Public Trust Board

Online

15/01/2025 09:30 - 12:00

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2. Apologies for Absence For noting	Trust Chair		
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4. Minutes of Previous Meeting held 6 November 2024 For approval	Trust Chair	10:00-10:05	4
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For noting				

22. Any Other Business — Trust Chair

For noting

23. Date of Next Meeting — Trust Chair

Wednesday, 12 March 2025 - Online meeting

East and North Hertfordshire NHS Trust

Minutes of the Trust Board meeting held Online on Wednesday, 06 November 2024 at 9.30am.

Present:	Ms Anita Day	Trust Chair
	Dr David Buckle	Non-Executive Director (NED)
	Ms Diana Skeete	Non-Executive Director
	Ms Janet Scotcher	Non-Executive Director
	Mr Richard Oosterom	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:	Ms Amanda Rowley	Director of Midwifery
	Ms Elizabeth Franklin-Jones	Divisional Director of Nursing and Quality for Children & Young People
	Ms Sylvia Gomes	Freedom to Speak Up Guardian (24/112)
	Ms Carly Barnes	Speak Up Champions and Professional Midwifery Advocate (PMA)(24/112)
	Ms Margaret Devaney	Director of Quality
	Dr Shamira Ghouse	Chief Registrar
	Ms Lorraine Williams	Deputy Director of Infection Prevention & Control
	Mr Stuart Dalton	Head of Corporate Governance
	Mrs Debbie Okutubo	Deputy Company Secretary (Board Secretary - minutes)
Observer	Professor Zoe Aslanpour	Dean, University of Hertfordshire Medical School
	Mr Neil Tester	Chair, Healthwatch Hertfordshire
	Ms Ivana Chalmer	Chief Executive, Healthwatch Hertfordshire

No	Item	Action
	The Chair welcomed everyone to the meeting and commented that this was a live streamed meeting of the Trust Board to ensure transparency to patients, staff and the wider community.	
24/110	**DECLARATIONS OF INTEREST** There were no new interests declared.	
24/111	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Mrs Karen McConnell, Deputy Trust Chair.	

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24/112 STAFF STORY

Carly Barnes and Sylvia Gomes presented to the board. Members were advised that October was 'Speak up month'.

The staff story this month was about a preceptee midwife Speaking Up about their experience in their first year as a midwife. They explained that they found the year challenging particularly due to activity and staffing pressures. As senior colleagues seemed busy, they were reluctant to approach them for support.

Over the next few weeks, several preceptee midwives Spoke Up about their experience during the preceptorship period. All felt unsupported and did not feel psychologically safe to raise concerns.

Concerns raised included:

- Incivility and rudeness
- Poor shift pattern
- Redeployment when short staffed to areas within maternity where they had not previously rotated
- Feeling blamed when involved in clinical errors
- No sense of belonging and
- Deteriorating culture.

The themes were shared with the wider maternity team including senior managers and a more focused approach to improve staff experience was implemented in August 2023. The 'Civility saves lives' training was undertaken and credit was given to the maternity team who were willing to learn despite them being uncomfortable with what they were hearing.

Board members asked that with all the work done around culture, civility and safety what would the Freedom to speak up Guardian do differently. In response she commented that she would support them more as they were in their first year.

Members asked about the solutions implemented last year and asked if they thought the system was now in place to sustain the momentum. In response it was noted that stay interviews were now taking place not just exit interviews and that they were carried out on a quarterly basis.

Members further commented that the key lessons learnt which were implemented in the maternity division should also be implemented throughout the Trust.

It was noted that there were a number of champions in the maternity division and that there needed to be a working appetite for collaborative working and it was equally important to ensure that learning was embedded.

Members commented that data was powerful, it would therefore be good to capture new ways of working in the Trust.

The team were asked what was being done to support and enable middle managers across the Trust. In response, members were advised that a lot of time was devoted to training Band 7s to make them feel included and confident that they had the tools.

East and North Hertfordshire NHS Trust

Band 6s and 7s were also being upskilled in listening up skills, so that they were able to respond and act. There was also the equality, diversity and inclusion (EDI) training. Members were informed that the feedback to date was positive and staff were engaging.

Board members commented that this staff story was a good story to present and it was important to support the preceptorship midwives.

The board thanked the Freedom to Speak up Guardian and the Professional Midwifery Advocate.

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

24/113 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 11 September 2024 were **APPROVED** as an accurate record of the meeting.

24/114 ACTION LOG

The Board **NOTED** The status of the action log.

24/115 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

24/116 CHAIR'S REPORT

The Chair commented on the Industrial Action at the Trust which involved Clinical Support Workers taking action. She thanked all staff who stepped up as this ensured that patients were kept safe. The meeting was advised that due to the Industrial action, some executives might need to step out of the meeting to take care of issues.

The Chair welcomed Mr Neil Tester and Ms Ivana Chalmers from Healthwatch, Hertfordshire.

The Board **RECEIVED** and **NOTED** the Chair's report.

24/117 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 advised that as we were approaching winter, NHS England had sent a letter setting out its plans, together with expectations of ICBs and Trusts and the board would be updated in line with these expectations. The Trust had now launched dementia-friendly plates and cutlery as part of our commitment to providing quality care to patients and families. Refurbishment work had happened in the neonatal unit, making it possible for parents to be near their children.

After more than 18 months of hard work and dedication, our maternity unit had overseen significant improvements and assessed as ready to exit the Maternity Safety Support Programme. Huge efforts were put into the maternity unit, with supporting teams including digital, estates and facilities.

Thriving People
We continue to welcome new colleagues into our Trust each month whilst making them aware of our values and about 'Speaking up'.
The People Team won the Innovation Award at the HMPA conference. Well done to the team.
The new structure for the care groups had been implemented. With divisional leads commencing a leadership development programme to equip them with the tools to enable them function.

Seamless service
The Chief Executive reported that he attended the Hertfordshire and West Essex System Chief Executive Strategy Day working as a system rather than at individual trust levels.
During October, Ofsted and the Care Quality Commission (CQC) undertook a Joint Targeted Area Inspection (JTAI) of services for vulnerable children and families who need help in a local authority area. The Trust's Children's' Safeguarding Team contributed to this inspection, and we await feedback.

Continuous improvement
The ENH Production System (ENHPS) work continues with an increasing number of Positive Leader Rounds happening across the Trust. We are also seeing middle leaders going out to frontline staff speaking to them and making visible changes in their daily work.
The second Rapid Process Improvement Workshop (RPIW) took place in October. It was a week-long event with a number of suggested changes that could lead to cost savings and better experience for our patients.

OneEPR programme was now in operation, which was a step in the right direction as it meant that we were moving over from paper to electronic records.

Following the Darzi review – Independent investigation of the NHS in England, a programme to change NHS had been released.

There was power outage in Stevenage this week. A lot of what we do is digital which made this a challenge, but we maintained a safe site. The Board were advised that staff worked through the night to put things right and ensure that patients were kept safe with low impact. All staff involved in this were thanked for their hard work.

Members commented on the OneEPR launch that it went well. On the dementia work it was highlighted that there was significant improvement. Dr David Buckle, Chair, Quality and Safety Committee (QSC) stated that there was an annual report to QSC and improvement areas were listed in the report. It was emphasised that there was no room for complacency.
Members thanked the teams who were involved in the outage incident and asked if we were going to do a business continuity plan lessons learned. In

response, it was advised that we would be doing our lessons learned, but we were still going through the recovery stage. In addition, the Trust had a strong emergency planning team and a real-life practice test was usually carried out as well as a black building test.

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

24/117a

WINTER AND H2 PRIORITIES

The Board was advised that NHSE had written to us about the winter and H2 priorities and that the full discussion would be held at the next Finance, Performance and Planning Committee meeting (FPPC). It was noted that NHSE confirmed operating assumptions for the remainder of this financial year.

The Board **NOTED** the winter and H2 priorities.

24/118 ESTATES AND FACILITIES STRATEGY

The Director of Estates and Facilities presented this item. The Board was reminded that the condition and suitability of our estate directly impacted and influenced the care given to patients and the experience of those who work in the Trust.

It was noted that the strategy had undergone a number of iterations which had led to a change in format but not objectives. It was stated that our environment was safe to ensure clinical teams were able to take care of patients. The Board was advised that it was a developing document that would adapt to local and national changes and that we had a legal obligation to comply with our statutory compliances. It was noted that we were working towards a 'healthier hospital for a healthier community'.

Members commented that the strategy was a good read and very usefully laid out. In terms of maintenance requirements, members asked if we had the capital for what we need to do or if there was more, we could do commercially.

Members also commented that a couple of the metrics could be included for instance, how well we are doing, for example the costs per square metre and the cost of the facility management. In response, the Director of Estates and Facilities commented that we had a backlog of maintenance. The Director of Finance also commented that NHS generally had a backlog of maintenance which was a national issue but as a Trust we would start by prioritising what was important and make difficult judgments. It was appreciated that this was a difficult environment but there were good people working for the safety of patients.

Members commented that it would be good to have some metrics in the strategy going forward.

Members also asked about car parking and asked if there was an update as the issue had previously been brought to the Board. In response it was noted that a lot of work had gone into car parking including the off-site car parking that we manage. It was stated that there were a number of actions carried out over the summer. It was agreed that it would be taken to the subcommittee who would then monitor progress to date.

Action: Following further discussion, it was agreed that a status update would be taken to FPPC periodically.

The question was asked that when we get into the implementation stage, how would we ensure that issues did not get lost. In response, it was agreed that staff at all levels would be involved to ensure representation.

It was also suggested that we provide a patient dementia friendly side room and environment.

It was remarked that the future arrangements for Mount Vernon Cancer Centre (MVCC) relocation was subject to public consultation and the cost of improving the current site to be able to provide safe care to patients was being collated.

The Chair commented that it was a good conversation and it was recognised that a lot of capital work was needed but we did not have the money to do it all.

The Strategy would be risk assessed regularly and assurance provided that the process was as robust as it needed to be.

Action: Progress reports to be reported through the QSC.

The Board **RECEIVED** and **APPROVED** the Estates and Facilities Strategy.

24/119 GREEN STRATEGY

The Director of Estates and Facilities presented this item. Members were reminded that Mrs Karen McConnell, NED and Deputy Chair of the Trust was the sustainability champion. It was agreed that updates would be reported into the FPPC.

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

24/120 DIGITAL UPDATE

The Chief Information Officer presented the programme in month 5 to the Board and commented that OneEPR had been launched.

It was noted that the clinical digital team were leading engagement with clinical colleagues along with chairing the design workshops which had clinical, digital and Dedalus representation.

The Board was advised that at the launch, the Dedalus chair and medical director were present and that there was a strong governance model in place. It was stated that it would be a complete cloud delivery and have a programme board progressing it. The governance of it would be monitored by Trust Management Group (TMG) and the FPPC.

Demonstrations would start next month and there is an expectation that clinicians would engage with it.

Members commented that they were pleased to see clinicians involved.

The Board **NOTED** the digital update.

24/121 ENHPS DELIVERY PLAN UPDATE

The Chief Kaizen Officer presented this item. Following initial training and certification of staff from the recently established Kaizen Promotion Office (KPO), they had delivered the new 'Introduction to ENHPS' session to over 450 staff. They had also commenced leadership training for 60 senior leaders on the 'ENHPS for Leaders' programme.

A rapid process improvement workshop (RPIW) is a KPO facilitated five-day workshop and the second one on ophthalmology took place in October generating 62 new ideas.

Members commented that there was a visit to ophthalmology last week and it was a very positive environment it was also obvious that staff were embedding the new training.

They also suggested that the Virginia Mason Institute (VMI), was a globally recognised leader in improvements with a proven methodology and asked how the executive would make sure that improvements realised were sustainable and how they would be measured. It was also important to balance the short term and the long term aims. In response, it was noted that output from RPIW would get reported back into the 30-60-90-day process. Also, the ground up and top-down positive leadership rounds was another way to ensure that it was embedded. There was also a transactional model to look at short term and long term.

It was further noted that there were financial targets and delivery of the strategic priorities would also be measured.

Members asked about the cultural aspect and if there would be coaching. It was suggested that the detailed report would be going to the People and Culture Committee.

The Board **NOTED** the ENHPS delivery plan update.

24/122 BOARD ASSURANCE FRAMEWORK (BAF)

The Head of Corporate Governance presented this item. Following the introduction a discussion ensued.

On BAF Risk 7 - System inertia, it was proposed that the risk score be reduced from 16 to 12. To reflect that a gap had been addressed by the Chief Executive attending ICB Board, co-chairing the Hertfordshire Health

and Care Partnership (HCP) and the increasing focus of work at HCP level. The question was asked if the ICB would support this. In response, it was noted that the ICB and various partners were in support of this.

The Board was reminded that at a previous meeting it was agreed that two risks would be brought to every board meeting and at this meeting we were looking at BAF risk one – Investment and BAF risk 2 – Health inequalities.

On Risk 2, health inequalities, the Board was advised that smoking on the hospital premises was an issue. Members asked if vaping would be included in the non-smoking 'stop to swap' campaign. In response, it was noted that it depended on national guidance.

The Chair commented that there was a desire/appetite for a health inequality discussion and suggested that it be scheduled for a future board in order to have a detailed conversation. The Chair urged all members to read through the detail and that it will be scheduled as an agenda item at a future meeting with more time to discuss.

Head of Corporate Governance /Medical Director

The Board **NOTED** the Board Assurance Framework (BAF).

24/123 LEARNING FROM DEATHS

The Medical Director presented this item. It was noted that reducing mortality remained one of the Trust's key objectives and at the Trust we had low mortality rates.

The Board was advised that our medical examiners had now taken over the scrutiny of community deaths and that this would be reflected in the data being presented going forward.

In response to a question, the QSC Chair commented that at QSC, cardiovascular disease which was one of the main causes of death and disability in the UK had popped up over the last three to four years. At the QSC meeting this gets looked at in detail and regularly and there is very good analysis of the data.

Members asked about structured judgement reviews (SJR) and that only 4% of hospital deaths had received a formal SJR and asked if we had the resources we need to get to where we should be. In response the board was assured that we should get there before the end of this financial year.

The Board **NOTED** the learning from deaths report.

24/124 INTEGRATED PERFORMANCE REPORT

The Executive Directors gave an update on their respective areas.

Quality

The Chief Nurse commented that the number of accumulated open incidents remained an improvement priority across divisions. However, there was significant positive improvement noted across Planned Care.

Unplanned Care remained an area of priority with highest reported rate of incidents and highest proportion of open incidents.

On sepsis screening and management, there was sustained improvement with no serious harms reported in September.

The Medical Director advised the Board that there was an increase in the number of C difficile cases for the month of September 2024 compared to the previous months. It was noted that he was chairing weekly meetings in order to understand the reason for increase in cases. At C diff meetings, primary care is involved in the discussions as patients tend to have multi-morbidities. These meetings are usually multi-disciplinary teams involved, which enables all involved to better understand the reasons for the increase.

The QSC Chair commented on the number of PALs referrals and stated that it remained high. The chief nurse responded that it was a constant challenge for us but the team were looking to redeploy staff to assist in clearing backlogs.

Operations

The Chief Operating Officer commented that the urgent and emergency care (UEC) was still seeing staff shortages. On cancer waiting times (CWT), work was continuing with the operational teams sustaining and improving CWT performance for the Trust.

The Board was advised that there was a refreshed capacity and demand modelling for MRI underway to determine impact of outsourcing and substantive capacity required post backlog clearance.

Members commented that they were re-assured by the actions described in the report and asked what we were doing about the percentage of patients discharged to get home early. In response, members were advised that there was now an Internal Discharge Group among other initiatives to ensure this was embedded.

Finance

The Chief Finance Officer presented this part of the report and reminded the Board that we were at the half year point. He further advised the Board that the Trust approved a surplus plan of £1.0m for 2024/25. The plan assumed that a £33.8m cost improvement programme (CIP) would be delivered, and ERF performance of 138% would be achieved.

In Month 6, the Trust reported an actual deficit of £1.3m which was adverse to plan by £0.7m. It was explained that the gap related to lost income resulting from Industrial action earlier in the year.
It was further noted that pay was £0.6m adverse to plan in month, excluding non-recurrent reserves. It was noted that pay hotspots included, high levels of waiting list initiative payments; high locum usage for medical staff within the emergency department (ED) and paediatric department; and high midwifery usage.
There were mitigating action plans with the Finance Recovery Group who met monthly to monitor and report into the Finance, Performance and Planning Committee (FPPC). The FPPC Chair commented that the focus was on accountability.

People
The Chief People Officer presented this part of the report and commented on the vacancy rate. It was noted that more work was being done around the bank staff filling vacancies.
Grow Together was moving well, but work was underway to explore simplification of the system as the compliance rate stood at 85%.
The Board was advised that turnover rate was lower than the target at 9.2%.
Members commented that there is more to do around job planning.

The Chair thanked all committee members who scrutinised various aspects of the Trust at committee level.

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

24/124a MATERNITY SAFETY SUPPORT PROGRAMME

The Divisional Director for Women and Children presented the item. The Trust formally entered the Maternity Safety Support Programme in April 2023 and since then had been working through identified key workstreams.
The Board was reminded that the Trust was currently in the improvement phase of the programme and a full progress update was presented to the Trust Board in September 2024.
Having demonstrated improvements across all workstreams, and working closely with our Maternity Improvement Advisors, the service had produced a sustainability action plan (SAP) which had been reviewed and approved by the Maternity Improvement Advisor.
The Board was assured that maternity services was required to continue to provide evidence to the Trust Board, NHS England, and other external partners providing assurance of their continued commitment to quality and safety.
The Board was asked to approve the Trust sustainability action plan and support the steps outlined within the plan that were needed to deliver sustainable improvements across the service.

The Board **RECEIVED** and **APPROVED** the Maternity Safety Support Programme.

24/125 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.

BOARD COMMITTEE REPORTS

24/126 FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Finance, Performance and Planning Committee meeting held on 24 September 2024.

The Committee Chair commented that there was a later report as a meeting was held in October but that this would be presented at the January 2025 Board meeting.

24/127 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on 25 September and 23 October 2024.

24/128 PEOPLE AND CULTURE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the People and Culture Committee meeting held on 17 September 2024.

24/129 CHARITY TRUSTEE COMMITTEE REPORT TO THE BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Charity Trustee Committee meeting held on 9 September 2024.

24/130 ANNUAL CYCLE

The Board **RECEIVED** and **NOTED** the latest version of the annual cycle.

24/131 ANY OTHER BUSINESS

The Chair thanked Mr Neil Tester and Ms Ivana Chalmers for attending the meeting and commented that in future they would be bringing their own insights.

Both Neil and Ivana thanked the Board and said that it was good to see the ENHT annual cycle which would inform when they would be bringing their briefings to the ENHT board.

The Chair passed on seasonal greetings to everyone present as this was the last public meeting this year and wished everyone a happy new year.

24/132 DATE OF NEXT MEETING

The date of the next meeting is 15 January 2025.

Ms Anita Day
Trust Chair
November 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 JANUARY 2025

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
11/9/24	24/097	Quality account to target our audience	A summary of the Quality Account to be produced for the end user.	Work is underway with stakeholders to combine an easy read handheld version for the Quality strategy, which will encompass quality account objectives. We anticipate this being completed by quarter four.	Chief Nurse	March 25
06/11/24	24/122	There is a desire/appetite for a health inequality discussion	Health inequality to be brought to a future Board meeting.	It remains a standing agenda item at the QSC meetings and will come to the May Board meeting.	Head of Corporate Governance/Medical Director	May 25

East and North Hertfordshire NHS Trust

Chief Executive's Report

January 2025

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

Quality

Winter is here and bringing significant pressures across our Trust and across the wider NHS – both in terms of the volume of patients we are seeing, and the seriousness of the conditions of the patients we are seeing, alongside a notable rise in staff sickness adding further strain to our services. This has inevitably led to some periods of time where bringing patients in from ambulances has been delayed and moving patients to inpatient beds from ED has taken longer than desired, particularly when side rooms were required due to flu and other infections.

This month the Government and NHS England published its plan for how the NHS will reform elective care services and meet the 18-week referral to treatment standard by March 2029. Long waiting times remain a major concern for the Trust, but we have continued to be one of leading trusts in the NHS in delivering elective activity beyond that delivered pre-pandemic. As detailed planning guidance and the financial framework becomes available, I will update the Board.

Thriving People

2024 was a year full of success and achievements for our Trust. The highlights include our Cancer team reached the finals at the HSJ Awards for the Chemo at Home programme, our security team won the Healthcare Security Team of 2024, and our people team won the Healthcare People Management Association (HPMA) Award for Innovation for our intranet virtual assistant Enquire.

The Trust has been awarded the Armed Forces Covenant Employer Recognition Scheme Gold Award. As Chief Executive, I am incredibly proud of our staff who exemplify our Trust values every day.

Our ViP awards continue to celebrate and showcase the thriving individuals who make our Trust exceptional. We received an impressive 290 nominations in 2024.

In addition, I held 19 'Chat with the Chief Exec' sessions across all four of our main sites. These sessions provided a great opportunity to celebrate both team and personal achievements, gather valuable feedback, and to have a general chat. It is always a pleasure to be able to connect with so many of my colleagues across the Trust.

And finally, the Trust welcomed the next MSc 2024 Student Nurse cohort from the University of Hertfordshire in December 2024. Welcome to all, and I wish you all the best during your training period.

Seamless Services

A frailty conference was held on 13 November. This brought together clinicians from across East and North Herts Health and Care Partnership to further develop services and models of care with the ambition to deliver a reduction in hospital admissions of 25% of frail patients who could be better cared for in an alternative setting.

Women will now have immediate and convenient access to contraception following the birth of their child – following the launch of a new improvement project – the Postnatal Contraception Service.

The service – one of the first of its kind in the East of England – enables new mothers to make informed choices about their reproductive health and receive contraception without the need for a separate appointment at a GP or sexual health clinic. Women will be able to access the service shortly after childbirth, before they leave hospital.

Continuous Improvement

During December 2024, Professor Nikhil Vasdev attended a conference in New York where he and his team were presented with a prestigious international award for outstanding contribution for their State-of-the-Art Artificial Intelligence collaborative research between the East and North Hertfordshire NHS Trust, and the University of Hertfordshire.
The research presented represents significant improvements for patient care, the first study showed data on 2 trials using AI to analyse MRI data from patients with prostate cancer to assist with planning during nerve sparing robotic prostate cancer surgery and the second study presented looked at different pressures of gas used during Robotic Bladder Cancer surgery.

Finally, I want to congratulate our Chief People Officer, Thomas Pounds who has been successfully appointed to the same post at the Royal Free London NHS Foundation Trust. Whilst sad to see Thom leave us, we congratulate him on his new role and will have opportunity to thank him before he leaves us at the end of March.

Adam Sewell-Jones
Chief Executive

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	9
Report title	Renal Patient Safety Incident Investigation (PSII)	**Meeting Date**	15 January 2025
Presenter	Medical Director		
Author	Associate Medical Director Patient Safety		
Responsible Director	Medical Director	**Approval Date**	24 December 2024

Purpose (*tick one box only*) [See note 8]	**For information only**	☐	**Approval**	☒
	Discussion	☒	**Decision**	☐

Report Summary:

Patient safety incident investigations (PSIIs) are undertaken to identify new opportunities for learning and improvement. A PSII was carried out following the closure of Bedford Renal Unit in February 2024.

The investigation report has been discussed at Quality and Safety Committee and Trust Management Group and a summary of the findings is now escalated to the Board for discussion.

The report relates to an incident that happened in February 2024 and had an impact on patients, staff and service resilience.

Harm was caused to patients.

The report describes multiple causes which lined up to lead to the incident in a 'Swiss Cheese' model. It also describes a complex set of actions, many of which were completed at the time of the incident. Focus is now needed to complete the remainder of these.

Impact: tick box if there is any significant impact:

Equality (patients or staff)	☐	**Patients / Public benefit or detriment**	☒	**Financial / Resourcing**	☒	**Legal / Regulatory**	☒	**Green Sustainability**	☐

The incident affected the wellbeing of patients.
There has been a significant impact on the finances of the organisation and the wider system.

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*

The Renal service had several risks prior to this incident. As a result of this incident, it was placed on the corporate risk register.

Report previously considered by & date(s):	
Quality and Safety committee 18.12.24 Trust Management Group 10.11.25	
Recommendation	The Board is asked to note the paper and discuss the findings within it.

To be trusted to provide consistently outstanding care and exemplary service

Patient Safety Incident Investigation report: Bedford Renal Unit

East and North Hertfordshire NHS Trust

January 2025

What happened?

East and North Hertfordshire NHS Trust

- In February 2024, 69 of the 97 patients receiving dialysis at the Bedford Renal Unit had a drop in their haemoglobin
- This led to concerns about the quality of the water at the unit.
- This incident is likely to have contributed to 15 patients needing admission to hospital because they became unwell
- In total 30 patients required a transfusion
- 1 patient suffered a stroke which is likely to have been contributed to by the treatment of anaemia (which was caused by the incident)

How has this been investigated?

East and North Hertfordshire NHS Trust

- The Trust patient safety incident review panel (PSIRP) commissioned a patient safety incident investigation (PSII), conducted by a learning response team
- The panel incorporated the independent engineering reports obtained following the incident
- The panel spoke with patients affected and the Lister Area Kidney Patients association (LAKPA)
- Immediate improvements were put in place during the investigation
- The report was then discussed at the Trust Quality and Safety Committee
- The investigation report has made several further recommendations for the near, mid, and long-term future

Why did it happen and what have we learnt? (1)

NHS East and North Hertfordshire NHS Trust

- The report identified 17 contributory key findings, these have been grouped together into 11 themes

Theme	Factor	Detail
1	Water quality testing	• Protocol outdated, inappropriate response to abnormal findings
2	Tools and equipment	• Alarm panel not in use
3	Communication	• No clear documentation of escalation process in response to abnormal results
4	Governance	• Oversight of dialysis water quality was unclear • Not following manufacturers guidance • Non-technical line management of the renal technical team • Short term fixes for engineering problems • Unclear contract, out of date, poor contract management

Why did it happen and what have we learnt? (2)

East and North Hertfordshire NHS Trust

Theme	Factor	Detail
5	Maintenance	• Unclear lines of responsibility regarding preventative maintenance
6	Skills, knowledge and training	• Gap in technical oversight and assurance
7	Engineering	• Inadequate installation of softener components • Inappropriate pump installation
8	Risk management	• Risks relate to capacity and age of plant • Risks poorly assigned • Risks not responded to in a timely way

Why did it happen and what have we learnt? (3)

East and North Hertfordshire NHS Trust

Theme	Factor	Detail
9	Capacity modelling	• Different understanding or capacity • Increased demand on the service
10	Staffing model	• Demand on technical team • Nursing requirement
11	Physical environment	• Temporary fixes

Areas for improvement and actions

East and North Hertfordshire NHS Trust

- The learning response team identified 28 areas of improvement that were required
- All immediate improvements were put in place rapidly
- There remain some longer-term improvements that are required

- Improvements completed include
  - The Bedford unit water treatment plant has been replaced
  - The St Albans treatment plant has also been replaced
  - There is clear governance around the responsibility for changes to the plant engineering
  - There is clear governance around the responsibility for water quality
  - Improved risk management structure

- Future plans
  - The Lister level 3 unit will be replaced in spring 2025
  - An additional 20 station modular unit has been purchased for the Lister site
  - Additional nurse recruitment agreed and recruitment underway
  - Contract management within the Trust is being reviewed
  - Demand and capacity is being discussed with commissioners

Thank you

NHS
East and North Hertfordshire
NHS Trust

- To the investigation team – Dr Jon Bramall, Clare Carr, Sam Hoskins and Kim Walker
- To LAKPA
- To our patients
- To our staff

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	10
Report title	Teaching Status – Draft Establishment Order for Board Approval	**Meeting Date**	15 January 2025
Presenter	Partnership Manager		
Author	Partnership Manager		
Responsible Director	Medical Director	**Approval Date**	19 December 2024

Purpose (*tick one box only*) [See note 8]	**For information only**	☐	**Approval**	☐
	Discussion	☐	**Decision**	☒

Report Summary:

Following board approval of the application documents in May 2024, the Trust applied to the Department of Health and Social Care (DHSC) to become a Teaching Trust.

DHSC have redrafted the Trust's Establishment Order to reflect the name change and to add a university appointed non-executive director to the board.

DHSC has also taken the opportunity to amend the Trust's EO in line with current policy including a broader definition to allow for more flexibility when it comes to the interpretation of the NHS Trust's functions and changes to several out-of-date provisions. These were non-material in nature; received in the Trust in September and approved by the Head of Corporate Governance and In-house Solicitor.

Impact: tick box if there is any significant impact:

Equality (patients or staff)	☒	**Patients / Public benefit or detriment**	☒	**Financial / Resourcing**	☐	**Legal / Regulatory**	☐	**Green Sustainability**	☐

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*

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

Report previously considered by & date(s):

Board approved decision to apply for teaching status January 2023
Execs and NEDs discussed name June/August 2023
Board approved application for teaching status May 2024

Recommendation	The Board is asked to review and approve the draft establishment order and to nominate a start date for these changes to take effect.

To be trusted to provide consistently outstanding care and exemplary service

Establishment Order for Teaching Status

East and North Hertfordshire NHS Trust

Teaching Status - Draft Establishment Order for Board Approval

1. Purpose

To seek Board approval for changes to the Trust Establishment Order.

For Board to consider when the changes should take effect from.

2. Background

Following approval of the application documents at Trust Board in May 2024; the Trust submitted all appropriate documentation to the Department for Health and Social Care (DHSC) seeking permission to become a Teaching Trust.

In response to our application, DHSC have redrafted our Trust Establishment Order (EO); the Statutory Instrument issued by the Secretary of State designating Trust as a legal entity. The new draft EO is below along with our original establishment order from 2000 for information and comparison.

The new order changes the Trust name to East and North Hertfordshire Teaching NHS Trust and adds to the Board constitution a non-executive director from the University of Hertfordshire.

East and North Hertfordshire Teaching NHS Trust

DHSC has also taken the opportunity to update some of the language of the EO to reflect policy changes since the original was drafted in 2000; these were non-material and have been approved in advance by both the Trust In-house Solicitor and Head of Governance.

3. Commencement date

It is normal for changes to establishment orders to have a lead time of at least 2 months to allow time for rebranding to signage and Trust templates etc. and for both internal and external communications to maximise the impact of Teaching status.

We therefore are recommending a commencement date of 1 April 2025 which also coincides with the start of the new financial and reporting year. This is subject to approval from DHSC.

Please note: the start date for our new university appointed non-executive director, Zoe Aslanpour, will be the same as the commencement date.

4. In Conclusion

The Board is asked to approve:

- the new Establishment Order below (the Chief Executive then will respond to DHSC confirming that the Trust wishes to proceed to Teaching Hospital status).

- recommended commencement date for the new Establishment Order of 1 April 2025.

STATUTORY INSTRUMENTS

2000 No. 535

NATIONAL HEALTH SERVICE, ENGLAND

The East and North Hertfordshire National Health Service Trust (Establishment) Order 2000

Made - - - -	*1st March 2000*
Coming into force - -	*13th March 2000*

The Secretary of State for Health, in exercise of the powers conferred on him by section 5(1) of, and paragraphs 1, 3, 4 and 5 of Schedule 2 to, the National Health Service and Community Care Act 1990(**1**) and of all other powers enabling him in that behalf, having completed the consultation prescribed under section 5(2) of that Act(**2**), hereby makes the following Order:

Citation, commencement and interpretation

1.—(1) This Order may be cited as the East and North Hertfordshire National Health Service Trust (Establishment) Order 2000 and shall come into force on 13th March 2000.

(2) In this Order, unless the context otherwise requires—

"the Act" means the National Health Service and Community Care Act 1990;

"community health services" means any services which the Secretary of State may provide under section 3(1)(d) or (e) of, or Schedule 1 to, the National Health Service Act 1977 and any service which has a duty to provide under section 5(1) or (1A) of that Act(**3**).

"establishment date" means 13th March 2000;

"operational date" has the meaning assigned to it in paragraph 3(1)(e) of Schedule 2 to the Act;

"the trust" means the East and North Hertfordshire National Health Service Trust established by article 2 of this Order.

(**1**) 1990 c. 19; section 5 was amended by paragraph 69 of Schedule 1 to the Health Authorities Act 1995 (c. 17) and by the Health Act 1999 (c. 8) section 13; paragraph 1 of Schedule 2 is cited for the definition of "an order": paragraph 3 of Schedule 2 to the 1990 Act was amended by the Health Act 1999 section 13(7).
(**2**) *See* S.I. 1996/653.
(**3**) 1977 c. 49; section 5(1) was amended by, and section 5(1A) was inserted by, the Health and Medicines Act 1988 (c. 49), section 10(1); Schedule 1 was amended by the Education Reform Act 1988 (c. 40), Schedule 1, the Health and Medicines Act 1988 (c. 49), Schedule 2, paragraph 7 and the Education Act 1996 (c. 56), Schedule 37, paragraph 46.

Establishment and name of the trust

2. There is hereby established an NHS trust which shall be called the East and North Hertfordshire National Health Service Trust.

Nature and functions of the trust

3.—(1) The trust is established for the purposes specified in section 5(1) of the Act.

(2) The trust's functions shall be to provide goods, hospital accommodation and services and community health services, for the purposes of the health service at or from the following hospitals, establishments or facilities—

(a) Lister Hospital, Coreys Mill Lane, Stevenage, Hertfordshire SG1 4AB,

(b) Queen Elizabeth II Hospital, Howlands, Welwyn Garden City, Hertfordshire AL7 4HQ,

and at or from any associated hospitals, establishments and facilities.

Directors of the trust

4. The trust shall have, in addition to the chairman, 5 executive directors and 5 non-executive directors.

Operational date and accounting date of the trust

5.—(1) The operational date of the trust shall be 1st April 2000.

(2) The accounting date of the trust shall be 31st March.

Limited functions before operational date

6. Between its establishment date and its operational date the trust shall have the functions—

(a) of entering into NHS contracts;

(b) of entering into other contracts including contracts of employment;

(c) of doing such other things as are reasonably necessary to enable it to begin to operate satisfactorily with effect from its operational date.

Assistance by Health Authorities before operational date

7.—(1) East and North Hertfordshire Health Authority shall discharge the liabilities of the trust, incurred between the establishment date and the operational date, that are of a description specified in paragraph (2) of this article.

(2) The liabilities referred to in the preceding paragraph are—

(a) liability for the remuneration and travelling or other allowances of the chairman and non-executive directors of the trust;

(b) liability for the travelling or other allowances of the members of committees and sub-committees of the trust who are not also directors of the trust;

(c) liability for the remuneration of persons employed by the trust; and

(d) any other liability which may reasonably be incurred by the trust for the purpose of enabling it to begin to operate satisfactorily with effect from the operational date.

