	• ICB theatre utilisation is 77.2% against an 85% target • Comparable performance v. peers for all aspects, excluding number of cases, and average unplanned extensions **Other data** • Average cases per session for the ICB (2.3) is slightly higher than peer average (2.2), although PAH is below average (1.9) • Average early finishes are on a par with peer average (76), although much higher than the expected 15-30 minutes • BADS rate is 82.3% - slightly lower than the 85% target	• Overall productivity has improved in May, but particularly at PAH and WHTH • ENHT – although generally good performance, capped utilisation has yet to achieve the national target of 85% and dropped to 76.3% • PAH – consistently high conversion from day case to inpatient rate, alongside a low day case rate, with capped utilisation improving to reach 75% • WHTH - capped utilisation rates and average cases per session have maintained improvement over the last 6 months, with recent utilisation at 79.2%	• Improvement programmes are discussed at the Theatre Utilisation Network Group • A series of reviews have taken place with Trusts through the GIRFT theatre programme team and improvements are underway as can be seen through the improved numbers • Active theatre improvement programmes at each of the acute providers • There was a further GIRFT review in June 2024

Hertfordshire and West Essex Integrated Care System

Cancer





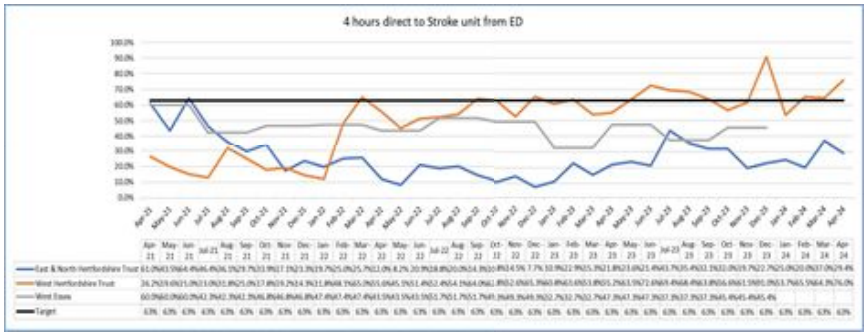


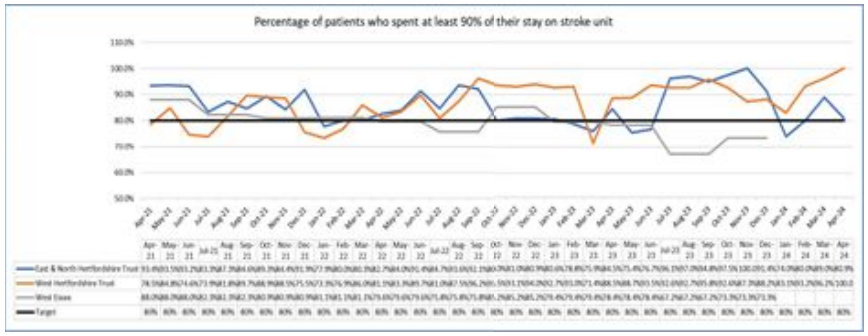
Hertfordshire and West Essex Integrated Care System

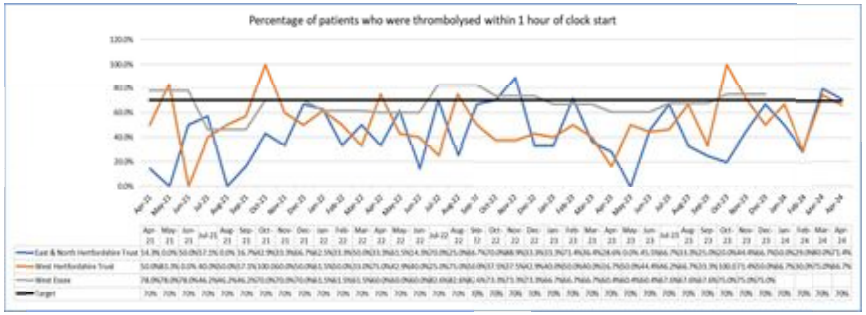
Cancer

What the charts tell us	Issues	Actions
• 28-day Faster Diagnosis Standard (FDS) performance has declined over the last two months but is still meeting the target at 75.4% • ENHT & WHTH surpassed the 75% FDS standard, although PAH has dropped to 70.7%. High confidence of returning to compliance in May • The 31-day 95% target was not met in April, reaching 93.7% collectively • Performance against the 62-day standard remains below the national target but is achieving the 70% standard expected in the 24/25 National Planning Guidance • There is significant 62-day variation between HWE Trusts of between 46% and 85% as detailed in the previous slide • The 62-day backlog has been static over the last three months	• There are no 62-day backlog targets for 24/25 • Oversight is focussed on achievement of the national FDS, 31 & 62-day standards **ENHT** • In May, the 31-day standard was not met (94.6% vs target of 96%). However, this was expected by the Trust due to issues with radiotherapy staffing • For the week ending 16 June, there were 171 patients on the cancer backlog (>62 days). This is a significant reduction over the past four weeks, but still above the Trust's fair share target • This is primarily due to late transfers (60 compared to an original plan of 25) • In addition, there have been patient choice delays on Urology pathways **WHTH** • 62-day backlog continues to decrease with 82 pathways over 62 days recorded at the end of May. This is lower that the NHSE objective to have a backlog of no more than 6.4% of the total PTL • Challenges with outpatient, surgical and diagnostic capacity particularly in Breast, Urology, Colorectal and Gynaecology • Delays in tertiary centre pathways (joint clinics, genomic sequencing, and histopathology) • Histopathology workforce issues and capacity **PAH** • Urology staffing, Cystoscopy capacity, and increase in prostate referrals • Urology is particularly challenged in both FDS and 62-day % performance • Skin / Oral and Maxillofacial Surgery (OMFS) capacity • Reliance on tertiary centres for multiple tumour sites	**ENHT** • Urology two-stop service by end of July and increased flexible cystoscopy capacity by end of June. Urology nurse has been trained to start TP biopsies by end of September 24 • Head and neck one-stop service increasing to 8 slots per week by end of June and all 2WW referrals to be triaged by end of June • Expecting to start endoscopic ultrasound fine needle assessment at Lister by end of June 24 to support with upper GI pathways **WHTH** • Cancer Improvement Programme Board now overseeing service level improvement plans and service developments • Benign diagnosis project (discharge from MDT via template letter) rolled out to all specialities • Review of Gynae and Urology USC referral forms continues. Process delayed due to the complexity of the changes required and the introduction of mandatory fields • Demand and capacity review ongoing to increase OPA and follow- up capacity • New one-stop pathway for Urology in development. Funding now approved from Cancer Alliance to support this • Ongoing improvement work in Radiology and workforce recruitment in histology to address the delay in diagnostic and histopathology turnaround times • Implementation of Cancer Alliance funded post to improve Gynae and Urology pathways and start work up for introduction of Targeted Lung Health Checks **PAH** • Princess Alexandra Hospital are in Tier 2 of the national oversight and support infrastructure for Cancer recovery. Fortnightly tiering meetings with the NHSE EOE regional team • Work is progressing with all services to align their improvement plans to support the 62-day recovery, with regular reviews at PTL level • Funding approved for Vanguard Urology Theatre • Rivers ISP providing additional Cystoscopy support • Funding approved for Breast Surgery outsourcing • Implementation of robotic surgery in Gynaecology • Joint Skin / Oral and Maxillofacial Surgery (OMFS) pathway improvement programme • Focussed work to drive more timely transfers to tertiary providers

Stroke







ICB Issues and actions

West Essex

Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for WE patients, reported quarterly via SSNAP. The Trust's overall 23/24 Q3 SSNAP performance rating improved from D to C.

- Continued high demand for bed occupancy, with larger complex strokes requiring longer treatment plans
- TIA – Improvement following escalation of pathway delay issues. 26 days response reduced to 8 days but has since increased to 14 days. Recently received 50 referrals in one week, which is challenging to manage
- EPUT staffing - 2 x WTE have left the service and 1 requesting to be re-deployed. Meeting due to discuss plans to cover
- Catalyst Project – Vocational rehab pilot is live, concerns for continuation of the service due to funding. Expected to cease October. Business case being worked through
- SQUIRE ICSS – Paper to May LTC board. Support for ICSS is confirmed and discussed priorities for the year (ICB and changes to HCP). NHSE target of 75% of people who have a stroke will have access to the comprehensive care by 2027/28
- WE comms campaign – Funding required to notify the population that Princess Alexandra Hospital (PAH) does not have a HASU / ASU service, and that this will delay care if stroke patients present at PAH

ENH

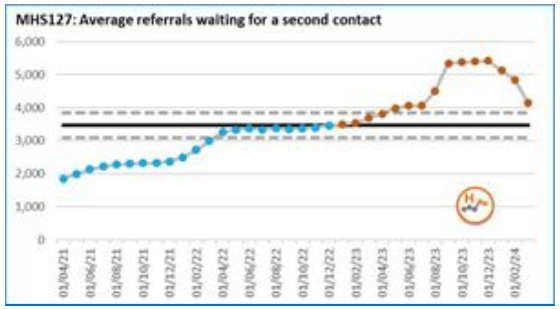
- The ENHT SSNAP performance rating for Q3 23/24 remained as a B rating. There is a risk to maintaining a B rating going forward due to therapies establishment and alignment with the new clinical guidelines. Q4 23/24 rating is due in June
- The % of patients reaching a stroke unit within 4 hours remains significantly below the target of 63%. The most significant delays tend to be for out-of-hours patients
- The % of patients spending >90% of their stay on a stroke unit remained above the 80% target in April. Four ring-fenced stroke beds remain in place
- The % of patients thrombolysed within 1 hour of arrival met the target of 70% target for the second month in a row.
- Thrombolysis in Acute Stroke Collaborative (TASC) project underway to support improvement in Thrombolysis performance rate to 14%. Process mapping session conducted with stakeholder group to support review of ED pathway
- High number of late presentations by patients

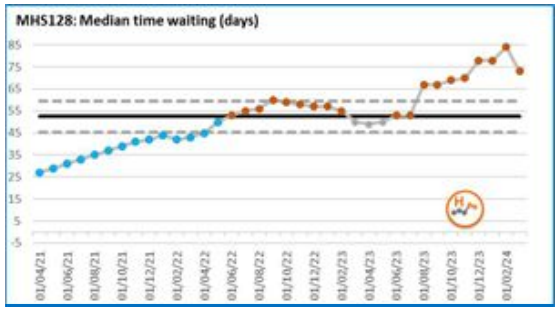
S&W Herts

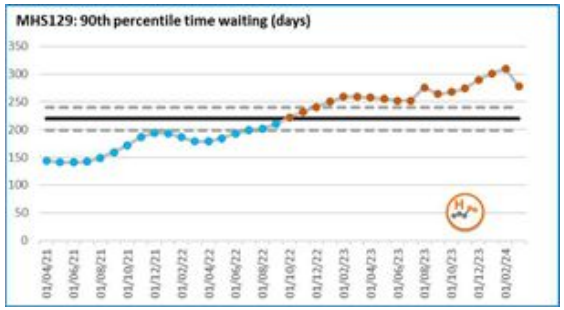
- 4 hours direct to stroke unit from ED: Improved from 64% to 76% in April but remains below standard. Performance is however significantly above the national average of 46% and higher than neighbouring providers. Wider system pressures such as late referrals, bed capacity constraints and patients admitted to another ward before the Stroke unit due to an unclear diagnosis are all pressures which delay provision. Ring-fenced beds on HASU and a side room for thrombolysis remain in place however are not consistent and there have been increasing numbers of medical outliers on HASU/ASU. Patients receive stroke consultant input for their care while waiting for admission to the stroke unit
- 100% of Stroke patients are spending 90% of their time on stroke unit, the national target is 90%.
- The % thrombolysed within 1 hour of clock start has improved to 67% in April from 30% in February
- WHTHT / EOE Ambulance Video Triage pilot (started 12/23). It is the first nurse led site in the region and has resulted in rapid door to CT times (2-5 mins best regionally) and a reduction in door to needle and door to HASU times
- WHTHT are currently achieving a 10% thrombectomy conversion rate which is ahead of the NHS England target and even greater than the conversion at the tertiary referral centre

Mental Health – Community Waits

Adults and Older Adults – time still waiting for second contact





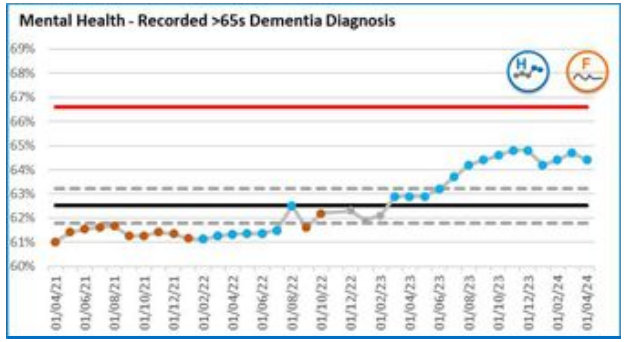


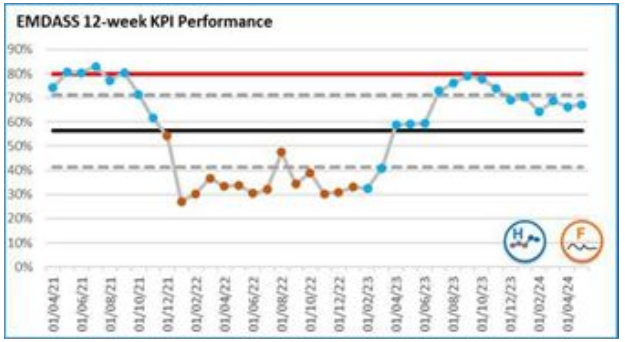
ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times for a 2nd appointment improved to 73 days
	• 8 days benchmarks well against the national average of 118 days, however there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 60 and 80 days:
	  • East & North Herts 60 days
	  • South & West Herts 80 days
	  • West Essex 66 days
	• 90th percentile waits improved to 278 days
	• 278 days benchmarks well against the national average of 727 days, however again there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 253 & 408 days:
	  • East & North Herts 253 days
	  • South & West Herts 285 days
	  • West Essex 408 days
		• Datasets are not currently complete, and work is ongoing with ICBs and NHSE to finalise collections and reporting. Issue is related to data validation as here is variation from local data sets to nationally published data
		• In Hertfordshire the data flow from Primary care and VCSFE providers to MHSDS or the GP equivalent has not been worked through. This relates to the transformed PCN areas that have ARRS workers and Enhanced Primary Care. The data collection from these new services is recorded locally on System one or EMIS but this is not a shared system with the MH Trust
		• West Essex VSCE data flow is via a shared system with MH Trust
			• NHSE working with all ICBs to finalise the data and understand variations
			• In Hertfordshire, a CQI approach is being taken to introducing the new waiting times. Current workstreams are developing internal reporting in the absence of NHSE SQL scripts being made available and ensuring all SNOMED codes are mapped correctly. Data is being analysed to understand the reasons for the longest waits
			• Hertfordshire is also working with NHSE and Voluntary Community, Faith and Social Enterprise (VCFSE) providers to look at the data flow from them to MHSDS, to include as part of the second contact information
			• Additional CQI process for Older Peoples services to ensure that referrals and treatment are recorded as for all adults