Signed by authority of the Secretary of State for Health

Hunt
Parliamentary Under-Secretary of State
Department of Health

1st March 2000

Document Generated: 2023-06-01
Status: *This is the original version (as it was originally made). This item of legislation is currently only available in its original format.*

EXPLANATORY NOTE

(This note is not part of the Order)

This Order establishes the East and North Hertfordshire National Health Service Trust, an NHS trust provided for in section 5 of the National Health Service and Community Care Act 1990. It also provides for the functions of the trust (article 3) and the number of executive and non-executive directors (article 4). It specifies the operational date (the date on which the trust assumes all its functions) and the accounting date of the trust (article 5), the trust's limited functions before the operational date (article 6) and the trust's liabilities which will be discharged by the East and North Hertfordshire Health Authority if incurred between the establishment date and the operational date of the trust (article 7).

This Order should be read in conjunction with the East Hertfordshire and the North Hertfordshire National Health Service Trusts (Dissolution) Order 2000(**4**).

(**4**) S.I. 2000/536.

STATUTORY INSTRUMENTS

2024 No.

NATIONAL HEALTH SERVICE, ENGLAND

The East and North Hertfordshire National Health Service Trust (Establishment) (Amendment) Order 2024

Made - - - - ***

Coming into force

The Secretary of State makes the following Order in exercise of the powers conferred by sections 25(1), 272(7) and (8) and 273(1) of the National Health Service Act 2006.

In accordance with section 25(3) of that Act, the Secretary of State has completed the consultation prescribed by regulations made under that section.

Citation, commencement, interpretation and extent

1.—(1) This Order may be cited as the East and North Hertfordshire National Health Service Trust (Establishment) (Amendment) Order 2024 and comes into force on [date].

(2) In this Order "Establishment Order" means the East and North Hertfordshire National Health Service Trust (Establishment) Order 2000(**a**).

(3) This Order extends to England and Wales.

Amendment of interpretation provision

2. In article 1(2) of the Establishment Order (citation, commencement and interpretation) substitute "In this Order, "the trust" means the East and North Hertfordshire Teaching National Health Service Trust established by article 2 of this Order.".

Change of name and savings

3.—(1) In article 2 of the Establishment Order (establishment and name of the trust), for "East and North Hertfordshire National Health Service Trust" substitute "East and North Hertfordshire Teaching National Health Service Trust".

(2) The change of name effected by paragraph (1) does not—

(a) affect any right or obligation of any person; or

(b) invalidate any instrument (whether made before, on or after the day on which this Order comes into force) which refers to the East and North Hertfordshire National Health Service Trust, and all instruments or other documents which refer to that name must be

(**a**) S.I. 2000/535

construed as referring to the East and North Hertfordshire Teaching National Health Service Trust.

Change to nature and functions of the trust

4. For article 3 of the Establishment Order (nature and functions of the trust), substitute—

"Functions of the trust

3. The trust's functions are to provide goods and services for the purposes of the health service.".

Change of requirements relating to directors

5. For article 4 of the Establishment Order (directors of the trust), substitute—

"4.—(1) The trust must have, in addition to the chairman, 5 executive directors and 6 non-executive directors.

(2) Since the trust is to be regarded as having significant teaching commitment, one of the non-executive directors must be appointed from the University of Hertfordshire.".

Removal of specification of "operational date"

6. For article 5 of the Establishment Order (operational date and accounting date of the trust), substitute—

"Accounting date

5. The accounting date of the trust is 31 March.".

Revocation of expired provisions

7. Article 6 (limited functions before operational date) and article 7 (assistance by health authorities before operational date) of the Establishment Order are revoked.

Signed by authority of the Secretary of State for Health and Social Care

PLEASE DO NOT SIGN

Department of Health and Social Care

EXPLANATORY NOTE

(This note is not part of the Order)

This Order amends the East and North Hertfordshire National Health Service Trust (Establishment) Order 2000 ("the Establishment Order"), which established the East and North Hertfordshire National Health Service Trust ("the trust").

Article 2 omits definitions that are no longer of any on-going relevance and amends the definition of the trust.

Article 3 amends the name of the trust to East and North Hertfordshire Teaching National Health Service Trust.

Article 4 sets out the functions of the trust as being to provide goods and services for the purposes of the health service.

Article 5 increases the number of non-executive directors and specifies that one non-executive directors must be appointed from the University of Hertfordshire.

Article 6 omits the trust's "operational date" as it is of no on-going relevance.

Article 7 revokes articles 6 and 7 of the Establishment Order as they relate to the period before the trust's operational date and are of no on-going relevance.

A full impact assessment has not been produced for this instrument as it has no effect on private sector or civil society organisations, and no significant effect on the public sector.

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 08 | 2024-25

	P	?	F
H / L	1	9	6
	6	42	10
H / L	2	4	4

Data correct as at 25/12/2024

Performance Highlights

East and North Hertfordshire NHS Trust

Quality

- *C difficile (C diff.)* - There has been a decrease in the number of cases this month (5) compared to the previous month (9 cases). Although this remains at par with the monthly threshold.
- MRSA BSI - There were zero MRSA BSI in the month of November'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 Nov-24, HSMR remained below 100 and SHMI is same as previous month in their latest respective publications.

Operations

- Urgent and Emergency Care - Performance decreased to 67.2%, impacted by staff sickness and closed medical beds due to business continuity incidents.
- Cancer Waiting Times - The Trust achieved all 3, 28-day Faster Diagnosis, 31-day decision to treat to treatment and 62-day referral to treatment standards in Oct-24
- 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 number and proportion of patients waiting over 6 and 13 weeks continued to decrease in response to work to improve productivity.

Finance

- The Trust approved 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 8, the Trust has reported an actual YTD surplus of £0.2m. This is adverse to plan by £0.7m. This gap relates to lost income resulting from Industrial Action earlier in the year.
- Financial performance YTD has been defined by slower than planned mobilisation of additional elective capacity; slippage against a range of intended savings programmes and in addition significant overspending against a number of expenditure budgets, such as maternity, medical staffing as well as pathology and medical consumable costs.
- Utilisation of a non-recurrent reserves has been required to compensate for these pressures and Divisions have developed a range of recovery plans.

People

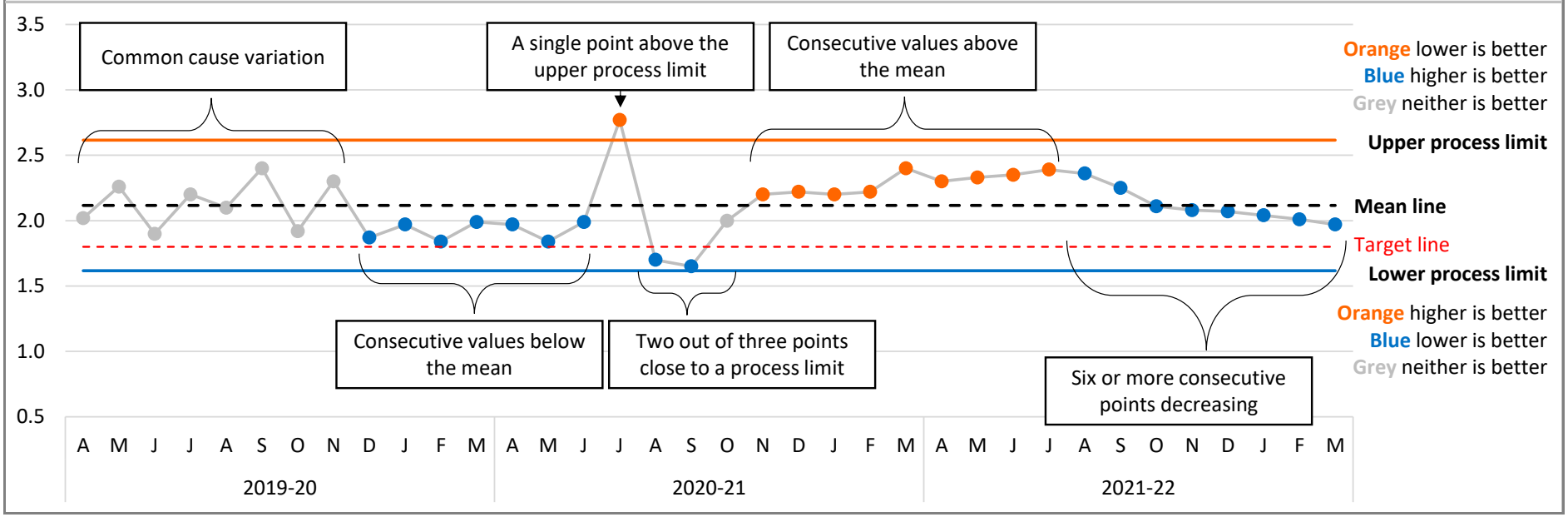
- Progress is being made on improving the vacancy rates (8.8%) due to commencement of newly qualified nurses and midwives, as well as key medical posts being filled.
- The improved vacancy rate and stronger monitoring have reduced bank spending to 8% from 10.2% in August. Although covering winter sickness absences may increase costs, monitoring should minimize the impact.
- The staff survey field work concluded with a 50% response rate. Indicative results will be made available in month 10 with full bench marking data to be released in the following months.
- Sickness absence rate is above average at 5%. Targeted work to support leaders to prevent and manage sickness absence continues, with coaching for managers, occupational health advice and sickness absence case review meetings.

Month 08 | 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

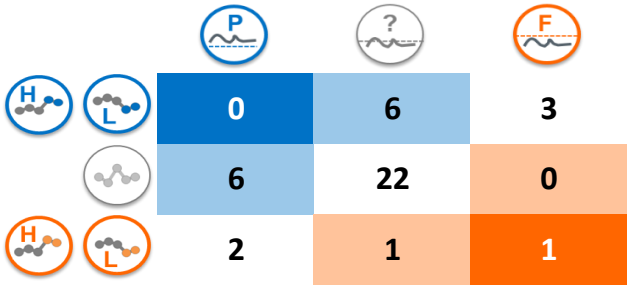
Assurance

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

East and North Hertfordshire NHS Trust

Quality

Month 08 | 2024-25



Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Nov-24	n/a	1,598			2 points above the upper process limit No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Nov-24	0	0			12 points below the mean Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Nov-24	0	5			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Nov-24	0	3			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Nov-24	0	8			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Nov-24	0	1			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Nov-24	0	0			Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Nov-24	0	0			24 points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Nov-24	80%	93.8%			Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Nov-24	n/a	82.8%			11 points above the mean No target
	Staff shortage incidents	Nov-24	n/a	43			1 point above the upper process limit No target

Month 08 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Nov-24	n/a	0.61			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Nov-24	n/a	0.41			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Nov-24	95%	87.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Nov-24	95%	62.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Nov-24	95%	89.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Nov-24	95%	71.3%	H	F	10 points above the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Nov-24	85%	56.9%	L	F	2 points below the lower process limit Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	Nov-24	n/a	122	H		12 points above the mean No target
	Number of HAT RCAs completed	Nov-24	n/a	10			Common cause variation No target
	HATs confirmed potentially preventable	Nov-24	n/a	0			Common cause variation No target
PU	Pressure ulcers All category ≥2	Nov-24	0	8		?	Common cause variation Metric will inconsistently pass and fail the target

Month 08 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Nov-24	n/a	4.4			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Nov-24	n/a	0.0%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Sep-24	0	0			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	Nov-24	95%	96.4%		P	Common cause variation Metric will consistently pass the target
	A&E positive feedback	Nov-24	90%	87.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Nov-24	93%	92.1%	H	F	10 points above the upper process limit Metric will consistently fail the target
	Maternity Birth positive feedback	Nov-24	93%	100.0%	H	?	7 points above the mean Metric will inconsistently pass and fail the target
	Maternity Postnatal positive feedback	Nov-24	93%	96.4%	H	?	3 points above the upper process limit Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Nov-24	93%	97.2%	H	F	5 points above the upper process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	Nov-24	95.0%	96.8%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Nov-24	n/a	344		-	Common cause variation No target

Month 08 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Nov-24	n/a	76		-	Common cause variation No target
	Number of complaints closed in-month	Nov-24	n/a	74		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Nov-24	75%	97.4%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Nov-24	80%	80.0%		?	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	Nov-24	3.3%	4.1%	H	?	1 point above the upper process limit Metric will inconsistenly pass and fail the target
	3rd and 4th degree tear vaginal	Nov-24	2.5%	0.7%		?	Common cause variation Metric will inconsistenly pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Nov-24	4.5%	1.5%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear instrumental	Nov-24	6.3%	5.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Nov-24	6.0%	6.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Nov-24	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

Month 08 | 2024-25

Quality

East and North Hertfordshire NHS Trust

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Nov-24	12.5%	6.9%		P	Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Nov-24	2.3%	5.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Nov-24	50.5%	64.4%	L	P	2/3 points close to lower process limit Metric will consistenly pass the target
	Breast feeding initiated	Nov-24	72.7%	73.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	Number of serious incidents	Nov-24	0.5	0		?	Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Nov-24	12.8	8.0	L	?	10 points below the mean Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Nov-24	12.8	9.0			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Oct-24	100	86.0		?	Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Oct-24	100	83.0			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Jun-24	100	84.0		?	Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Jun-24	100	92.0			Rolling 12-months - unsuitable for SPC

Month 08 | 2024-25

Quality

Summary

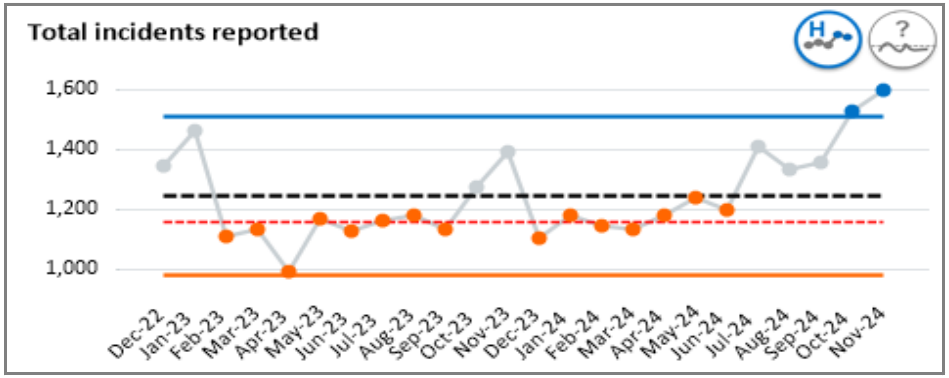
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Oct-24	n/a	859	H		4 points above the upper process limit No target
	Rate of emergency re-admissions within 30 days of discharge	Oct-24	9.0%	6.4%	H	P	9 points above the mean Metric will consistently pass the target
Length of Stay	Average elective length of stay	Nov-24	2.8	2.2		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	Nov-24	4.6	4.4	L	?	11 points below the mean Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Nov-24	n/a	95.2%			Common cause variation No target
	Individualised care pathways	Nov-24	n/a	25			Common cause variation No target

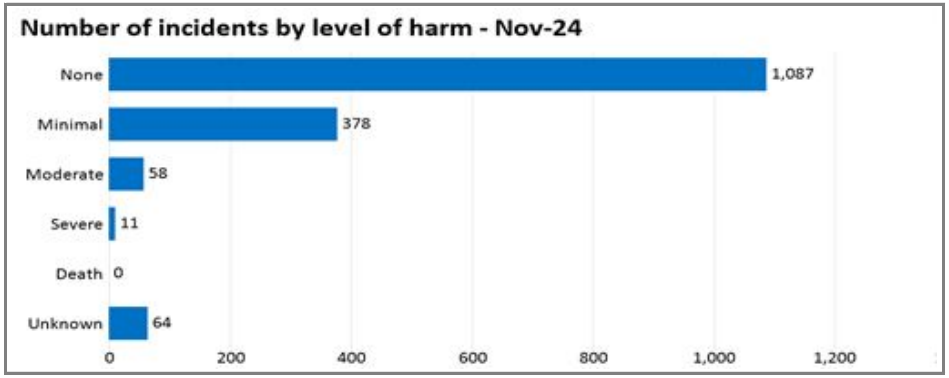
Month 08 | 2024-25

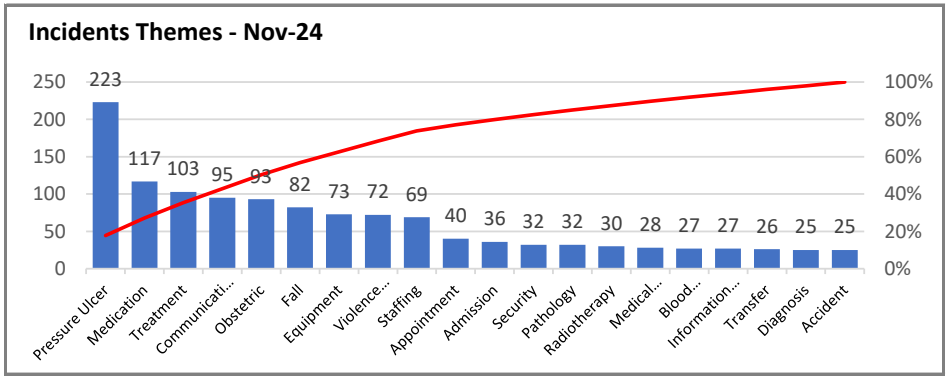
Quality

Patient Safety Incidents

East and North Hertfordshire NHS Trust

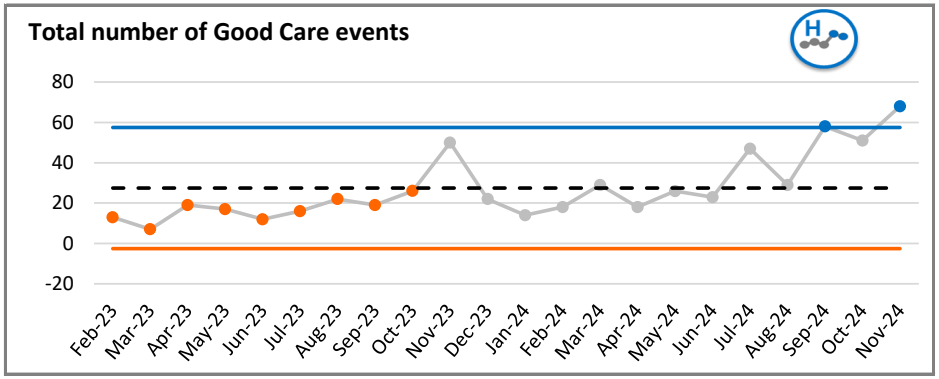






Key Issues and Executive Response

- Special cause variation in incident reporting. Influenced by active promotion of reporting within maternity and the emerging use of daily incident review huddles across Care Groups.
- Increase of V&A incidents reported in Paediatrics, roundtable to be undertaken and learning re therapeutic holding
- Theme seen within Planned care about insulin related incidents-learning includes check of training, reminder memos issued. Deep dive to be presented to medication forum by Planned Care pharmacist. Learning added to Trust-wide learning points document for RHD
- Emergency Medicine and Obstetrics continue to be the highest reporting specialties
- The number of accumulated open incidents remains an improvement priority ; extraordinary support to be provided to Unplanned Care
- Womens services holding incident clinics to support with incident management and dedicated time for risk management midwife.
- Planned Care introducing cold de-brief learning response
- Four serious incidents remain open, all relate to Paediatric Audiology.
- 1 new PSII agreed in November; administration of VTE prophylaxis when contraindicated.

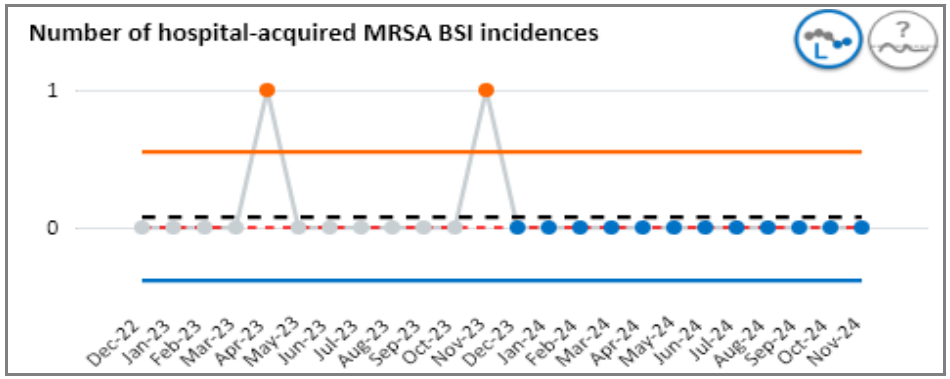


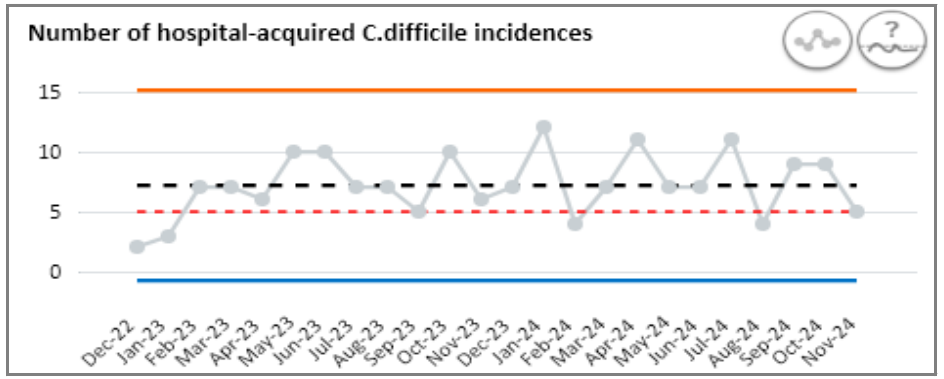
Month 08 | 2024-25

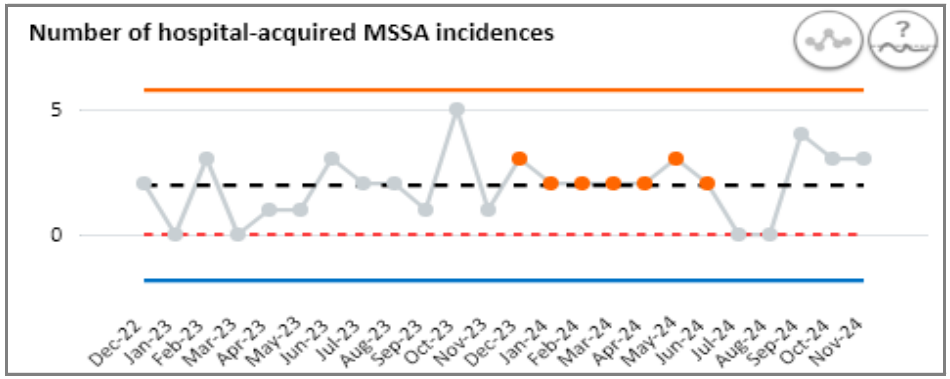
Quality

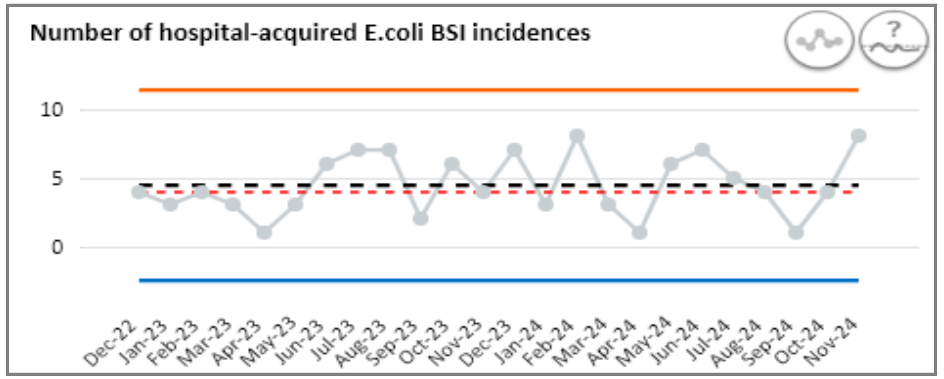
Infection Prevention and Control

East and North Hertfordshire NHS Trust









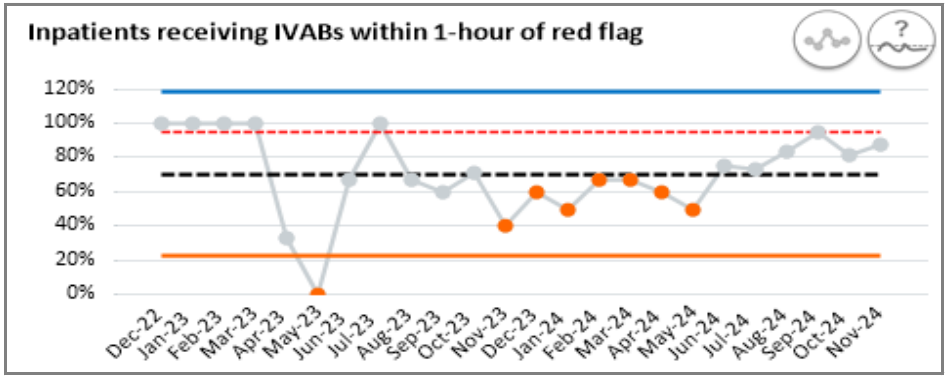
- *C difficile (C diff.)* infection (CDI) - the number of CDI cases for the month of November 2024 has decreased and is on the threshold level for the month. Four cases within the Unplanned Care division whilst one were within Planned Care. The weekly multidisciplinary team (MDT) meetings were continuously held with satisfactory attendance from the treating clinicians which enabled the infection control doctor (ICD) and the antimicrobial pharmacist to provide timely treatment management support. Year to date (YTD), there are 63 cases against the threshold of 92, slightly above trajectory.
- MRSA BSI - there were zero MRSA BSI YTD.
- MSSA BSI - there were three MSSA BSI cases in October 2024, similar to the previous month. The IPC team continued to inform clinicians of any learning identified within the IPC post infection review. YTD 17, zero threshold.
- *E.coli BSI* - there were eight cases of healthcare-associated infection in November 2024, which is a significant increase from the previous month. YTD 35, threshold of 55. The IPC team continues to work with the vascular access lead nurse in improving management of intravenous devices and working with urology nurse specialist for indwelling urinary catheter device care.

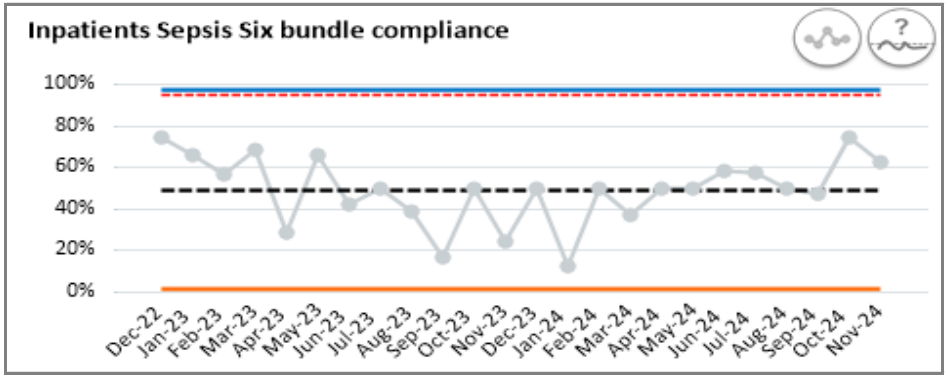
Month 08 | 2024-25

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust





Themes

Sepsis IP	2023-24				2024-25							
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	78%	57%	100%	63%	78%	88%	75%	95%	65%	67%	88%	93%
IV antibiotics	60%	50%	75%	67%	60%	50%	75%	74%	83%	95%	81%	89%
IV fluids	83%	57%	100%	100%	67%	71%	67%	77%	83%	80%	83%	93%
Lactate	60%	25%	86%	63%	89%	100%	75%	89%	59%	81%	88%	78%
Urine measure	60%	50%	57%	75%	89%	88%	92%	74%	94%	76%	94%	95%

Key Issues and Executive Response

Themes

- Sepsis six bundle compliance sits at 63% for November which is a decrease from 75% for October however individual percentages have improved in 5/6 separate sepsis six elements.
- IVABX administration compliance is increasing again to acceptable levels.
- Compliance for oxygen administration remains at 100%.
- There has been a noted improvement in blood culture compliance from 88% to 93%.
- Urine measurement has maintained at a high level of compliance at 95% for November.

Response

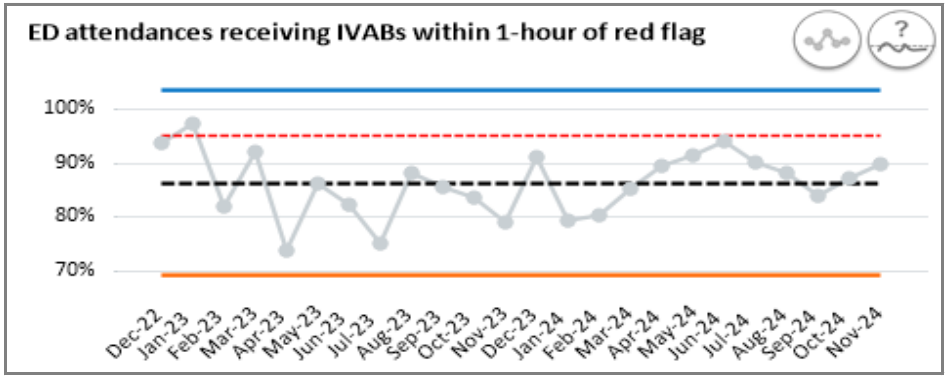
- No harms were reported due to delayed recognition or management of sepsis.
- Sepsis Grab boxes are fully embedded across the Lister site - the Sepsis Team are currently in the process of auditing the continued use. We have received positive feedback on the use of these from multiple sources.
- Ad hoc teaching and continued presence in key areas for potentially septic patients including members of the MDT.
- Quality Improvement Project in place for urine output measurement in problem areas.
- IMT teaching arranged for this month to address medical shortfall in compliance.
- Virtual Student forum planned to address student shortfall for future guarding.

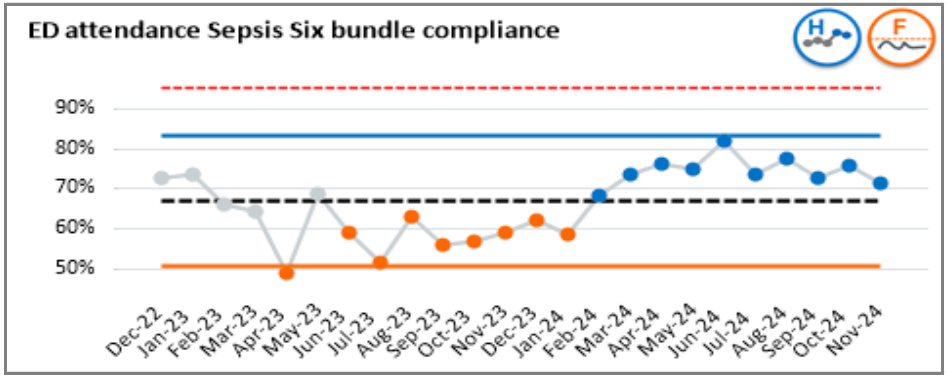
Month 08 | 2024-25

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust





Themes

Sepsis ED	2023-24				2024-25							
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Oxygen	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	91%	92%	100%	97%	97%	91%	100%	99%	93%	97%	97%	90%
IV antibiotics	91%	79%	80%	85%	89%	92%	94%	90%	88%	84%	87%	90%
IV fluids	92%	82%	85%	84%	91%	92%	94%	92%	90%	87%	93%	95%
Lactate	95%	98%	100%	98%	100%	100%	100%	100%	96%	98%	99%	97%
Urine measure	67%	66%	78%	86%	79%	83%	86%	74%	79%	81%	80%	81%

Key Issues and Executive Response

Themes

- 50% of the Sepsis Six has exceeded Trust targets within November - this has maintained since September. This includes oxygen, IV fluid and lactate collection.
- Urine output measurement has maintained its percentage in comparison to last month.
- IV fluid and antibiotic compliance have shown an incline in compliance sitting at 95% and 90% respectively from 93% and 87%.
- ED has maintained a high standard with improvements in areas mentioned above.

Response

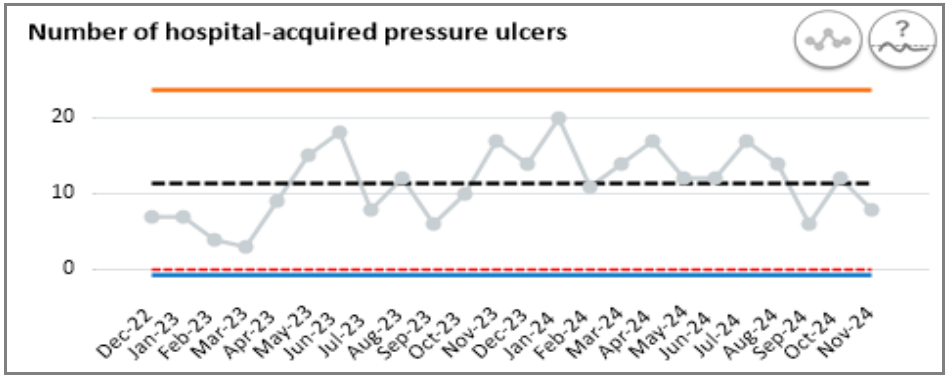
- No serious harms were reported in October.
- The Sepsis Team continue to provide bedside education to staff, often attending patients in ED and going through the Sepsis Screening Tool in real time.
- ENHance reports are submitted to ED matrons for non-compliance to be reviewed and set a plan for continuous improvement.
- Sepsis drawer now implemented in all Resus spaces to allow for prompt treatment.
- Mandatory e-learning is being updated to include a detailed video showing how to use the digital screening tool.
- The team collaborates with an antimicrobial pharmacist to provide teaching to nursing staff regarding appropriate and timely antimicrobial use in septic patients.