Hertfordshire and West Essex Integrated Care System

Mental Health – Dementia Diagnosis in Primary Care & Herts EMDASS Service



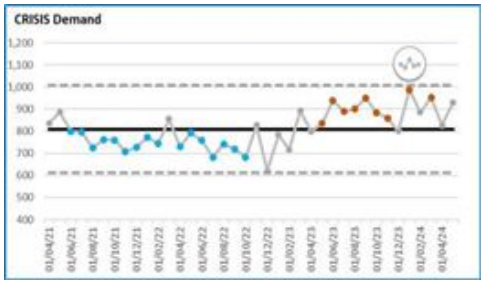


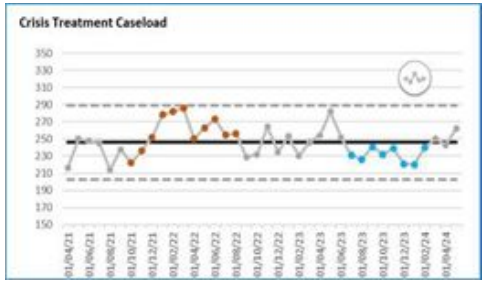
ICB Area	What the charts tell us	Issues	Actions

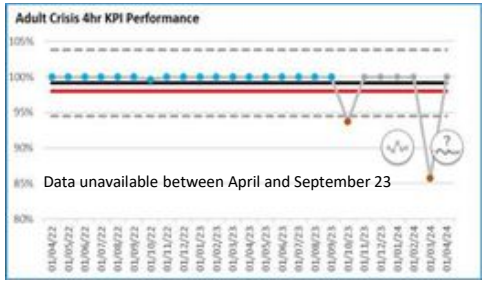
Dementia Diagnosis in Primary Care
 	
Herts EMDASS Service
	• May 2024 data (recently published and not shown on charts):
	  ○ ICB – 64.7% (an increase from February of 0.3%. However, this remains below the national target of 66.7%
	  ○ West Essex continue to achieve the standard at 71.7%, a further increase of 0.5%
	  ○ East and North Herts achieved 62.9% (increase of 0.1%)
	  ○ South & West Herts achieved 62.6% (increase 0f 0.5%)
	
	• EMDASS service (in Hertfordshire only) – the 80% seen within 12 weeks target is not currently being met.
		• Estimated prevalence rate of people with dementia rises month on month. Constant growth and increasing demand, particularly in Hertfordshire
		• In Hertfordshire there is a significant waiting list for dementia diagnosis
			• Diagnosis is a key focus of the Herts dementia strategy, with a subgroup progressing actions to improve diagnosis
			• Twice monthly meetings continue to monitor progress. Weekly performance report is produced
			• EMDASS pathway has been revised. A Primary Care Nurse has been brought in house to increase capacity, as well as changes to the screening process
			• Work to revise the EMDASS recovery trajectory is underway to reflect recent changes in activity and staffing levels, as well as the changes to the screening process. New plan to be in place by end of Q2

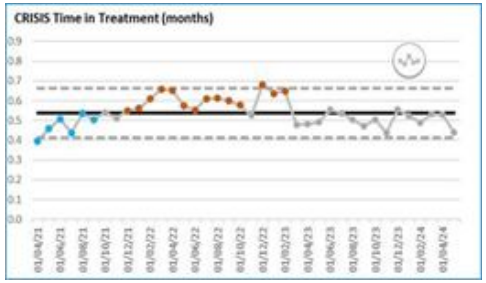
Hertfordshire and West Essex Integrated Care System

Mental Health – Adult Crisis Services









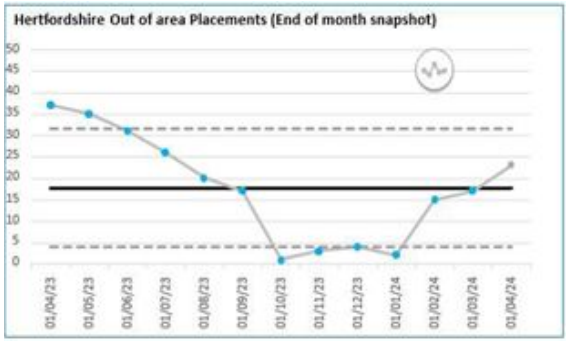
ICB Area	What the charts tell us	Issues	Actions
• Crisis Services – Adults and Older Adults • West Essex data is not included in the caseload chart as the service does not hold a caseload	• Crisis demand remains high. Referral have been above the historic mean since January 24 • Caseload is variable but within expected common cause variation limits • Hertfordshire has re-modelled the way they record waiting times in line with the latest UEC guidance • 100% of people requiring a very urgent assessment were seen within 4 hours in April and May • The average time in treatment remains stable	• There is increased demand into the crisis service through supporting acutes with early discharges to manage bed pressures and flow issues • Recruitment to vacancies continues to be a significant issue across the ICS	• Ongoing focus on recruitment to vacancies and retention of existing staff • Review of community mental health caseloads to improve flow • Changes to the Care Programme Approach (CPA) in HWE: Design and implement a process for transformation of individualised approaches to care, as part of the move away from CPA towards personalised care approaches across HWE, specifically around advanced crisis planning and accessing crisis pathway • Continue to promote 24/7 crisis lines (through NHS 111 for public and dedicated professionals' lines) • Continue to make use of crisis alternatives including Mental Health Urgent Care Centre and voluntary sector provision – Night light, crisis beds, café, SHOUT text line • Wider communications of crisis directory shared with system partners • ICB ongoing programme of engagement with ambulance and urgent care partners • Continue to identify delayed transfers of care on crisis caseload • Ongoing monitoring and MDT discussion to identify treatment pathway and discharge plans

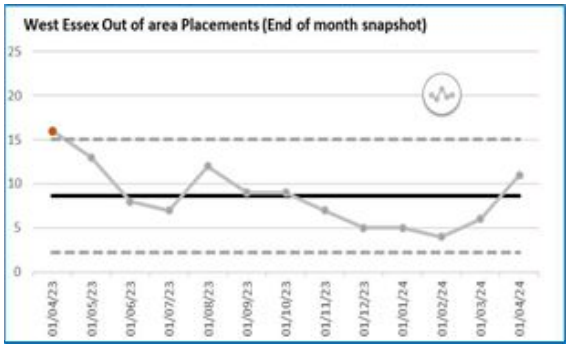
Hertfordshire and West Essex Integrated Care System

Mental Health – Out of Area Placements (OAPs)

Number of active inappropriate adult acute OAPs at month end

- The basis for measurement of OAPs has changed for 24/25
- Previous reporting was based on the number of out of area bed days in the month
- From April 24, reporting is based on the number of active OAPs at month end
- Historical data for Hertfordshire is not currently available
- A Hertfordshire SPC chart will be included in this report once there is sufficient data

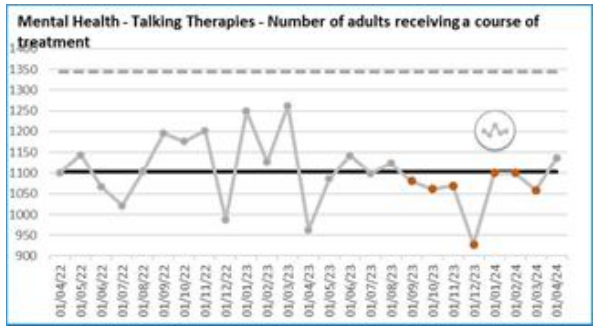




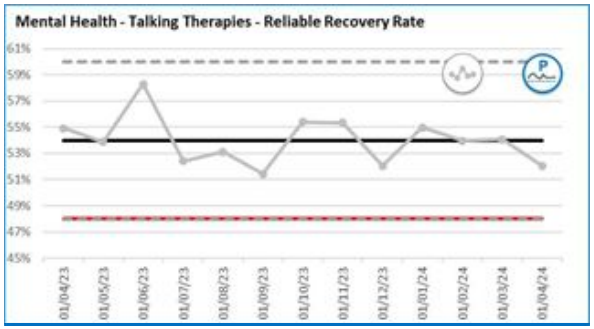
ICB Area	What the charts tell us	Issues	Actions
West Essex	• The number of OAPs increased in March in April • However indicative data for May shows one patient in an OOA bed at month end, and a total of 16 bed days	• A national shortage of MH beds and increased pressures on service use of inappropriate OOA beds is likely to continue • Essex risk share of inpatient beds, with increased usage of beds at place by Essex wide footprint	• Review of Essex bed stock and Essex wide risk share contract continues • Review of West Essex Community Rehab has seen an increase in discharges at place to support repatriation • Weekly system Delayed Transfer of Care (DTOC) calls and ongoing focus on 'time to care and purposeful admissions' • OOAP Elimination & Sustainability Impact System Group (Essex wide) to monitor the impact of the NHSE OOAP Action Plan • Continued engagement with national Getting It Right First Time (GIRFT) programme to identify areas of improvement • Full review of the bed occupancy and risk share agreement across Essex, including OOA, rehab and repatriation.
Herts	• Following a sustained period of improvement, Out of Area Bed Days rose in February due to a combination of increased demand and delayed transfers • March saw a further increase due to the closure of Aston ward (20 beds) at Lister site from March due to Water Safety Incident	• Hertfordshire low number of beds per population – now supported by provision of additional block beds • A national shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Challenges finding suitable placements for service users with complex needs who are clinically ready for discharge • Inpatient and Community recruitment • The closure of Aston Ward has impacted the pressure on demands and reduced the capacity	• Introducing further alternatives to admission – Crisis House – in early stages of planning • Wider Executive led work at system level to support placement of longer term DTOCs • Bed management system went live in Hertfordshire w/c 17 June 2024, supported by new arrangements in place to monitor demand and capacity • The decant from Aston Ward is ongoing. Access to the ward is expected from early July. Ongoing joint working with ENHT to resolve the estates issue. OAP trajectory being monitored regularly and adjusted accordingly • The National Director for MH issued a Letter in May 24 regarding reducing mental health OAPs. The communication included initial proposals for national and regional action, setting actions for providers to reduce these placements. Much of the ask is already in place in HWE

Talking Therapies

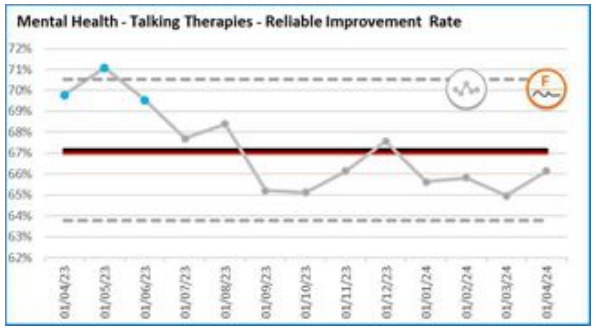
Number of people who are discharged having completed a course of treatment
Number of patients that achieved reliable recovery
Number of patients that achieved reliable improvement



Adults receiving treatment	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Hertfordshire	841	951	969	933	976	921	901	923	778	925	930	875	920
WECCG	122	135	173	166	147	160	160	146	150	175	170	184	216
ICS	963	1086	1142	1099	1123	1081	1061	1069	928	1100	1100	1059	1,136



Reliable recovery rate	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Hertfordshire - Actual	54.6%	53.9%	56.4%	52.4%	53.1%	51.3%	55.8%	55.8%	52.8%	55.2%	53.9%	54.0%	50.76%
West Essex - Actual	68.8%	52.0%	55.9%	53.1%	52.4%	57.1%	44.0%	42.9%	33.3%	46.0%	56.0%	57.1%	57.00%
ICS Actual	54.9%	53.9%	56.3%	52.4%	53.1%	51.4%	55.4%	55.1%	52.0%	55.0%	54.0%	54.1%	52.06%



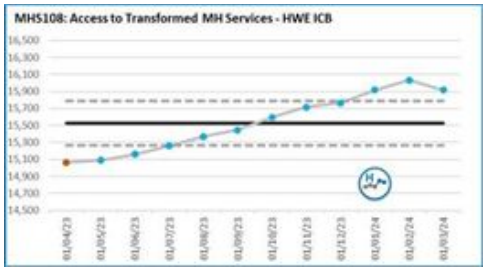
Reliable improvement rate	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Hertfordshire - Actual	69.6%	70.9%	68.9%	67.1%	67.7%	65.1%	64.3%	66.3%	68.3%	65.7%	65.3%	65.7%	64.71%
West Essex - Actual	71.31%	72.59%	72.83%	73.33%	73.38%	65.63%	70.00%	65.07%	64.00%	65.14%	68.82%	71.20%	72.22%
ICS - Actual	69.78%	71.09%	69.53%	67.75%	68.40%	65.22%	65.13%	66.14%	67.56%	65.64%	65.82%	64.97%	66.14%

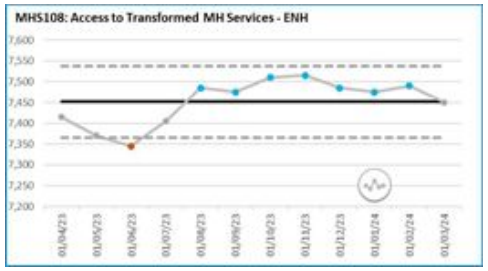
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• The number of people completing a course of treatment is variable but within expected common cause variation limits • The System and Places are consistently achieving the reliable recovery 48% standard • West Essex is achieving the reliable improvement 67% standard. Hertfordshire performance is slightly lower at 64.7%	• Understanding and interpreting the new national targets to ensure consistency of data collection and quality across the system. • Focus on addressing attrition and drop-out rates are a key challenge following the change in counting for 24/25. Measurement now relates to completion of a course, with at least two appointments. Previously the focus was on access / first appointments • Reliable improvement rate for those completing a course of treatment in Hertfordshire requires slight improvement. However, indicative data for May shows improvement to 66.8%	• Partnership working across the system with NHSE to provide support clarity and data validation • Introduction of a ICB wide NHS Talking Therapy group specifically looking at new metrics that will support HWE performance • Procurement of counselling providers in Hertfordshire by January 25, leading to an improvement of pathways and ensuring right modality in place for service user