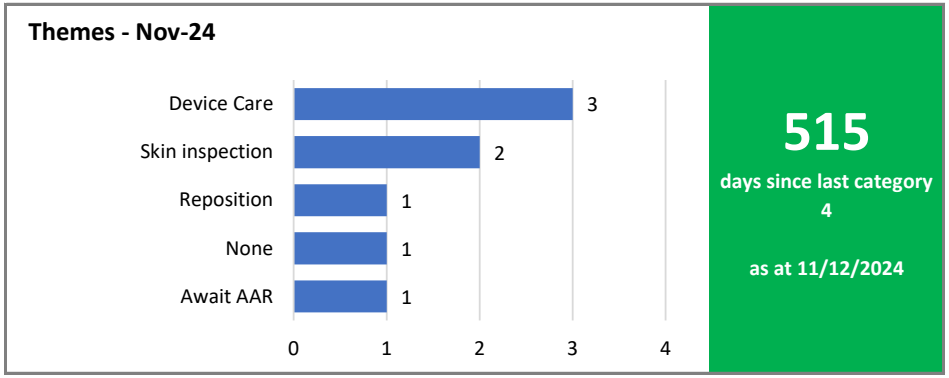
Month 08 | 2024-25

Quality

Pressure Ulcers | VTE

East and North Hertfordshire NHS Trust

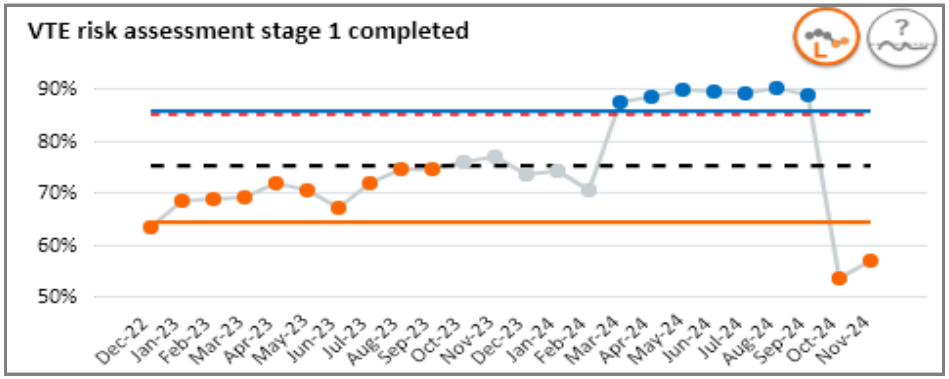




515

days since last category 4

as at 11/12/2024



Key Issues and Executive Response

Pressure Ulcers

- Approval to adopt PURPOSE-T has been granted by Leeds University. The Digital team have been forwarded all the relevant paperwork for their input. This move will align our Trust with the ICS/ICB and NWCSP recommendations for PU prevention.
- New categorisation as per NWCSP is now embedded in our Trust and service. Ongoing teaching and support is provided by the Tissue Viability team.
- Band 3 Tissue Viability HCA joined our team, the role focus will be Pressure Ulcer Prevention Champion.
- As part of response to PSIRF the Tissue Viability service has amalgamated the Pressure Ulcer report among the Divisions to encourage Local and trust wide shared learning.
- Heel Pressure Ulcers continue to lead regarding new PU by location. Care Groups are focusing on reducing Heel PUs by ensuring ward managers are ordering enough supply of Heel protection equipment. There has been an 83% decline in the reporting of heel PUs for the past 6 months.
- TVT Actions FOR 2023/24: Risk assessment and pressure ulcer prevention care planning improvement project within CDU in ED; (Paused as requiring more support).

VTE

- In October, Trust agreed to adopt 14-hour timescale to complete VTE risk assessments in line with NHSE requirements. This led to an anticipated drop due to a stricter timescale.
- Continue local QI projects with ongoing speciality involvement. Reports are continuously being analysed to provide focused data-driven quality improvement projects in specific areas and teams.
- Trust wide pilot of digital 'welcome pack' to improve patient awareness of VTE, VTE risk assessments and VTE prevention.

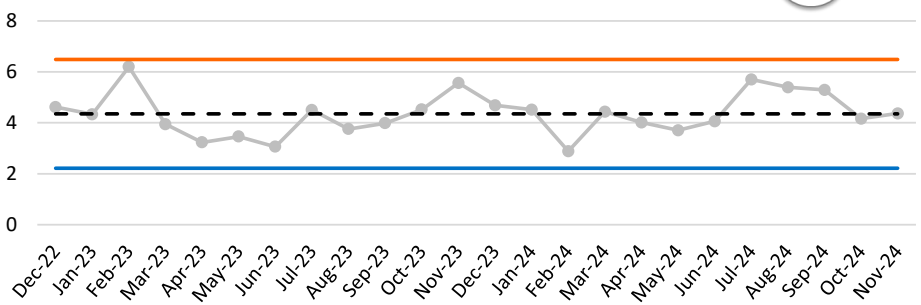
Month 08 | 2024-25

Quality

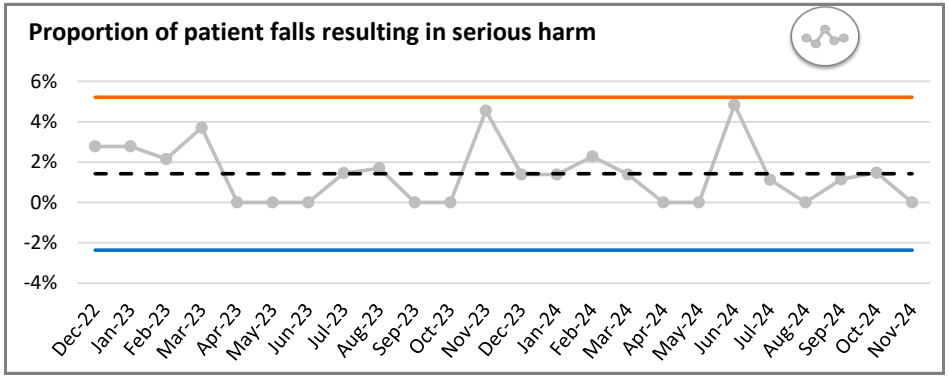
Patient Falls

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

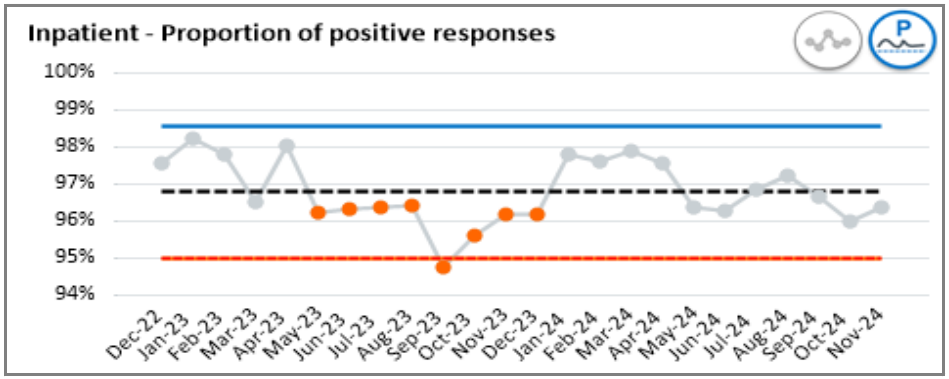
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- Communications sent to wards offering support and Quality improvement project as felt needed.
- ED, Swift, 10A, 6A, & SSU are areas with high inpatient falls incidence, between 5-9 incidences. Highlighted the importance of compliance with completing lying/standing blood pressure for patients over 65 and Baywatch-offered support for training
- No inpatient fall with serious harm recorded for the month of November.

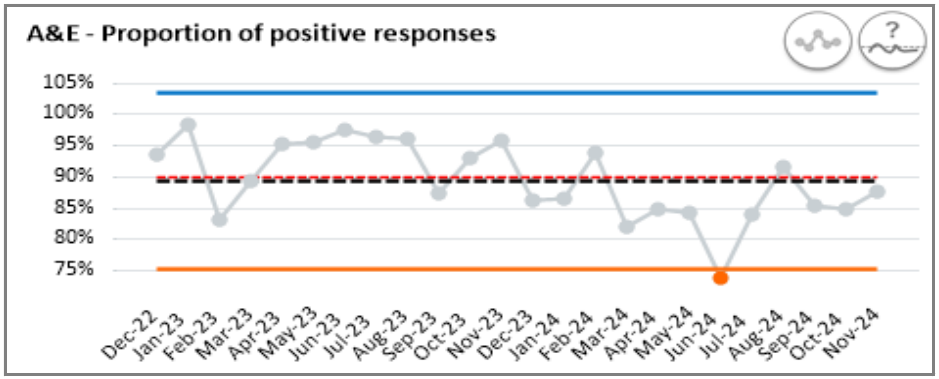
Month 08 | 2024-25

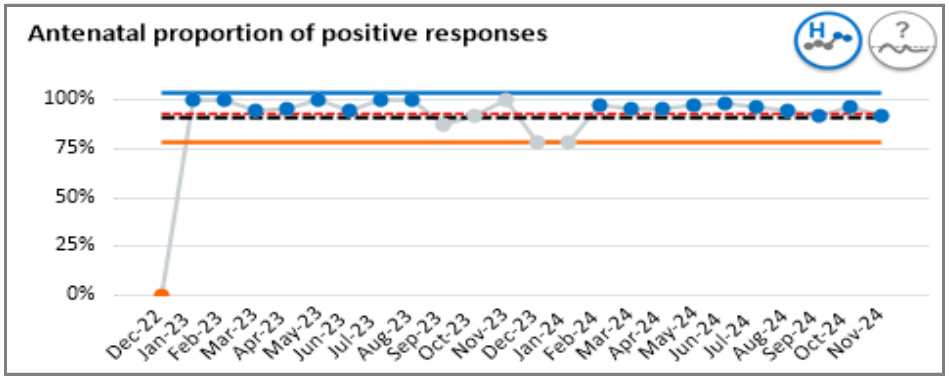
Quality

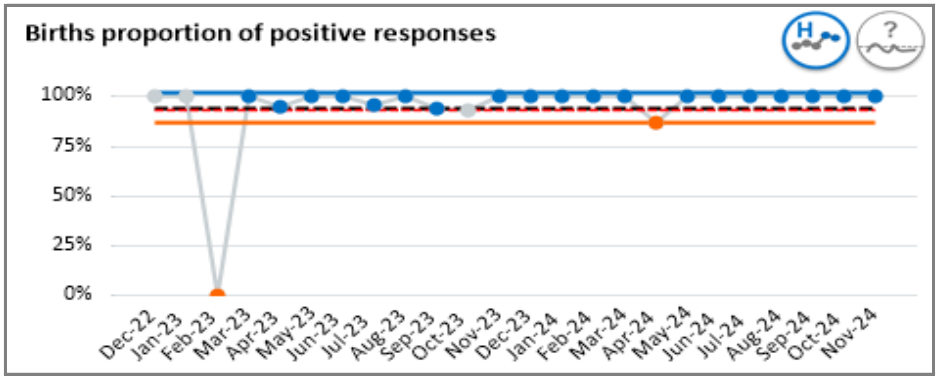
Friends and Family Test

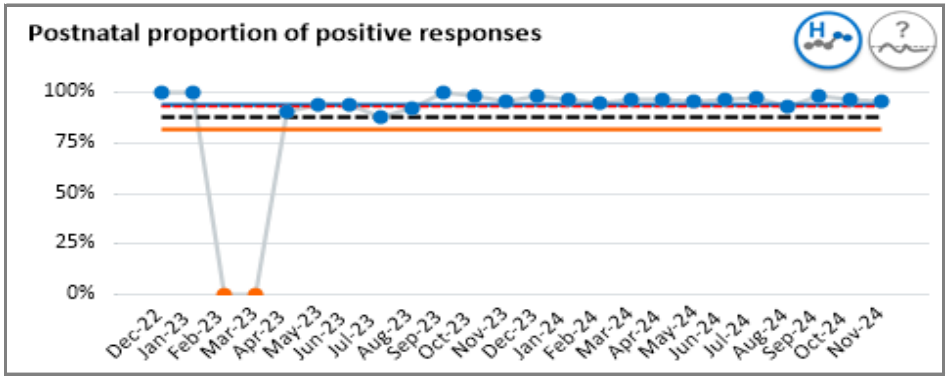
East and North Hertfordshire NHS Trust

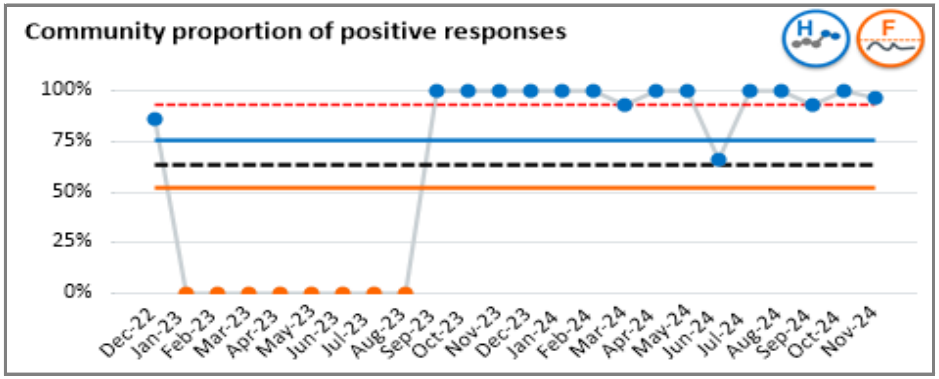










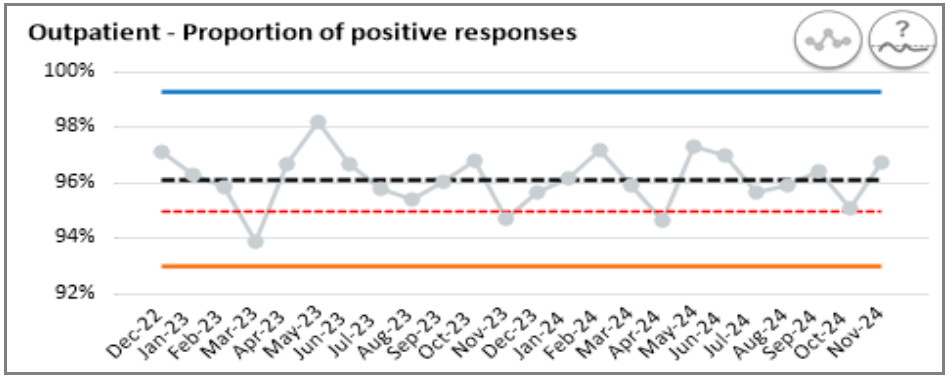


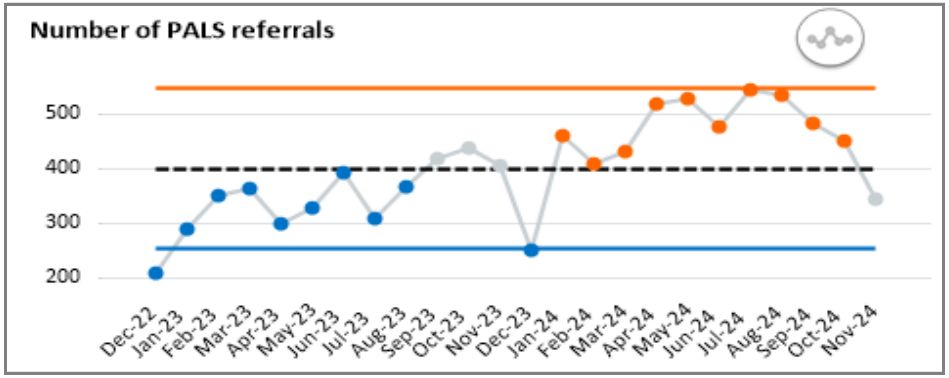
Month 08 | 2024-25

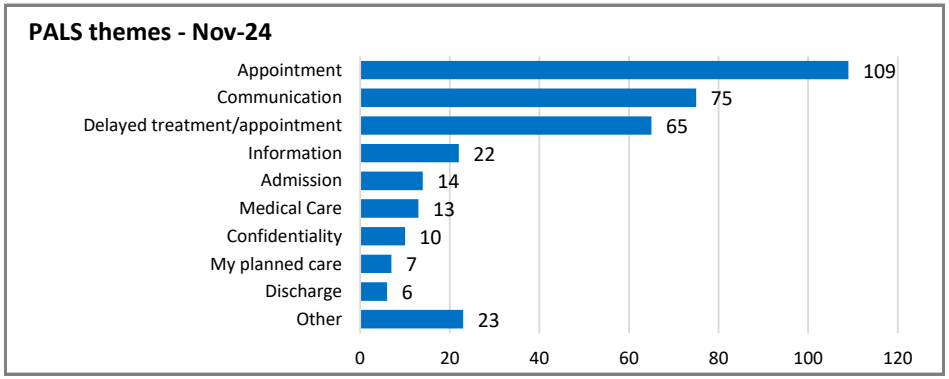
Quality

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

- Continued roll out of QR codes within inpatient and outpatient areas. Positive impact with monthly numbers increasing.
- Themes within the comments remain consistent related to lack of communication, cleanliness and medication delays These comments have all been highlighted to the senior divisional nursing teams.

Patient Advice Liaison Service

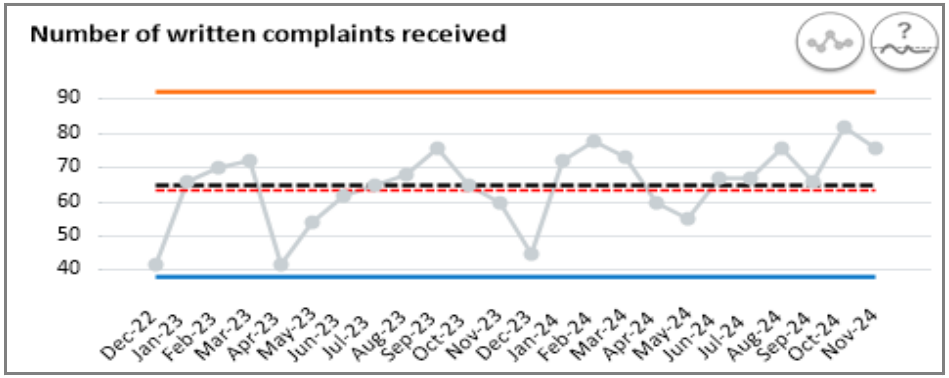
- PALS continues to receive a high volume of emails and phone calls. Despite considerable efforts and a reduction in the turnaround time for enquiries to within a 5 week response timeframe, the team inbox is sitting around 150 emails due to the number of enquiries coming in each week.
- There continues to be a reduction in the amount of concerns raised, which we hope will have a positive effect to trying to close cases.
- High volumes of concerns raised about appointments that are cancelled and not rebooked.
- High volumes of concerns around the waiting time on the appointment lines. People being cut off after waiting long periods or having to wait over an hour to speak to someone.

Month 08 | 2024-25

Quality

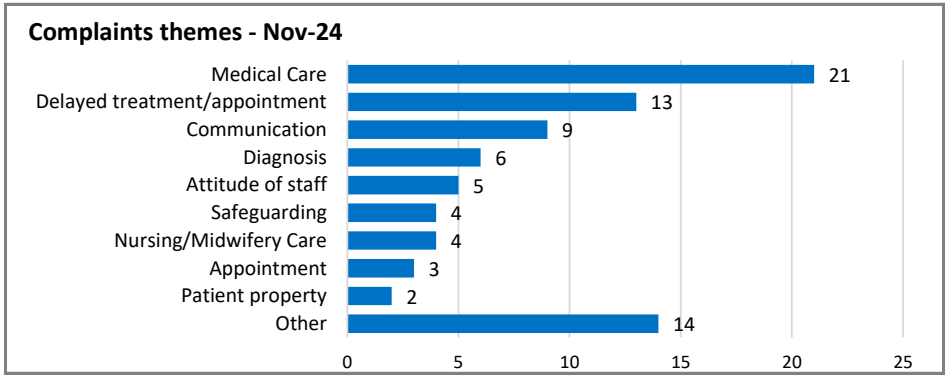
Complaints

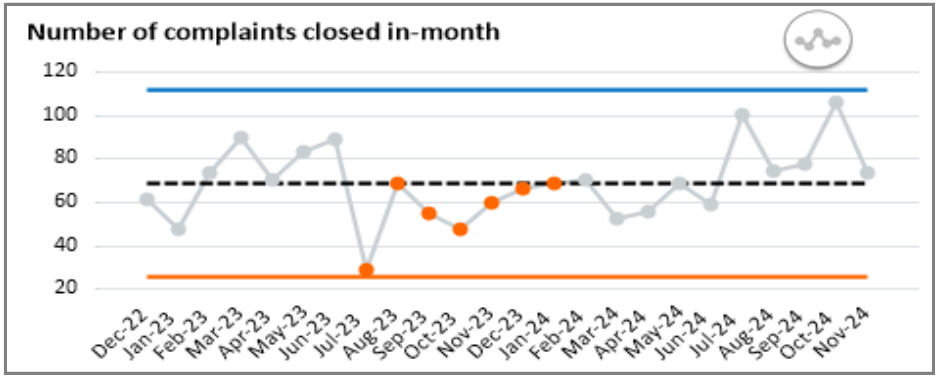
East and North Hertfordshire NHS Trust

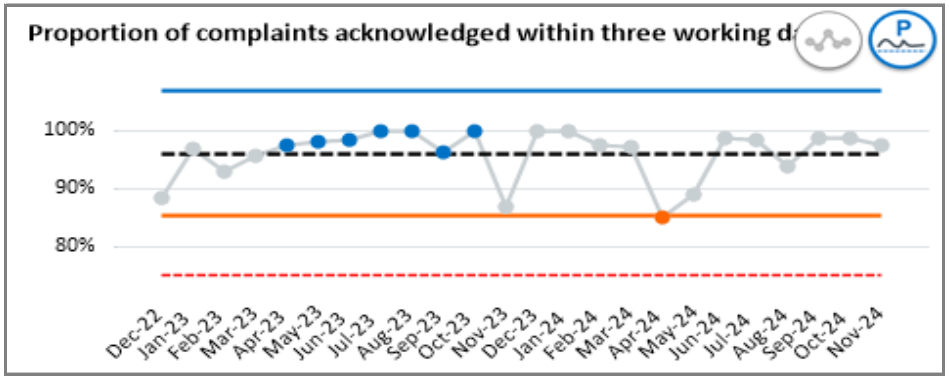


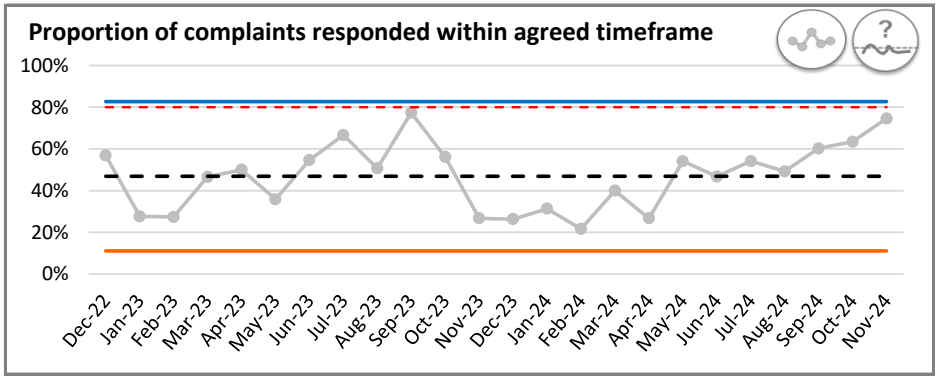
Key Issues and Executive Response

- At the end of November 2024 , the Trust had 124 open complaints, with 15 complaints awaiting for scope confirmation.
- Open complaints are at the lowest open since 2023.
- ED saw a rise in complaints in November 2024.
- ED (16), General Surgery (5) Trauma and Orthopaedic (5) are the top three directorates to receive complaints in November 2024.
- The number of complaints responded to by the Trust has increased to 74.5% which is the highest response rate since September 2023.
- The priority focus is to reduce the oldest overdue complaints in particular







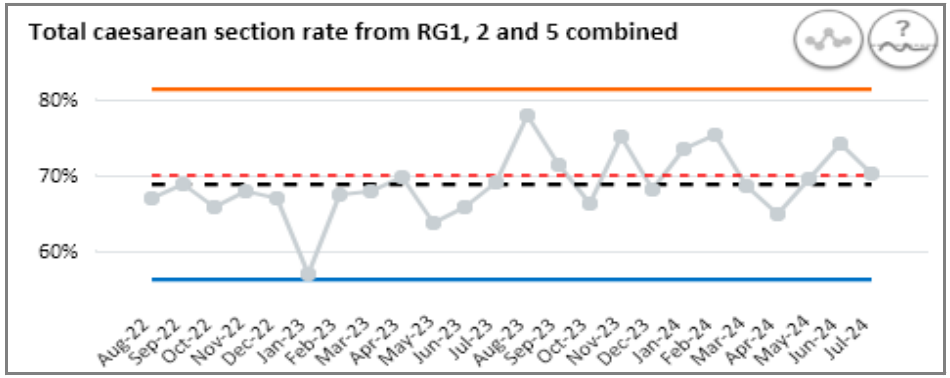


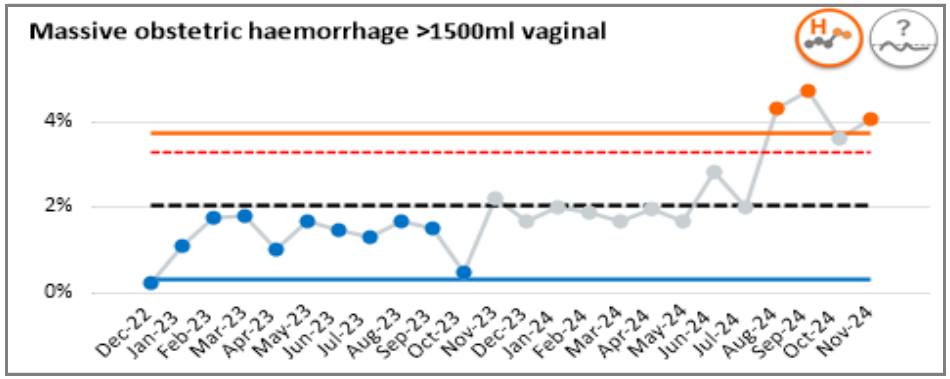
Month 08 | 2024-25

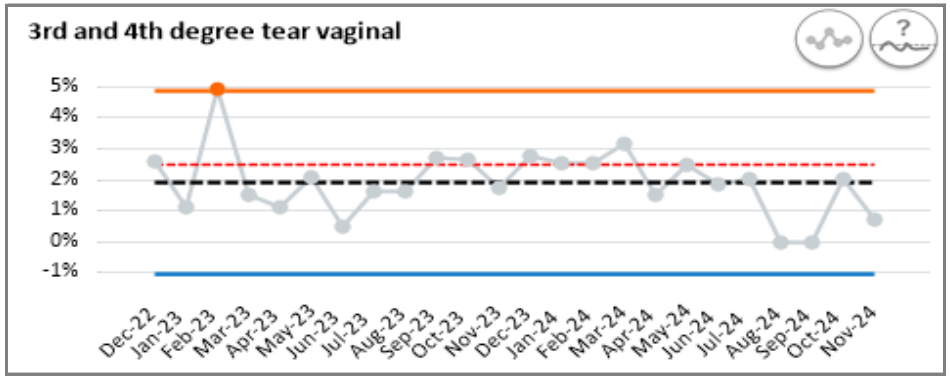
Quality

Maternity | Safety Metrics

East and North Hertfordshire NHS Trust







Key issues and executive response

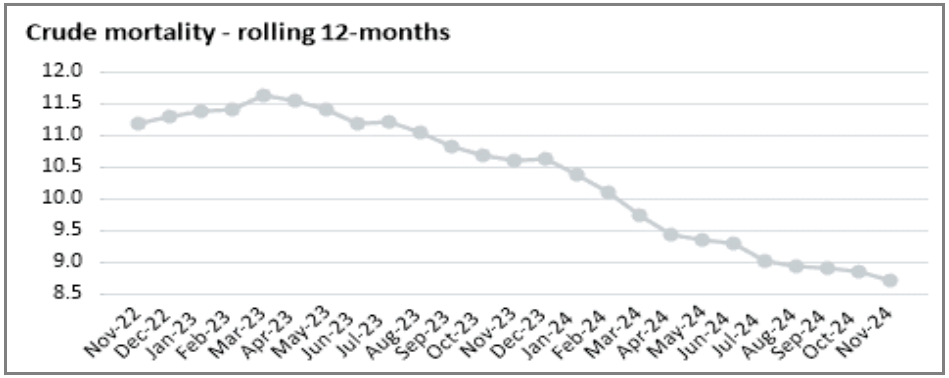
- No PSII declared or cases meeting criteria for referral to MNSI during November 2024. Learning from completed MNSI case investigation presented at QSC & to LMNS.
- 3rd/4th degree tears at vaginal and instrumental births below target limit for November 2024. Ongoing review of cases by obstetric risk lead. OASI2 care bundle launch November 2024. Training package in place.
- Normal variation for MOH ≥ 1500mls at LSCS. No correlation with known increased LSCS rates. Active use of carbetocin in conjunction with other uterotonics. Significant increase in rates of MOH ≥ 1500mls at vaginal deliveries with special cause variation, despite continued monitoring and vigilance by way of thematic review - ongoing work across LMNS. Findings presented at Divisional Rolling Half Day. Actions including proforma adaptation (user-friendly scribe sheet) for upload to maternity EPR, and early administration of tranexamic acid. Rate of MOH > 2000mls remains low. Data reflects triangulation with ENHance incident reports received.
- Fluctuation in ATAIN rate above goal limit. TC risk acknowledged on risk register due to capacity restraints. Weekly ATAIN reviews continue. No avoidable cases for the month of November 2024.
- Not all gestations at bookings are documented on K2 for the month of November 2024 due to it being a non-mandatory field. There are 4 records with gestation at booking missing. Therefore, we cannot provide assurance that there are not more cases of bookings <10/40.
- Unable to provide Robson Group criteria reports due to incomplete K2 data entry by clinicians regarding denominators including onset of labour (n=134). Escalation to K2 as lack of induction/'no labour' option. Data for the month of November for caesarean section rates is as follows:
- Total LSCS= 155 (42.82%)
- Total Cat 1-3 (Emergency) = 86 (23.80%)
- Total Cat 4 (Elective) = 68 (18.80%)

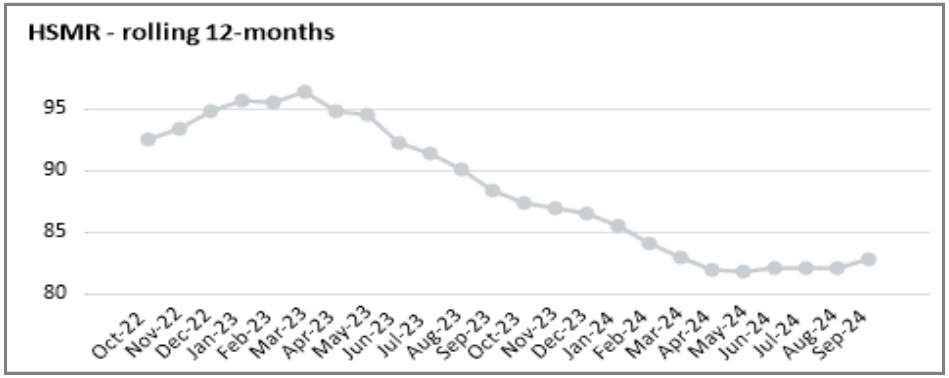
Month 08 | 2024-25

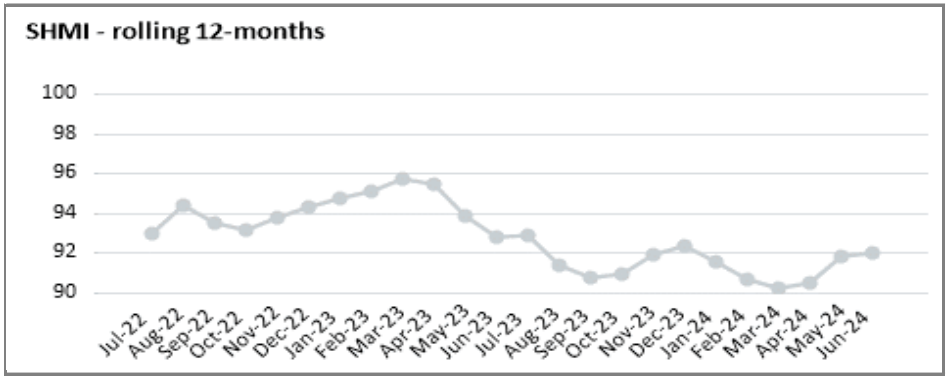
Quality

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 maintain a high standard of clinical 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.
- The significant downward trend in rolling 12-month HSMR seen since March 2023 has levelled since April 2024.
- The latest rolling 12-month HSMR to Sep-24, reported by CHKS, stands at 82.2. 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 90.0. CHKS has confirmed that a rebase of their HSMR is due imminently.
- Latest NHSD published rolling 12-month SHMI available to June 2024, shows a slight decrease from 92.08 to 91.9. This positions us in the first quartile of trusts nationally and well below the national average.
- The latest in-month figure provided by CHKS for Jun-24 stands at 83.5, well below the national average.
- For the period to Jun-24, CHKS reported 5 3SD outlier alerts: Coronary atherosclerosis, Respiratory failure/cystic fibrosis; other respiratory disease, UTI, Nephritis group and Skin disorders.

Month 08 | 2024-25

NHS
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NHS Trust

Operations

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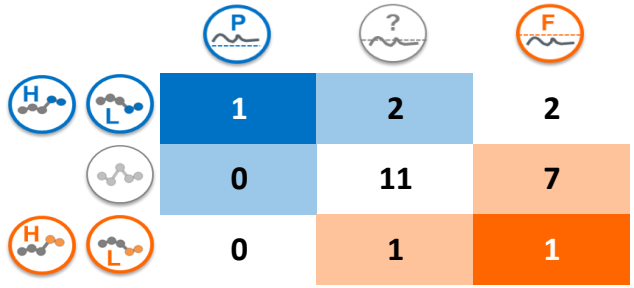


Urgent and Emergency Care

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	Nov-24	95%	67.2%			9 points above the mean Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Nov-24	2%	7.2%			Common cause variation Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	Nov-24	65%	12.6%			Common cause variation Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Nov-24	80%	49.9%			Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Nov-24	240	204.0			10 points below the mean Metric will inconsistently pass and fail the target
	Average (mean) time in department - admitted patients	Nov-24	tbc	601.0			9 points below the mean No target
	Average minutes from clinically ready to proceed to departure	Nov-24	tbc	210			Common cause variation No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Nov-24	92%	54.8%			8 points above the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Nov-24	0%	53.5%			8 points above the mean Metric will consistently fail the target

Month 08 | 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	Oct-24	85%	86.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-day decision to treat to treatment standard	Oct-24	96%	96.9%	H	?	15 points above the mean Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Oct-24	75%	76.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Oct-24	7%	15.2%		F	Common cause variation Metric will consistently fail the target
	Number of cancer PTL waiting more than 104 days	Oct-24	16	116		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	Oct-24	0	12		?	Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for suspected cancer	Oct-24	93%	84.1%	L	?	3 points below the lower process limit Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Oct-24	93%	88.3%		?	Common cause variation Metric will inconsistently pass and fail the target

Month 08 | 2024-25

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

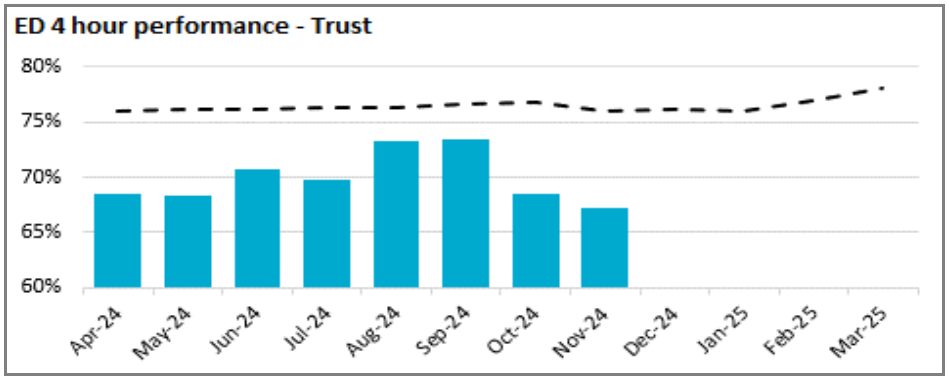
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q2 2024-25	A	**B**			
	4-hours direct to Stroke unit from ED	Sep-24	63%	34.0%		F	Common cause variation Metric will consistently fail the target
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Sep-24	80%	100.0%	H	P	7 points above the mean Metric will consistently pass the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Sep-24	63%	32.0%		F	Common cause variation Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	Sep-24	n/a	56			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Sep-24	80%	89.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Sep-24	50%	62.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Scanned within 12-hours - all Strokes	Sep-24	100%	97.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	% of all stroke patients who receive thrombolysis	Sep-24	11%	13.0%		?	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)	Sep-24	70%	29.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with JCP	Sep-24	80%	91.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	Sep-24	50%	69.0%		?	Common cause variation Metric will inconsistently pass and fail the target

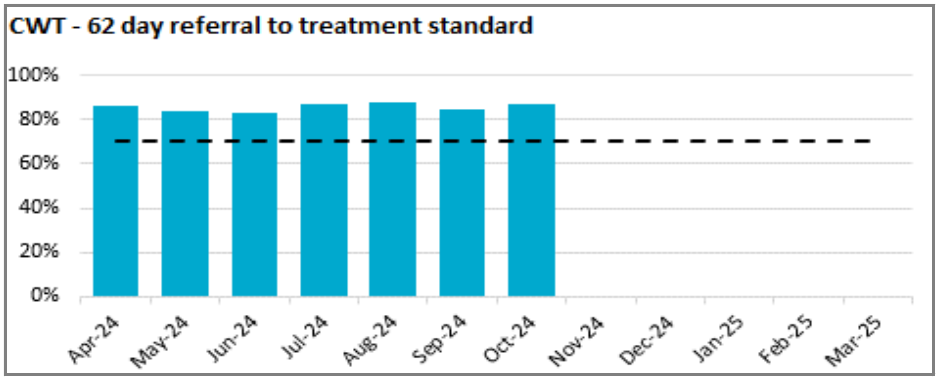
Month 08 | 2024-25

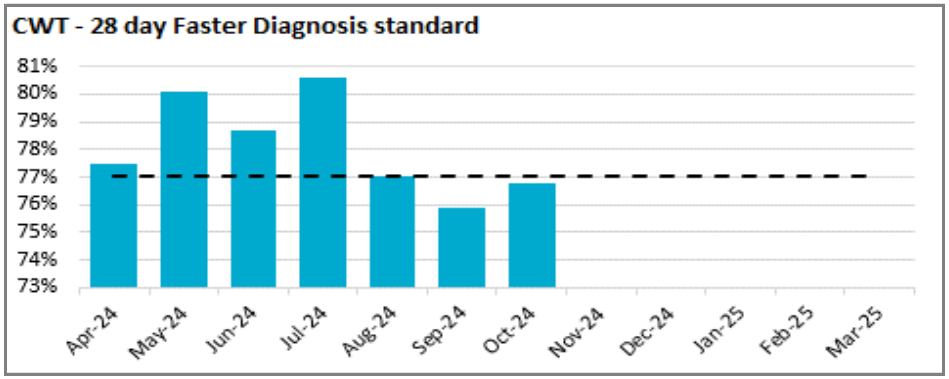
Operations

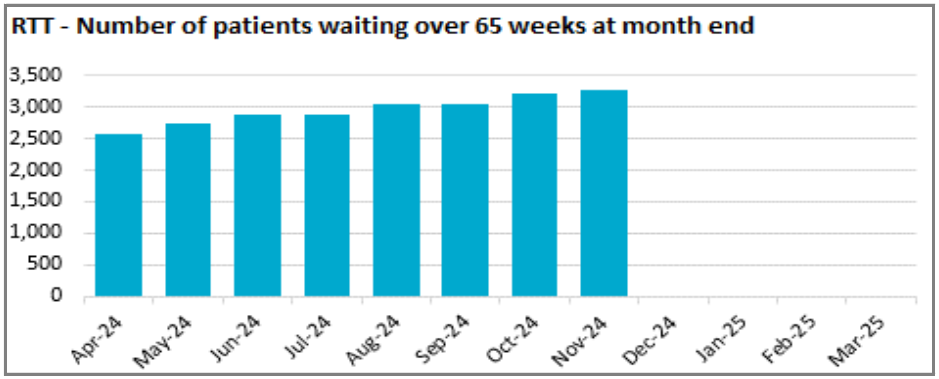
Trajectory monitoring 2024-25

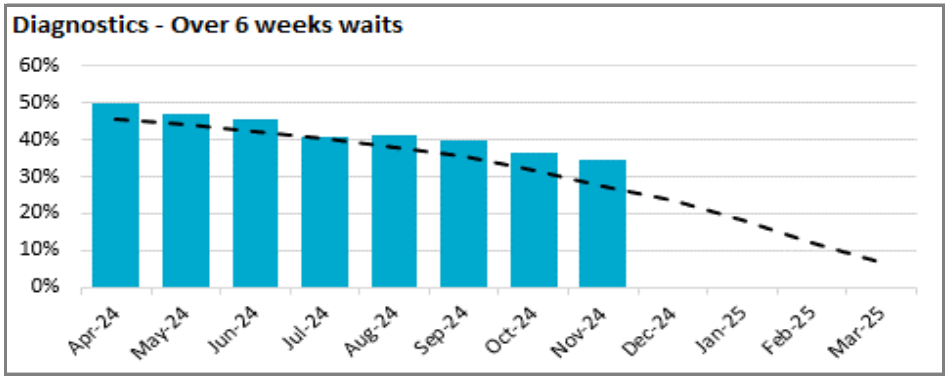
East and North Hertfordshire NHS Trust











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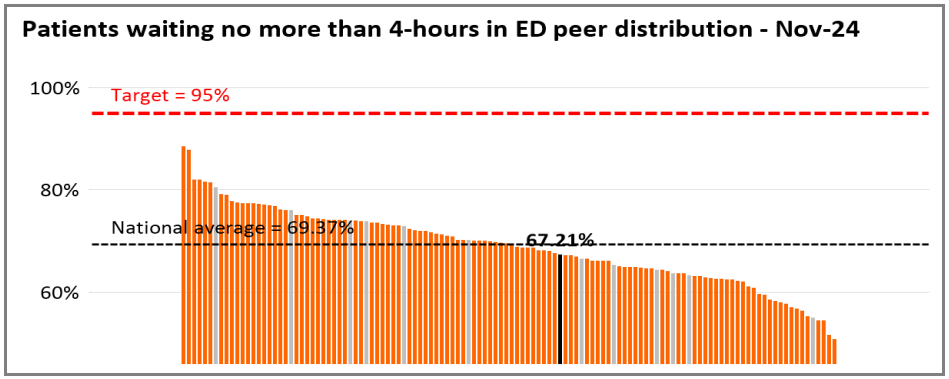
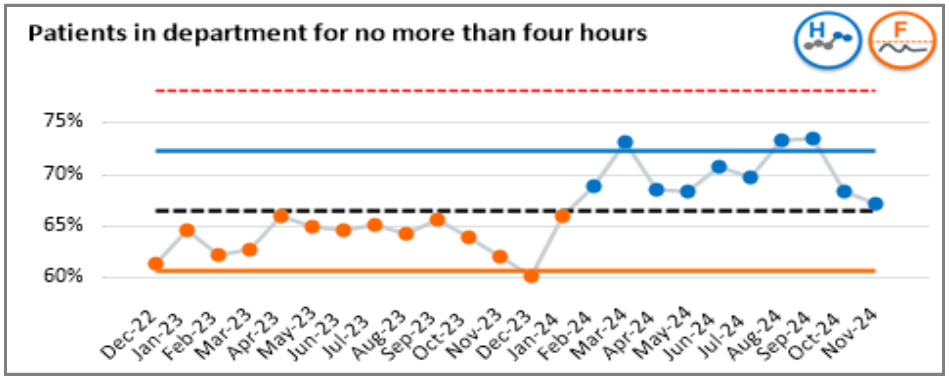
Operations

Urgent and Emergency Care New Standards

East and North Hertfordshire NHS Trust



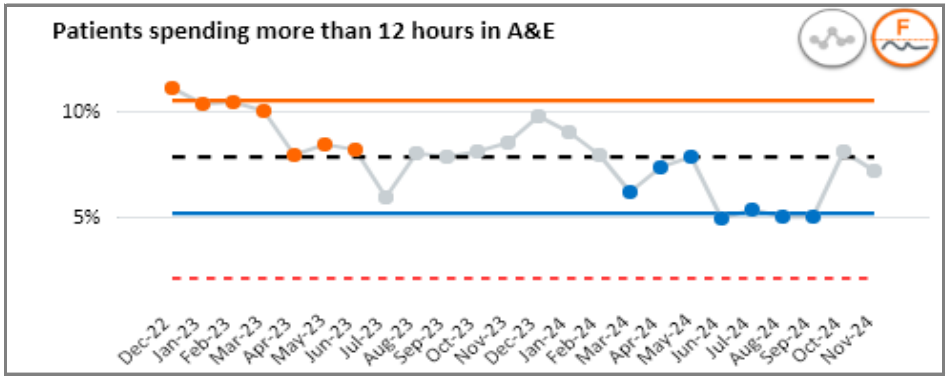


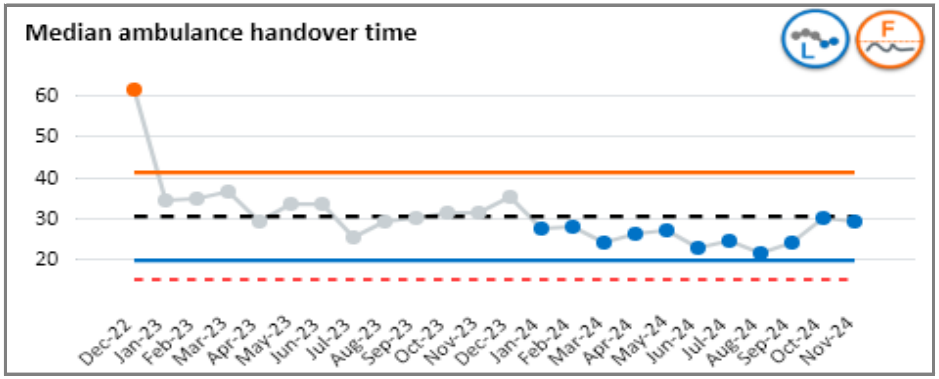
Key Issues and Executive Response

- In November, only 67.3% of patients were treated within 4 hours, impacted by staff sickness, high bed occupancy and closed medical beds due to business continuity incidents. Performance deterioration was consistent across HWE.
- Ambulance arrivals remain higher than last year; handover times rose slightly, but mean offload remains under 30 minutes.

Actions:

- EEAST introduced 45 minute Release to Respond from 29/11; we have agreed to open two additional corridor offload spaces when needed, to facilitate this.
- Direct Ambulance offload to acute medical services (SDEC / AMU) launched 2/12.
- Efforts to expand Medical SDEC activity include space optimisation to enhance throughput.
- Efforts focus on improving ED KPIs, including triage, doctor wait times, specialty transitions, and CDU chair utilisation.
- Interim Lead Divisional Director for Unplanned Care started 2/12 with focus on UEC pathways and process.
- MADE week 16-20 Dec - piloting new approach to AMU bed allocation, pharmacy support for TTOs, full use of Discharge Lounge & CDU.



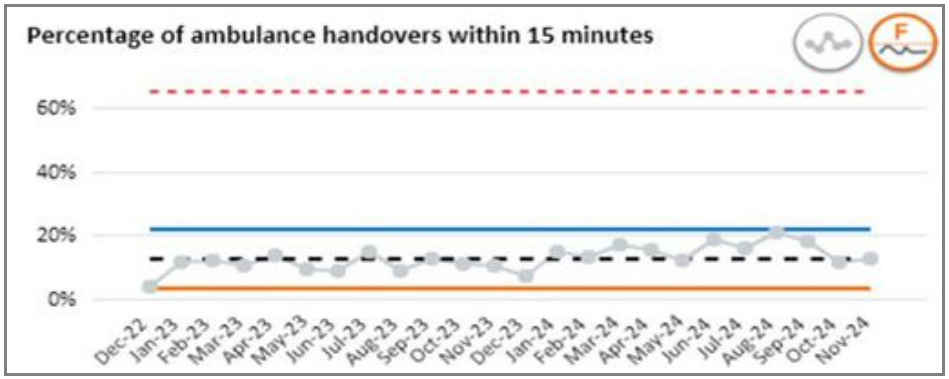


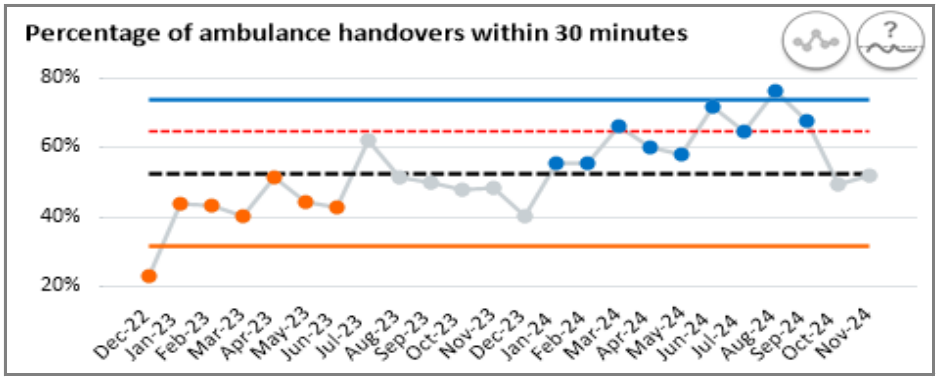
Month 08 | 2024-25

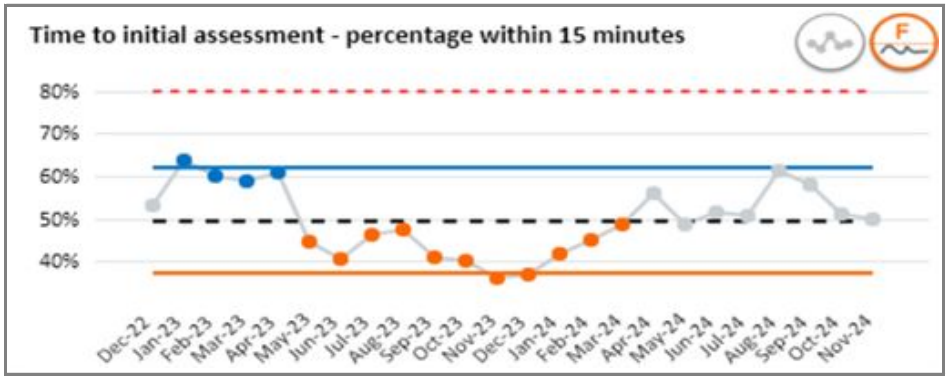
Operations

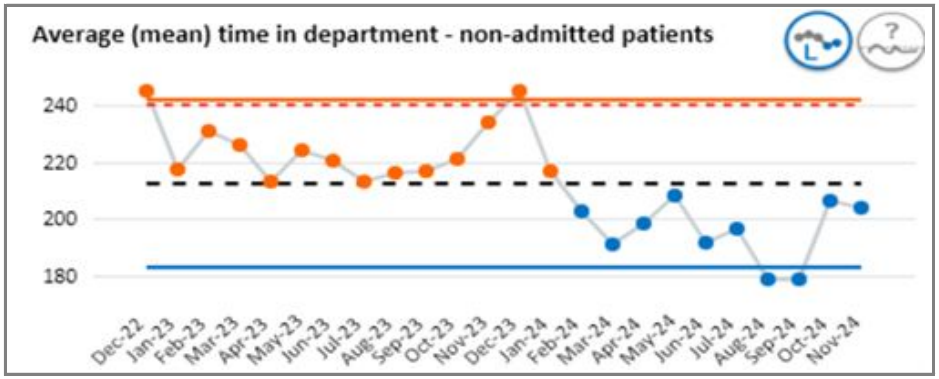
Urgent and Emergency Care | Supporting Metrics

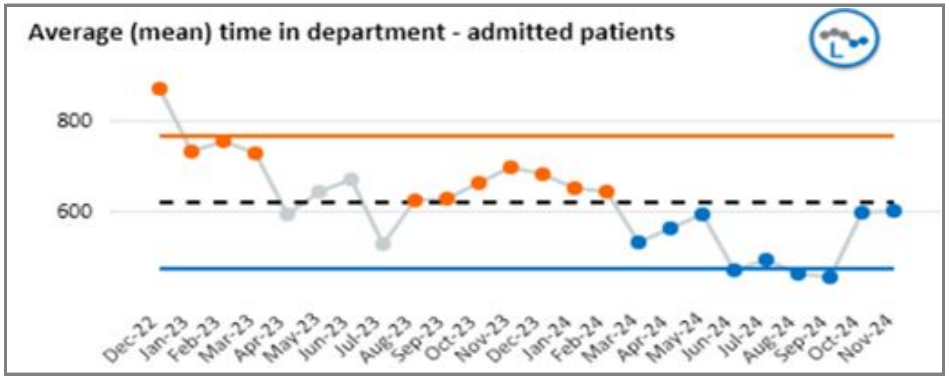
East and North Hertfordshire NHS Trust

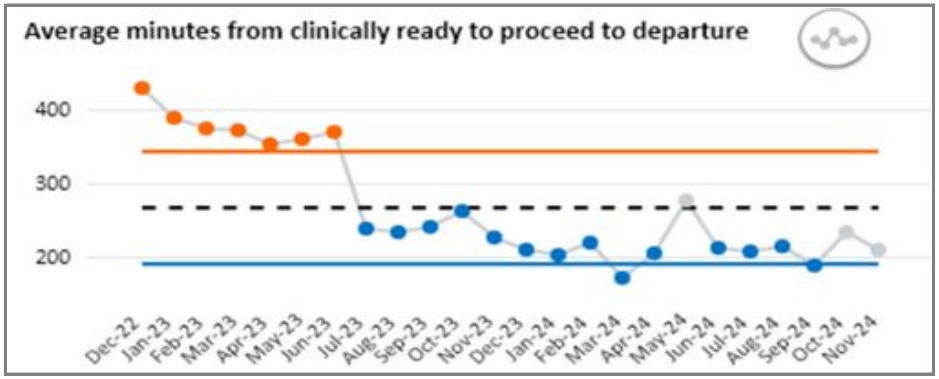




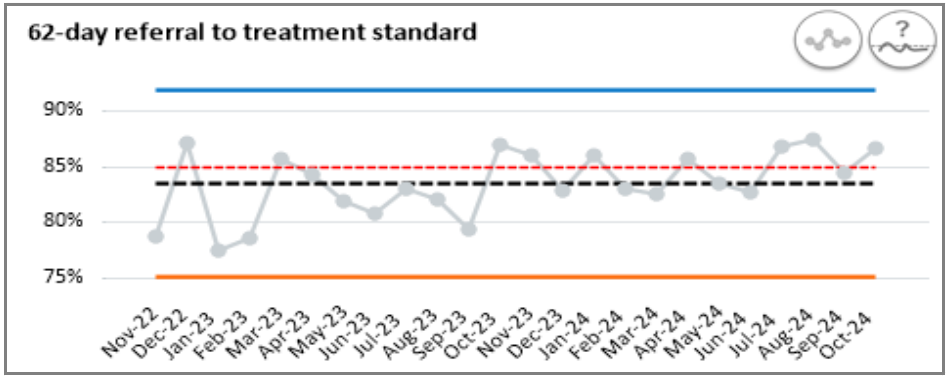


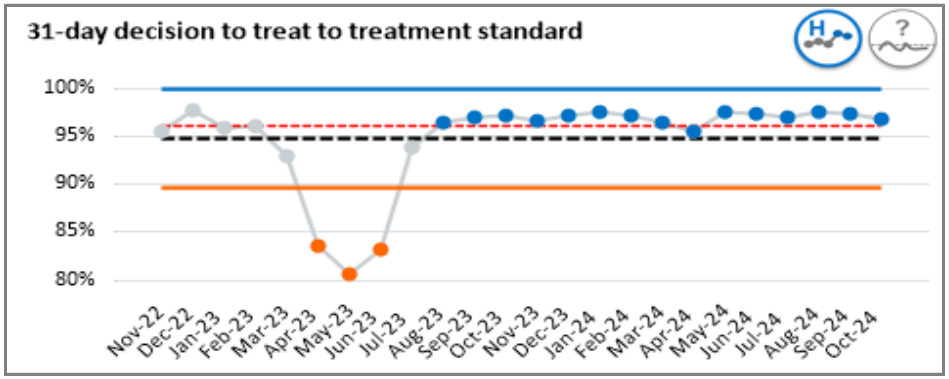


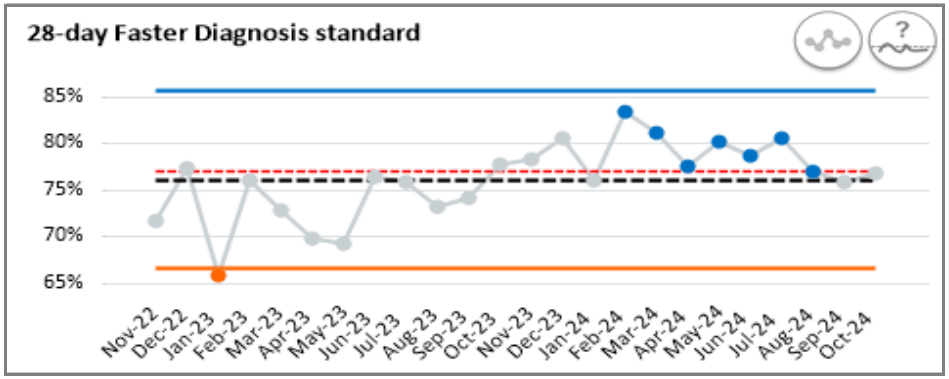




Month 08 | 2024-25







Key Issues and Executive Response

- We achieved 3 out 3 of the national targets in October '24 with compliance in the 28 General Faster Diagnosis Standard (FDS), 31-Day General treatment standard, and the 62-Day general treatment standard. All 3 standards continue to be met year to date - and exceed regional and national performance levels by around 20%.
- Despite seasonal dips in performance the aggregate 62day performance for the year shows a compliant performance at 86.9%.
- Work continues with the operational teams to sustain and improve CWT performance for the Trust with more focus on the Lower GI colonoscopy capacity (partly mitigated with WLI and use of private sector colonoscopy), MRI capacity (mitigated with mobile MRI at Lister), breast radiology delays (partly mitigated with WLI and locum radiologist) and radiology reporting (partly mitigated with WLI and prioritisation of cancer patients).
- 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.

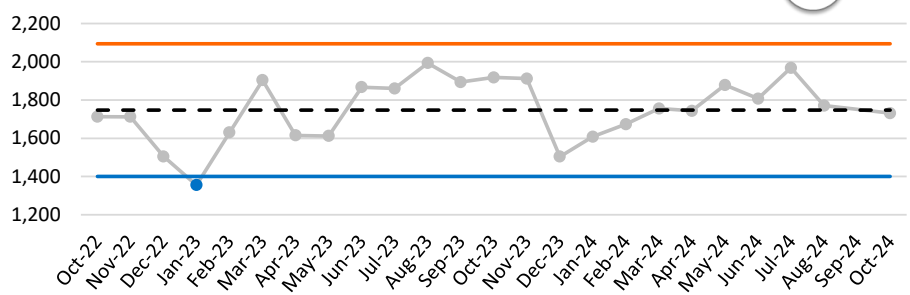
Month 08 | 2024-25

Operations

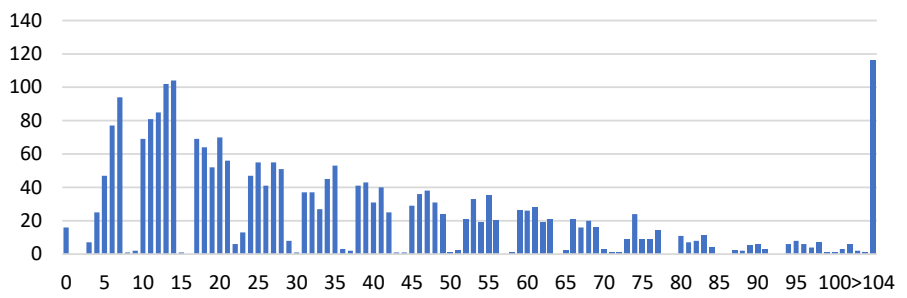
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

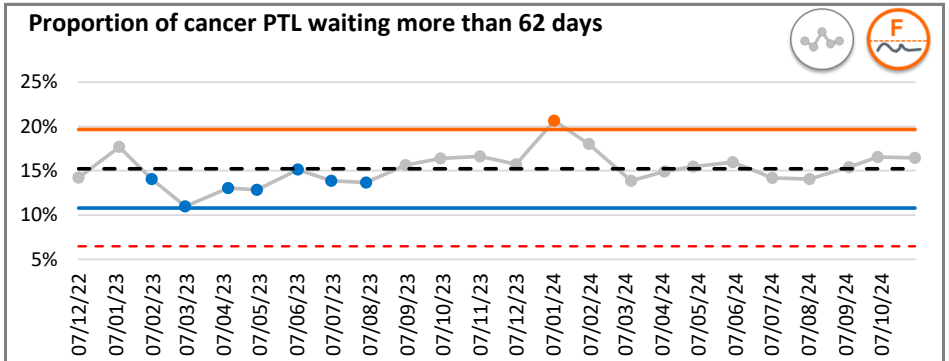
Suspected cancer referrals



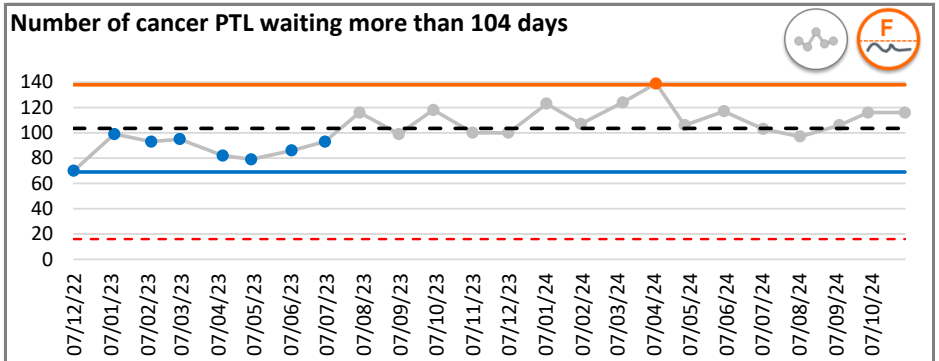
62-day PTL as at 04/11/2024



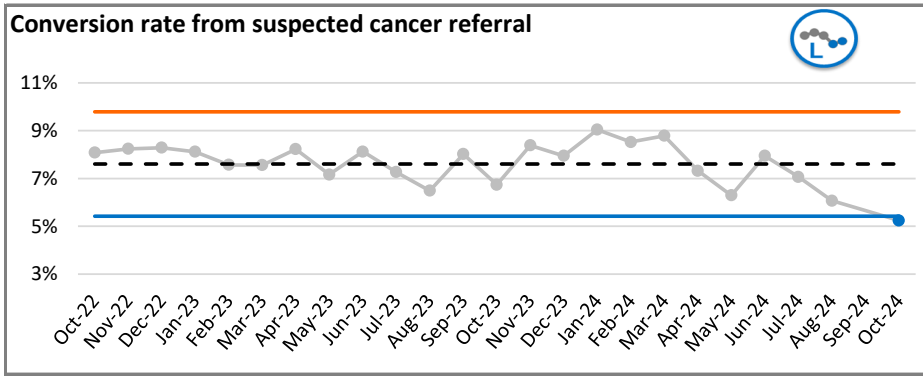
Proportion of cancer PTL waiting more than 62 days



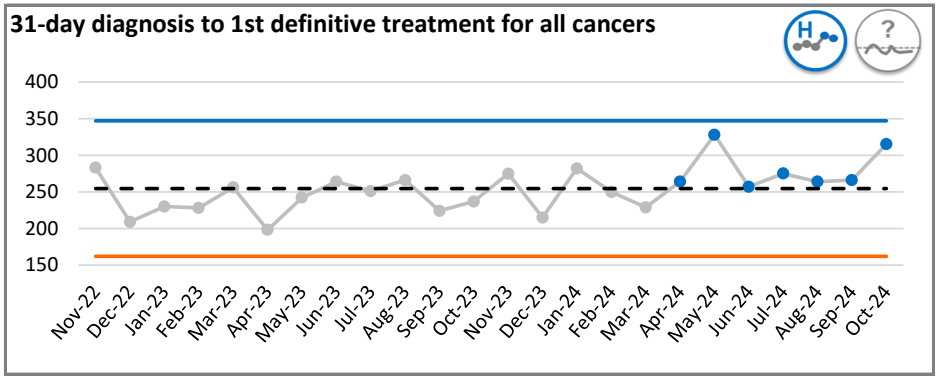
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



31-day diagnosis to 1st definitive treatment for all cancers

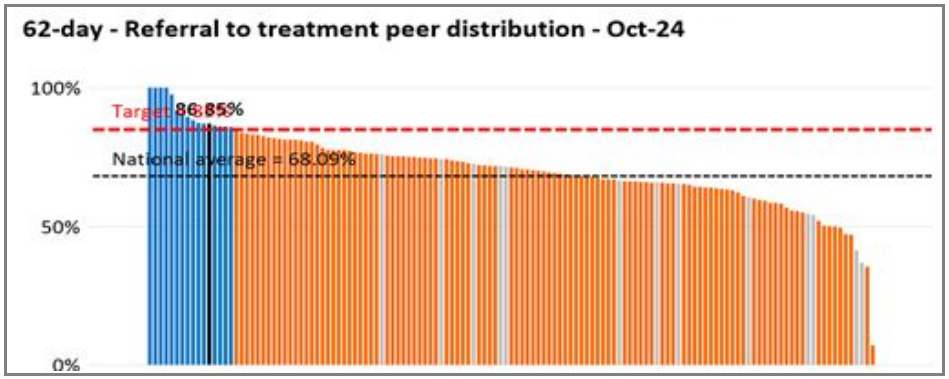


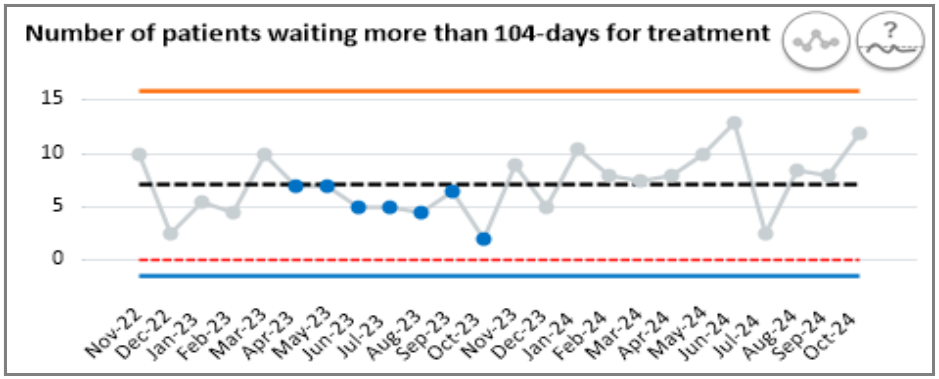
Month 08 | 2024-25

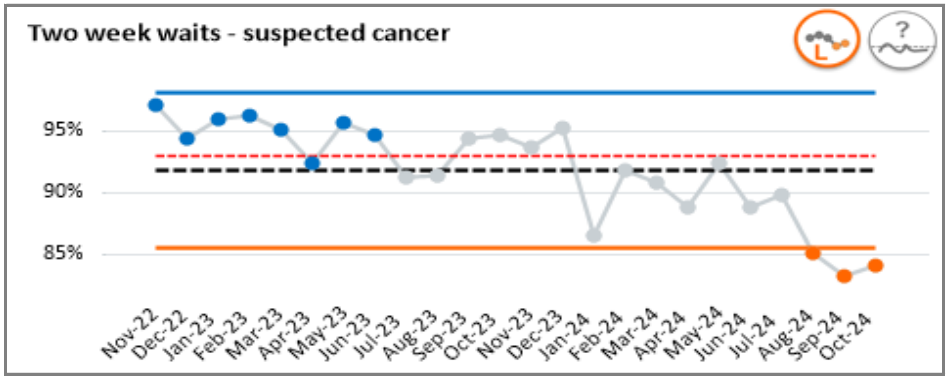
Operations

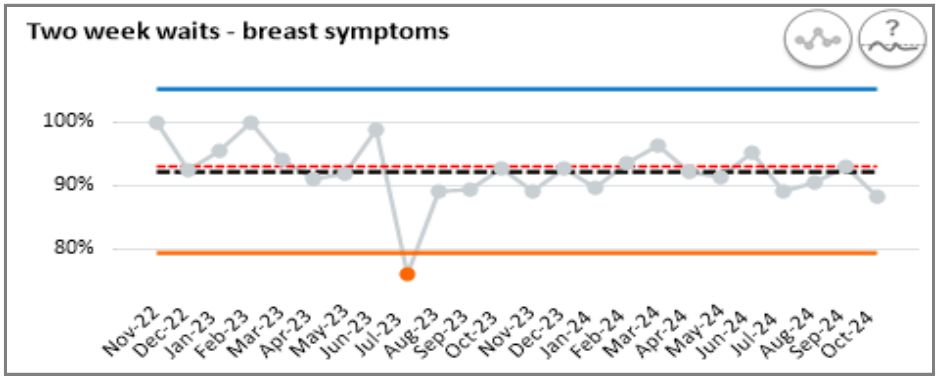
East and North Hertfordshire NHS Trust

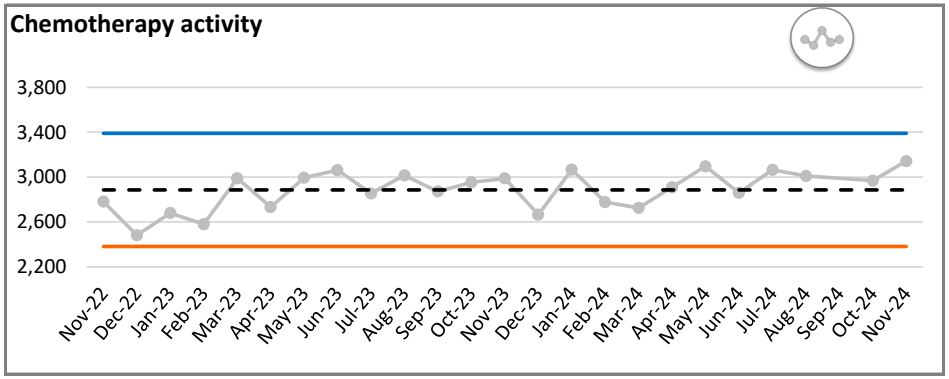
Cancer Waiting Times | Supporting Metrics

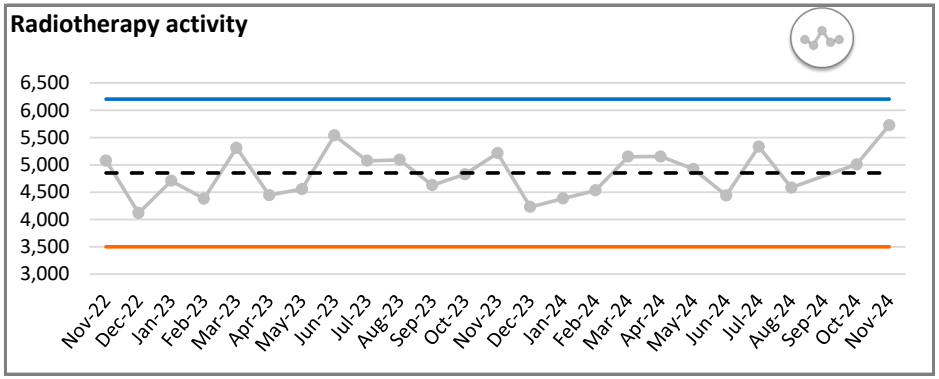










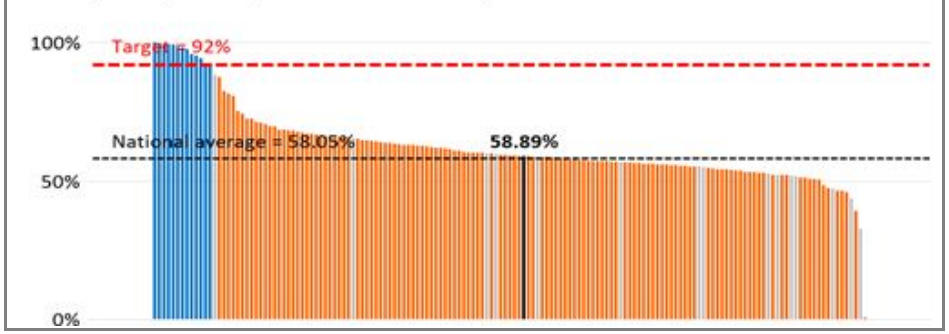


Month 08 | 2024-25

Operations

RTT 18 Weeks

East and North Hertfordshire NHS Trust



Key Issues and Executive Response

Community Paediatrics

- Community Paediatrics is now reported via the Community Data Set.
- The waiting list continues to increase, driven by high referral levels for neuro diversity assessment; 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 HWE system transformation work.
- This includes a standardised system-wide referral form and a single point of administrative triage. Improved reporting is intended through developing a Community Services reporting and coding dashboard.
- 104 Weeks - There were 1,280 Community Paediatric patients waiting over 104 weeks at the end of November.
- 78 Weeks - There were 2,563 patients waiting over 78 weeks at the end of November, compared to 2,288 the previous month, an increase of 275 patients.