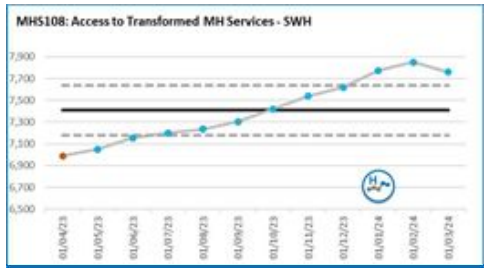
Hertfordshire and West Essex Integrated Care System

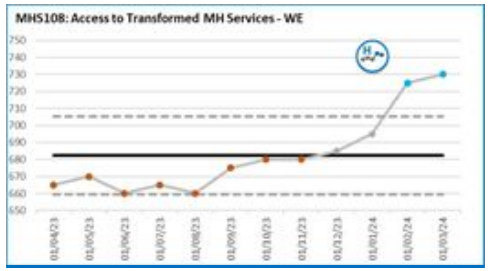
Transformed Community MH Pathways

Number of people who receive two or more contacts from transformed NHS or NHS commissioned community mental health services (in transformed PCNs) for adults and older adults with severe mental illnesses







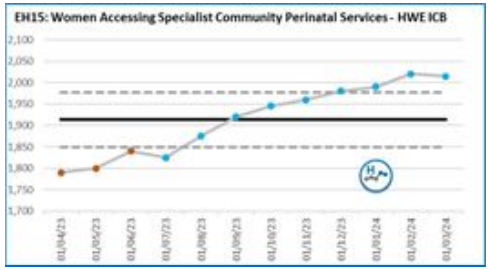


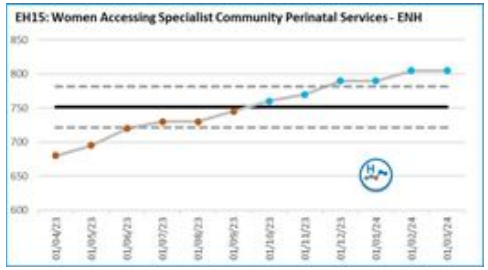
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• The number people receiving two or more contacts from transformed community MH services is on an improving trend across the system, and in each Place	• Potential inconsistencies in data between systems • In Hertfordshire, the current contacts do not include older adults • Whereas in West Essex, Community MH Pathways are 18+ (and older adults are part of the integrated community offer)	• At the Hertfordshire and West Essex Primary Care and Community Assurance Group, commissioners and providers are joint working to understand data recording and quality for this metric with NHSE regional colleagues • For Hertfordshire, this includes working with VCSFE providers to incorporate their data into the two contacts metric for the future pathways. This is an ongoing part of the local data systems development and management, along with recording and sharing of records as the EPR systems differ

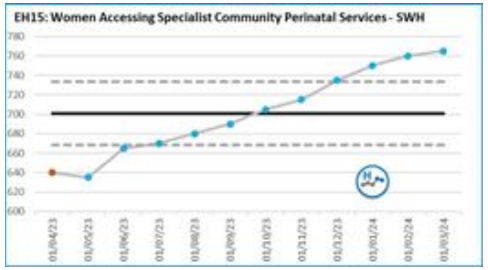
Hertfordshire and West Essex Integrated Care System

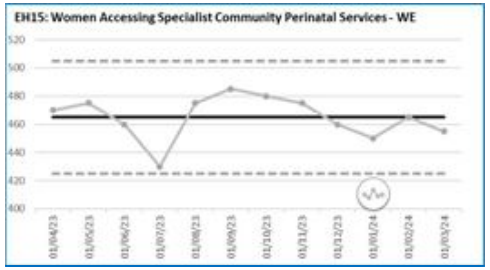
Community Perinatal Mental Health

Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months







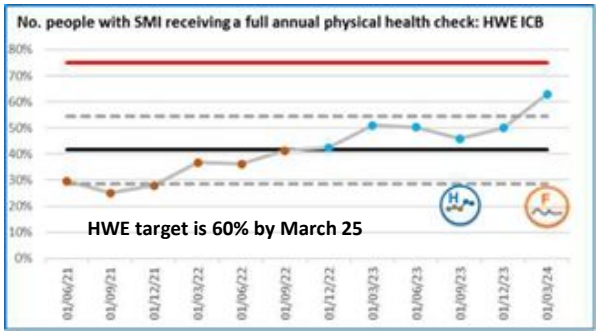


ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• The number of women accessing Specialist Community Perinatal MH Services is on an increasing trend across the system • West Essex access is within expected common cause variation limits • Access in Hertfordshire is continuing to increase	• No issues of concern	• Hertfordshire - Perinatal performance and outcome measures are above target. Outcome measures are the top of performance at region • West Essex Perinatal offer is part of the Pan-Essex service. Ongoing monitoring of activity and performance

Hertfordshire and West Essex Integrated Care System

Severe Mental Illness (SMI) Health Checks

Number of people with severe mental illness (SMI) receiving a full annual physical health check – percentage achievement in the 12 months to the end of the period

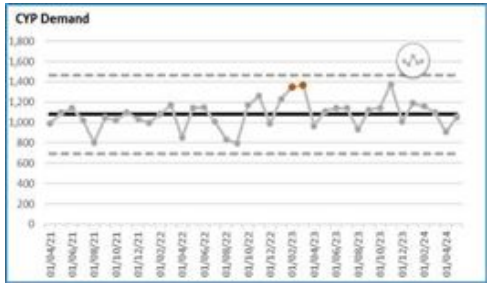


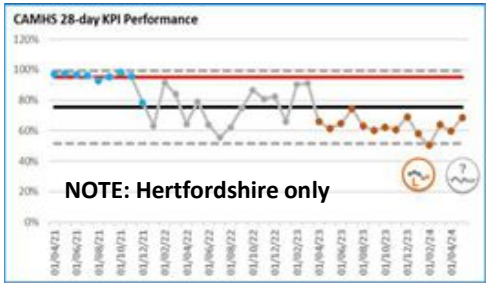
	2021/22				2022/23				2023/24			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
East and North Herts Place	19.6%	11.9%	15.1%	25.8%	24.0%	36.3%	40.4%	45.9%	49.7%	47.7%	49.4%	60.5%
South West Herts Place	39.4%	38.2%	39.5%	47.5%	44.6%	46.4%	43.6%	55.9%	51.0%	44.8%	52.2%	66.9%
West Essex Place	28.9%	24.5%	30.6%	36.5%	38.5%	38.9%	44.0%	50.4%	49.4%	44.8%	46.4%	59.2%
NHS Herts & West Essex ICB	**29.6%**	**25.1%**	**27.9%**	**36.7%**	**36.1%**	**41.3%**	**42.4%**	**51.0%**	**50.2%**	**45.9%**	**50.0%**	**63.0%**

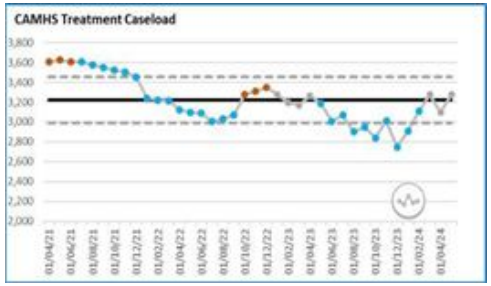
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Notable improvement in Quarter 4. 60% end of year HWE achieved, but not achieving the 75% national standard	• Requirement to develop and sustain services that meet the physical health care needs for people with a severe mental illness diagnosis, including physical health checks and onward service provision.	• Implementation of SMI PH working group • MH leads to understand population health needs across the ICB • Review local treatment pathways and accompanying protocols and guidance • Identify any gaps in provision • Monitor performance against the physical health check performance targets • Agree service developments and joint working with primary care • Monitor quality and improvement • Support the improvement of interoperability and rovider electronic care records and information systems to enable monitoring of performance against equity of access to care • Working with Regional MH Team support • Feedback to the NHS England regional and national teams • Agree actions in line with national audits
Herts	• Notable improvement in Quarter 4. 60% end of year HWE achieved, but not achieving the 75% national standard		

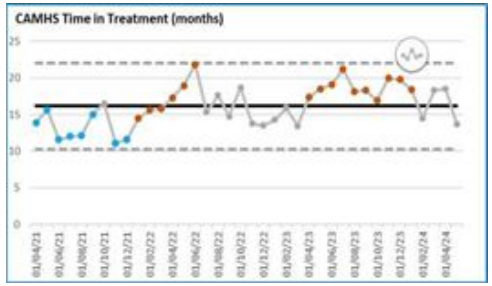
Hertfordshire and West Essex Integrated Care System

Mental Health – CAMHS Services







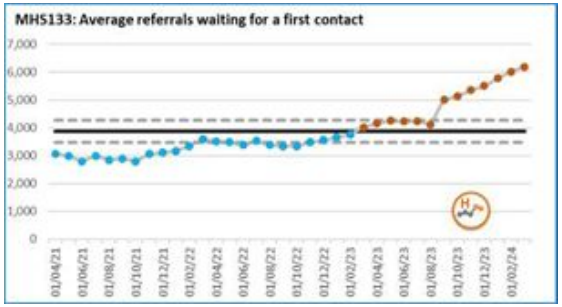


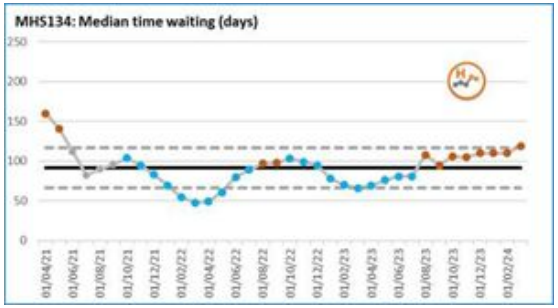
ICB Area	What the charts tell us	Issues	Actions
CAMHS Herts and West Essex. The CAMHS 28-day KPI Performance target relates to Herts only	**West Essex** • West Essex does not have a formal KPI for 28 days, but this is monitored at monthly provider meetings • Demand at SPA remained high during Q4 23/24 • CAMHS caseload remains on an improving trend through 23/24 **Herts** • Demand into the service remains stable and within expected seasonal variation patterns • Caseloads have seen a steady increase since December, and not above expectations • 28 days from referral to initial assessment remains below standard at 41.6% - recovery action plan in place to address it • Time in treatment is variable, close to the historic mean	• Active issue regarding recruitment to vacancies across Herts and West Essex impacting on capacity and performance • Acquiring highly skilled CAMHS clinicians remains difficult. Non-health support roles being used to bolster teams	• Hertfordshire Community Quadrant Teams have action plans is in place with weekly recovery meetings focusing on recruitment & review of resources across all teams • In Hertfordshire, the primary issues are in the West and East Teams. Both teams are being supported by the wider leadership team • Ongoing focus on recruitment and retention in both HPFT & NELFT, including recruitment incentives in NELFT, and more recently exploring international recruitment • Successful recruitment to senior clinical posts in West Essex CAMHS • WE - New SPA team manager recruited and rolling advertisement for ED clinical lead • SPA Triage Tool improved to meet “5 day pass on to teams” target in Hertfordshire • The Hertfordshire service had forecast recovery of the the 28-day KPI by end of Q4. However continuing vacancies have meant that the recovery prediction has moved to Q2/3 24/25. A revised recovery trajectory is in place

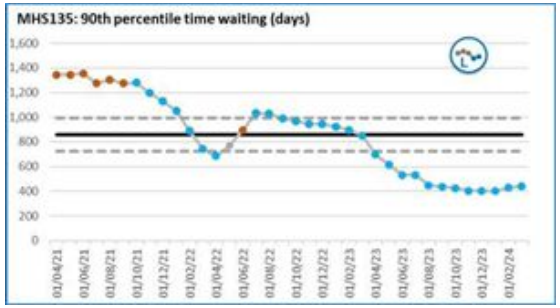
Hertfordshire and West Essex Integrated Care System

Mental Health – Community Waits

Children – time still waiting for a first contact





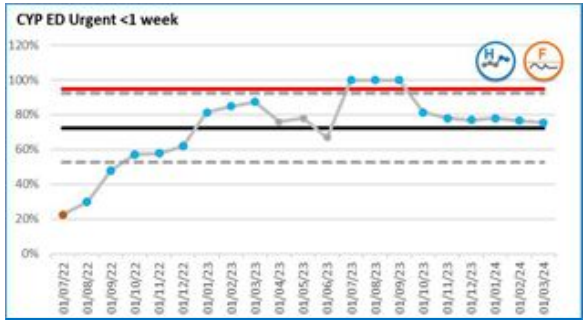


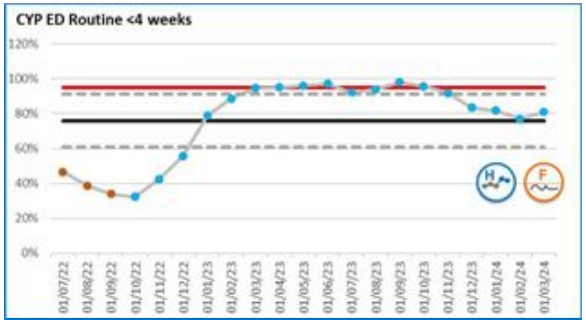
ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times increased to 119 days and have been trending above the historic mean since August 23
	• 119 days benchmarks well against the national average of 187 days
	• Within the system there is variation of between 35 and 144 days:
	  • East & North Herts 35 days
	  • South & West Herts 144 days
	  • West Essex 69 days
	• 90th percentile waiting times are broadly unchanged at 442 days, and on a long-term trend of improvement
	• 422 days benchmarks well against the national average of 735 days
	• Within the system there is variation of between 298 & 459 days:
	  • East & North Herts 298 days
	  • South & West Herts 459 days
	  • West Essex 341 days
		• South & West Hertfordshire data is reflective of the historically longer waiting times in the patch
		• The biggest impact on the Hertfordshire waiting list (long waiters) is Autism & ADHD backlogs / waiting lists for diagnostic pathways
		• The 18+ week waiters within West Essex (NELFT) are predominately within the Getting Help element of the Thrive model. As @ end of April there were 3 x 18+ week waiters in the service
			• In Hertfordshire a CQI project has been initiated to take forward the new waiting times and ensure that they are reflected in the design and processes of services. Ongoing work to produce internal reporting, finalise SNOMED codes and better understand the reasons for some of the longer waits
			• GIRFT project looking at CYPMHS waiting times (up to Dec 2023) excluding ASD/ADHD
			• Local provider dashboards in place assessment & treatment activity, caseloads and waiting times. Recovery action plans in place where applicable and closely monitored by commissioning leads
			• Commissioners, HPFT and now a HCT representative are linked into EOE waiting times standards group. HPFT submitted their readiness slide to NHSE. HCT is working on theirs
			• In NELFT all waiters over 18 weeks have a clinical harm review in place and teams are working towards seeing all longest waiters

Hertfordshire and West Essex Integrated Care System

Mental Health – CYP Eating Disorders

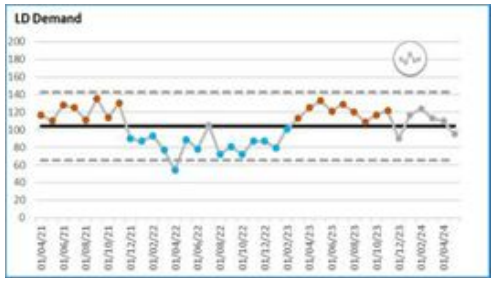


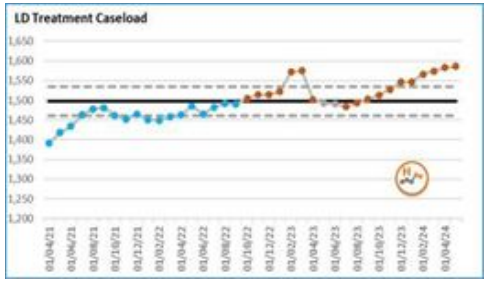


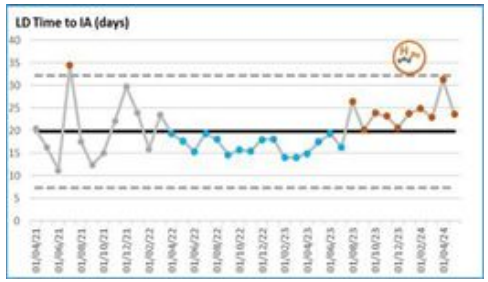
Description	Target		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
CYP ED Urgent <1 week	95%	Herts	12%	20%	43%	53%	54%	58%	80%	83%	86%	76%	78%	67%	100%	100%	100%	80%	77%	76%	77%	75%	73%
		West Essex	92%	92%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CYP ED Routine <4 weeks	95%	Herts	37%	30%	26%	25%	36%	49%	75%	86%	94%	95%	96%	97%	92%	94%	98%	96%	92%	83%	81%	76%	80%
		West Essex	97%	97%	97%	96%	96%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	90%	90%	100%	100%	100%

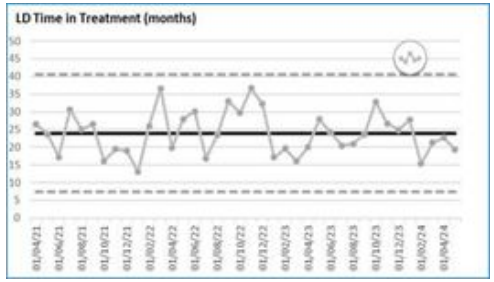
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Urgent 1 week standard consistently achieved in West Essex • Performance dropped to 90% in Q3 for routine referrals, but has returned to 100% compliance	• Due to low volume, much of the data flowed to MHSDS is supressed • Essex SPA and Eating Disorders (ED) services are undergoing changes to site location and management. Currently no clinical lead in CYPED team posing additional area of risk	• Commissioners working with NELFT and NHSE to secure more current data, as well as to flow data through the MHMDS • Essex SPA re-located, new manager, new staff, triage waiting times back on track. • NELFT Kent ED team providing support and supervision to Essex ED service • Rolling advertisement for Essex ED clinical lead
Herts	• The Eating Disorders Team had been performing consistently until a spike in referrals in Oct-Dec23, coupled with an increase in vacancies • There are small numbers of urgent referrals, so each breach significantly impacts % achievement • Local reporting for April shows 100% for urgent & 80% for routine – only 1 CYP breach to patient choice	• The increase in referrals Oct-Dec is seasonal and mirrors previous years • 23/24 referrals are broadly similar to 22/23 • Review of the ED service is still be finalised. Acuity and complexity tool shows CYP remain in service for a considerable amount of time and require input from a number of clinical resources. We have no baseline for acuity & complexity so cannot demonstrate the increase, but clinicians are flagging this as an issue	• The following actions are in place to improve access to the service: o Caseload and RAG rating review and equitable redistribution of caseload across workforce o Agreement for First Steps ED Service to take some of the stabilised children and young people from our caseload o Additional 2 x Band 5 nurses for 1 day per week o Agreement for bank and agency to support with extra demand

Mental Health – Learning Disabilities Services









ICB Area	What the charts tell us	Issues	Actions
• Learning Disabilities Service • LD services are 18+ years and includes those with a learning disability who may have a diagnosis of Autism	• Overall referrals remain stable • Caseload continues to rise and has been consistently above the historic mean for the last 18 months • Time in treatment is subject to common cause variation • Within the services there is a wide range of treatment types with timeframes ranging from a few days, to many years	• Lack of social care placement and housing in West Essex impacts on in-patient Length of Stay • Physical Health needs has a very clear area of focus for all MHLDA	• Service user and carer engagement and involvement programme continues aimed at improving care planning, service delivery and outcomes for LD service users across Hertfordshire and Essex • Work commenced on further development of the Adults Dynamic Support Register to increase support and access to services • Continuing work with commissioners to ensure that GPs are aware of and know how to refer directly into LD services • Inpatient flow is better, with some discharges in recent months and a reduction in length of stay. Some data on LOS to be shared in next update • Opportunities for capturing feedback - ongoing partnership working • Action plan approved for the new LeDeR three-year Essex plan • Overall LeDeR in Essex is performing better than both regional and national averages • In Herts 2023/24 - 98% of eligible LeDeR reviews were completed. 38% of reviews completed within 6 months and 27% of completed reviews that were focused

Hertfordshire and West Essex Integrated Care System

Mental Health – Learning Disability (LD) Health Checks

LD Health Checks March 2024	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to March 2023
NHS Hertfordshire and West Essex ICB	**7,507**	**6,136**	**338**	**1,033**	**81.7%**	**79.1%**
East & North Hertfordshire	3,092	2,382	154	556	**77.0%**	**75.2%**
South & West Hertfordshire	3,290	2,846	115	329	**86.5%**	**82.7%**
West Essex	1,125	908	69	148	**80.7%**	**79.1%**

*** 75% Year End Target**

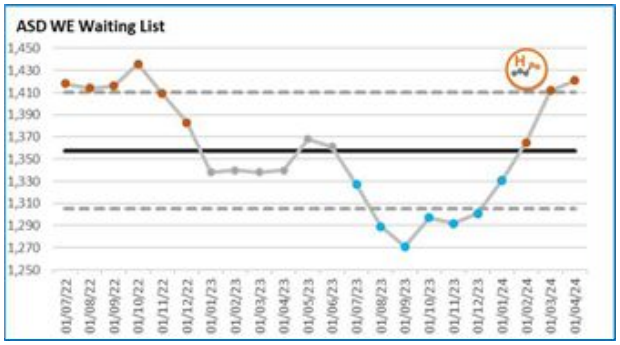
ICB Area	What the charts tell us	Issues	Actions

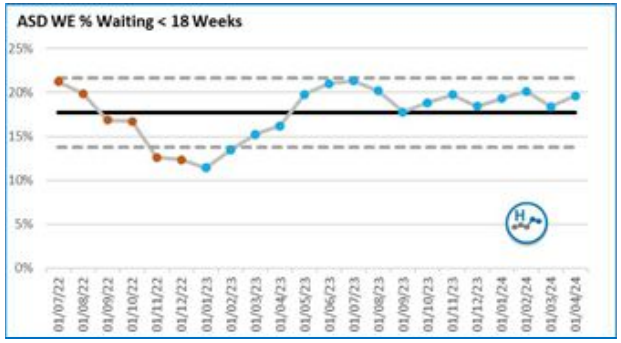
Hertfordshire & West Essex	• All three places achieved the 75% standard again this year
	• All three places and the ICS improved on last year's positions
	• HWE was the best performing system in EOE
	  • National average was 77.6%
	  • Regional average was 72.9%
		• The position may improve further as there are still some national checks of HWE data and whether any manual adjustments Should be applied
		• Local data shows HWE at 83.2%
			• Ongoing work between HWE Team and NHSE to cross check local data against national systems

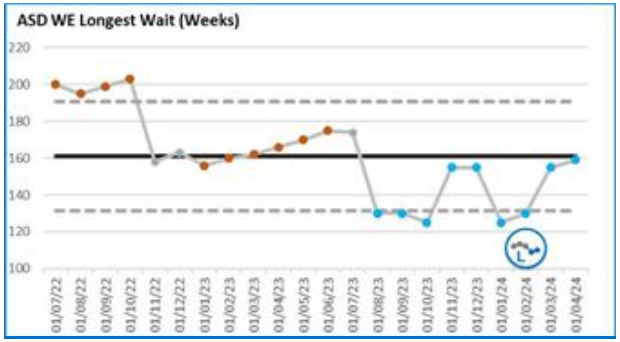
Hertfordshire and West Essex Integrated Care System

Autism Spectrum Disorder (ASD) – West Essex

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	1412	1421		18.41%	19.63%		155	159		April





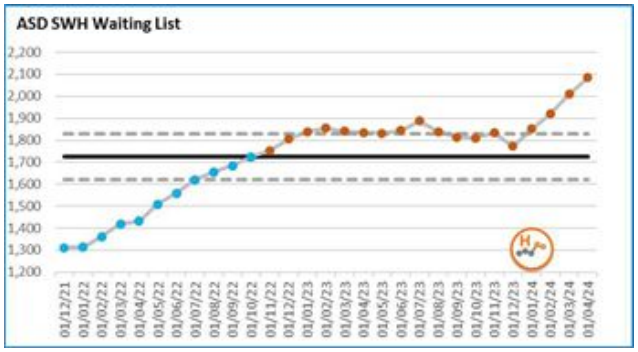


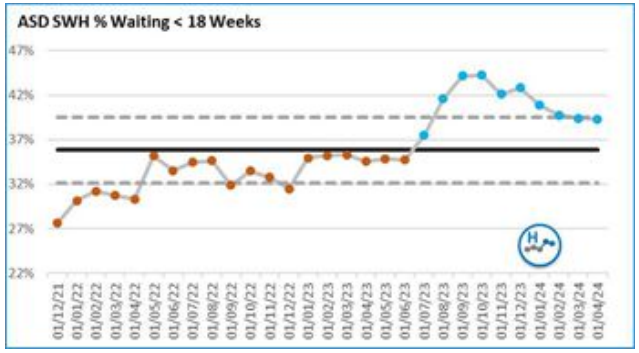
ICB Area	What the charts tell us	Issues	Actions
West Essex	• The ASD waiting list continues to increase and is now at the highest level since October 22 • The number of ASD waiters <18 weeks continues to fluctuate between 18-20% • The longest wait increased slightly to 159 but remains just below the historic mean • 175 of the 1,421 total waiting list are >104 weeks	• Average monthly referral rate for Q4 increased to 73, against commissioned capacity of 40 assessments per month • Demand and capacity analysis forecasts continued waiting list growth • Imminent CQC / Ofsted SEND Inspection for Essex. ASD waiting times and progress with improvement since last inspections in 2019 and 2022 expected to be highlighted	• Business case submitted to increase core capacity for sustainable delivery - not supported due to available funding but remains open, evidencing the gap in capacity vs. demand. In the meantime, waiting lists continue to rise • 'Waiting well' workstream continues with local partners at place, led by HCRG, also linking in with Essex wide joint commissioning initiatives • Grant funding for a local voluntary sector organisation (PACT) has been approved for 24/25, providing much needed support for those waiting on the JADES pathway and post-diagnostic

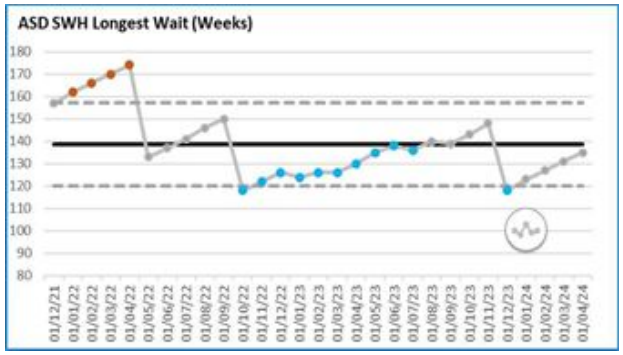
Hertfordshire and West Essex Integrated Care System

Autism Spectrum Disorder (ASD) – South & West Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	Children	2010	2085		39.40%	39.33%		131	135		April

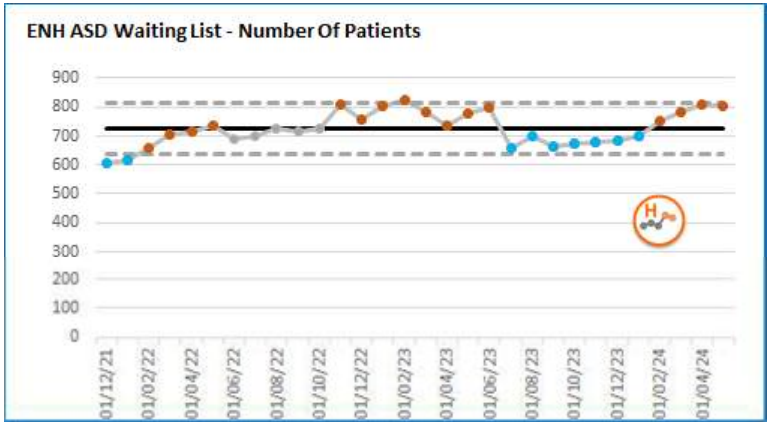






ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The overall waiting list remains consistently above the historic mean and increased further to its highest level in April • The % of ASD waiters < 18 weeks remains above the historic mean, but has fallen by c.5% since October • The longest wait is now 135 weeks, up slightly in each of the last four months	• Capacity in existing services does not meet demand • Further increases in demand predicted • Awaiting confirmation of investment into the service for 2024/25	• Procurement process is progressing to outsource assessments for autism due to provider agreed funding • Additional internal capacity and processes have been improved significantly • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through clinical governance and agreed by operational teams to inform the business case. The business case is complete and agreement on governance route is being confirmed • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in September 24 • Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB was successful. The 25 schools identified in Hertfordshire are currently completing self-assessments to inform planning