Key Issues and Executive Response

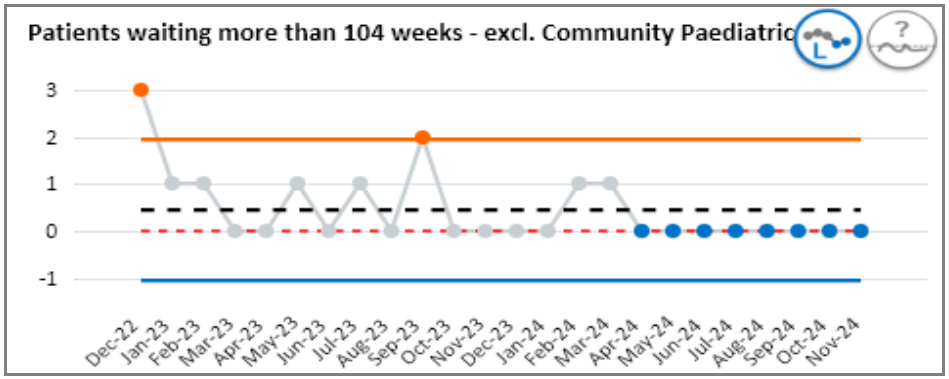
Excluding Community Paediatrics

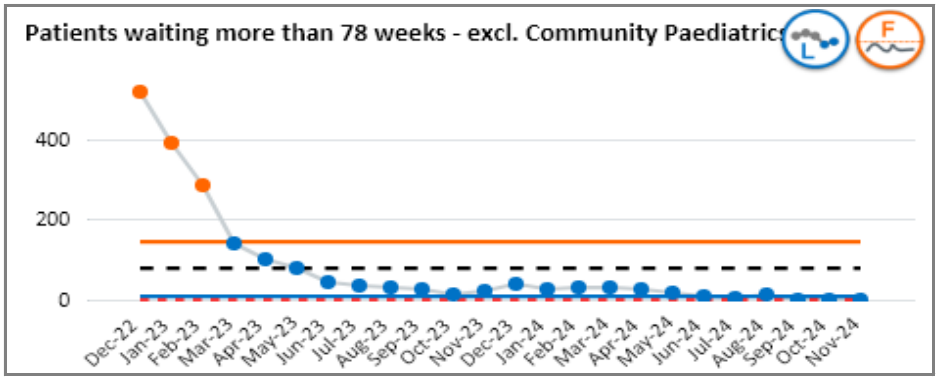
- The Trust reported an improved performance of 59.16% of patients treated within 18 weeks in November, which remains above last month's national average of 58.05%.
- **65 Weeks** - The Trust had 25 patients waiting more than 65 weeks at the end of November 2024. Less than half of these breaches (9) were due to capacity issues in T&O and Pain. The rest were due to complexity, patient choice or fitness to proceed. This compares well to performance regionally.
- ENHT were the only Trust in the region with a maintained position of 0 x 78 week breaches and ranked first Nationally.
- Due to seasonal challenges the end of December forecast is between 30 to 40 patients waiting over 65 weeks, with the main risks remaining in T&O. Patient choice and reduced capacity is limiting flexibility to offer alternative dates in month. Focused management at patient level to mitigate is in place. No breaches beyond January are anticipated.
- 52 Weeks - Number of 52 week waiters reduced by 300 patients in month to 1,254, with the biggest decreases seen in T&O and Gastro.
- Many services are already 52 week compliant, with the majority of the remaining specialities over 95% compliant.
- Revised demand and capacity modelling has been finalised for optimum opportunity to deliver 52 weeks across all services by end March 2025.
- There has been a decrease of 1,428 in the overall RTT waiting list from last month.

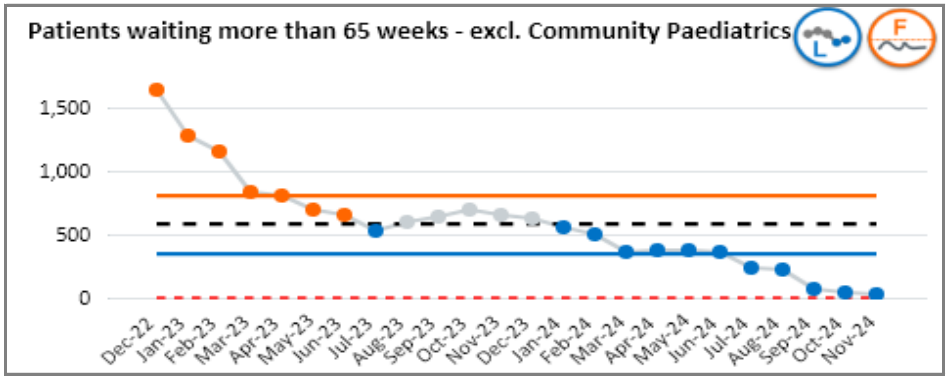
Operations

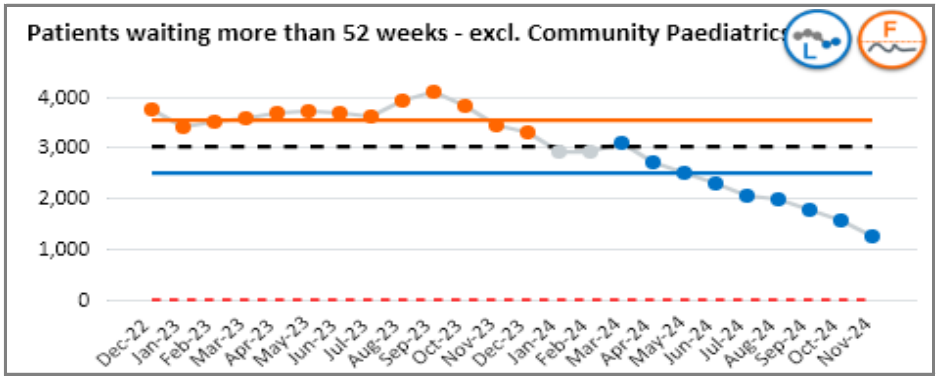
RTT 18 Weeks

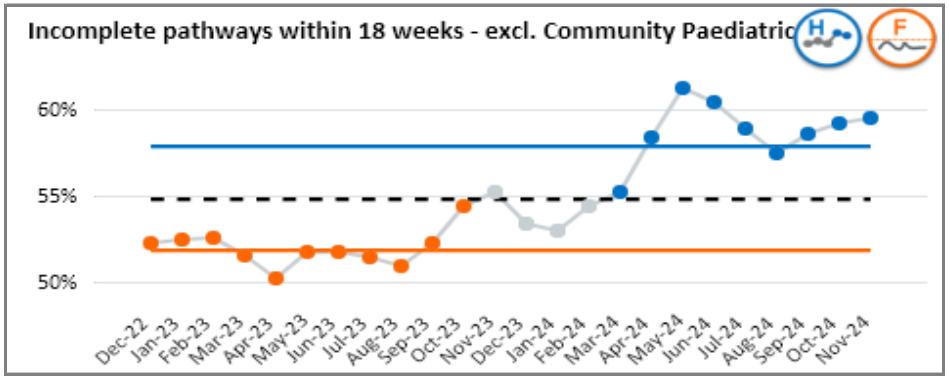
East and North Hertfordshire NHS Trust

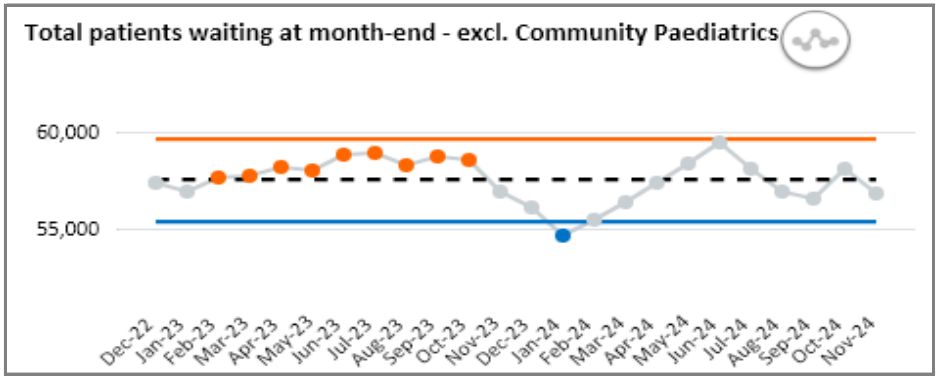










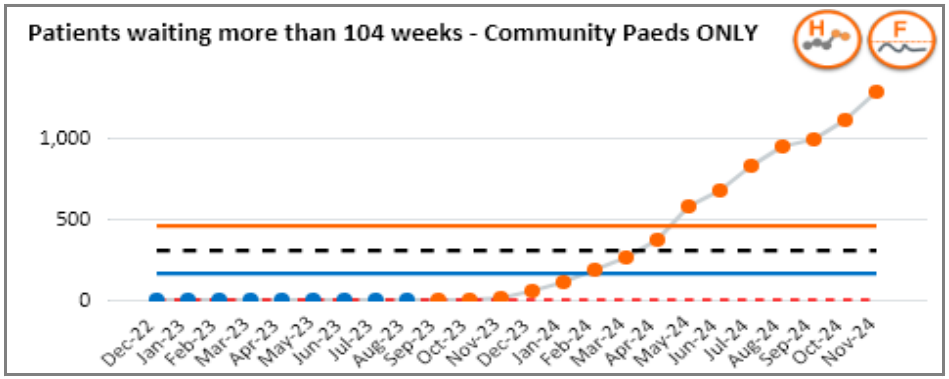


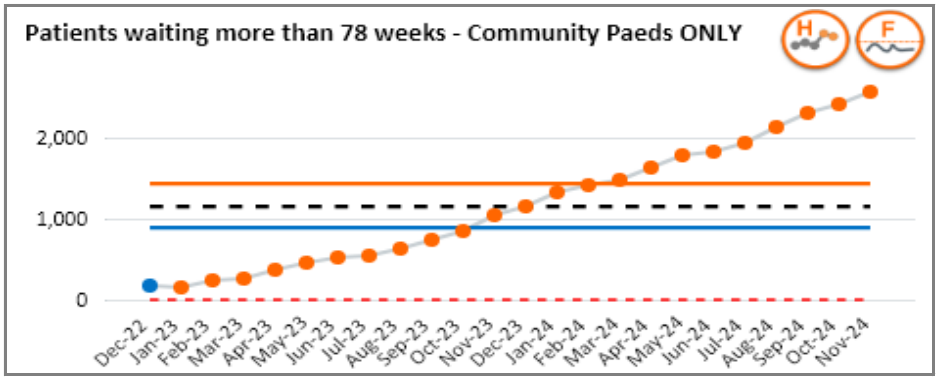
Month 08 | 2024-25

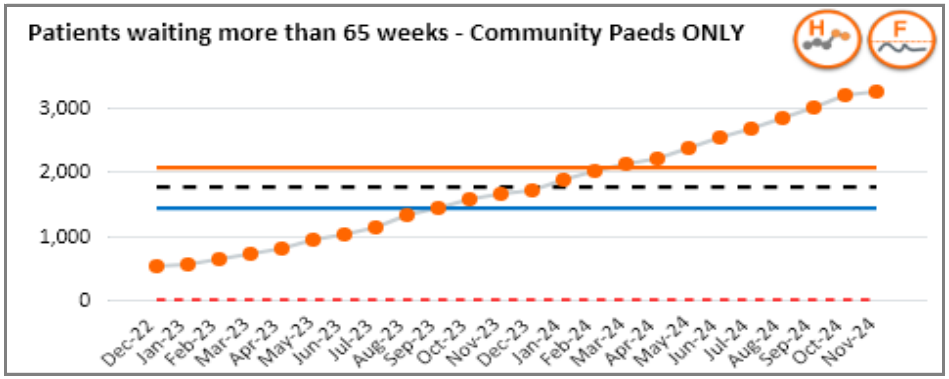
Operations

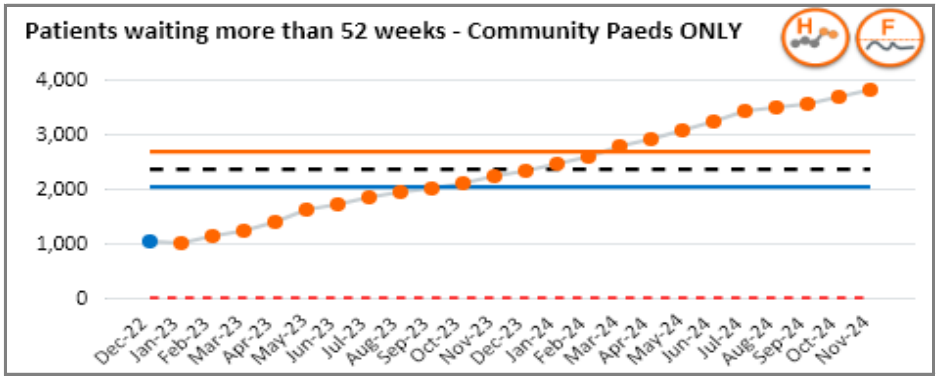
RTT 18 Weeks

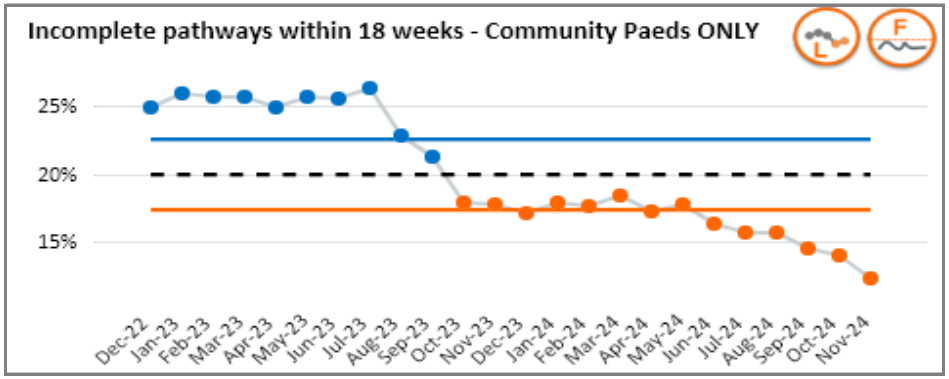
East and North Hertfordshire NHS Trust

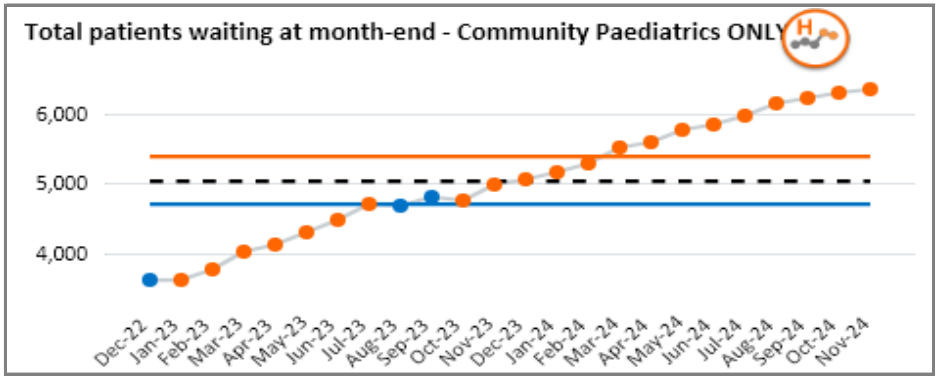










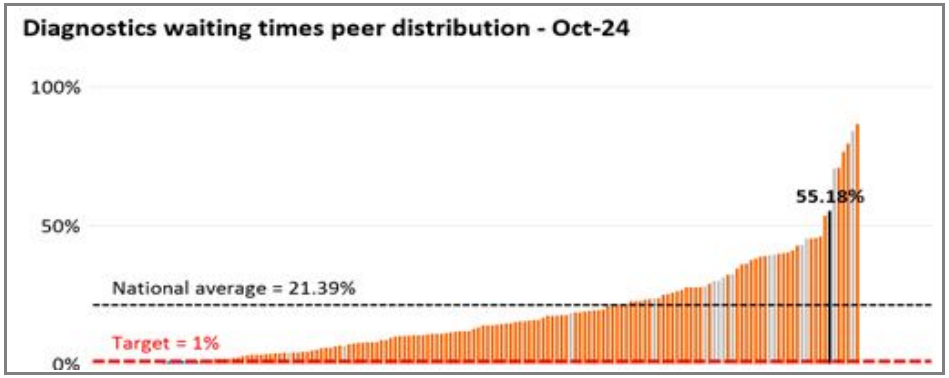


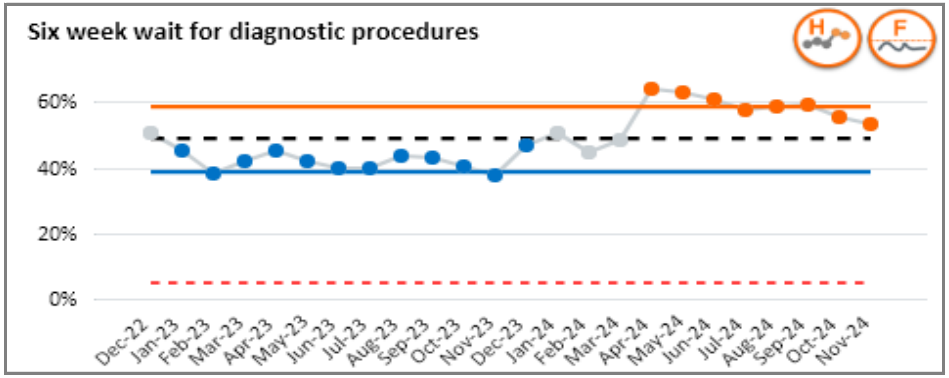
Month 08 | 2024-25

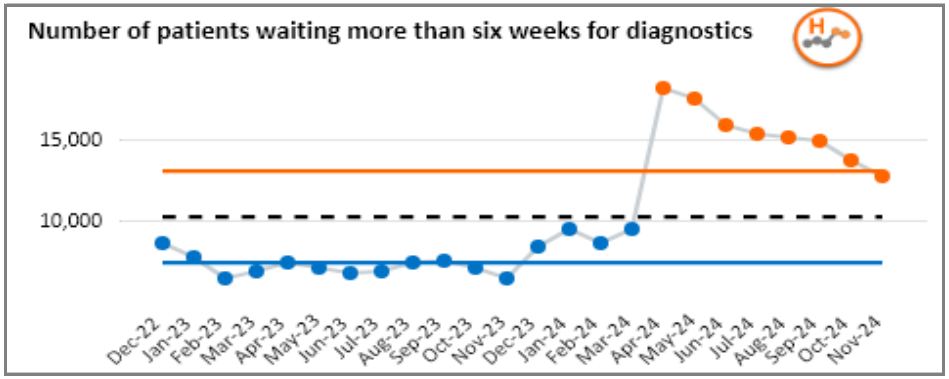
Operations

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- November DM01 performance including audiology improved from 55.19% to 53.53%.
- Excluding audiology and MRI, the overall DM01 trajectory is on track to deliver target performance by March 2025.
- Patients waiting >6 weeks and > 13 weeks continued to reduce.
- Excluding Audiology average wait down from 6.9 to 4.9 weeks, April to November.

Challenges / Actions

- There is a significant MRI capacity gap in house to meet service demand and DM01 compliance by March 2025. Cancer demand has increased and is being addressed through additional 37 MRI van days from August to December on the Lister site.
- Refreshed capacity and demand modelling for MRI has been completed which shows significant gap (110 scans/wk) in capacity to meet demand and backlog clearance.
- Paediatric Audiology PTL validation is completed and Adult PTL validation is underway. Audiology capacity and demand modelling is underway with development of clear recovery trajectories, using outsourcing where possible. 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 WLI capacity, and business case for insourcing which has now been approved. D&C model has been completed with compliance in March 25.
- Specialist US MSK, Head & Neck and cardiology CT scans remain a challenge for capacity. Active recruitment underway to address gap in capacity.
- Work with partners to promote GP uptake of community diagnostic capacity.

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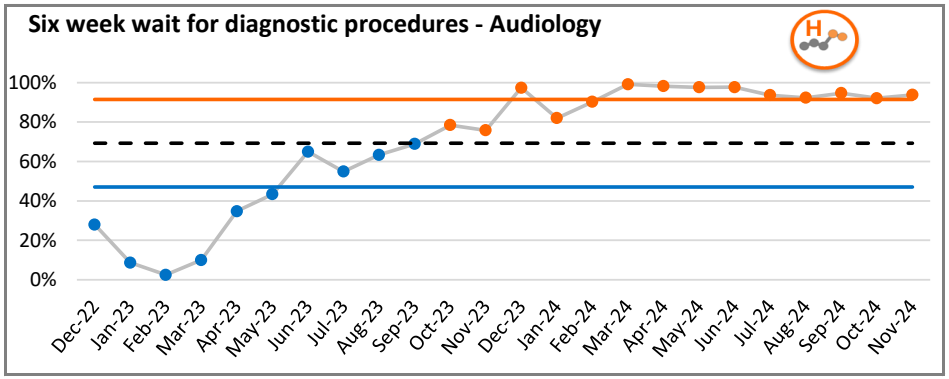
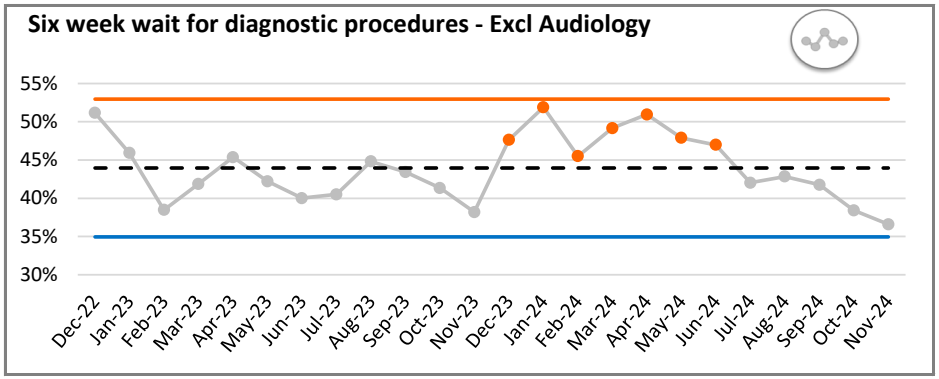
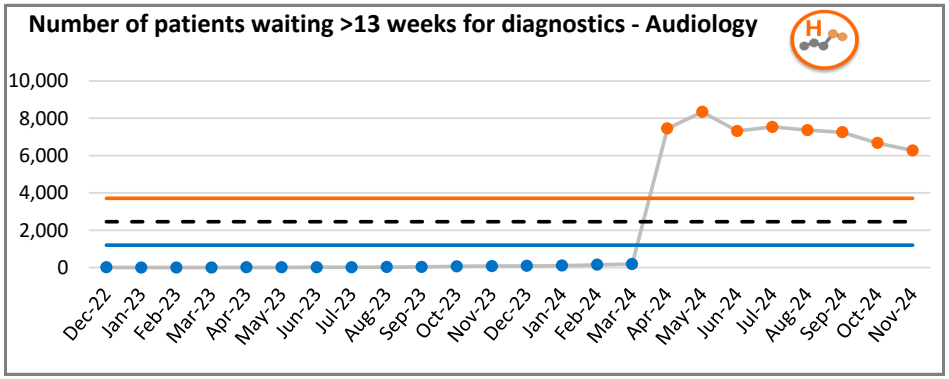
Operations

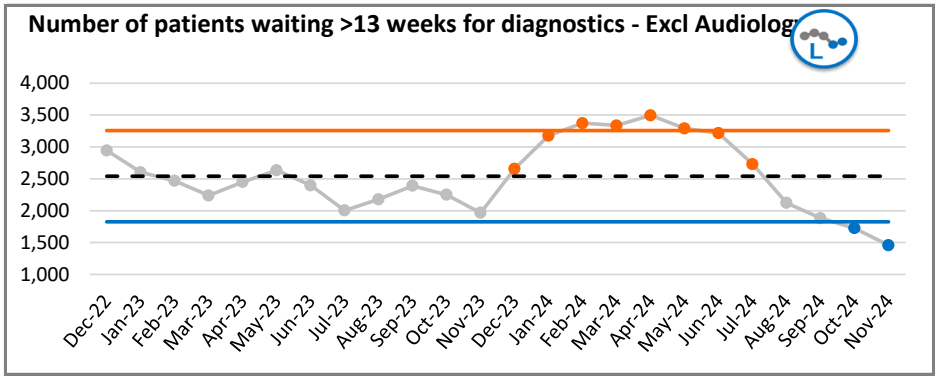
Diagnostics Waiting Times - Audiology

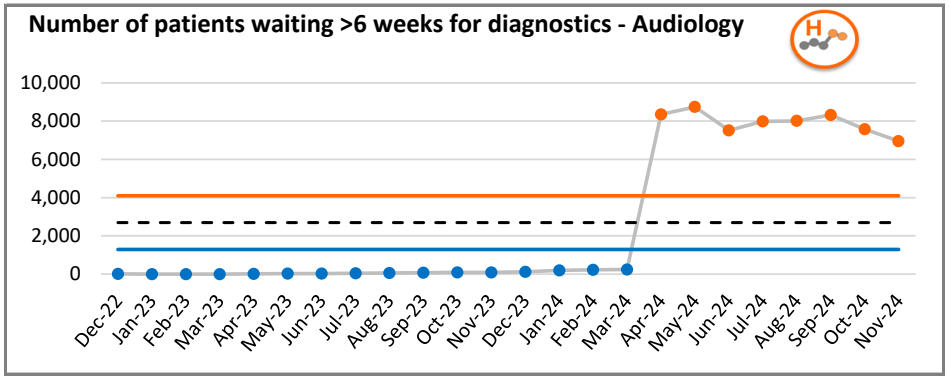
East and North Hertfordshire NHS Trust

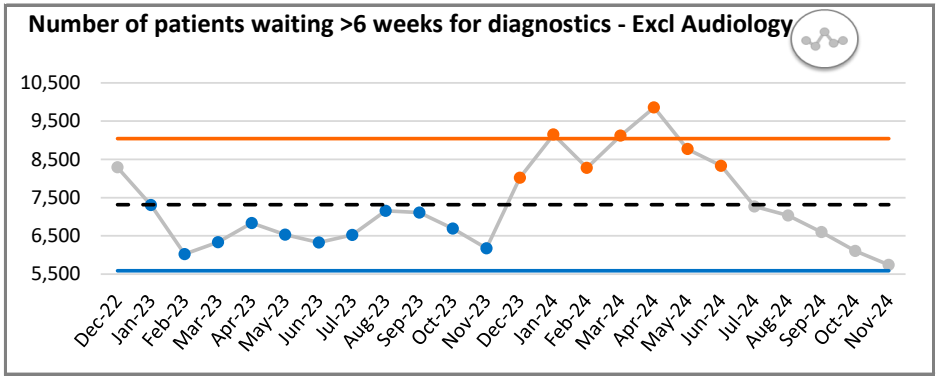










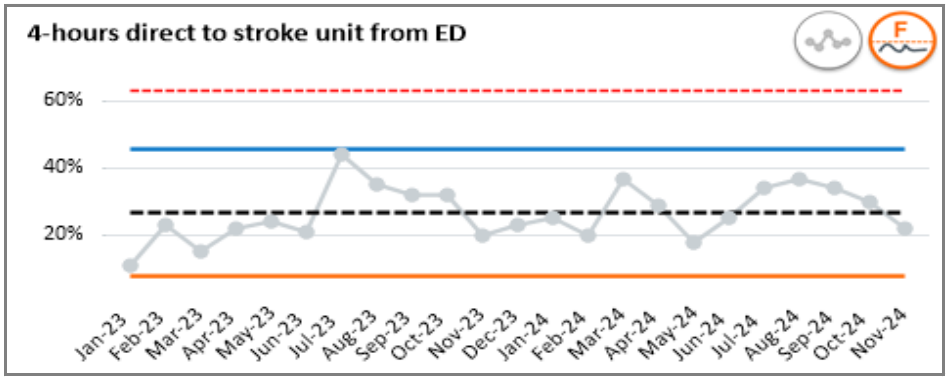


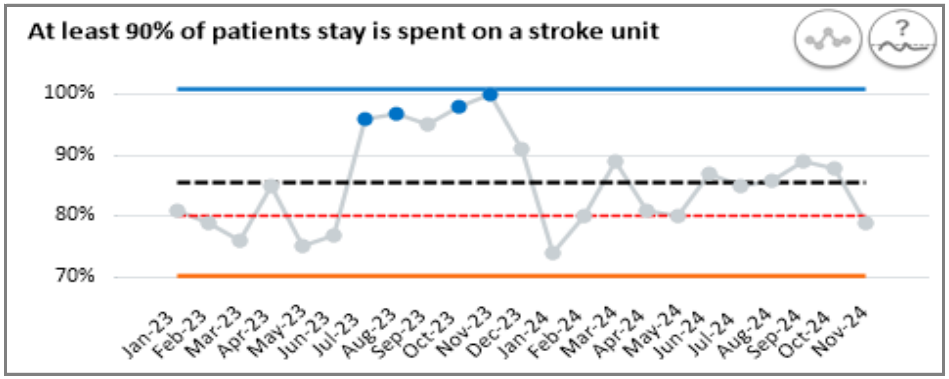
Month 08 | 2024-25

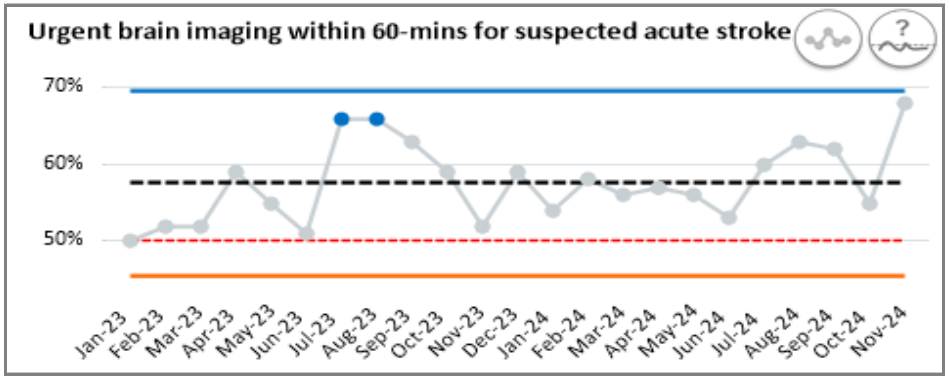
Operations

Stroke Services Supporting Metrics

East and North Hertfordshire NHS Trust

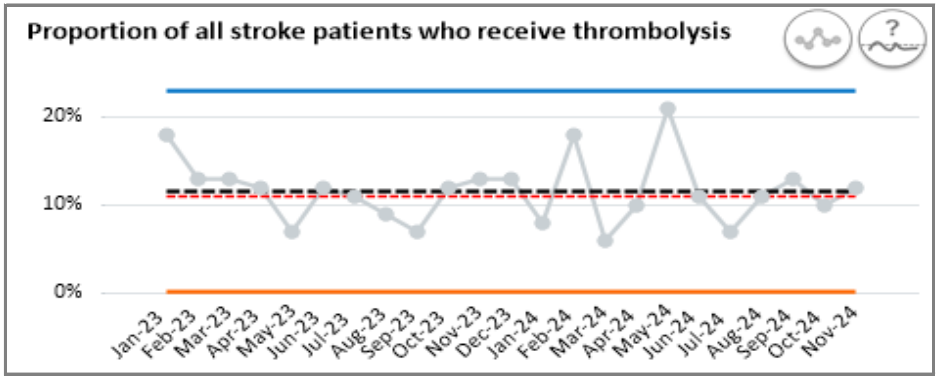






Key Issues and Executive Response

- Thrombolysis rating improved from a D to a C - Thrombolysis % = 10.7% Q2 [c10.3% Q3] ↑. Statistical improvement in average. TASC project finalised. Trust specific Thrombolysis performance rate of 14%. Pre-alert & ED Pathways projects underway to streamline ED Stroke pathways. September = 12.5%. Second highest referring hospital for Thrombectomy [within catchment]. Stroke Video Triage to be brought in-house (cost-neutral)
- SSNAP dataset changes October- will impact performance with stricter key performance indicators. This will increase workload particularly within the therapy and data teams. SLT frequency declined from C to E in Q2. Main issues = % patients given therapy, and frequency of days therapy is provided. Recruitment pipeline in place - b7 educational post recruited for long-term/sustainable improvement plan.
- Predicted improvement in 4hr admission % = 24.1% Q2 [c34.9% Q3]. Action: SU SOP sign-off. Time to first rv by SpR/Consultant declined from 7hrs to 12hrs in Q2. 90% Stay on SU has improved. Overall, challenged mainly due to lack of OoH support = long waits in ED overnight. Action: 1/3 SPR recruited, 1 since declined offer + 1 not accepted. Job back out to advert (Nov 24). Additional SpR to provide 08:00 - 22:00 7/7 cover to improve pathway efficiency; target to recruit 3 SpRs . Impact on SU performance - aim to reflect in Q1 2025. Ward Move = unprecedented staffing impacts if bedbase increases.