Autism Spectrum Disorder (ASD) – East & North Hertfordshire



- In ENH, patients have a first appointment with Community Paediatrics. If the clinician then considers that the patient requires an ASD assessment then they are added to the ASD waiting list
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments once a patient has been added to the ASD assessment waiting list. However, data is not available for both pathways combined
- The chart opposite shows the trend in the number of patients waiting for an ASD assessment once they have been referred by a community paediatrician
- The table below summarises how long patients on the ASD waiting list have been waiting (as of Apr-24):

Waiting list bucket	Number of patients (Feb-24)	Number of patients (Apr-24)
<18 weeks	125	136
18 – 65 weeks	406	450
66 – 78 weeks	95	86
>78 weeks	103	135

ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting list continues to fluctuate within the normal range of 600-800 patients • However, the last two points are very close to the upper process limit and there are clear indications that there has been an increase the waiting list size • Furthermore, the number of patients waiting >78 weeks for an ASD assessment has been increasing in recent months from 86 in Dec-23 to 135 in Apr-24 • The waiting list shown above does not include patients waiting for their first community paediatrics appointment, even if they have been referred by their GP as query ASD. It only shows patients who have been assessed by a community paediatrician and referred for a detailed ASD assessment	• Data not currently reportable on the same basis as the other two ICB Places • Backlog funding ended December 2023 and waiting lists are increasing. In addition to this, further increases in demand predicted • Awaiting confirmation of investment into the service for 2024/25	• Procurement process to outsource assessments for autism paused as funding has not been confirmed • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through clinical governance and agreed by operational teams to inform the business case. The business case is complete and agreement on governance route is being confirmed • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in September 24 • Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB was successful. The 25 schools identified in Hertfordshire are currently completing self-assessments to inform planning

Attention Deficit Hyperactivity Disorder (ADHD)
West Essex & East & North Hertfordshire

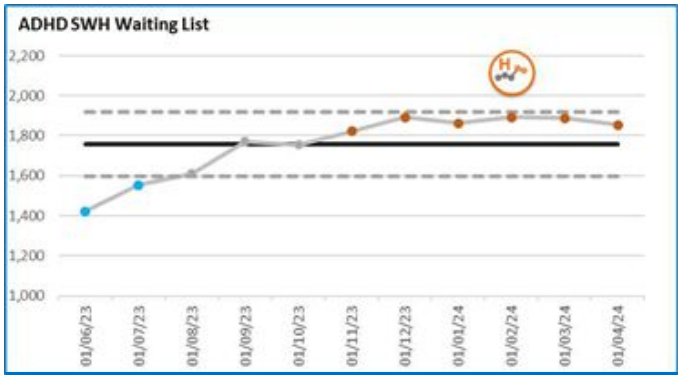
ICB Area	What the charts tell us	Issues	Actions
West Essex	• HCRG commenced reporting of ADHD commenced to commissioners from April 24 • A number of data recording issues have been identified in the initial reporting, therefore figures cannot be included in this report	• Reporting supplied only covers part of the ADHD pathway and also excludes a cohort of children due to coding issues • Referral rates continues to rise, resulting in risk to maintaining waiting list performance	• Working with HCRG to resolve data quality issues • Pathway redesign planned to incorporate ASD and ADHD into a single Neuro Diagnostic Service. Full accurate reporting will not be possible until this work is complete – ambition to complete by Q3 • Aiming to include interim manual ADHD in the next iteration of this report • As noted on ASD slide, business case submitted to increase core capacity for sustainable service - not supported due to available funding but remains open, evidencing the gap in capacity vs. demand. In the meantime, waiting times will continue to rise

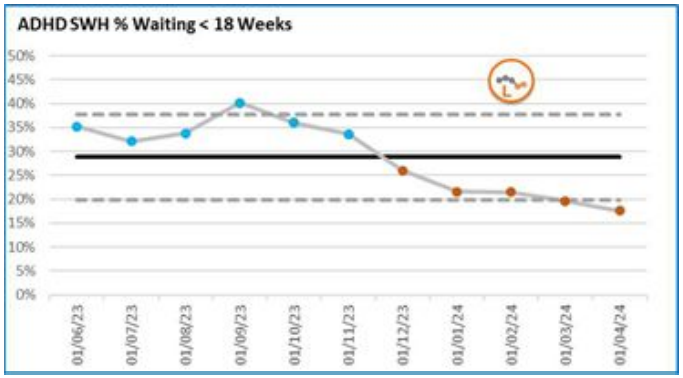
- ENHT is not currently able to report on waiting times / waiting list sizes for patients waiting for an ADHD assessment

Hertfordshire and West Essex Integrated Care System

Attention Deficit Hyperactivity Disorder (ADHD) – South & West Hertfordshire

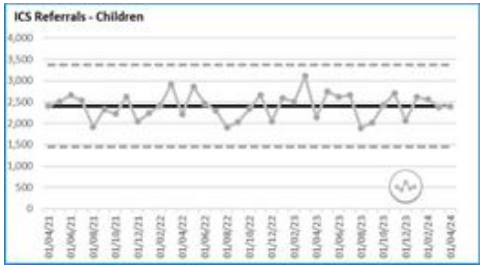
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HPFT	Children	1888	1854		19.65%	17.64%		-	-	-	April

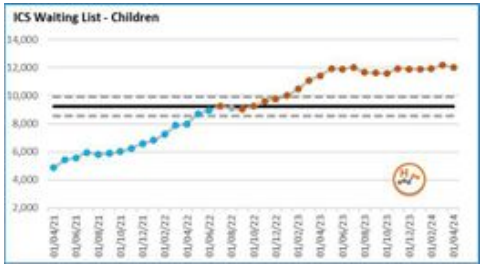


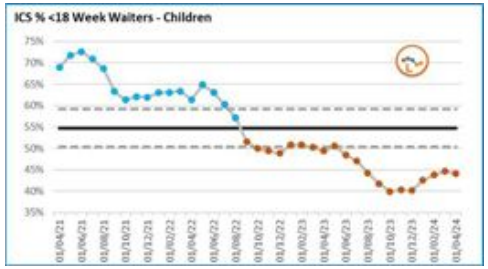


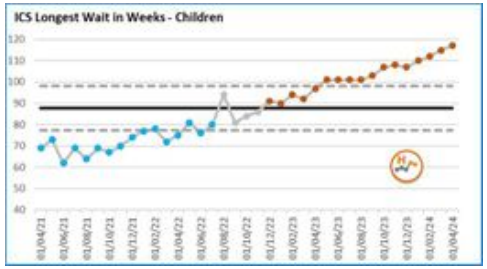
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Overall waiting list if steady at c.1,900 patients but has been consistently above the historic mean for the last six months • The % of ADHD waiting <18 weeks has been consistently deteriorating for the last 7 months	• Longest wait data is not currently available from HPFT • Awaiting confirmation of investment into the service for 2024/25	• Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through clinical governance and agreed by operational teams to inform the business case. The business case is complete and agreement on governance route is being confirmed • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in September 24

Community Waiting Times (Children)









		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	2381	2393	↑	12191	11993	↓	44.66%	44.17%	↓	115	117	↑	April
Place	Provider													
ENH	HCT	312	335	↑	990	860	↓	77.78%	78.95%	↑	55	50	↓	April
ENH	AJM/Millbrook	25	28	↑	123	122	↓	73.17%	75.41%	↑	38	36	↓	April
ENH	ENHT Community Paeds.	252	288	↑	5525	5587	↑	18.43%	17.18%	↓	115	117	↑	April
ENH	**All**	**589**	**651**	↑	**6638**	**6569**	↓	**28.29%**	**26.35%**	↓	**115**	**117**	↑	**April**
Place	Provider													
SWH	HCT	1348	1321	↓	4560	4462	↓	59.43%	61.07%	↑	77	71	↓	April
SWH	AJM/Millbrook	21	22	↑	117	109	↓	71.79%	83.49%	↑	31	35	↑	April
SWH	**All**	**1369**	**1343**	↓	**4677**	**4571**	↓	**59.74%**	**61.61%**	↑	**77**	**71**	↓	**April**
Place	Provider													
WE	EPUT - Wheelchairs	17	27	↑	23	26	↑	100.00%	100.00%	→	17	16	↓	April
WE	HCRG / Virgin	406	372	↓	853	827	↓	87.92%	87.55%	↓	36	36	→	April
WE	**All**	**423**	**399**	↓	**876**	**853**	↓	**88.24%**	**87.92%**	↓	**36**	**36**	→	**April**

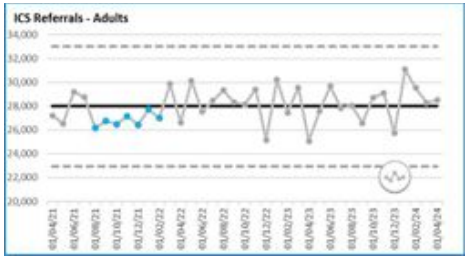
Hertfordshire and West Essex Integrated Care System

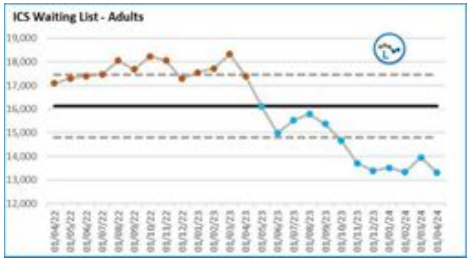
Community Waiting Times (Children)

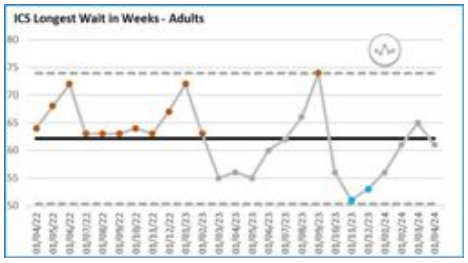
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance.

ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals continue to fluctuate within expected common cause variation limits • The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks remains of concern at c.44%, and lower than the national average of 56.9% • The longest waits are within the ENHT Community Paediatrics Service at 117 weeks. There are also long waits of up to 71 weeks within HCT services in South & West Hertfordshire • Consultant led 18-week RTT performance: SWH Community Paediatrics – 48.8% SWH Children's Audiology – 54.5% ENH Community Paediatrics – 17.2% WE Community Paediatrics – 89.7%	**Hertfordshire** • Referrals to HCT children's specialist services are up 50% YTD 2024/25, compared to 2019/20, with most services seeing a marked increase in demand • Waiting times in the SWH HCT Community Paediatrics service are improving, with a decreasing number of long waiters • There are continued waiting time pressures in Paediatric Audiology in SWH, but there has been improvement with a 35% decrease in total waiters since a high point in June. The service is also currently supporting ENHT newborn hearing pathways • Waiting times across Hertfordshire for children's therapies (OT, Speech & Language and Physiotherapy) remain under pressure, but EHCP performance and workforce position is improving **West Essex (WE)** • 18 week % continues to decline, but remains comparatively strong at 87.9% • The volumes on the Community Paediatrics waiting list continue to increase • Waits for first appointments have increased – ongoing demand and capacity challenge • Business case for additional funding remains unresolved • Dietetics waiting lists are growing month on month to a dietician vacancy	**Hertfordshire** • For HCT services the number of over 52-week waits has reduced from 605 in July 2023, to 253 in May this year, and continues to improve in the most recent data • Focus on reducing DNA/NBI rates for children living in relatively more deprived neighbourhoods • Outsourcing in place in several services • Community Paediatrics in SWH is receiving non-recurrent additional investment to increase workforce capacity and introduce new specialist nursing posts. Recruitment remains a risk • Community Paediatrics also working with NHSE Elect to optimise waiting list management • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow ups, and signposting to interim advice whilst awaiting assessment. Demand and capacity analysis now completed to identify required staffing model to reduce the waiting list • Children's Therapies – increasing capacity through successful recruitment, waiting list initiatives and outsourcing. Pilot for self-booking in one locality has reduced NBI by over 50% • EHCP dashboard developed to improve waiting list management **Community paediatrics ENHT** • New clinical model agreed by all providers: HPFT, HCT and ENHT • Business case has been developed and is currently being reviewed by exec sponsors to agree next steps through governance • Single system referral form expected to be in place by Sep-24 • Target implementation date for the new model is Apr-25 • Outsourcing for ASD assessments has not been agreed for 24/25 due to funding constraints • ICB / HCC has agreed to expand the Neurodiversity Support Centre across Hertfordshire until Mar-25 (staffed by experts by experience). Diagnosis not required to access the support • HCC local offer to be updated with consolidated support and patient signposting **West Essex (WE)** • Community Paediatrics Business Case: 23/24 requested investment has been rolled into year 2 of the 3-year investment plan. Process for 24/25 in year pressures remains unresolved • Procurement planning initiated. Gap in current funding envelope. Investment will be required in order to procure a sustainable service going forward • Dietician post not yet filled – exploring agency / bank cover and outsourcing

Community Waiting Times (Adults)







		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	28286	28517	↑	13956	13312	↓	91.62%	92.51%	↑	65	61	↓	April
Place	Provider													
ENH	HCT	7329	8000	↑	7919	7557	↓	90.68%	91.70%	↑	65	61	↓	April
ENH	AJM/Millbrook	117	123	↑	491	513	↑	74.95%	79.53%	↑	41	43	↑	April
ENH	**All**	**7446**	**8123**	↑	**8410**	**8070**	↓	**89.76%**	**90.93%**	↑	**65**	**61**	↓	**April**
Place	Provider													
SWH	CLCH	7271	7169	↓	1502	1323	↓	97.60%	98.72%	↑	32	32	⇨	April
SWH	Circle	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	April
SWH	HCT	1056	946	↓	1230	1203	↓	88.94%	87.95%	↓	49	47	↓	April
SWH	AJM/Millbrook	122	159	↑	532	572	↑	76.50%	82.34%	↑	40	42	↑	April
SWH	**All**	**8449**	**8274**	↓	**3264**	**3098**	↓	**90.90%**	**91.51%**	↑	**49**	**47**	↓	**April**
Place	Provider													
WE	EPUT	12301	12018	↓	2197	2047	↓	99.50%	99.90%	↑	26	26	⇨	April
WE	EPUT - Wheelchairs	90	102	↑	85	97	↑	100.00%	100.00%	⇨	17	16	↓	April
WE	**All**	**12391**	**12120**	↓	**2282**	**2144**	↓	**99.52%**	**99.91%**	↑	**26**	**26**	⇨	**April**

NOTE: **Circle Health MSK data is currently unavailable for April following reprocurement of the service. Historic Connect data has been removed for consistency.**

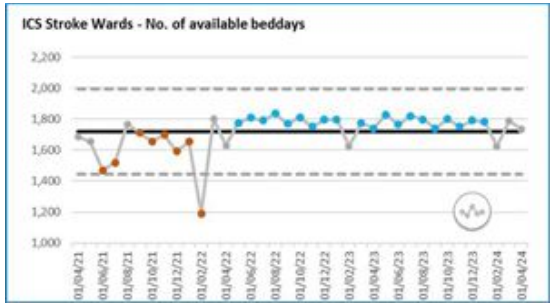
Hertfordshire and West Essex Integrated Care System

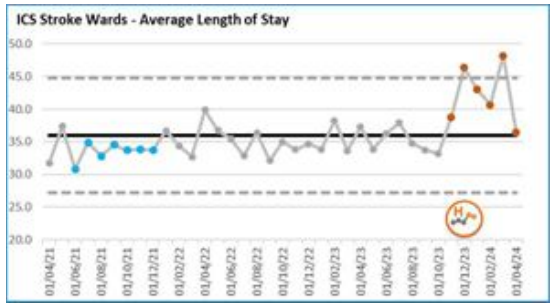
Community Waiting Times (Adults)

The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance.