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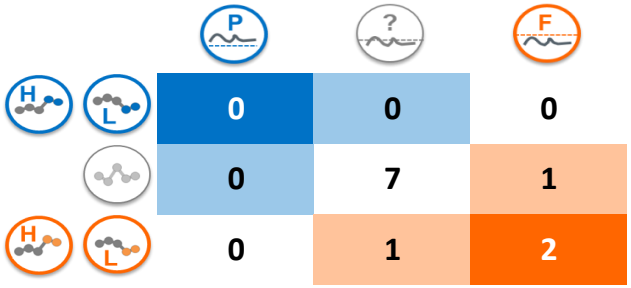
NHS
East and North Hertfordshire
NHS Trust

Finance

Month 08 | 2024-25



Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Nov-24	-2.4	-0.02		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Nov-24	1,245	2,445			Common cause variation No target
	Cash balance	Nov-24	77.9	31.2	L	F	4 points below the lower process limit Metric will inconsistently pass and fail the target
Key Financial Drivers	Income earned	Nov-24	45.3	58.7		?	Common cause variation Metric will inconsistently pass and fail the target
	Pay costs	Nov-24	29.5	35.6		?	Common cause variation Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	Nov-24	15.5	23.1	H	F	2 points above the upper process limit Metric will consistently fail the target

Month 08 | 2024-25

Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Nov-24	24.9	31.6		?	Common cause variation Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	Nov-24	0.9	5.2		F	Common cause variation Metric will consistently fail the target
	Agency costs	Nov-24		0.9			Common cause variation No target
	Unit cost of agency staff	Nov-24		11.4			Common cause variation No target
	Bank costs	Nov-24	3.7	3.1		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Nov-24	0.5	0.9	H	?	10 points above the mean Metric will inconsistently pass and fail the target
Other Financial Metrics	Private patients income earned	Nov-24	0.4	0.6		?	Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	Nov-24	2.8	3.4		?	Common cause variation Metric will inconsistently pass and fail the target

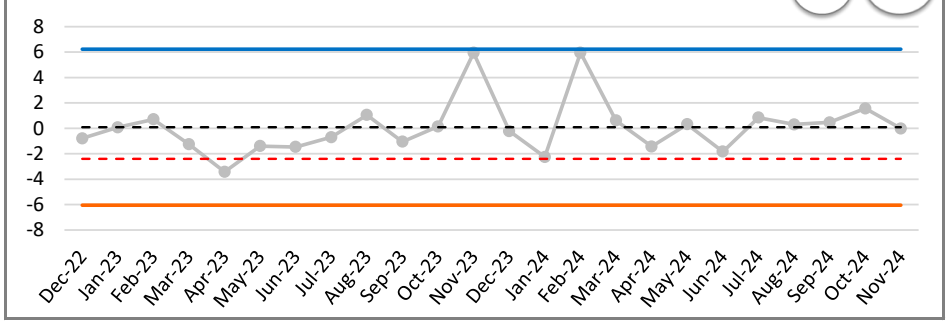
Month 08 | 2024-25

Finance

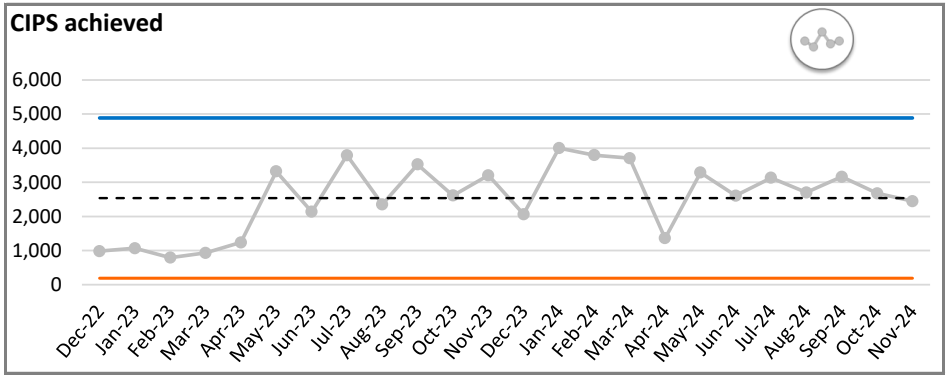
Summary Financial Position

East and North Hertfordshire NHS Trust

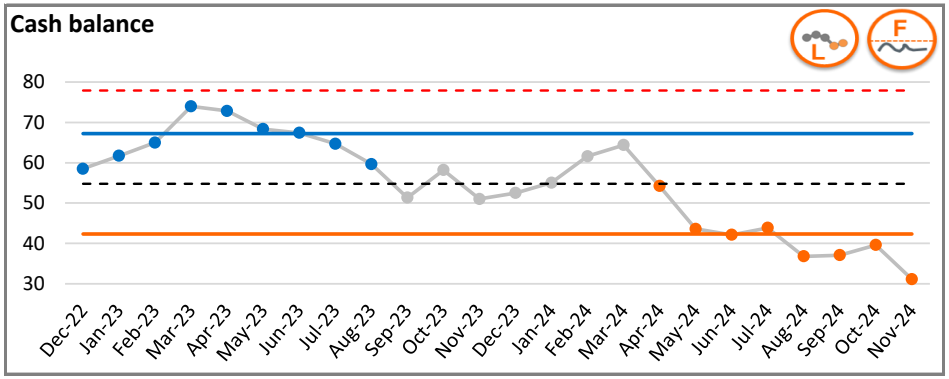
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust approved 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 8, the Trust has reported an actual surplus of £0.2m. This is adverse to plan by £0.7m. This gaps relates to lost income resulting from Industrial Action earlier in the year.
- 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 £0.8m. A number of hotspots of concern have also emerged in respect of management of medical, nursing and admin spend staffing spend. Non pay budgets report a significant overspend of £6.5m YTD, although this is matched against income recovery overperformance of a similar value.
- 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.

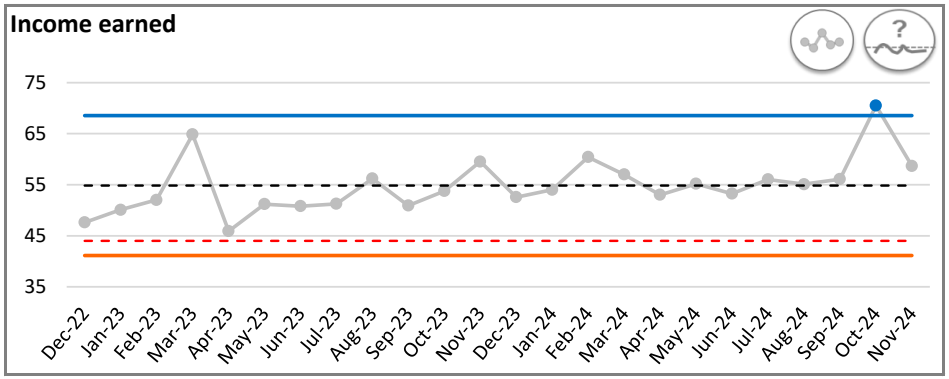
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	678.0	451.6	457.9	6.3
Pay	-426.7	-285.5	-286.3	-0.8
Non Pay	-216.5	-142.7	-149.2	-6.5
EBITDA	34.8	23.5	22.4	-1.1
Financing Costs	-33.8	-22.6	-22.2	0.4
Surplus / Deficit (excl Fin Adj's)	1.0	0.9	0.2	-0.7

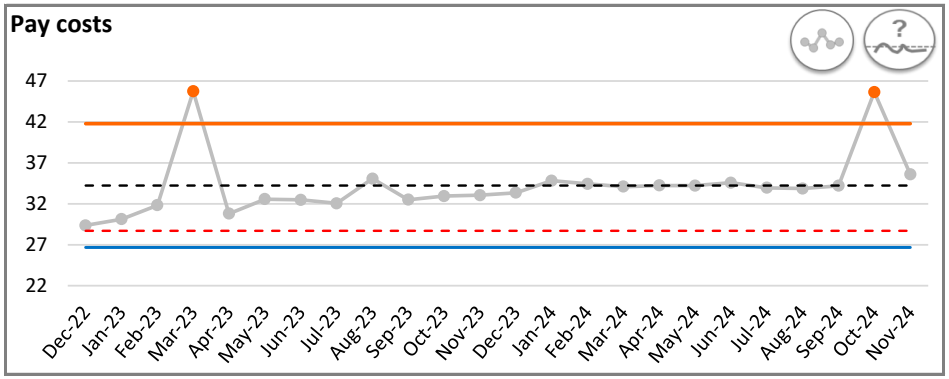
Month 08 | 2024-25

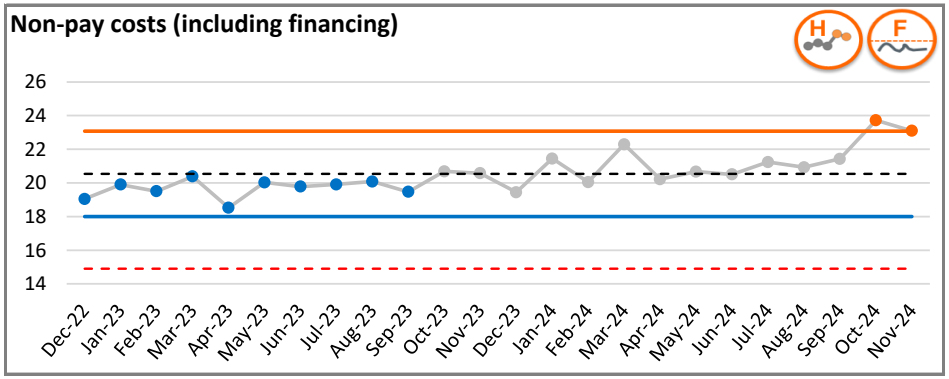
Finance

Key Financial Drivers

East and North Hertfordshire NHS Trust







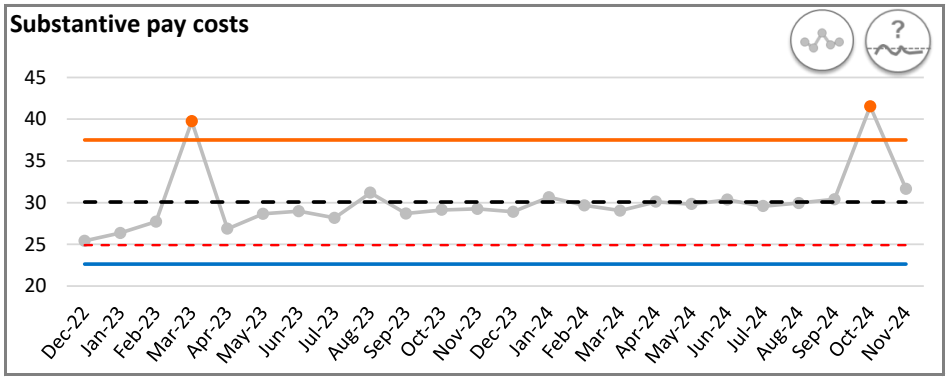
- At Month 8 year to date, there was a planned surplus of £0.9m, and an actual position of £0.2m. The £0.7m adverse variance is entirely due to the ERF activity impact of a 7 day junior doctor strike during June/July.
- Excluding the impact of industrial action, the year to date position is in line with plan, however, this includes 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 to improve the run rate in future months.
- The YTD, and in month, position includes the final impact of the paid 2024/25 pay awards, including backdated payments, which were paid in September. This has been offset by confirmed uplifts to our SLA income, as well as an estimate for the uplift of the training and education income. This income has not been confirmed yet, so could pose a risk to the reported position.
- In month, the Trust delivered a £18k deficit, which was in line with the planned deficit of £11k.
- Pay was £0.5m adverse to plan in month, excluding the impact of non recurrent reserves. This has mainly (£0.4m) been driven by higher waiting list initiative payments. There continues to be improvement in the run rate within ED and Paediatric medical staff due to revised rota's and improved governance arrangements.
- High midwifery usage continue to be a pay hotspots and actions are being undertaken to mitigate in future months.
- Agency expenditure continues to be below the 3.2% target set by NHSE and was 2.2% of pay expenditure in month. Year to date agency expenditure is 2.7% of pay expenditure.
- 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. There are also significant non-pay hotspots in renal, orthopaedics and cardiology, as well as drugs across a number of specialties. These hotspots are only partially explained by an increase in activity. Mitigating actions, and enhanced governance arrangements, have been developed as part of the financial recovery plan.

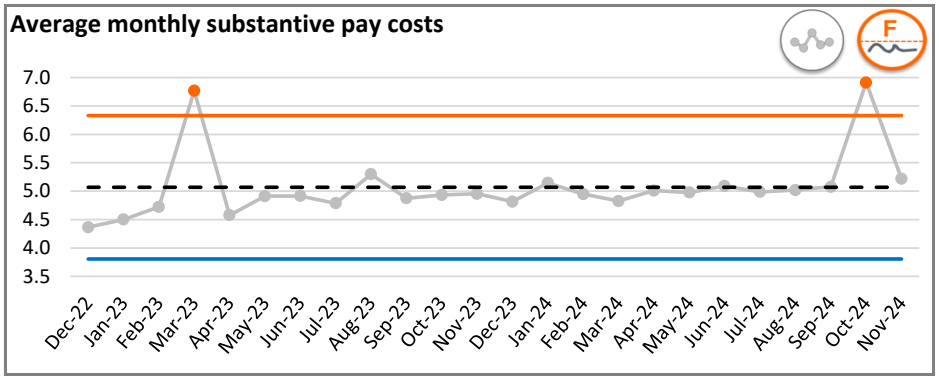
Month 08 | 2024-25

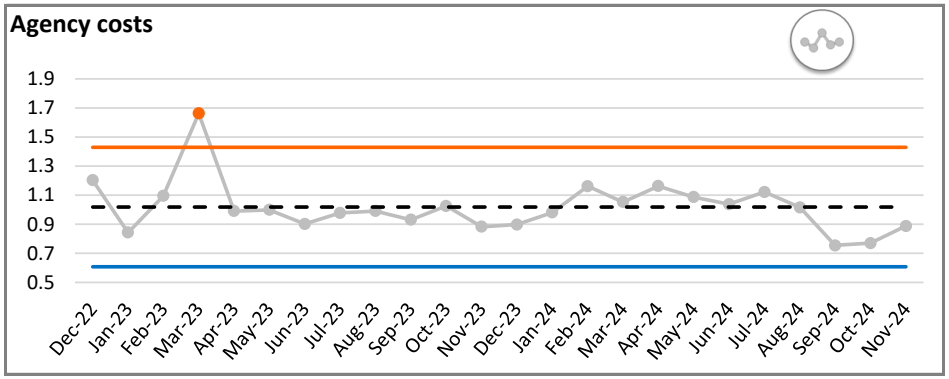
Finance

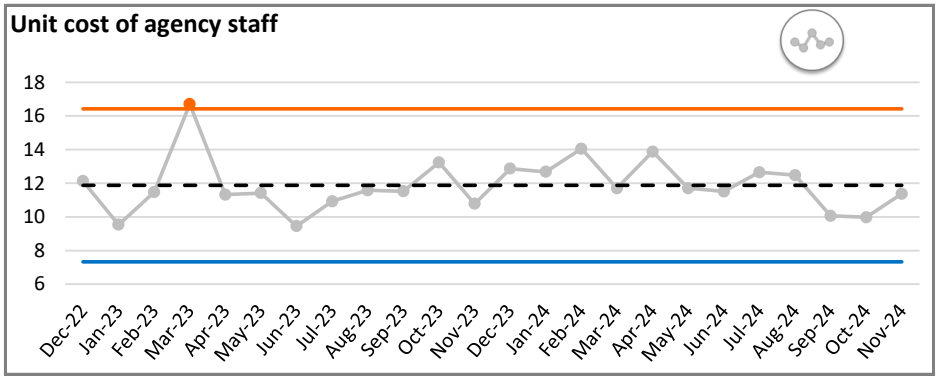
Other Financial Indicators

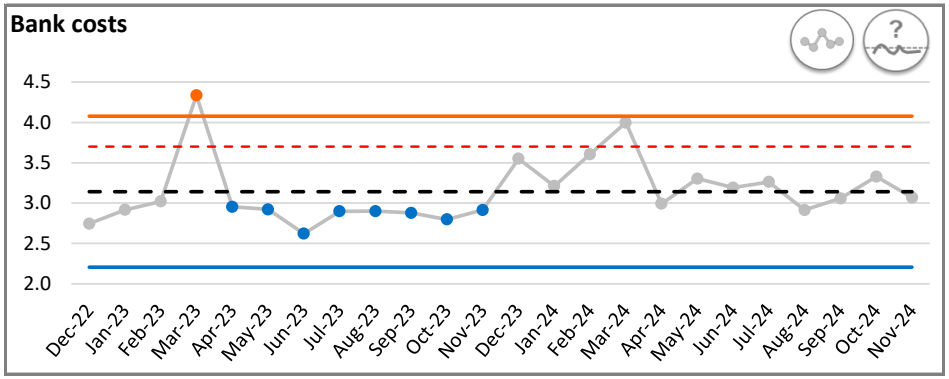
East and North Hertfordshire NHS Trust

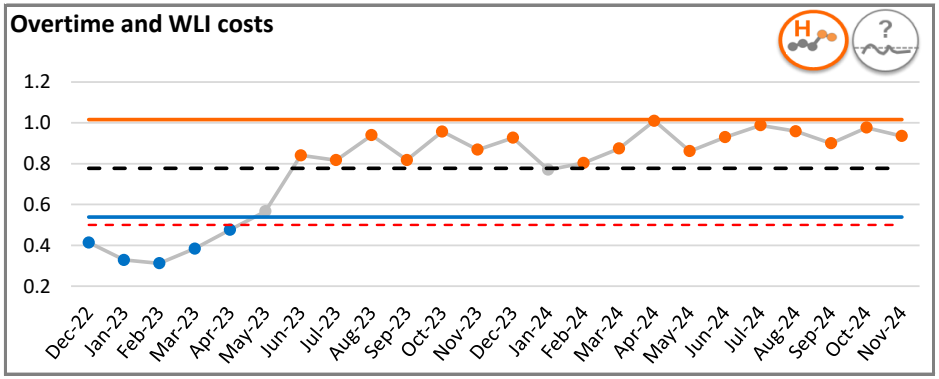












Month 08 | 2024-25

NHS
East and North Hertfordshire
NHS Trust

People

Month 08 | 2024-25

		P	?	F
H	L	0	1	1
		0	2	2
H	L	0	1	0

People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Nov-24	8%	8.9%	H	?	8 points above the mean Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Nov-24	5%	8.0%		F	Common cause variation Metric will consistently fail the target
	Agency spend as a proportion of WTE	Nov-24	3%	2.6%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Nov-24	90%	88.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Appraisal rate	Nov-24	90%	85.0%	H	F	3 points above the upper process limit Metric will consistently fail the target
Thrive	Turnover rate	Nov-24	10.5%	8.6%	L	?	10 points below the lower process limit Metric will inconsistently pass and fail the target
Care	Sickness rate	Nov-24	4.0%	5.0%		F	Common cause variation Metric will consistently fail the target

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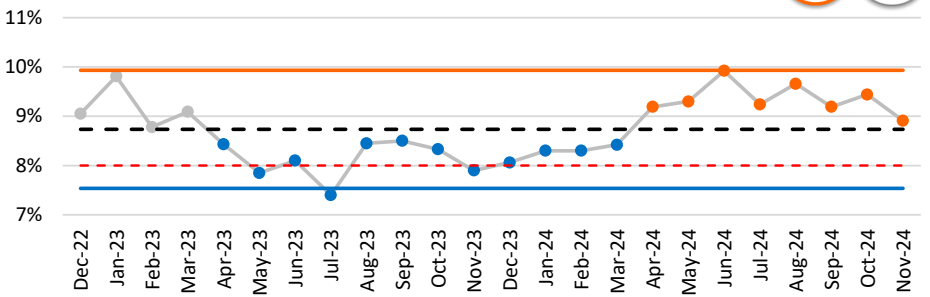
People

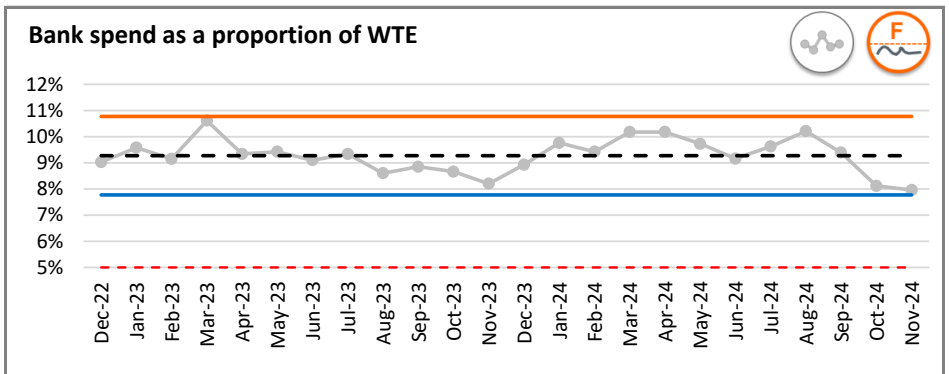
Work Together

East and North Hertfordshire NHS Trust

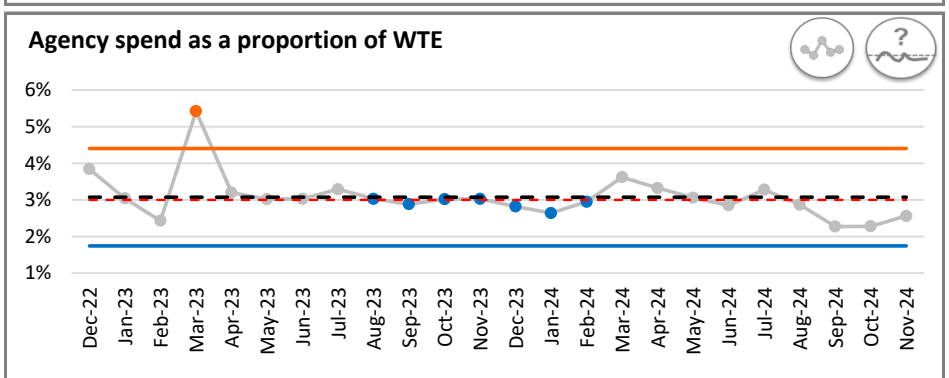
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- Progress is being made on improving the vacancy rates due to commencement of newly qualified nurses and midwives, as well as key medical posts being filled.
- The trust has been running recruitment campaigns for Care Support Workers using the new band 3 job description to great success and we expect an improved vacancy position in the new year as they begin.
- The improved vacancy rate as well as enhanced monitoring and controls has had a positive impact on bank spend. It will be challenging to sustain during the winter months as we see an increased need to cover sickness absence however the monitoring processes are expected to keep the impact to a minimum.
- Agency spend increased slightly, which is consistent with the increase in usage due to early winter/sickness pressures but remains ahead of target.
- In month, there was a 7-day increase in the time taken from conditional offer to pre-employment checks. To address this, the team has reallocated workloads, assigning someone to focus on quality assurance and finalising pre-employment checks, which is expected to positively impact December's figures.
- 'Triple Lock' controls for new vacancies and temporary staffing remains in place
- To support financial sustainability targets, the trust is aiming for 100% of bank and agency doctors to be 'directly engaged (DE)' and now at 97% throughout, with only 1 remaining non-DE locum.
- Robotics build for Resourcing process remains in test - when ready to go live, this will enable data to be transferred automatically from the recruitment system ensuring that the applicants journey can continue outside of core hours.

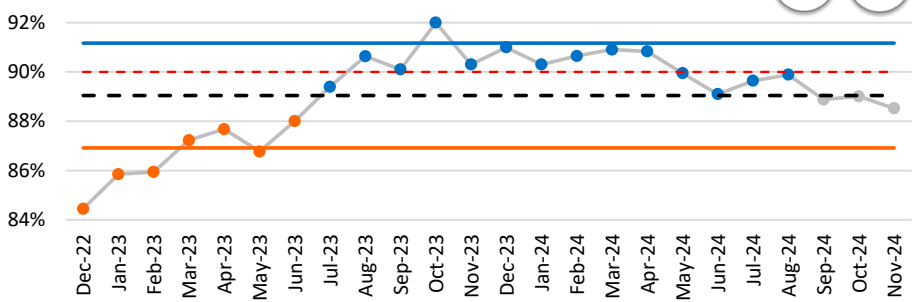
Month 08 | 2024-25

People

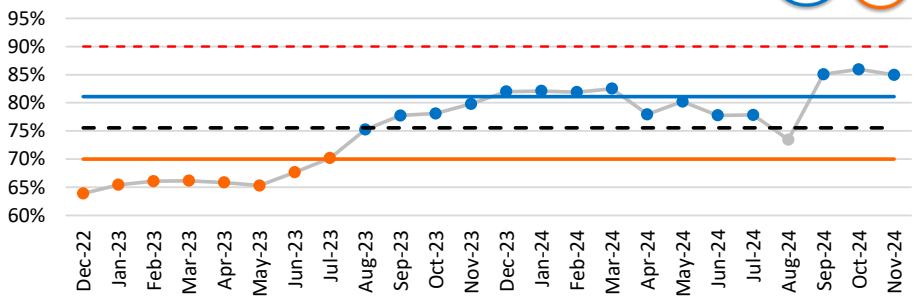
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

Grow Together - Clinical & Medical Education

- To improve overall statutory and mandatory training the trust is working on improving moving and handling compliance which is now 92.7% - level 1 and 81.9% level 2.
- As part of the clinical workforce expansion plans the trust currently has 84 students on site across all programmes and 103 members of staff currently on preceptorship programme
- A new cohort of 13 degree apprentices (Top up) are due to commence in January
- International Nurse Training continues but at a lower level with 9 people currently on the OSCE programme (8 internal + 1 external), 5 SIFE, 3 standard, 1 external – Exams have been booked for December
- Training needs analysis for 25/26 this has been distributed and drop in sessions created to ensure the trust optimises the use of continuous professional development monies.
- Educational activity project will begin in M10 and will focus on cleansing/updating of electronic staff records against training posts.
- Departments of low appraisal rates are being targeted to provide support and close down remaining Grow Together Reviews.
- The trust continues to support the development of it's talent with system programmes ready to launch in the new year including the Emerging System Leaders Programme and Aspiring Director Development Programme.

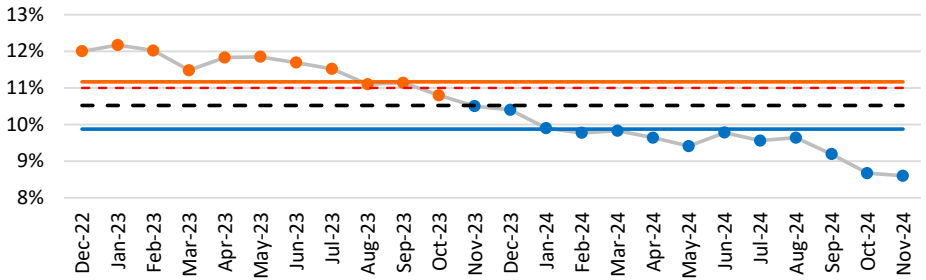
Month 08 | 2024-25

People

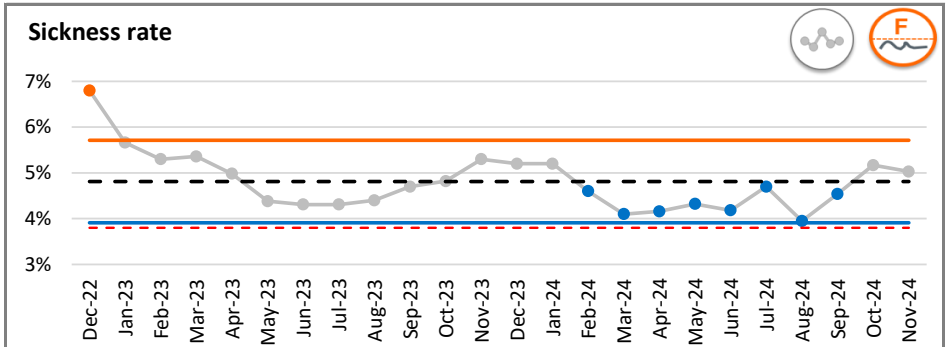
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

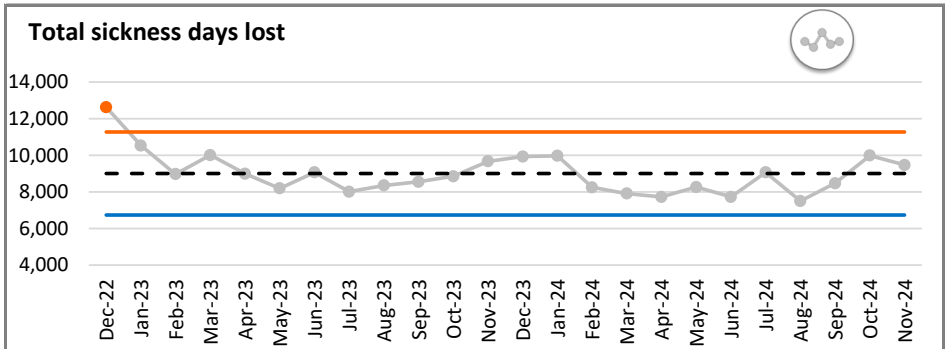
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- The staff survey field work concluded with a 50% response rate. Indicative results will be made available in month 10 with full bench marking data to be released in the following months.
- Preparations are in place to launch the EDI steering group from January 2025 and a new EDI dashboard in in development.
- Ongoing Pathology TUPE on track and scheduled to go live 1 March 2025
- With support from FTSU Divisions/Teams with poor execution of Trust values plans of action being designed and delivered
- Continued MOB (Making ourselves better) and increased training delivery in niche staff performance areas such as Managing Change to improve management capability in various aspects of staff performance

Care Together

- Targeted work to support leaders to prevent and manage sickness absence continues, with coaching for managers, occupational health advice and sickness absence case review meetings.
- Wellbeing promotion events are planned to support colleagues to improve wellbeing, access support and make healthier lifestyle choices. In December National Grief week awareness events highlighted bereavement support available.
- A service level agreement with EPUT is being developed to enable opportunities for group reflection sessions and support from a psychologist.
- Flu and COVID vaccines continue to be available for all colleagues throughout winter, the uptake is currently 29.4% for flu and 16.8% for COVID. Roaming teams are focusing on lowest uptake clinical areas.

Month 08 | 2024-25

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	12
Report title	Summary Learning from Deaths Report	**Meeting Date**	15 January 2025
Presenter	Medical Director		
Author	Mortality Improvement Lead		
Responsible Director	Associate Medical Director for Reducing Unwarranted Variation	**Approval Date**	11 December 2024

Purpose	**For information only**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

Reducing mortality remains one of the Trust's key objectives. This quarterly report outlines the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

It also incorporates information and data mandated under the National Learning from Deaths Programme.

Impact: tick box if there is any significant impact:

Equality (patients or staff)	☒	**Patients / Public benefit or detriment**	☒	**Financial / Resourcing**	☐	**Legal / Regulatory**	☒	**Green Sustainability**	☐

Equality:

- Consistently deliver quality standards, targeting health inequalities and involving patients in their care
- Reduce unwarranted variation through the creation of an environment of learning, autonomy, and accountability

Patients' benefit/detriment:

- Continuously improve services by adopting good practice, maximising efficiency and productivity and exploiting transformation opportunities
- Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners

Legal/Regulatory:

- Compliance with the requirements stipulated in the National Guidance on Learning from Deaths (NQB 2017)

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*

Please refer to page 3 of the report

Report previously considered by & date(s):

Mortality Surveillance Committee: 11 December 2024 (approval of full report)

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

To be trusted to provide consistently outstanding care and exemplary service

1. Executive Summary

1.1 Summary

Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

It also incorporates information and data mandated under the National Learning from Deaths Programme.

1.2 Impact

1.2.1 Strategic ambitions

The Trust has developed a framework of strategic objectives to support and drive continuous improvement. These are listed on the front cover of this report. Additionally, a set of mortality focussed objectives have been developed to echo and support the overarching Trust's strategic ambitions. A new iteration of the strategy is currently being developed to provide focus through 2025-27.

1.2.2 Compliance with Learning from Deaths NQB Guidance

The national Learning from Deaths guidance states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This paper provides this information for Q2 2024-25. An in-depth Learning from Deaths Report covering the same period was provided to both the Quality & Safety Committee, and Mortality Surveillance Committee in December 2024.

1.2.3 Potential impact in all five CQC domains

At the heart of our learning from deaths work are the questions posed by the CQC's five domains of care, whether through the conduct of structured judgement reviews and clinical thematic reviews, through the monitoring and analysis of mortality metrics and alerts or invited service review. Whatever the approach taken, in all domains of care we seek to identify and reduce unwarranted variation in the care we provide and the associated outcomes for our patients.

Figure 1: Learning from deaths and CQC domains of care

1.3 Risks

The following represent the current key risks identified by the service:

Table 1: Current risks

Risks	Red/amber rating
Cardiology: recurrent HSMR and SHMI alerts Following recurrent mortality alerts and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was agreed. This work remains ongoing. The latest update to the Mortality Surveillance Committee in September indicated there are still mis-matches between MI clinical activity and coding with collaborative review continuing. The update also looked at heart failure and reported a significant mis-recording of HF among patients admitted under General Medicine. A further update was agreed for March 2025 when coronary atherosclerosis (the only diagnosis group still alerting) will be focussed on.	
Ovarian Cancer SACT 30 Day Mortality: External review findings In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report has been completed. Associated actions are scheduled to continue to the end of the year. Until confirmation is received that these have been concluded this risk will be maintained.	
SJRPlus review tool Following transfer of the SJRPlus review tool from NHSE to Aqua, it took some time to gain the data protection assurances required by our Executive. An element of risk has remained, as to date Aqua has not conducted a Pen Test, on the basis that the App has moved from one part of the Azure platform to another. Our Chief Information Officer approved our use of the tool, on the basis that we logged this as a tolerated risk on the Risk Register. As this issue took time to resolve, the conducting of reviews was suspended for more than two months. To mitigate the risk, during the downtime, where prompt review was considered important, cases were allocated to Divisions/Specialties via ENHance. By the end of Q2 the number of deaths reviewed for the year has significantly increased, passing the lower threshold (15%), of what is suggested for good governance/learning.	
Implementation of the Patient Safety Incident Response Framework (PSIRF) Work remains ongoing to ensure cohesion between our SJR process and the new patient safety framework. We continue to work closely with the PSIRF implementation Lead, checking that relevant policies and procedures align. While new PSIRF processes become embedded across the Trust, it will remain important to check for alignment with our learning from deaths process.	

	Low risk		Medium risk		High risk

2. Context

Rich learning from deaths requires the triangulation of information from multiple sources, including mortality metrics, medical examiner scrutiny, structured judgement reviews, patient safety incident investigation outcomes, together with detail from other Trust quality and governance processes. This quarterly report provides a summary of key relevant activity, which has been reported in full to the Quality and Safety Committee.

2.1 Headline mortality metrics

Table 2 below provides headline information on the Trust's current mortality performance.

Table 2: Key mortality metrics

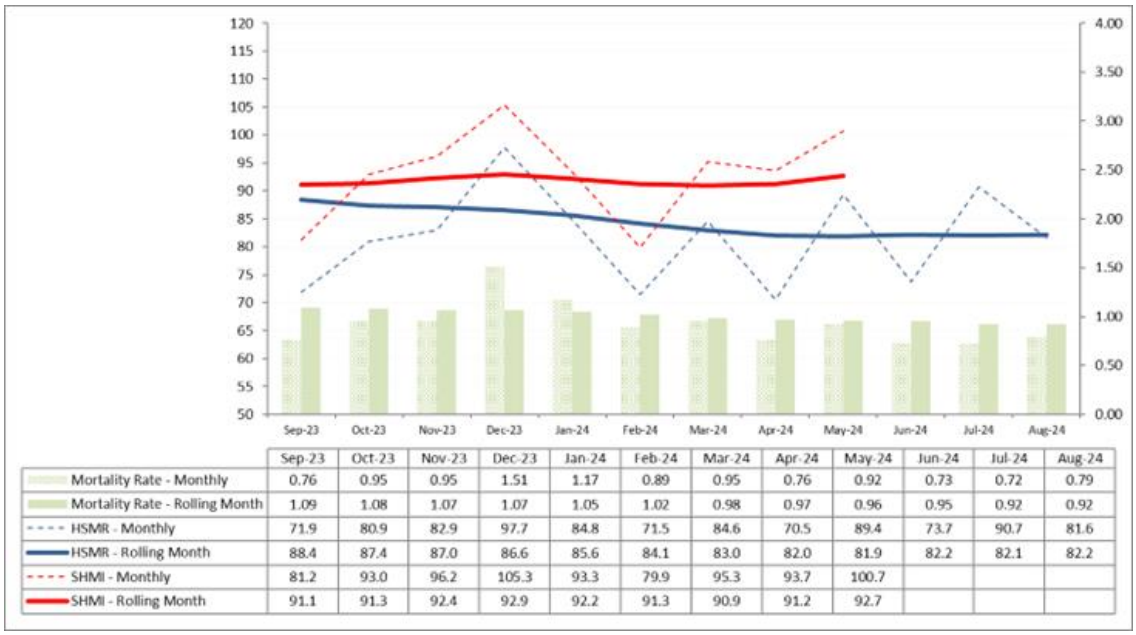
Metric	Headline detail
Crude mortality	Crude mortality is 0.91% for the 12-month period to Oct 2024 compared to 1.03% for the latest 3 years.
HSMR: (data period Sep23 – Aug24)	HSMR for the 12-month period is **82.16, 'First quartile'.**
SHMI: (data period Jul23 – Jun24)	SHMI for the 12-month period is **92.08, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 2nd (of 11) within the Model Hospital list* of peers.

* We are comparing our performance against the recommended peer group indicated for ENHT in the Model Hospital (updated in November 2022). Further detail is provided in 2.1.3.

The chart below shows the Trust's latest in-month and rolling 12-month trend for the three key mortality metrics: Crude mortality, HSMR and SHMI, as reported by CHKS. This shows that rolling 12-month Crude mortality has remained on a steady downward trend. It now stands below pre-pandemic levels. Following a prolonged downward trend since March 2023, rolling 12-month HSMR has plateaued over the last 3 months.

Rolling 12-month SHMI reported by CHKS stands at 92.74 to May 2024. This represents a marginal increase from the last reported **92.0** for the 12 months to February 2024.

Figure 2: Trust key mortality metrics: Latest position



	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Mortality Rate - Monthly	0.76	0.95	0.95	1.51	1.17	0.89	0.95	0.76	0.92	0.73	0.72	0.79
Mortality Rate - Rolling Month	1.09	1.08	1.07	1.07	1.05	1.02	0.98	0.97	0.96	0.95	0.92	0.92
HSMR - Monthly	71.9	80.9	82.9	97.7	84.8	71.5	84.6	70.5	89.4	73.7	90.7	81.6
HSMR - Rolling Month	88.4	87.4	87.0	86.6	85.6	84.1	83.0	82.0	81.9	82.2	82.1	82.2
SHMI - Monthly	81.2	93.0	96.2	105.3	93.3	79.9	95.3	93.7	100.7			
SHMI - Rolling Month	91.1	91.3	92.4	92.9	92.2	91.3	90.9	91.2	92.7			

2.2 Mortality alerts

2.3.1 CQC CUSUM alerts
There have been no CQC alerts in Q2.

2.2.2 HSMR CUSUM alerts
There are no HSMR CUSUM red alerts which constituted a rolling 12-month 3 standard deviation outlier, for the year to August 2024.

2.2.3 SHMI CUSUM alerts
CHKS report indicated six SHMI CUSUM red alerts for the period to May 2024 which constituted rolling 12-month 3 standard deviation outliers, as detailed in the table below.

Table 3: SHMI Outlier Alerts June 2023 to May 2024

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths*	Included Spells
101 - 159: Urinary tract infections	145.04	97	67	30	1254
79 - 131: Respiratory failure; insufficiency; arrest (adult)	192.36	35	18	17	72
100 - 156, 158: Nephritis; nephrosis; renal sclerosis, Chronic renal failure	292.52	19	7	13	322
108 - 198, 199, 200: Skin disorders	195.47	24	12	12	371
35 - 50: Diabetes mellitus with complications	206.53	20	10	10	270
58 - 101: Coronary atherosclerosis and other heart disease	338.40	13	4	9	261

* Excess deaths are defined as the number of deaths above what would be expected in a given period based on historical data. Excess deaths are derived from a statistical model. They do not represent actual deaths. They are, however, an important indicator for further review, particularly where the number of excess deaths is significant. In such situations it is important that review of the actual deaths underpinning a mortality rate alert are reviewed to ensure there are no clinical or operational factors negatively impacting on patient outcomes.

On the back of recurrent alerts for Diabetes and Respiratory failure; insufficiency; arrest, further review and monitoring between Coding and the relevant services has commenced. Additionally, while an in-depth UTI review was undertaken at the start of the year, as this group has continued to alert, and involves a high volume of deaths, further review work has also commenced.

Both the nephritis group and coronary atherosclerosis are under scrutiny with collaborative work ongoing between Coding and the Clinical Leads involved.

Following an update by Coding, who have monitored the skin disorders group, their findings were shared with the Community, but no further internal work is currently planned.

2.2.4 Other external alerts
There are no current active external alerts.

2.2.5 Key Learning from Deaths Data

2.2.5.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q2 2024-25.

Table 4: Q2 2024-25: Learning from deaths data

	Jul-24	Aug-24	Sep-24
Total in-hospital deaths (ED & inpatient)	95	114	99
SJRs completed on in-month deaths (at 1.11.24)	11	31	27
Patient safety incident escalation from SJR (by month of death) (at 1.11.24)	2	5	5
SJR outcome: Deaths more likely than not due to problem in care (≥50%)	1	0	0
Learning disability deaths	0	1	0
Mental illness deaths	1	0	3
Stillbirths	2	2	0
Child deaths (including neonats/CED**)	1	0	1
Maternity deaths	0	0	0
PSIIs declared regarding deceased patient	0	0	0
PSIIs approved regarding deceased patient	0	0	0
Complaints received in month regarding deceased patient	3	2	6
Requests received in month for a Report to the Coroner	10	12	11
Regulation 28 (Prevention of Future Deaths)	0	0	0

* *Medical termination of pregnancies where the baby is born with signs of life are not included in these figures

2.2.5.2 Learning from deaths dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This dashboard is provided at Appendix 1.

3.0 Scrutiny to SJR

3.1 Medical Examiner Scrutiny

Table 5: Medical Examiner scrutiny data: Q2 2024-25

Scrutiny detail	Jul	Aug	Sep	Q2 Total
Total in-hospital deaths (excluding MVCC)*	95	113	98	306
ENHT deaths scrutinised by ME	93	111	98	302
MCCDs not completed within 3 calendar days of death	4	6	7	17
ME referrals to Coroner	19	18	8	45
Deaths where significant concern re quality of care raised by bereaved families/carers	0	0	0	0
Patient safety incidents notified by ME office as a result of scrutiny	0	1	1	2
ME referrals for SJR	13	30	24	67
Community deaths reviewed	146	184	162	492
Deaths referred by the Coroner to ME office to review	43	43	47	133
Total deaths reviewed	**282**	**338**	**307**	**927**

**MVCC deaths are excluded as these deaths are not scrutinised by our Trust, they are instead scrutinised by Hillingdon.*

3.2 Structured Judgement Reviews

3.2.1 SJR process and methodology

Adoption of the FutureNHS/Better Tomorrow SJR Plus mortality review format and e-review tool successfully went ahead from July 2022, with supporting standard operating procedure, Qlik Sense mortality report and Mortality Support intranet page.

As previously reported, from the end of April 2024, the SJRPlus review tool transferred from NHSE to Aqua (Advancing Quality Alliance), an NHS health and care quality improvement organisation working across the NHS, care providers and local authorities.

3.2.2 SJR and deaths YTD headline data

Table 6: Headline Year to date SJR and deaths data

Data count	Apr	May	Jun	Jul	Aug	Sep	Total
Total in-patient deaths	89	112	85	92	98	87	563
Total ED deaths	11	7	12	3	16	12	61
SJRs completed on in-month deaths (at 01.11.24)	13	10	6	11	31	27	98

The above table shows that to date, 16% of hospital deaths have received a formal structured judgement review. This is a significant improvement on the Q1 figure of 4% following the hiatus in reviewing which resulted from the transfer of the online tool from NHSE to Aqua. This means that at the end of Q2 we are already meeting the 15-20% review target suggested by the Better Tomorrow team (now part of Aqua) as being needed to provide robust learning/assurance. Our aim is to further increase this to ≥20% by the end of the financial year.

3.2.3 Learning beyond SJR

3.2.3.1 SJR patient safety incident escalations

Table 7: Year to end of Q2 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 01.11.24)	Apr	May	Jun	Jul	Aug	Sep	Total
Patient Safety Incident Escalations from SJRs	4	5	1	2	5	5	22

For deaths in the current year which have been subject to an SJR, 22 cases have been escalated as a patient safety incident. When we adopted the SJR format and revisited our internal quality and governance processes, it was agreed with our patient safety team, that there are three triggers in the SJR which should result in the case being logged and investigated as a patient safety incident.

These criteria for further review are broader than those historically used to identify areas of concern which means more cases may be identified for further scrutiny, but some will involve a lower level of concern, but still provide valuable opportunities to learn.

Learning from concluded patient safety incident investigations relating to deaths will be collated and added to themes and trends identified in SJRs to inform future quality and improvement work. This quarterly report will detail outcomes of incidents escalated from SJRs where the reviewer judged the death to be more than 50:50 likely preventable and/or the quality of care to have been very poor. Additionally, incidents relating to deaths which are subject to PSII under PSIRF will be included, which will often not have received an SJR. The report will cover cases concluded in the current quarter, irrespective of the date of death of the patient.

In Q2 no cases matching these criteria were concluded and discussed at Mortality Surveillance.

As the Patient Safety Incident Response Framework (PSIRF) becomes fully embedded in the Trust, it will be vital that internal pathways for review and investigation continue to be revisited and clarified to ensure a seamless fit that ensures effective processes that combine to maximise learning potential.

3.24. Learning and themes from concluded mortality reviews

Historically, throughout the year emerging themes have been collated and shared across the Trust via governance and performance sessions and specialist working groups. The information has also been used to inform broad quality improvement initiatives.

With the introduction of the ENHance platform for patient safety incident monitoring; together with the new PSIRF approach to learning from incidents, we are continuing to look for new ways in which learning can be shared and regarding the methods to be used for assessing its impact and effectiveness.

A quarterly 'Food for Thought' presentation is now created, each iteration focussing on a particular aspect of SJR outputs. These presentations are shared in forums such as Mortality Surveillance Committee, Divisional Quality & Safety meetings and with the ICB. A condensed version of these presentations is now also shared in Rolling Half Day documentation packs.

4.0 Improvement activity

4.1 Focus areas for improvement/monitoring

Table 9: Focus Areas for Improvement

Diagnosis group	Summary update
Ovarian Cancer	In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. With completion of the assurance work, a final SI report has now been completed, with associated actions scheduled to continue to the end of the year. The Mortality Surveillance Committee will continue to monitor ongoing work until all actions on the remedial action plan have been completed.
Cardiology diagnoses	Following recurrent MI mortality alerts and a report by the Cardiology Clinical Director, Cardiology committed to a joint initiative with Coding to review all cases with an admitting diagnosis, or cause of death, of acute MI, to identify and exclude 'coding error' cases and ensure appropriate learning. This work remains ongoing with regular updates provided to the Mortality Surveillance Committee. Critically, to date the improvement work has not found evidence of clinical concerns. There are no current alerts for either Acute myocardial infarction or congestive heart failure, which have been the focus of the work to date.
Sepsis	While HSMR performance relative to national peer remains extremely well placed, achievement of sepsis targets remains variable. The sepsis team continues to develop multiple initiatives aimed at improving compliance.
Stroke	The Trust has maintained a SSNAP rating of B for the period April to June 2024. After a long delay, SSNAP finally provided an updated risk adjusted mortality report covering the 2-year period April 2021 to March 2023. While this indicated that the Trust was not an outlier for mortality, it also showed no improvement since the last reported risk adjusted metric for 2019-20. At the same time HSMR and SHMI have both showed significant improvements since the April 2021-March 2023 period. It is likely to be some time before we can see whether the SSNAP metric follows a similar trajectory. As our SSNAP risk adjusted mortality is not well placed versus our national peers, mortality performance will continue to be monitored. The recent focus has continued to be working with the national team on the Thrombolysis in Acute Stroke Collaborative (TASC) project. This has resulted in the SSNAP rating for Thrombolysis going from a D to a C rating. Collaborative working at a regional level with the East of England Integrated Stroke Delivery Network (ISDN) remains ongoing. The Trust is currently involved

	with the National Stroke Imaging Pathway compliance auditing, including the implementation of CT perfusion and the rollout of Tenecteplase for Thrombolysis in line with new national /NICE guidance, all of which will improve Thrombolysis and Thrombectomy pathways.
Emergency Laparotomy	National Emergency Laparotomy Audit (NELA) year 10 has now closed with 130 cases, which is fewer than in previous years. With only 6 mortalities recorded, this indicates a crude mortality of less than 5%. It will be some time before the risk adjusted mortality is published. While focused improvement work continues, case ascertainment remains a challenge. The NoLap Audit commenced in April 2024. This will show how the case selection is affecting the mortality of those not operated on. The long-anticipated re-establishment of the Surgical Assessment Unit commenced from mid-January 2024 and has improved emergency surgical patient flow, thereby significantly improving the care for NELA patients. Collaborative deaths review work is also ongoing with the Coding department, aimed at improving the quality of coding and thereby improving the accuracy of submitted HES data, which forms the basis of mortality indicators.

5.0 Preventable deaths

Currently we are here referring to those deaths that have been judged more likely than not to have been preventable on the basis of an SJR. 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) provides an invaluable, powerful indication that further in-depth investigation of the case is required using the Trust's Patient Safety Incident processes.

The table below provides H1 deaths/SJR/Preventability data (detailing SJRs conducted up to 1 November 2024). The outcome of investigations and actions relating to deaths judged more than 50:50 preventable will be discussed by the Mortality Surveillance Committee.

The preventability of death data provided in this report is taken from mortality reviewers assessment in their structured judgement reviews. Where cases are escalated for further patient safety review/investigation, the additional rigour employed may bring to light detail which results in a downgrading (or increase) to the level of harm deemed to have been caused. The results of these more in-depth reviews are taken into consideration when estimating the number of deaths judged to be more likely than not due to a problem in healthcare reported in the annual Quality Account.

Table 10: 2024-25 SJR preventable deaths data Year to the end of Q2

Data count (at 01.11.24)	**Apr**	May	**Jun**	**Jul**	**Aug**	**Sep**	**Total**
Hospital deaths (ED & inpatient)	100	119	97	95	114	99	624
SJRs completed on in-month deaths	13	10	6	11	31	27	98
% of deaths subject to SJR to date	13%	8%	6%	12%	27%	28%	16%
Deaths judged more likely than not to be due to a problem in healthcare	1	1	0	1	0	0	3
% SJRs assessed ≥50:50 preventable	8%	10%	0%	9%	0%	0%	3%

6.0 Options/recommendations

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

Appendix 1: Learning from Deaths Dashboard

East and North Hertfordshire Trust: Learning from Deaths Dashboard - September 2024-25

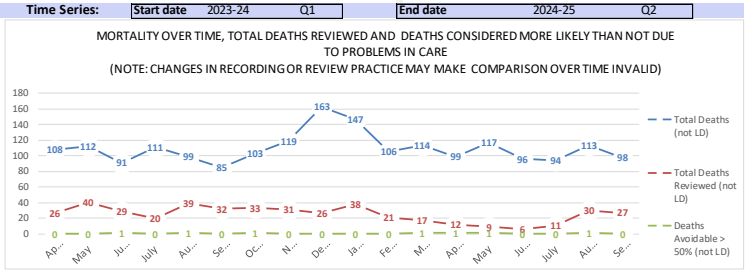
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology (SJRPlus)

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
98	113	27	30	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
305	312	68	27	1	2
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
617	1358	95	352	3	4

Time Series: Start date 2023-24 Q1 End date 2024-25 Q2



Total Deaths Reviewed, categorised by PRISM Score/SJRPlus preventability score

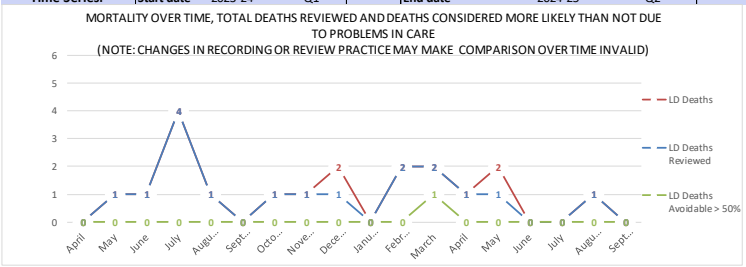
Score 1 Definitely preventable			Score 2 Strong evidence of preventability			Score 3 Probablypreventable (more than 50:50)			Score 4 Probably preventable but not very likely			Score 5 Slight evidence of preventability			Score 6 Definitely not preventable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	3	11.5%	This Month	23	88.5%
This Quarter (QTD)	1	1.5%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	4	6.1%	This Quarter (QTD	61	92.4%
This Year (YTD)	1	1.1%	This Year (YTD)	0	0.0%	This Year (YTD)	2	2.2%	This Year (YTD)	2	2.2%	This Year (YTD)	6	6.5%	This Year (YTD)	82	88.2%

Summary of total number of learning disability deaths and total number reviewed using the SJR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	3	1	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	15	3	14	0	1

Time Series: Start date 2023-24 Q1 End date 2024-25 Q2



Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	13	
Report title	**Board Assurance Framework (BAF) – Strategic Risks**		**Meeting Date**	15 January 2025	
Presenter	Head of Corporate Governance				
Author	Head of Corporate Governance				
Responsible Director	Deputy CEO		**Approval Date**		
Purpose	**For information only**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☒

Report Summary:

Board spotlight on two BAF risks

Spotlight BAF Risk 3 *(System and internal financial constraints) - Martin Armstrong*

- Finance, Performance and Planning Committee (FPPC) in June 2024 requested the BAF description be amended to include system financial constraints to reflect the risk is wider than internal financial constraints and significantly impacted by the local health system economy.
- It is important to understand that this risk relates to the ability to deliver our strategic objective, *"Consistently deliver quality standards, targeting health inequalities and involving patients in their care",* rather than purely financial constraints in their own right.
- Of all the risks on the BAF, it is the one risk where the risk score has fluctuated most (scoring 16, then 20, then 16 and it has been at its lowest score of 12 for the last 12 months). It has an overall assurance score of 4.
- Next year's financial environment appears even more challenging than that experienced in 2024/25. The delivery of step change levels of productivity and savings will be required to set a balanced financial plan; which may see the risk score increase. In this context the Board may wish to consider if there are any additional monitoring or assurance measures desired relating to impact on quality standards. For example, if the risk score increases, indicating increased risk to quality and safety standards would it be helpful for QSC to consider this risk as well as the lead committee, FPPC?
- Positively, all the four identified actions to achieve delivery of planned Elective Recovery Fund activity have been completed.

Spotlight BAF Risk 4 *(Workforce shortages and skills mix) – Thomas Pounds*

- When this risk was first added to the BAF in July 2022 vacancy rates were above 10% and there was a backlog of consultant vacancies whilst the Trust was also managing a bulge turnover period after COVID because COVID conditions had created an artificially low turnover rate in trusts across the country. In the last year overall staff vacancy rates have remained below 10%. The consultant vacancy backlog has been targeted. In 2022 there was no national workforce strategy and since then a first ever NHS-wide workforce strategy is now in place. An updated People Strategy has been approved for the Trust by the Board as well as an Equality, Diversity and Inclusion Strategy which is crucial for retention in the context that 41% of our workforce are from ethnic minorities. A People and Culture Committee has been established to help improve focus on workforce matters. Therefore, whilst the risk score has remained at 12 for the last two years (it was previously 16), significant mitigations have taken place

and there is the potential to reframe the workforce risk for next year's BAF on other elements of workforce risk.
- Targeted waiting list reduction has required an investment in additional workforce often on a premium basis using waiting list initiative payments or high cost locums. In these cases, Cost Improvement Programme (CIP) delivery is often dependent on delivering additional activity without the premium spend, therefore is reliant on good job planning and targeted and efficient recruitment.
- The rapid advancement of AI technology and robotics is already being utilised by the Trust and may offer the potential to help towards addressing elements of this risk.
- A development area identified is better triangulation between FPPC and the People and Culture Committee relating to workforce planning and the monitoring and understanding of movements of total workforce hours.

Key other updates:

- Changes to the BAF are denoted by tracked changes.
- All risks now have an overall assurance score. Traditionally the Board and Committees have considered risks through the lens of risk scoring. The addition of an assurance score for each BAF is intended to aid the Board determine where more focus may be needed where assurance scores are lower. The new assurance methodology the Trust chose to adopt was identified as best practice prior to our newest non-executive director, Gill Hooper, joining the Board but by coincidence Gill developed this assurance methodology which is being adopted by different trusts across the country. Therefore, executive BAF risk owners may also wish to tap into Gill's insights on the subject.
- There are no score changes since the system inertia risk BAF 7 reduced to 12 at the last Board. Five of the twelve risks are rated 16 but none are higher than this. The risks with 16 scores are: Culture, leadership and engagement; Autonomy and accountability (both of these will be spotlighted at March Board); Performance and flow; the Future of cancer services; and Digital transformation (these will be spotlighted at May and July Boards).
- The Board Seminar on 4 December 2024 identified the desire to utilise the BAF more in committee annual planning and agenda-setting. This has been started, with the Quality & Safety Committee's annual cycle setting on 23 December including BAF triangulation and FPPC has agreed to include the BAF as part of a review of FPPC efficacy on 15 January.
- A few actions have hit or will soon hit their due dates on some BAFs. Therefore, committees in the new year will be asked to specifically consider overdue actions where updates have not been provided by the Executive lead to clarify the status.

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**	☐

The BAF risks present potentially significant negative impacts relating to inequality, patients, finances, the system and regulatory compliance should the risks materialise which is why they are top risks on the BAF.

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*

The BAF is based on risks to these strategic objectives and the top three risks to each strategic objective are included on the BAF.

Report previously considered by & date(s):

People & Culture on 19 November; Finance, Planning and Performance on 16 December; and Quality & Safety on 18 December. The BAF was last considered at 6 November Board.

Recommendation	The Board is asked to discuss and **NOTE** the BAF.

To be trusted to provide consistently outstanding care and exemplary service

East and North Hertfordshire NHS Trust

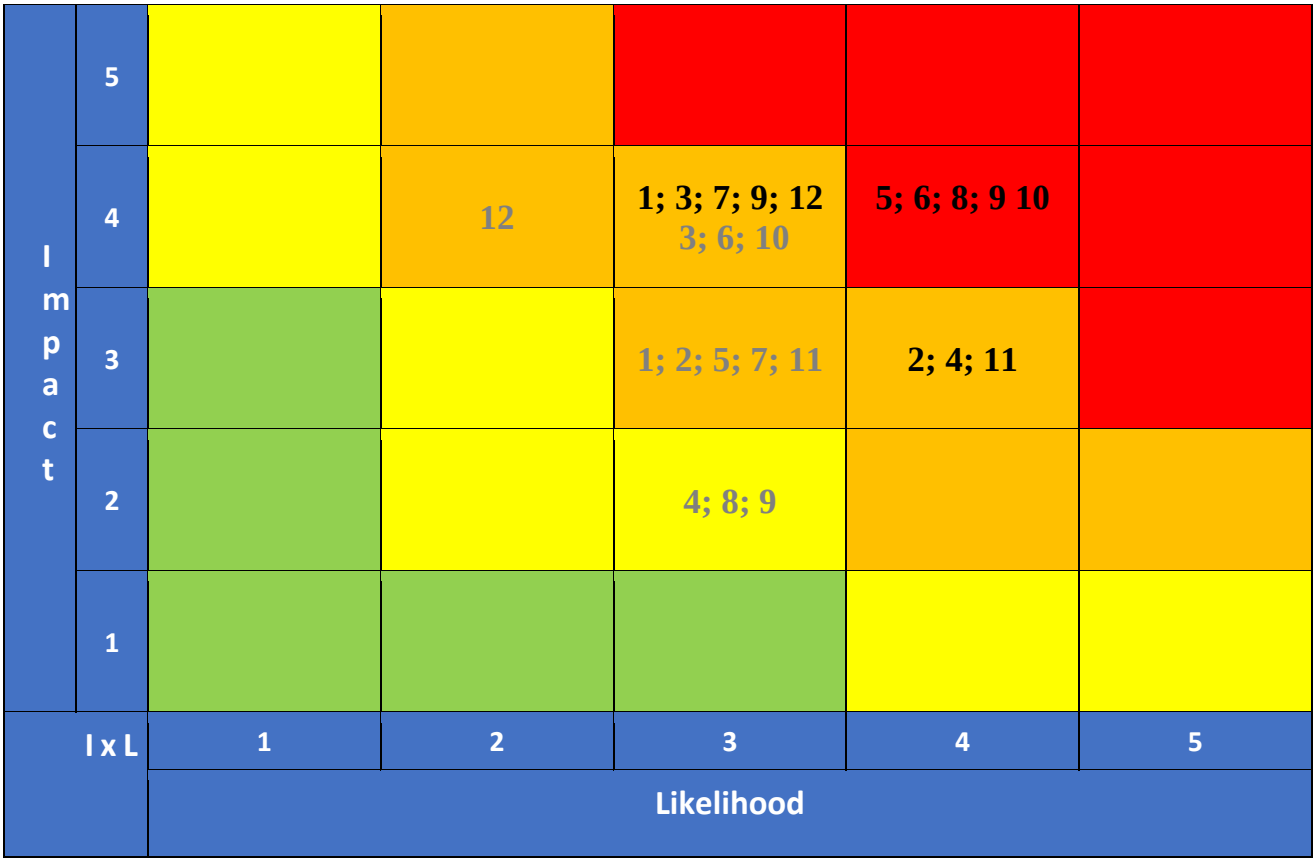
BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

Risk no	Strategic Risk	Lead(s) for this risk	Assurance committee(s)	Current score	Trajectory
Consistently deliver quality standards, targeting health inequalities and involving patients in their care					
1.	**Investment (capital, system allocation and no growth)**	Chief Financial Officer	Finance, Performance & Planning	12	⟷
2.	**Health inequalities**	Medical Director	Quality & Safety	12	⟷
3.	**System and internal financial constraints**	Chief Financial Officer	Finance, Performance & Planning	12	⟷
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
4.	**Workforce shortages and skills mix to meet quality standards**	Chief People Officer	People	12	⟷
5.	**Culture, leadership and engagement**	Chief People Officer	People	16	⟷
6.	**Autonomy and accountability**	Chief People Officer	People	16	⟷
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
7.	**System inertia**	Deputy Chief Executive (CFO)	Finance, Performance & Planning	12	⟷
8.	**Improving performance and flow**	Chief Operating Officer	Finance, Performance & Planning	16	⟷
9.	**The future of cancer services**	Chief Operating Officer	Quality & Safety	16	⟷
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	**Digital Transformation**	Chief Information Officer	Finance, Performance & Planning	16	⟷
11.	**VMI – getting out what the Trust needs**	Chief Kaizen Officer	People	12	⟷
12.	**Clinical engagement and change**	Medical Director (Chief Nurse)	Quality & Safety	12	⟷

Section 2 Strategic Risk Heat Map

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



Section 3 Risk Appetite

Risk level	0 - Avoid Avoidance of risk and uncertainty is a Key Organisational objective	1 - Minimal (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 - Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 - Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 - Seek Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 - Mature Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	
Quality			✓			
Financial				✓		
Regulatory				✓		
People					✓	
Reputational					✓	

Section 4 Risk Scoring Guide

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

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

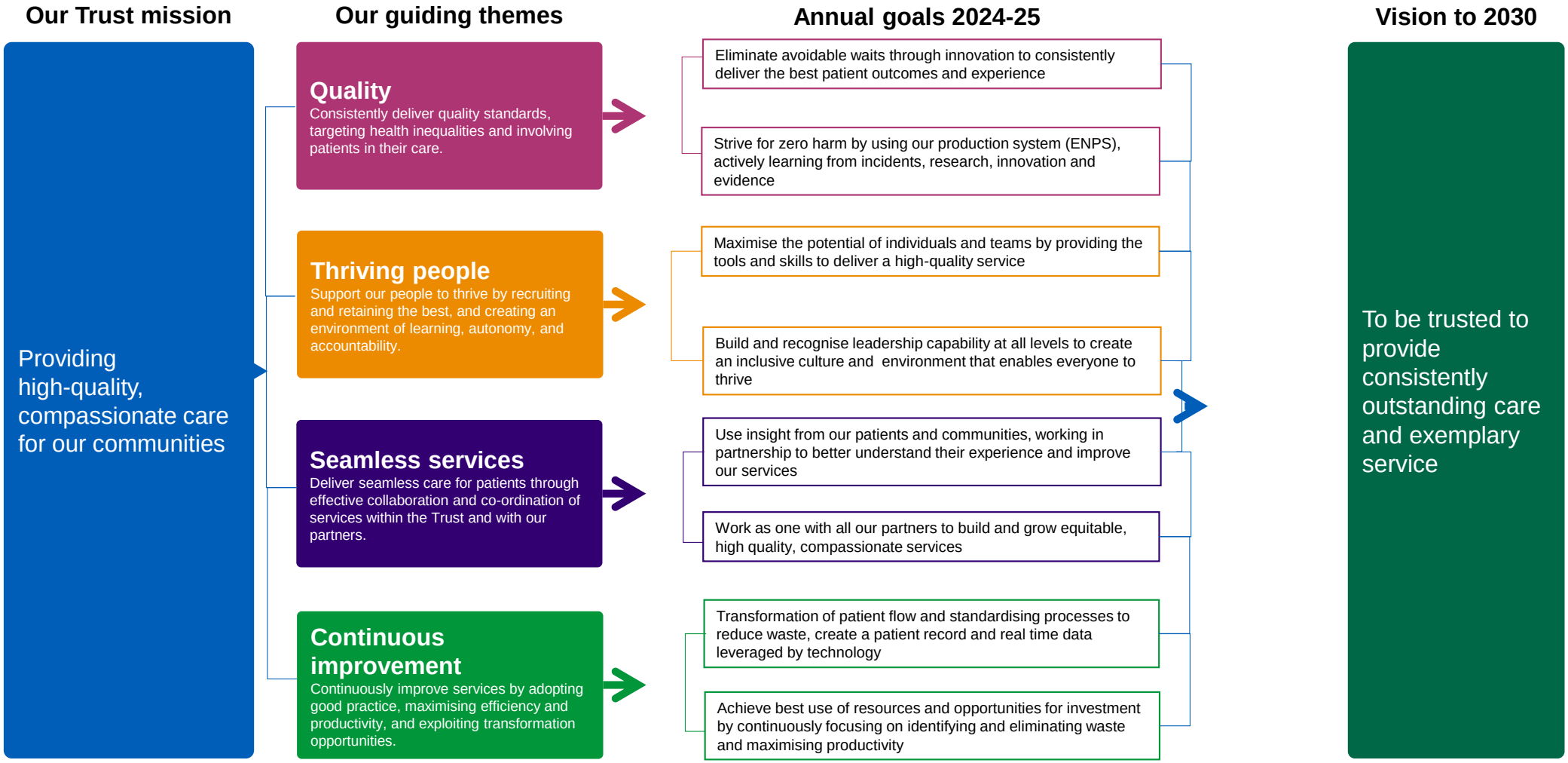
Likelihood	**1 Rare (Annual)**	**2 Unlikely (Quarterly)**	**3 Possible (Monthly)**	**4 Likely (Weekly)**	**5 Certain (Daily)**
Death / Catastrophe 5	5	10	15	20	25
Major 4	4	8	12	16	20
Moderate 3	3	6	9	12	15
Minor 2	2	4	6	8	10
None /Insignificant 1	1	2	3	4	5

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

Section 5 Assurance Scoring Guide

Rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of delivery of all of the significant agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e. 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with reasonable evidence of the achievement of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Evidence of a number of agreed actions being delivered, with limited evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systematic causes/reasons for performance variation.	Some measurable impact evident from actions taken AND desired outcomes with measures to evidence improvements agreed.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken. Desired outcomes sought being defined.
Level 2	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	No improvements yet evident.
Level 1	Emerging action not yet agreed with all relevant parties.	No improvements evident.