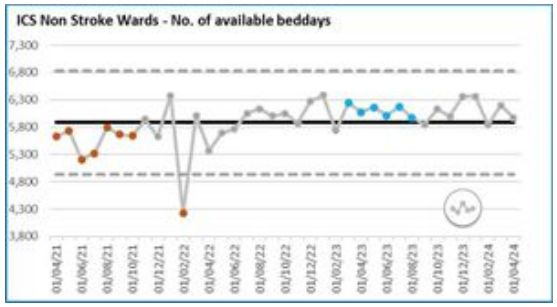
ICB Area	What the charts tell us	Issues	Actions
ICB	• **SWH MSK data excluded from reporting following DQ issues in April data after award of new contract to Circle** • Referrals continue to fluctuate within expected common cause variation limits • The % of patients waiting less than 18 weeks continues to fluctuate at c.93%, compared to the national average of 83.8% • There is a continued trend of improvement for the total number of adults waiting on waiting lists • Longest waits are within HCT services in East & North Hertfordshire, however there was improvement in April for the first time in 6 months • Consultant led 18-week RTT performance: ENH Skin Health – 95.9% SWH Respiratory – 98.5% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Referrals have increased by 14% compared to 2019/20 and are also up compared to 2022/23. • Overall 'waiting within target' performance continues to be more favourable when compared to the pre-pandemic baseline **South & West Hertfordshire (SWH)** • MSK services previously delivered by Connect have been reprocured with Circle. There may be some interruption to data flows during mobilisation • Slight decrease in referrals at CLCH. The number of patients waiting continues to reduce, as does the number of patients waiting above 18 weeks. Respiratory service is now achieving 97% • CLCH longest waiter remains within the Neuro Rehab service. However long waiters witing for ABI psychology input reduced significantly • CLCH have now recruited to ABI Psychology post – to start in August • CLCH Lymphedema and Bladder and Bowel services now within agreed waiting times target • Total number of patients waiting and number of patients waiting above 18 weeks continues to improve **West Essex (WE)** • Pulmonary Rehab continues to recover following recruitment to vacancies • Small number of breaches in Bladder & Bowel services & Wheelchair Services	**East & North Hertfordshire (ENH)** • All waits are closely monitored and subject to robust internal governance • Service productivity analysis continues • Forecasting suggests a stable trend over the next 12 months, and that overall current waiting time performance will be maintained or slightly improved • Comprehensive health inequalities metrics in place. Health inequalities analytics has allowed the Trust to compare waiting times and DNA rates for those living in relative deprivation versus those that do not, and targets have been set to address discrepancies **South & West Hertfordshire (SWH)** • **Working with Circle and ICB contract leads to resolve reporting issues following re-tender of SWH MSK contract from 1st April. Data expected to be reinstated in the next report** • External provider continuing to support with PD / MS Nursing and ABI caseloads • External provider now also supporting with planned care therapy and NETT waits • Agree August start date for substantive ABI Psychology starter • Recruit to additional PD nursing post (funding secured from PD UK). Difficulty recruiting (out to advert for 2nd time) • Divisional weekly waiting times group remains in place which also feeds into Trust group • Division specific recruitment plan underway, including developing videos to compliment adverts and targeting social media channels. A number of recruitment fairs held, with more being planned • Trajectories now in place for all services of concern. These are reviewed and monitored weekly **West Essex (WE)** • Pulmonary Rehab recovery trajectory agreed. Compliance with 8-week standard on track for end of June • Bladder & Bowel – temporary staffing in place to cover maternity leave. Only one patient exceeding 8-week standard at end of May

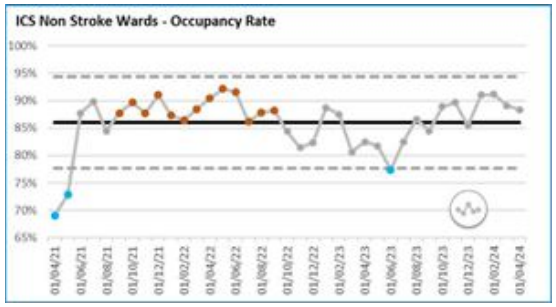
Community Beds (Stroke & Non-Stroke)

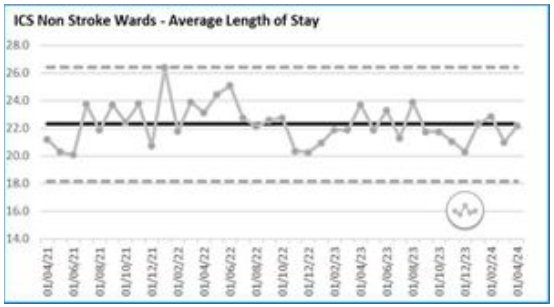




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	744	720	↓	98.52%	89.72%	↓	41.4	35.4	↓	April
SWH	CLCH	610	594	↓	99.34%	100.00%	↑	46.2	32.4	↓	April
WE	EPUT	434	420	↓	97.47%	86.90%	↓	63.0	45.0	↓	April
ICS	**All**	**1788**	**1734**	↓	**98.55%**	**92.56%**	↓	**48.2**	**36.5**	↓	**April**







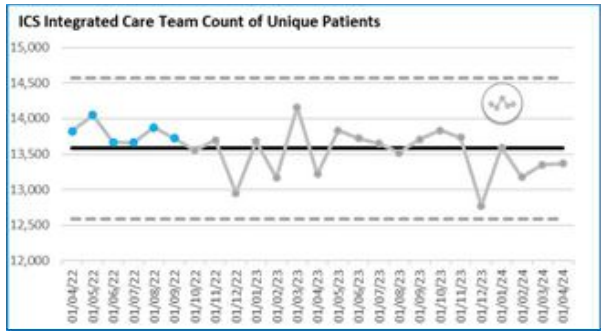
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1767	1618	↓	80.93%	78.55%	↓	22.8	25.5	↑	April
SWH	CLCH	2168	2167	↓	94.97%	96.91%	↑	23.8	24.3	↑	April
WE	EPUT	2263	2190	↓	89.92%	87.21%	↓	16.9	17.6	↑	April
ICS	**All**	**6198**	**5975**	↓	**89.13%**	**88.38%**	↓	**21.0**	**22.2**	↑	**April**

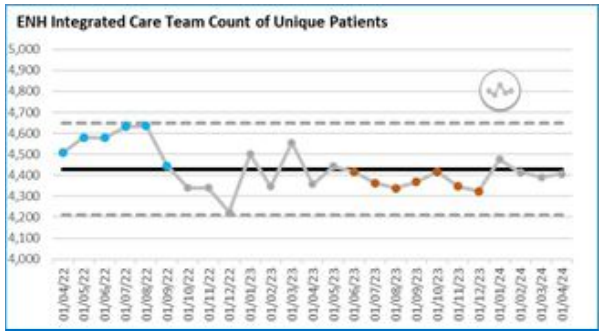
Community Beds (Stroke & Non-Stroke)

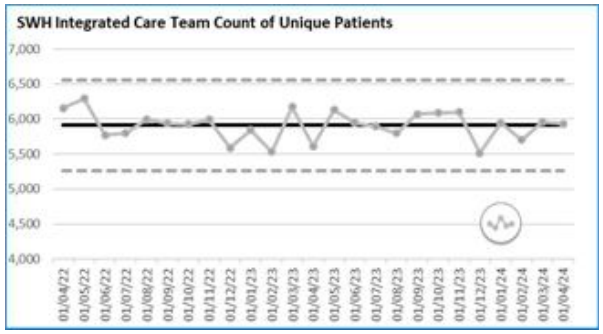
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds Days** • Available stroke bed days remain consistent at c.1,750 per month • Overall stroke bed occupancy rates continue to trend above the historic mean, but April was the best position in the last 6 months • Overall length of stay returned to historic mean levels, with improvements seen in each of the three Places **Non-Stroke Beds Days** • Available non-stroke bed days remain consistent at c.6,000 per month • Overall occupancy rates across the system have reduced slightly over the last two months, but remain within expected common cause variation limits • Overall length of stay also remains within common cause variation limits	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 93% over the past 12 months. Herts & Essex and QVM have an average occupancy of 80% and 84% respectively • Average length of stay over the past 12 months for Herts & Essex averaged 25 days, and 27 days at QVM. At Danesbury, there is now normal variation with an average of 38 days. Admissions into community hospitals show no significant change in trend at Herts and Essex and QVM • Danesbury has the least admissions with an average of 17 a month, with QVM averaging 18, and Herts & Essex averaging 31 **South & West Hertfordshire (SWH)** • Continued high occupancy rates across all beds due to supporting system flow and admitting higher acuity patients • Slight reduction in average length of stay in stroke wards due to better management of No Criteria to Reside (NMCTR) patients **West Essex (WE)** • Length of stay on stroke ward has significantly reduced but continues to be impacted by a complex patient. Extension to stay has been agreed with ICB commissioners	• ICS Community Providers reviewing WE comparatively low non-stroke LOS for potential learning **East & North Hertfordshire (ENH)** • New process regarding criteria to reside in place to support discharge **South & West Hertfordshire (SWH)** • Daily assurance calls remain in place with HCC with clear escalation process • In collaboration with system partners, action plan agreed to support flow and winter plan also drafted • In collaboration with system partners, SPOC review completed, and action plan agreed which is currently being worked through (most actions completed) • In partnership with social care colleagues, currently reviewing escalation plan **West Essex (WE)** • Daily escalation calls in place to support all delayed discharges • EPUT are working with PAH to identify patients to identify transfers into the community. Initiative will support planned elective care recovery and maximise system capacity during Summer months

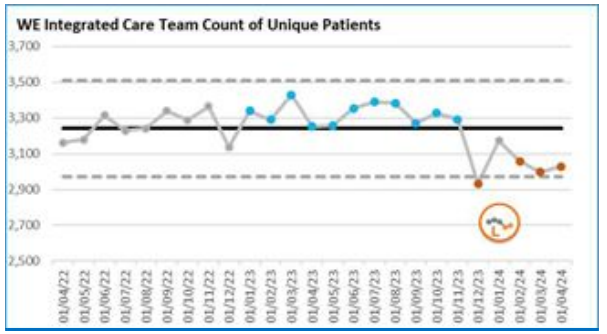
Hertfordshire and West Essex Integrated Care System

Integrated Care Teams (ICT)









			Contacts (unique patients)			Contacts (unique patients) per 1000 population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	4392	4406	↑	6.9	7.0	↑	April
SWH	CLCH	All	5959	5930	↓	8.7	8.6	↓	April
WE	EPUT	All	2997	3029	↑	9.0	9.1	↑	April
ICS	**All**	**All**	**13348**	**13365**	↑	**8.1**	**8.1**	↑	**April**

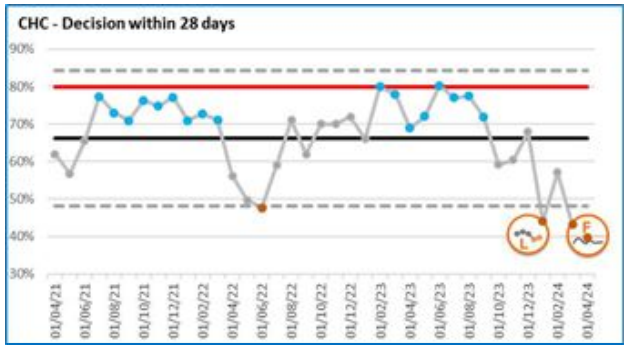
Hertfordshire and West Essex Integrated Care System

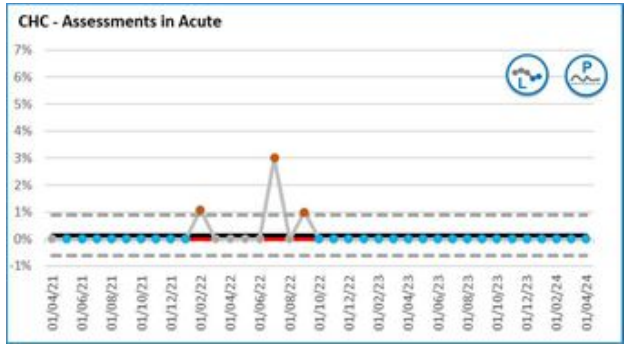
Integrated Care Teams (ICT)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Unique contacts across the ICS and within the two Hertfordshire Places are within expected common cause variation limits • Unique contacts in West Essex increased slightly in April, but have been below the historic mean for the last five months	**East & North Hertfordshire (ENH)** • Referrals have shown a decrease in recent months compared to pre-pandemic, although the pattern differs at Locality level • Increase in caseload compared to pre-pandemic levels • Increasing patient complexity has driven an increase in caseload and first to follow up ratios • Performance focus on deferral rates **South & West Hertfordshire (SWH)** • Slight reduction in overall number of unique contacts in month **West Essex (WE)** • Since April 2021 ICTs have seen a reduction in referrals. Contacts per patient however have increased from 7.5% to 9.7% (c.30% increase), suggesting an increase in acuity of patients receiving care in the community	• Community services review underway across HWE to reduce variation and shift to reporting outcomes and impact, to compliment the activity driven data that exists **East & North Hertfordshire (ENH)** • Steering group in place chaired by HCT Chief Operating Officer • Various recruitment initiatives underway • A comprehensive support programme in place focused on workforce, wound care and diabetes management with the ICT • Additional activity support with locality cross team working to reduce deferrals • SystmOne optimisation project underway aiming to streamline use of the clinical systems with a prospective productivity gain **West Essex (WE)** • Investment since 2021 into the Urgent Community Response (UCR) Team has reduced the number of urgent referrals to the ICTs. This has in turn provided additional capacity to support the shift to pro-active care delivery in the Integrated Neighbourhood Teams • Increased joint working between the ICTs and the community urgent care pathways via the Care Co-ordination centre • Continued focussed work with Care Homes by the ICTs to maximise use of all community urgent care pathways and reduce calls to 999

Hertfordshire and West Essex Integrated Care System

Continuing Health Care (CHC)





	What the charts tell us	Issues	Actions

HWEICB	• The 28-day standard continues to present a significant challenge, most notably in South & West Hertfordshire
	• Performance has deteriorated for the last 3 months
	• May overall performance is similar to April as below, but there has been further slippage in West Essex:
	  ○ Overall ICB – 40%
	  ○ West Essex – 62%
	  ○ ENH – 65%
	  ○ SWH – 23%
	• The assessments in an acute setting <15% standard continues to be routinely achieved
		• Workforce - new starters do not have CHC experience and require robust training and development
		• Recovery of the 28-day standard is forecast to take at least 6 months and targets will be met by Q4 24/25. This has been agreed with NHSE
		• WE 28-day performance is 9% worse in May v. April. Key issue is delays in allocation of social workers from ECC due to recruitment challenges
			• Weekly meetings are in place across all areas to monitor performance. Additional assurance meetings are being held with NHSE
			• A further comprehensive layer of management control and support has been implemented across the SWH service to significantly improve work allocation, daily analysis of completed work, case status and risk identification
			• The same process for all areas will be implemented moving forwards
			• ECC continue to focus on social worker recruitment

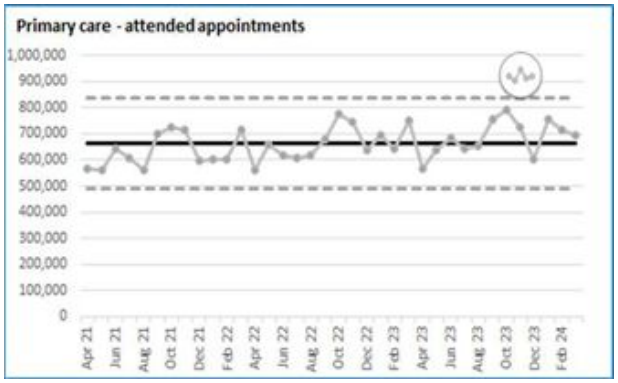
Hertfordshire and West Essex Integrated Care System

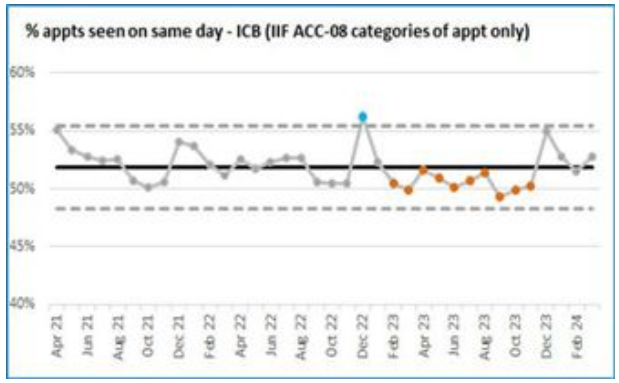
Primary Care – performance summary

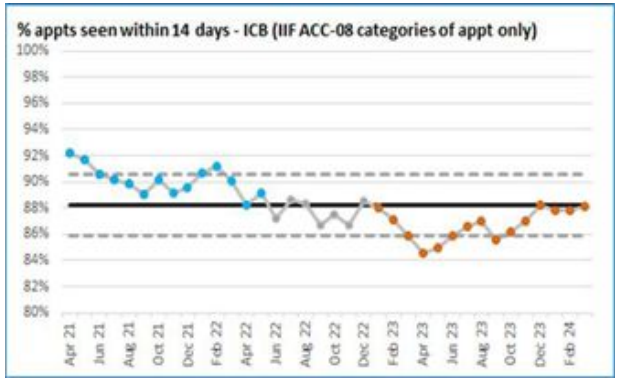
Current Performance Period vs Prior Period								ICB	ENH	SWH	WE
Area	Indicator	Type	Prior Mth	Current	Change	Movement	Period	Rank (out of 42 ICBs)	Rank (out of 106 ICBs)		
Primary Care	S001a: Number of general practice appointments per 10,000 un-weighted patients	Monthly	4,468	4,227	(240)	↓	Feb-24				
	% of appointments which are seen on the same day	Monthly	46.2%	44.7%	(1.5%)	↓	Feb-24				
	% of appointments which are seen within 14 days	Monthly	84.2%	83.9%	(0.3%)	↓	Feb-24	23	92	31	40
	S074a: FTE doctors in General Practice per 10,000 weighted patients	Monthly	6.22	6.13	(0.09)	↓	May-23				
	S075a: Direct patient care staff in GP Practices and PCNs per 10,000 weighted patients	Quarterly	6.29	6.67	0.38	↑	Q4 23-24	35			
	S037a: Percentage of patients describing their overall experience of making a GP appointment as good	Annual	54.5%	52.4%	(2.1%)	↓	2023	32			
	S085a: Proportion of people with severe mental illness receiving a full annual physical health check and follow up interventions	Quarterly	68.7%	74.9%	6.2%	↑	Q1 23-24				
	S030a: Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check ICB	Monthly	55.6%	71.1%	15.5%	↑	Dec-23	38			
	S055a: Number of referrals to NHS digital weight management services per 100k head of population	Quarterly	24.7	37.9	13.2	↑	Q4 22-23				
	S050a: Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	Quarterly	73.8%	73.6%	(0.2%)	↓	Q2 23/24	7	28	43	20
	S047a: Proportion of people over 65 receiving a seasonal flu vaccination	Seasonal	80.3%	80.7%	0.4%	↑	Feb-23	26	47	51	82
	S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Annual	67.1%	72.5%	5.4%	↑	2022-23				
	S044a: Antibiotic items prescribed in primary care per STAR-PU (specific age-sex related prescribing unit)	Monthly	0.995	0.991	(0.004)	↓	Jan-24	28	61	18	73
	S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	8.78%	8.78%	0.00%	↑	Jan-24	34	84	83	72

Hertfordshire and West Essex Integrated Care System

Primary Care – key indicator trends







NOTE: %s in the above charts are based on appointments made, not requests received

What the charts tell us

- GP appointments remain within expected common cause variation limits. However, there are indications of an overall growing trend in attended appointments
- The % of appointments which were seen on the same day of booking has been within common cause variation for the last four months. This follows a period of below average same day appointment bookings. The chart above now shows the % of same day appointments for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups
- The % of appointments which were seen within 14 days of booking has been consistently below the mean for the last 14 months. However, there are signs of a return towards the mean over the last four months, and performance is only marginally below this year's plan of 89%. The chart above now shows the % of same day attendances for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups

Hertfordshire and West Essex Integrated Care System

Primary Care – narrative

ICB Area	Issues	Actions
ICB	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • National contract for 24/25 imposed without agreement from profession, with Industrial Action in Primary Care a possibility and added to the risk register • 24/25 focus on cutting bureaucracy, helping practices with cash flow and increase financial flexibilities and continue to improve patient experience of access	**Engagement with the National Access Recovery Plan** • For 23/24 all 34 PCNs had an agreed Access Improvement Plan (AIP) as outlined in the Primary Care Access Recovery Plan. A year-end qualitative & quantitative review now undertaken; reported to ICB Board • Majority of PCNs/Practices have been able to demonstrate access improvements through the year to merit award of the full funding at the discretion of the ICB • ICB support will continue through 24/25, albeit reflecting the 'lighter-touch' national direction based on Clinical Directors' declaration of PCN/Practice status • Many practices transitioning to Modern General Practice (MGP) through demand / capacity analysis, use of cloud-based telephony, roll out NHS app, online GP registration, development of GP and PCN websites and testing triage models • Transition Cover funding (to support implementation of MGP) - Indicative £13.5k per qualifying practice available for 23/24, and the same for 24/25. Place teams reviewed and approved submissions from practices, with 95% of practices receiving funding in 23/24 • PC Teams supporting PCNs in maximising the increased functionality of new cloud-based telephony systems and maximising online consultation availability/use. This remains an area of considerable variance • National GP Improvement Programme - 30 practices & 4 PCNs participated in this nationally supported facilitated programme, enabling them to focus on key development areas to improve access • 28 sites have received cloud base telephony. A further 6 practices are now being upgraded from sub-optimal CBT systems to advanced CBT. 16 practices have been offered free of charge upgrades on their current systems which are CBT but lacking some functions. 16 practices currently have no funded upgrade path but are using a sub-optimal CBT system., currently working with region to understand options for these • Good progress on prospective records access . Many practices are now actively moving towards full enablement or have plans in place to enable; almost 700,000 patients across HWE have access to their records; over 90% of practices have as the default for new NHS app users; 60% of practices have 90%+ of patients with online access + records access enabled; almost 80% of practices with 80%+ • Partnership working to increase self-referrals in high volume services: Physio, IAPT, Podiatry etc. • Support Level Framework (SLF) - Self assessment tool to support practice teams in understanding what they do well, what they might wish to do better, and where they might benefit from development support. Roll-out of SLF facilitated sessions for practices at increased pace in 24/25 • Comms. to support ICB and practice websites, media statements and patient comms re the Delivery Plan • Development of PC Dashboard to include further metrics to allow triangulation / narrative in the absence of plan / reporting requirement in national contract **Other** • Enhanced Commissioning Framework (ECF) refined for 24/25 and include shared care monitoring arrangements • Trend analysis to identify practices with poor access via complaints and patient contacts • PCCC and Primary Care Board oversight of GPPS results. Action plan developed through the Access MDT Group • Initiatives for Primary Care Workforce to support recruitment and retention, supported by the HSE ICB Training Hub • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices • Pharmacy First now live, work with Community Pharmacy leads and practices to promote service

Performance v. 23/24 Operational Plans

		M12 Only					Year To Date				
POD	Description	Plan	Actual	Actual vs Plan %	Change	Performance	Plan	Actual	Actual vs Plan %	Change	Performance
EM13	Number of attendances at all type A&E departments	37,196	46,305	24.49%	9,109	↑	475,522	502,475	5.67%	26,953	↑
EM11a	Number of specific acute non-elective spells in the period with a length of stay of zero days	3,087	4,046	31.07%	959	↑	40,926	37,375	-8.68%	-3,551	↓
EM11b	Number of specific acute non-elective spells in the period with a length of stay of one or more days	6,117	7,229	18.18%	1,112	↑	74,110	81,080	9.40%	6,970	↑
EM10a	Elective day case spells	9,614	10,216	6.26%	602	↑	110,102	118,653	7.77%	8,551	↑
EM10b	Elective ordinary spells	1,012	981	-3.06%	-31	↓	13,812	10,802	-21.79%	-3,010	↓
EM32g	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance	39,958	43,057	7.76%	3,099	↑	514,915	505,806	-1.77%	-9,109	↓
EM32h	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance	53,407	65,533	22.70%	12,126	↑	628,787	782,550	24.45%	153,763	↑
EB20	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	1,535	1,127	-26.58%	-408	↓	27,422	35,702	30.19%	8,280	↑
	Operational planning modalities (provider)	37,491	35,082	-6.43%	-2,409	↓	431,256	415,281	-3.70%	-15,975	↓

ICB Issues and escalations

- 23/24 attendances, and non-elective spells with a length of stay of one of more days, were both higher than plan
- Non-elective spells with a zero-day length of stay were slightly below plan
- Elective inpatient activity was below plan for the year, with elective activity in all areas impacted by Industrial Action
- The number of 65-week waits did not achieve plan, however the target for zero 65ww breaches has been extended to end of September 2024

Hertfordshire and West Essex Integrated Care System

Appendix A – Performance Dashboard

April 2024

Herts & West Essex ICB (Commissioner)

Area	Activity	Target	Latest published data	Data published	Previous month	Trend *1	Variation	Assurance	NATIONAL position National vs (ICB)	REGIONAL position EoE Region vs (ICB)	ICB Ranking
111	Proportion of calls answered < 60 secs	95%	72.0%	May 24	57.52%	20.09%			71.66% (Better)	69.16% (Better)	15
	Proportion of calls abandoned	3%	5.6%	May 24	10.95%	-96.58%			5.72% (Better)	5.60% (Better)	11
A&E	% Seen within 4 hours	76%	73.5%	May 24	73.49%	-0.038%			73.96% (Worse)	73.77% (Worse)	25
	12 Hour Breaches	0	199	May 24	225	-13.07%			42,181 (0.43%)	2,913 (6.25%)	8
Cancer	31 days	96%	90.3%	April 24	91.20%	-1.04%			89.17% (Better)	87.73% (Better)	20
	62 days	70%	69.6%	April 24	65.73%	5.57%			66.63% (Better)	64.24% (Better)	13
	28 days Faster Diagnosis	75%	73.8%	April 24	77.53%	-5.07%			73.45% (Better)	69.17% (Better)	25
RTT	Incomplete Pathways <18 weeks	92%	56.6%	April 24	55.58%	1.88%			58.25% (Worse)	54.57% (Better)	26
	52+ weeks	0	9,156	April 24	9833	-7.39%			302,589 (3.03%)	51,428 (17.80%)	32
	65+ weeks	0	1,592	April 24	1514	4.90%			50,397 (3.16%)	10,515 (15.14%)	31
	78+ weeks	0	82	April 24	65	20.73%			5,013 (1.63%)	1,042 (7.87%)	33
Diagnostics	6 week wait	5%	30.6%	April 24	28.89%	5.58%			23.00% (Worse)	31.49% (Better)	36

Provider

ICB Aggregate Provider	Trend *1	ENHT	Trend *1	WHTHT	Trend *1	PAH	Trend *1
72.0%	20.09%						
5.57%	-96.58%						
73.47%	-0.04%	72.02%	-0.52%	79.80%	1.22%	66.98%	-0.60%
199	-13.07%	69	68.12%	1	0.00%	129	-56.59%
93.71%	-1.94%	94.62%	-1.45%	94.44%	-1.75%	87.33%	-5.69%
71.29%	3.65%	85.89%	3.95%	70.37%	-1.75%	46.64%	0.51%
75.44%	-4.54%	77.49%	-4.53%	77.74%	-0.46%	70.73%	-10.13%
54.67%	3.44%	58.21%	5.55%	52.80%	2.68%	51.24%	0.02%
7,063	-9.33%	2,696	-14.17%	2,334	-13.84%	2,033	2.26%
1,198	5.93%	373	2.68%	242	-1.24%	583	10.98%
54	-48.15%	25	-16.00%	0	0.00%	29	-72.41%
36.11%	4.97%	49.50%	2.51%	13.98%	16.28%	29.28%	3.59%

Herts & West Essex ICB (Commissioner)

Area	Metric	Target	Latest published data	Data published	Previous month	Trend *1	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking
111	Proportion of calls answered < 60 secs	95%	72.0%	May 24	57.52%	20.09%			71.66% (Better)	69.16% (Better)	15
	Proportion of calls abandoned	3%	5.6%	May 24	10.95%	-96.58%			5.72% (Better)	5.60% (Better)	11
Mental Health	Dementia Diagnosis rate	66.6%	64.4%	April 24	64.68%	-0.51%			64.60% (Worse)	63.00% (Better)	20
	OOA placements	0	34	April 24	n/a	last month's data missing			n/a	n/a	n/a
CHC	% of eligibility decisions made within 28 days	80%	43.2%	March 24	57.14%	-32.43%			72.94% (Worse) *2	70.43% (Worse) *2	36
	% of assessments carried out in acute	15%	0.0%	March 24	0.00%	0.00%			0.24% (Better) *2	0.40% (Better) *2	39

LEGEND

Performance against target
- On/above target
- Below target

Performance against previous month
- Improvement
- Deterioration
- No change

ICB Ranking
- First quartile
- Middle quartile
- Lowest quartile

Sub-ICB

East & North Herts	Trend *1	South & West Herts	Trend *1	West Essex	Trend *1
72.11%			19.59%	71.46%	22.12%
5.63%			-91.98%	5.33%	-116.03%
62.95%	-1.17%	61.98%	0.00%	71.26%	-0.28%
23			last month's data missing	11	45.45%
67.50%	-19.16%	23.53%	-50.30%	76.19%	-11.06%
0%	0.00%	0%	0.00%	0%	0.00%

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	15
Report title	Audit and Risk Committee 9 July 2024 highlight report	**Meeting Date**	11 September 2024
Chair	Karen McConnell – Committee Chair and Deputy Trust Chair		
Author	Deputy Company Secretary		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- Internal Audit summary internal controls assurance (SICA) report
- Internal Audit recommendation tracker
- Anti-Crime annual report
- Counter Fraud functional standard return 2023/24
- Progress report on external audit
- Integrated compliance report – incident, compliance and risk report
- Board Assurance Framework
- Charging overseas patients
- Data quality and clinical coding report
- Data quality policy
- Data quality improvement strategy
- Well led action plan progress update
- Digital submission – cyber security update
- Declarations of interest update
- Overpayment and underpayment salaries policy.

Alert:

- The Committee observed that open risks had increased to 540 and that there were too many for effective risk management. Benchmarking with similar sized Trusts showed that 300 and 350 open risks was the average.
- The key indicators around compliance to be addressed and reported back to the Committee. In particular the Committee was concerned that only 54% of risks have action plans to mitigate the risk.

Advise:

- New Internal Auditors have been appointed from RSM UK.
- The Committee were concerned at the backlog in FOI with 527 currently being processed. Progress will be considered at the next Committee.
- The Committee considered the Well-Led Action plan and in particular noted the need to consider how the Board obtained assurance on performance once the new Divisional structures were embedded.

Assurance:

- The Internal Audit Review of Stroke – SSNAP Performance Management concluded “reasonable assurance”. The Operations team in Stroke confirmed they have a standard operating procedure (SOP) that they work to. They are working towards a new SOP that will reflect current incoming national guidance and pathway requirements.
- In accordance with the Government Functional Standard 013 Counter Fraud, the Trust was required to complete a Counter Fraud Functional Standard Return (CFFSR) and had been assessed as an overall rating of GREEN for 2023/24.
- Cyber security risks were discussed and noted including those relating to suppliers.

Important items to come back to committee (items committee keeping an eye on):	
• The Committee noted that as at the date of the meeting the annual accounts had not been signed off due to some areas arising from the second partner review including: o Remuneration and pensions disclosures o NHS receivables o Income. The Committee was in ongoing dialogue with the external auditor and the Director of Finance. • The Committee noted that the external auditors would conclude their audit of VFM arrangements with the opinion work but that no significant weaknesses had been identified.	
Items referred to the Board or a committee for a decision/action:	
• The Internal audit report on Mortality and Medical Examiner's Process to be shared with Dr David Buckle, Chair Quality and Safety Committee (QSC).	
Recommendation	The Board is asked to **NOTE** the Audit and Risk Committee report.

To be trusted to provide consistently outstanding care and exemplary service

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	16
Report title	Finance Performance and Planning Committee – Highlight report July 2024	**Meeting Date**	11 September 2024
Chair	Karen McConnell - Committee Chair and Non-Executive Director		
Author	Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Performance and flow spotlight Outpatients
- Productivity spotlight Oral
- Finance position month 3
- Divisional CIP
- Capital Plan
- Front Entrance Milestones
- Productivity and ERF report
- Quarterly PMO report
- Performance report
- Green plan update
- IT/Digital update
- Board Assurance Framework

Alert:

- At Month 3 the Trust had a £2.9m cumulative deficit and was £0.5m adverse to plan. The in-month position included the impact of the 5 day Junior Doctor Strike in June where, in line with national guidance, it is assumed that the lost £0.5m ERF activity will not be funded. Although, excluding this impact of industrial action, the Trust is in line with the plan £3.1m of non-recurring support has been used to achieve this. ERF remains behind plan and staff recruitment to support ERF had been slow. More proactive management of budgets and CIPs is required by divisions to ensure the Trusts financial duties are met.

- UEC admitted type 1 Emergency Department 4 hour performance had improved to 70% but was below the external trajectory. New pathways to avoid ED where possible are being agreed and implemented.

Advise:

- Outpatients and medical records were moved from the Planned Care Division to Digital and service improvements including synergies were planned. Progress to date and planned changes to the Patient Hub were noted together with other digital service improvements identified in the first 8 weeks.
- Diagnostics recovery trajectories were on track excluding Audiology and MRI. Additional external MRI capacity has been secured. Additional on-site MRI capacity is being secured to meet cancer demand. DM01 performance deteriorated due to Audiology being included in the reporting following the 3 month suspension of service. Separate monitoring of performance will be put in place.
- Elective-65 week recovery trajectories were on track apart from Trauma and Orthopaedics and Pain.
- The Committee received an update on the progress of the PMO programme. Planned changes to the monitoring of agreed actions were noted.
- The Committee noted progress on the EPR upgrade programme which was broadly on track. Risks were discussed and the Committee expressed concern about the potential impact of spending controls on the recruitment of sufficient resource for the project. Assurance would be sought on the mitigation of this risk going forward.

Assurance:

- FPPC has received productivity reports throughout the year and these are continuously being improved and developed. The latest Productivity report for Oral Surgery showed positive overall productivity when compared against 2019-2020 but using benchmarking data further opportunities for improved productivity are being identified eg theatre utilisation where the opportunity to reduce late starts is being explored.
- The Committee received an update on the progress of the Trust against the Green Plan. The positive performance on the work streams was welcomed and the next steps noted.

Important Items to come back to committee:	

Items referred to the Board or a Committee for decision or action:	- The Committee approved the next steps on the Civic main entrance business case.

Recommendation	N/A

To be trusted to provide consistently outstanding care and exemplary service

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	19
Report title	Quality and Safety Committee 24 July 2024 - highlight report			**Meeting Date**	11 September 2024
Chair	Dr David Buckle - Committee Chair and Non-Executive Director				
Author	Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Allergies and ePMA
- Ophthalmology PSii
- Safe, Care, Effective update
- Get it right first time (GIRFT)
- Maternity Assurance report
- Stroke update – deep dive
- Gold Standard Framework
- Integrated compliance report- incident, compliance and risk report
- Quarterly Complaints and Patient Experience report
- Clinical Ethics Group AR
- Patient and Carer Experience Group.

Alert:

- Duty of Candour had been acknowledged as an organisational risk. This was now a standing item on the new Patient Safety Event Review Panel (PSERP) for oversight review.

Advise:

N/A

Assurance:

- The 'Get it Right First Time' report focused on the drive to equity of access and excellent clinical outcomes for the population through standardisation of pathways and adoption of best practice. The Committee found the information reassuring and requested that it be presented bi-annually.
- The overall Sentinel Stroke National Audit Programme (SSNAP) rating improved from D to B. This is good news but the Committee are aware that there is more work to be done.
- On policy compliance, the Committee was assured that this was improving and it
- was being monitored through ENHance.

Important items to come back to committee (items committee keeping an eye on):

- Digital transformation on the Maternity unit.

Items referred to the Board or a committee for a decision/action:

- N/A

Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report.

To be trusted to provide consistently outstanding care and exemplary service

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	18
Report title	People and Culture Committee – Highlight report 16 July 2024	**Meeting Date**	11 September 2024
Chair	Val Moore, Non-Executive Director		
Author	Committee Secretary		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- People Report
- Update on agency ceiling and off-framework target
- Divisional update – staff experience and staff engagement improvement plans – Unplanned care
- Voice of our people carers network
- Workforce Equality standards
- Statutory Mandatory training
- E-roster/Workforce Deployment
- University of Hertfordshire Partnership annual report
- Improving working lives of doctors in training
- Board Assurance Framework

Alert:

- The current challenge areas were care support workers which was not due to the Trust's ability to recruit but due to high levels of turn over with a number of those staff advancing into nurse associates.
- WRES indicator areas reported that required improvement were 2, 3 and 8.
- The medical eRostering implementation had slowed due to the effects of the Industrial action, however, mitigations were in process.

Advise:

- It was stated that the Infection Prevention Control team were working alongside staff who had not received the vaccination. The vaccination rate had increased from 78.9% to 91.2%.
- Registered nurse and midwifery percentages were anticipated to be in a positive position by October.
- Upon review of the staff survey a common theme was the lack of equipment within clinical areas which had since been ordered.
- The following WRES indicator areas that had seen improvement: 1, 4, 5,6 and 7.
- Statutory mandatory training compliance had fallen to 90%

Assurance:

Important Items to come back to committee:	- Impact of the closure of the Old School of Nursing on training compliance.

Items referred to the Board or a Committee for decision or action:	- Annual report on workforce race equality standard and Workforce disability equality standard.

Recommendation	The Board is asked to **NOTE** the People Committee report.

To be trusted to provide consistently outstanding care and exemplary service

Board Annual Cycle 2023-24

Notes regarding the annual cycle:

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

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Standing Items													
Chief Executive's Report	X		X		X		X		X		X		X
Integrated Performance Report	X		X		X		X		X		X		X
Board Assurance Framework	X				X				X				
Corporate Risk Register	X				X				X				X
Patient/Staff Story (Part 1 where possible)	X		X		X		X		X		X		X
Employee relations (Part 2)	X		X		X		X		X		X		X
Board Committee Summary Reports													
Audit Committee Report	X		X		X		X		X		X		
Charity Trustee Committee Report			X		X				X		X		X
Finance, Performance and Planning Committee Report	X		X		X		X		X		X		X
Quality and Safety Committee Report	X		X		X		X		X		X		X
People Committee	X		X		X		X		X		X		X
Strategic reports													
Planning guidance											X		
EPR implementation to Lorenzo	X		X		X						X		X
Trust Strategy refresh and annual objectives	X												X
Strategy delivery report					X						X		

Board Annual Cycle 2023-24

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Strategic transformation & digital update	X				X				X				X
Integrated Business Plan									X				
Annual budget/financial plan	X												X
System Working & Provider Collaboration (ICS and HCP) Updates	X		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)											X		
Estates and Green Plan													
Workforce Race Equality Standard											X		
Workforce Disability Equality Standard											X		
People Strategy											X		
Enabling Strategies													
Estates and Facilities Strategy							X						
Green Strategy									X				
Clinical and Quality Strategy											X		
Equality, Diversity and Inclusion Strategy	X												X
Digital Strategy			X										
Engagement Strategy					X								
Other Items													
Audit Committee													
Audit Committee TOR and Annual Report (if required)													

Board Annual Cycle 2023-24

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Review of Trust Standing Orders and Standing Financial Instructions (if required)													
Charity Trustee Committee													
Charity Annual Accounts and Report									X				
Charity Trust TOR and Annual Committee Review	X												
Finance, Performance and Planning Committee													
FPPC TOR and Annual Report					X								
Quality and Safety Committee													
Complaints, PALS and Patient Experience Annual Report							*X*						
Safeguarding and L.D. Annual Report (Adult and Children)													
Staff Survey Results	**X**		**X**										**X**
Learning from Deaths			X		X				X		X		
Nursing Establishment Review											X		
Patient Safety and Incident Report (Part 2)			X						X				
Teaching Status Report			***X***										
QSC TOR and Annual Review (if required)			X										
People Committee & Culture													
Workforce Plan													

Board Annual Cycle 2023-24

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Trust Values refresh					X								
Freedom to Speak Up Annual Report					X								
Staff Survey Results			**X**										
Equality and Diversity Annual Report and WRES							**X**						
Gender Pay Gap Report			**X**										
People Committee TOR and Annual Report (if required)			**x**										
Shareholder / Formal Contracts													
ENH Pharma (Part 2) shareholder report to Board					**X**								