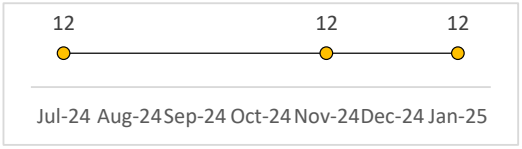
NHS East and North Hertfordshire NHS Trust



Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			**Risk score 12**
Strategic Risk No.1: **Investment (capital, system allocation and no growth)**			
If there is insufficient investment (capital, system allocation and no growth) to address rising costs, demand and aging infrastructure	***Then*** difficult choices will need to be made where to reduce costs or not to invest	***Resulting in*** services and infrastructure in those areas suffering and potential negative quality and safety impacts on patients and staff.	

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

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level 1st line (front line); 2nd (corporate); 3rd (independent)	Assurance score
Strategies and Plans		
Digital Strategy	Strategy approval by Board & annual progress report (2)	6
Estates Strategy	Strategy approval by Board & annual progress report (2)	2
Approved Financial & Capital Plans 24/25	Annual Capital Plan reviewed and approved by FPPC (2)	5
Integrated Business Plan and supporting strategies inform investment priorities	Strategy approval by Board & annual progress report (2)	4
Productivity Framework	Monthly report to FPPC defining a productivity framework and change at the Trust (2)	2
Operational Systems and Resources		
HWE ICS annual operating plan	ICB approval (3)	4
Trust LTFM & System Medium Term Financial Plan (MTFP)	System CEOs review (1) Reports to FPPC bi-annually (2) Regional and national NHSE review (3)	2
Governance & Performance Management Structures		
Finance People and Performance Committee	Monthly finance and performance reports to Committee Scheduled annual planning briefings to Committee (2)	3
Board seminar sessions (include strategy review)	Annual Board Seminar review (2)	4
Financial Recovery Group (FRG)	Co-ordination of financial improvement activity to support in year delivery of financial plan (2)	4
Monthly Capital Review Group meetings & Critical Infrastructure Weekly meetings	Reports (1) Qtrly Capital Plan Reports to FPPC (2)	5
ICS Directors of Finance meeting	Reports to ICS Directors meeting (1)	4
Trust Management Group ratification of investment decisions	Quarterly reports to TMG (1)	5

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Transformational solutions to address the system financial gap	• The System is evaluating options to structure transformation programmes across the system, and the potential commissioning of consultancy resource to pump prime delivery	MA	Q3 24/25
• Confidence in the appropriate deployment of resources across place and providers	• The system has invested in a PHM system that can generate data to support analysis of the distribution of system resources. Consultancy deployment may be required. Timeline TBC	MA	25/26 planning timetable
• Long Term Financial Planning Infrastructure	• Trust to refresh its LTFM (linking to system MFTP) to clearly set out options for resource utilisation within the context of national and local drivers and strategies. Complete during 2024.	MA	25/26 planning timetable
• Responding to in year investment opportunities	• In addition to the annual planning process, the Trust will establish a monthly 'Investment ~~Review~~ Group'. This will provide a forum to consider in year opportunities for affordable investment as they arise	DDOF	~~25/26 planning timetable~~Nov 24
• ICS capital prioritisation framework and associated investment plan	• Plan being produced by ICS Estates Director (reliant on ICS for the timescale to be met)	MA (internally)	Dec 24
• Absence of a clear space utilization baseline and strategy limits the effectiveness of estate investment	• Space Utilisation survey commissioned as part of the 24/25 capital programme to inform 25/26 and long term capital planning	AM	Mar-25
• Provider Collaborative framework and associated workplan	• Producing framework and associated workplan • Agreement of governance and strategy with providers • Mobilisation of work stream activity	ASJ	Nov 24
• Estates strategy finalisation, including addressing aging infrastructure, guiding local capital investment decisions	• Board Seminar strategy development input in April 24 • The Trust undertook a 10 year investment profile exercise as part of an ICS wide programme. • Board approval of Estates Strategy	KH KH KH	Complete Complete Nov 24
• Medium term financial plan	• FPPC review of medium term financial plan – to Oct FPPC	MA	Oct 24
• Consistent process/oversight of business case approval and post project evaluation	• Capital review group oversight of business cases to produce recommendations and undertake post implementation evaluation	MA	Dec 24

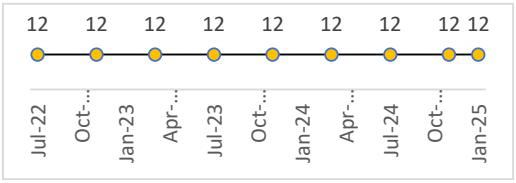
Current Performance – Highlights from the Integrated Performance Report:
• The Trust workforce has expanded significantly since COVID. This represents a significant financial investment, although activity delivery and productivity has declined. • Underlying in year financial performance is at significant variance to plan. • The Trust has agreed a £15m capital investment plan for 24/25.

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

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

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

Risk Trend



Risk Lead	Chief Medical Officer	Assurance committee	Quality & Safety Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
National Strategies		
Core 20 plus 5	National reporting (3)	7
System Plans		
ICS EDI Policy and Strategy 23-27	No current report on delivery of the Trust's elements	1
Trust Plans		
EDI strategy – which includes health inequalities	Report to People Committee and Board (2)	3
Appointment of deputy MD with responsibility for health inequalities (Started 1.11.24)	N/A	2
Changes to waiting lists for patients with learning disability	Report to QSC on LD annually (2)	4
Targeted lung health checks	National policy, enacted locally, assured via SQAS – (3)	7
Workforce health strategy	Brought to board, one off (2)	2

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Lack of a unified smoking cessation policy	• Developing a site policy	MD	• April 2025
• Large PTLs with associated risk post pandemic	• Increasing service awareness	COO	Individual national targets
• Paediatric audiology	• Weekly meetings with ICB and region whilst the service restarts	DON	See Corporate Risk Register

• Community paediatric long waits for assessment	• Ongoing ICB working group	COO	See Corporate Risk Register
• Childrens wellbeing bill • Tobacco and vape bill • Mental health bill	• Implement actions once legislation enacted	MD	2025
• Workforce health strategy – no evidence of impact being collected	• Decision not to seek data at present (gap tolerated)	MD	To close if Board accept no action
• An ICS delivery plan is needed for its Patient EDI Strategy	• Requesting ICS to produce a delivery plan	ICB	Apr 25
• Dedicated resource for health inequalities	• MD / deputy MD and MD ops lead spend a limited amount of time, in addition there is a small amount of support from the business planning team • For November Board spotlight discussion	MD	
• No dedicated work plan	• Lack of resource makes this challenging • For November Board spotlight discussion	MD	

Current Performance – Highlights from the Integrated Performance Report:

- ED 4 hour standard
- 28 day faster diagnosis standards
- DMO1 – audiology
- 65 week waits for community paediatrics

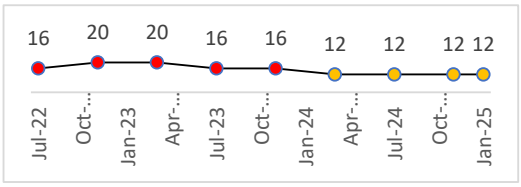
Update 12/24

- ENHT presented at the inaugural Centre for Population Health, Health Inequalities conference on the partnership working we were involved in following work done with The King's Fund
- TMG endorsed moving to a smoke free site from 4/25, with the decision going to QSC for approval in January 2025 and then to Public Board in March 2025 seeking ratification.
- Paediatric audiology – first large pathway reopened
- Community paediatrics - work ongoing
- Corporate risk 3079 – agreement to rebuild paediatric unit

Associated Risks on the Corporate Risk Register

Risk no.	Description	Current score
3027	Risk of Regulatory non-compliance within Audiology Service	20
3079	Disrepair of the Building Fabric and unmet electrical needs and mechanical requirements relating to Bluebell Ward & Bramble Day Services.	20
3420	NEW: Risk of increased waiting times for initial and subsequent appointments within Community Paediatrics	20

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**			**Risk score 12**
Strategic Risk No.3: System and internal **financial constraints**			
If far-reaching financial savings are required (either due to system financial instability or internal pressures), and we do not deliver greater efficiencies	***Then*** we will need to make difficult decisions that could have a negative impact on quality and delivery of our strategy	***Resulting in*** poorer patient outcomes, longer waiting times; reduced staff morale, reputational damage and not delivering all of our strategy.	

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	5	4	20	4	
Current	**4**	**3**	**12**		
Target	4	3	12		

Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Approved 24/25 Financial Plans	Monthly Finance Update to TMG (2)	4
	Monthly Finance Report / Key Metrics to FPPC (2)	4
	CIP report & productivity report to FPPC (2)	4
	Outturn Reports to TMG, FPPC and Board (2)	4
	Delivery & Progress reports to Finance Recovery Group (2)	4
	24/25 Financial plan submitted to & approved by NHSE (3)	4
Operational Systems and Resources		
Financial Reporting & BI Systems	Monthly financial reporting to NHSE & HWE System (1)	5
Detailed monthly CIP performance reporting	Reports to FPPC and FRG and national reporting (2)	4
Monthly ERF & Productivity Report to FPPC	Internal performance monitoring and Model Hospital / GIRFT / Use of Resources benchmarking (2)	3
Monthly Finance Reports	External / Internal audit review of key financial systems and processes (3)	4
Outturn Forecast report to TMG, FPPC and System	Review at FPPC and TMG (2)	4
Monthly ICS Financial Recovery Board	Facilitated by ICS financial and executive leaders (3)	2
Monthly system finance oversight meeting with NHSE	Regional confirm and challenge of Trust and system financial deliver (3)	3
Biweekly System CEO / CEO finance review meetings	System stakeholder review of financial delivery and planning (3)	3

Vacancy Review Panel & Non-Pay controls	Daily / Weekly executive led mechanisms to review and challenge the application of recruitment and spending request relative to tightened criteria (1)	3
Rostering & Job Planning system	Variety of Rota and rostering tools to regulate workforce deployment (2)	2
Ratified SFI's and SO's, Counter Fraud Policy	Annual review and ratification by Board and Audit Committee. Deployment in Trust finance, workforce and governance systems. Annual audit review of effectiveness (3)	4
Governance & Performance Management Structures		
FPPC, FRG & TMG Reporting	Monthly meetings Exec/ NED chaired – agreed agenda (2)	4
Divisional Finance Boards meetings	Monthly meetings Exec chaired – finance delivery review (2)	4
Monthly Capital Review Group	Monthly meeting DDOF chaired – capital plan review (2)	4
Weekly D&C / ERF delivery meetings	Weekly session – Info led / divisional attendance – review of ERF plans and delivery (2)	4
Monthly cost-centre / budget holder meetings	Scheduled review of CC performance with budget holders and finance managers. Frequency determined by performance (2)	4
Bi-weekly ICS Director of Finance meetings	System stakeholder review of financial delivery and planning (3)	3
Bi-weekly Income Recovery Group	Internal corporate review of counting and coding effectiveness and accuracy	4
Monthly Workforce Utilisation & Deployment Group & MEOG medical staffing group	Monthly workforce groups (exec chaired) to review temporary staffing deployment across key workforce groups (2)	2
Procurement Governance Board	Monthly meeting of procurement service stakeholders to review delivery against workplan (3)	4

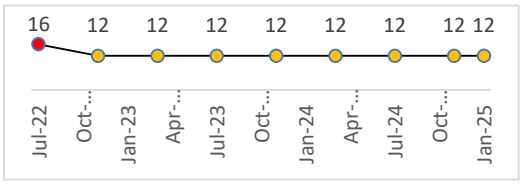
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Delivery of levels of planned ERF activity	• Establishment of Clinical Productivity workstream • Review of ERF recruitment activity • Work plan for Income Recovery Group • Weekly D&C / ERF review sessions with divisions	• KOH • CM • DP • LM	• In Place • In Place • In Place • In Place
• Risk of non delivery of CIP / Savings Targets	• Agreement of CIP delivery framework document • Establishment of FRG to oversee and drive delivery • Review and Implementation of PWC CIP actions	• MA • MA • MA	• In Place • In place • Nov-24
• Risk of significant overspend against Trust expenditure budgets	• Implementation of Non Pay Discretionary Controls • ~~Implementation~~Go Live of 'No PO – No Pay' system • Tightened Vacancy Control Panel • UEC and Establishment Growth Review Work steams • Pathology activity and cost control workstream	• MA • MA • MA • SJ / KOH • CM	• In place • ~~Oct-24~~ Jan-25 • Oct-24 • Oct-24 • Oct-24
• Understanding of financial dynamics underpinning service line performance	• Implementation and testing of SLR model • Service review and validation • Link of output to productivity metrics and levers • Development of supporting ~~incentivization~~incentivisation mechanisms	• DP / LL • Divisions • DP • MA	• Q3 24 • Q3/Q4 • Q3 24 • Q4 24

• Risk around absence of a short and long-term financial strategy for the system and stakeholders to address underlying deficit	• The Trust has generated a medium terms financial plan based upon agreed national and local assumptions. To be used to frame the development of the 25/26 financial plan	• MA	• Q1 25
• Absence of effective job planning framework	• Trust to develop a programme of activity to review (1) review historic additional duties allocations (2) benchmarking job planning principles and assumptions (3) link team job plans to demand and capacity modelling	• MA / JD / TP	• Q3 25
• Significant reductions in Trust productivity vs pre-pandemic levels. Significant increases in staff volumes and costs not related to activity change.	• This has framed areas for review and restatement. This is formalized in 'Establishment Growth' workstream, • Productivity report, with an emphasis on the development of a 'Productivity Index, to FPPC. Productivity QV app deployed to assist service line level productivity reviews.	• KOH • DP	• Oct-24 • Q3 24

Current Performance – Highlights from the Integrated Performance Report:
• The Trust reports a YTD ~~deficit~~surplus of £~~1.3m~~0.2m @ M8, this is adverse to plan by £0.7m • As at Month ~~6~~8 the Trust ERF plans are significantly behind plan. Significant pay and non pay hotspots have emerged. • The utilisation of significant reserves funding has been required to support YTD achievement of the financial plan. • All Divisions have been requested to develop and implement run rate recovery plans. • Additional Financial Recovery Workstreams have been developed and mobilized to bridge remaining gaps to plan~~..~~.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3026	Unavailability of safe medical equipment	16
0036	Risk of delay in patient treatment within plastics as a result of same day clinical appointment cancellation due to inadequate clinical space for paediatric plastics	15
3336	Water quality for the inpatient dialysis areas	15

Strategic Priority: **Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability**		Risk score **12**
Strategic Risk No.4: **Workforce shortages and skillset**		
If we fail to have sufficient high-quality staff, with the right technical and professional skillset, given the local, national and global workforce challenges in healthcare	***Then*** we will not be able to achieve the required number of skilled staff to meet the needs of the local populations	***Resulting in*** poor patient and staff experience, as well as potentially compromising health outcomes, quality of care and reputation.

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

Risk Lead	Chief People Officer	Assurance committee	People and Culture Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
People Strategy	People Committee reports (2) Annual report to Board (2)	6
Clinical Strategy 2022-2030	Report to QSC (safer staffing quarterly; Establishment review; Q&S metrics monthly) (2)	6
EDI Strategy	People Committee reports (2) Annual report to Board (2)	4
Annual Divisional demand and capacity modelling, workforce plans and local Skill mix reviews	Planning reports to FPPC and PCC (2)	6
Apprenticeship strategy	People Committee reports (2) Oversight at Education Committee (1)	5
Mechanisms for identifying hotspots and shortfalls	People Committee reports (temp staffing; resourcing; people report; retention deep dive) (2)	6
NHS Workforce long-term plan	Annual People Committee updates on progress (2)	5
Learning and Development		
Succession plans, talent management & development plans	Grow Together Reviews embedded within organisation and reported to PCC (2) VSM and future leaders' remuneration committee annual report (2) Annual talent review executive team meeting (1) Staff survey question on appraisals (3)	4
Apprenticeship schemes	People Committee reports on progress with strategy (2) Utilisation of apprenticeship levy (1)	5
Leadership and Manager Development programmes	Leadership and management training reported to Education Committee (1)	6

	Management competency framework reported on ENH Academy (1) Staff experience scores captured through pulse survey (1) Access to non-mandatory training captured within staff survey (3)	
Clinical skill development and clinical education	Utilisation of CPD funding – short course and Higher education qualifications - upskilling of staff (1) Bi-monthly update at Education Committee (1) Training needs analysis reviews (capability building) (1) Annual report to PCC (2)	6
Pre and post reg training programs	Bi-monthly update at Education Committee (1) Annual report to PCC (2)	6
Recruitment and attraction		
Workforce Plans aligned with Financial budgets and agreed establishments	Reported annually to PCC (2) Reported to ICB and monitored at ICB People Board (3)	5
Engagement with schools and colleges as part of the widening participation programme as well as offering work experience	Reported annually to PCC (2) ICS sustainable workforce supply committee (3)	5
Targeted campaigns, working with local job centers and open day events	Reported twice yearly to PCC (2)	5
Great for 8% - workforce deployment and bank/agency pay bill reduction programme	Reported annually to People Committee (2) Progress report taken to financial recovery board (1) Vacancy Control Panel implemented for approval and scrutiny of Bank and Agency requirements. Triangulation implemented for 360 view of Bank/Agency usage in line with vacancies, establishments, recruitment activity & pipeline and other pressures such as sickness levels	6
Retention		
Improvement to induction and onboarding, including coaching and mentoring support	Reported annually to PCC (2) Retention steering group (1)	4
Delivery of wellbeing being strategy – Care Support Pyramid	Reported annually to PCC (2) Wellbeing questions part of annual staff survey Included in monthly IPR (3) Sickness rates monitored in Divisional Performance Reviews (1)	6
Delivery of management competency framework	Reported annually to PCC (2)	6
Staff survey team talks and action plan	Divisional update provided to each PCC (2)	5
Governance & Performance Management Structures		
Medical establishment oversight working group	Held monthly & feeds into People report taken to PCC (2)	5
Clinical oversight working group	Held monthly & feeds into People report taken to PCC (2)	5
Recruitment and retention group	Held monthly & feeds into People report taken to PCC (2)	5
Workforce reports – time to hire, pipeline reports	Figures incorporated into the IPR which are taken to PCC and Trust Board (2)	6
Education committee	Held bi-monthly and feeds into People report taken to PCC (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• How we prioritise delivery • Capacity to deliver scale of changes alongside day to day service delivery	• Prioritisation of programmes through board and agreed by executives in line with annual planning cycle • Improving workforce plans at divisional levels to inform prioritisation of plans to Board in line with the annual planning cycle (planning cycle Sept-March) • Demand and capacity planning sessions support and inform the above	• Thomas Pounds • Lucy Davies • Laura Moore	• Apr 25
• Competition for funding and resources across budgets to enable change at scale to happen	• Commitment to new roles based on long term invest to save model aligned to long term workforce plan • Funding flows to support release for training time and sponsored courses.	• Thomas Pounds • Martin Armstrong	• Mar 25
• Capacity of key clinicians and senior leaders to work on the areas of change due to conflicting priorities	• Change in Care Group Structure and appointment to clinical roles with protected time build into job plans to increase level of clinical leadership.	• Theresa Murphy • Justin Daniels	• Mar 25

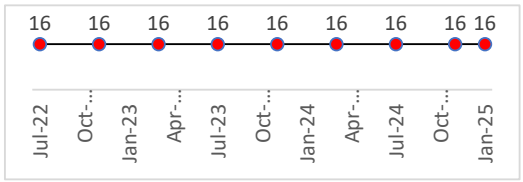
Current Performance – Highlights from the Integrated Performance Report:
• Successful recruitment drive for newly qualified nurses trained in the UK with increased attraction from outside of region and for key areas such as Emergency Department and theatres. • Significant numbers of Care Support Worker applicants with a renewed focus on assessment standards to ensure skills correctly align with role • Outputs from the '90 day challenge' which has focused on developing more inclusive recruitment practices is being built into new processes in order to broaden attraction and increase diversity • Working group set up to develop an action plan based on the recommendations from the Healthwatch report on internationally educated colleagues within the workforce.

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
	N/A	

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

	Impact	Likelihood	Score	Assurance
Inherent	4	4	16	5
Current	**4**	**4**	**16**	
Target	3	3	9	

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
People Strategy	People Committee reports (2) Annual report to Board (2)	6
People policy reviews	Key changes discussed at PCC (2) Trust Partnership (2)	6
Freedom to speak up strategy	Twice per year at PCC & annual report to Trust board (2)	6
EDI Strategy	People Committee reports (2) Annual report to Board (2)	4
People development plans – including education, learning and development	Annually to PCC (2) Education committee reports (1)	5
Learning and Development		
Healthy culture and healthy teams' framework	Reported annually to PCC (2) Divisional performance reviews (1) Divisional updates to PCC (2)	6
ENHT Values and behaviour charter	Aligned to CEO objectives (1) Positive leadership rounds (1)	4
Core Management Skills & Knowledge	Reported annually to PCC (2)	5
Delivery of wellbeing being strategy – Care Support Pyramid	Reported annually to PCC (2)	5
Mentoring and coaching programmes	Reported annually to PCC (2)	5
Talent management approach and programmes	VSM and future leaders' remuneration committee annual report (2) Annual talent review executive team meeting (1)	4

Grow Together Reviews training and support	Grow Together Reviews embedded within organisation and reported to PCC (2) Staff survey question on appraisals (3)	6
Retention		
Annual staff survey and quarterly pulse surveys	Reported in IPR taken to PCC (2) Twice per year updates to PCC & annual to Trust Board (2)	6
Delivery of EDI strategy including inclusive recruitment activities	Regular update reports at PCC focused on different areas (2)	5
Stay interviews and exit questionnaires	New approach agreed by PCC, assurance report to be presented by Mar 25 (2 once starts)	3
Staff survey team talks and action plan	Divisional update provided to each PCC (2)	5
Staff Engagement and Wellbeing		
Delivery of wellbeing being strategy – Care Support Pyramid	Reported annually to PCC (2) Wellbeing questions part of annual staff survey (2) Included in monthly IPR (2) Sickness rates monitored in Divisional Performance Reviews (1)	6
Core offer of support available linked to financial, physical, mental, spiritual and social wellbeing for all staff	Reported annually to PCC (2)	6
Annual engagement events and days to raise awareness of specific topics	Reported annually to PCC as well as monthly updates (2)	6
Staff networks /Freedom To Speak Up/ Meet the Chief Executive/ Positive Leadership Rounds	Voice of our people featured at PCC (2) Staff story featured at Trust board (2)	6
Internal communications - all staff briefing, in brief and newsletter	Reported through CEO report and IPR (2)	6
Governance & Performance Management Structures		
Divisional boards	Monthly and report through to Divisional Performance Review (1)	5
Recruitment and retention group	Held monthly and feeds into People report taken to PCC (2)	5
Staff networks	7 core networks held monthly and report to PCC (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement • Challenges in the level of organisational engagement across ENHT to make things happen and embed sustainable change	• Healthy Teams work is being implemented in Gynae, Maternity, Theatres, paediatrics, ITU and ED. to support leaders and teams develop a good leadership rhythm and build healthy culture • Staff survey action plans support improvements happening locally and results are used to identify priority areas and specific support to low score areas - Team talks on staff survey and also on values charters remain active within divisions. These are now based on the Care Support Pyramid (4 dimensions that make a difference to staff experience) this makes the intervention	• TP	• Mar 25

	organisationally consistent but locally owned and accountable.		
• Capacity to release staff and leaders to participate in development alongside day-to-day priorities	• Creative delivery and support to enable release and participation. Pilots with local events, bitesize and development coaching in order to use time effectively. Use of rolling half day and leadership forum as an opportunity for development. • Introduction to ENH Production System and ENH Production System for leaders now launched with participants supported to attend	• TP	• Mar 25
• Accountability for delivering key actions within the EDI Strategy • Investment and support levels organisationally for EDI programmes and resources restricts progress	• EDI steering group to be set up to oversee key actions and ensure milestones are met • Management competency framework now launched and being promoted across the organisation – EDI is one of the main pillars for learning and development • Wider delivery of programmes such as cultural intelligence and civility matters across the whole organisation – plans and costs being mapped out for 2024 onwards as part of EDI strategy delivery	• TP	• Jan 25~~Dec 24~~

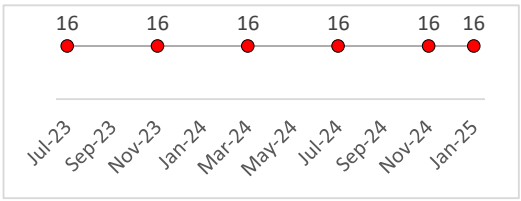
Current Performance – Highlights from the Integrated Performance Report:
• Staff survey fieldwork was completed at the end of November with an overall response rate of 50% - an improvement of 5%. • 'Healthy Teams' development work being targeted to key areas to support leadership and team culture improvement • Roll out of 'do no harm' programme focused on employees entering into formal employee relations procedures and educating managers on early resolution

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
	N/A	

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

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

Risk Trend



Risk Lead	Thom Pounds, CPO	Assurance committee	People

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
People Strategy	People Committee reports (2) Annual report to Board (2)	6
ENHT Production System	Reported annually to board (2)	6
Freedom to speak up strategy	Twice per year at PCC & annual report to Trust board (2)	6
EDI Strategy	People Committee reports (2) Annual report to Board (2)	4
People development plans – including education, learning and development	Annually to PCC (Education committee	5
Governance & Performance		
Revised Scheme of Delegation	ARC and Board review annually (2)	5
Balanced scorecard	Divisional Board reports (1)	4
Well-led review action plan	ARC & TMG progress reports (2)	4
Management Structures		
Divisional operating model – structure and responsibilities	Reviewed as part of Trust Management Group (1)	4
Divisional Performance reviews	Reviewed as part of Trust Management Group (1)	5
Divisional boards	Divisional Performance Reviews (1)	5
Grow together reviews and talent forums	Reported annually to PCC (2)	5
Improvement Partner		
Principles and values related to the ENH Production system to be embedded through training programmes	To be reported to PCC (2 once start)	3
Positive leadership rounds	To be reported to PCC (2 once start)	3

Core skill and knowledge programmes (management and Leadership)	Reported annually to PCC (2)	5
Staff Engagement and Involvement		
Staff networks /Freedom To Speak Up/ Meet the Chief Executive (Ask Adam)	Voice of our people featured at PCC (2) Staff story featured at Trust Board (2)	6
Internal communications - all staff briefing, In Brief and newsletter, leadership briefings	Reported through CEO report and IPR (2)	6
Reciprocal mentorship programme	Update provided to PCC (2)	6

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Lower tiers operational & clinical restructure – operating model change	• Consultation concluded and new Care Group structure in place • Review of the full organisation chart taking place to ensure clear lines of accountability • Divisional performance review structure under review following set up of Care Groups	• LD	• Mar 25
• Organisation goals affectively cascaded to Care Group and department level	• Focus on driving up Grow Together Review compliance rates • ~~Organisation Goal approved by board and template disseminated~~ • ~~Reviewed~~Assessment of dissemination and understanding of goals as part of Positive Leadership Rounds • Reviewed in divisional performance review meetings	• Exec and Divisional Directors • TP	• ~~Dec 24~~Mar 25
• Values charter not yet embedded in all areas	• Part of CEO objective to have Values charters visible in all departmental areas • Reviewed as part of Positive Leadership Rounds • Healthy leadership/healthy teams training and coaching taking place	• CEO	• Mar 25
• Leadership culture modelling/enabling autonomy	• Exec development and team building programme – phase one completed and phase 2 planned for January • ~~LEIPA (360 review) being completed for all members of the Trust Guiding Team~~ • VMI visit – Execs and Lead Directors • Completion of ENHPS for leaders • Increased visibility through Positive Leadership Rounds	• Exec	• ~~Dec 24~~Jan 25 • Aug 25
• The efficacy review and feedback of the performance framework (active cycle of learning) e.g. efficacy of pushing it down within the organisation	• ~~Engagement with divisions to support evolution of the format and feedback shared in performance reviews~~ • Externally led cultural assessment	• KOH~~MA~~	• Aug 25~~Dec 24~~

Current Performance – Highlights from the Integrated Performance Report:
• Follow on from care group development sessions to support on-going learning and development needs. • Leadership live session completed to engage senior colleagues on strategic challenges and support with developing and embedding strategic priorities as all levels.

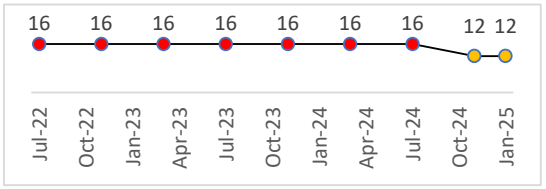
- Positive Leadership ~~r~~Round now embedding with better structure and greater frequency.
- ENHPS for leaders has started for 3 cohorts
- Latest RPIW completed for Ophthalmology

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
	N/A	

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 12**
Strategic Risk No.7: **System inertia**		
If effective system working does not develop at pace	***Then*** the issues the Trust needs system solutions to resolve will perpetuate	***Resulting in*** in enduring areas of sub-optimal health services and patient outcomes and costs.

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

Risk Trend



Risk Lead	Chief Executive	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Trust Strategy and Trust objectives·linking and helping deliver the ICB strategy	• Annual Board approval of new strategic priorities (2) • Annual Board review of Strategy delivery (2) • CEO update to Board includes system developments (2)	5
ICB strategy includes creation of HCPs as multi-agency delivery vehicles	• Approved by ICB (3) • ICB Chair & CEO walks the Board through ICB priorities at least annually	5
HCP Strategy pillar covers ways of working	• ToRs HCP Partnership Board & committees approved by ICB (3) – but lacks Trust Board oversight	3
Financial Controls		
System finances reviewed monthly	• DoFs bi-weekly meeting (1) • CEOs monthly meeting (1) • ICB Board & Finance Committee (3) review system finances • Report to Trust Board includes the system financial position (2)	5
Governance & Performance Management Structures		
NHSE East of England oversight of ICS	• Letter of assessment from NHSE Director to ICB (3)	N/A
ICS Directors of Finance bi-weekly meeting	• Reports/updates to FPPC (2)	5
Relational		
Provider Trust Chairs Forum	• Chair's update to Board where relevant (2)	N/A
Trust CEOs group development work	• CEO's update to Board where relevant (2)	N/A

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date

• Improving how is the Board currently assured/updated on progress with system working	• Embedding newly started CEO system updates to the Board • Minutes from HCP to start being provided to Board	• CEO	• Mar 25 • Jan 25
• Trust objectives linking and helping deliver the ICB strategy	• When 25-26 priorities ICB/HCP priorities will be explicitly referenced.	• CEO	• Q1 25
• ICB BAF does not include effective system-working	• Propose to the ICB that effective system-working is added to the ICB BAF	• CEO	• Q4 25
• Lack of a shared view across Providers and ICB on optimal structuring to create a sustainable financial and operational delivery model	• CEOs developing the delivery strategy for the ICB.	• CEO	• Q1 25
• Embedding the effectiveness of the HCP	• Carry out HCP Board effectiveness review	• CEO	• Q4 25

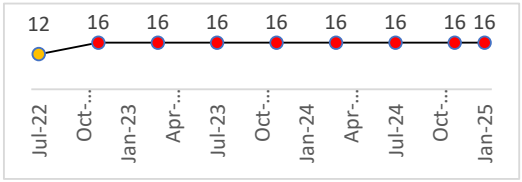
Current Performance – Highlights from the Integrated Performance Report:
• The over-arching system financial plan targets achievement of £30m deficit in 24/25. • Output of HCP effectiveness review • CQC assessment of ICB • HCP performance dashboard metrics tracking progress against HCP priorities

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
1923	Emergency Department pressures	16

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

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

Risk Trend



Risk Lead	Chief Operating Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Recovery trajectories (Elective, cancer, diagnostics), refreshed for 24/25	• Board IPR; transformation reports; escalation reports (2) • FPPC (IPR & deep dives papers (2) • Access Board reports (1)	6
Cancer timed pathway analysis work and associated action plan	• Herts & West Essex Cancer Board reports (3) • Cancer Board reports (1) • Access Board reports (1)	6
UEC Recovery Trajectory and Transformation Plan	• Board report (2) • FPPC report (2) • Access Board report (1)	4

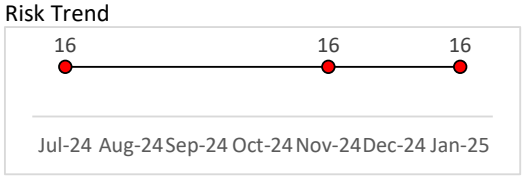
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Embed ~~Agreed~~ Opel Status and Escalation Pathways for ED	• Local triggers and escalation for triage and WTBS • Regular safety huddles in ED led by EPIC and duty matron • Optimise SDEC pathway • Optimise frailty pathway • Redesign of specialty pathways • Full escalation policy	• Junaid Qazi • Chief Nurse (pathways work)	• Nov 2024
• Ambulance intelligent conveyancing - lack of proactiveness	• System solution to intelligent conveyancing/ambulance intelligence will improve, but not fully address the challenge – ongoing • EEAST trialing call before convey and access to the stack to identify those patients who would be best cared for by alternative providers. • EEAST Local Operations Cell participation in HWE System Coordination Centre	• Lucy Davies	• Jan 2025

• Robust pathway oversight and earlier discharge planning for medical specialties • Lack of social care and community capacity to support discharge • Utilisation of Hospital at Home not yet optimal – further work being undertaken to increase uptake.	• Extending scope of hospital at home to support timely discharge for medically optimised patients. • Work ongoing with system partners on discharge processes. • MADE week – focus on utilisz~~z~~ation. • Further work required to prevent admission for frailty patients to include a frailty assessment unit in ED	• Redeemed Mzila	• March 2025
• Diagnostic wait times – MRI and U/S	• Weekly PTL tracking meetings for all modalities now in place. • Recruitment into ultrasound / MRI / CT / echo and neurophysiology • Clear recovery trajectories created with action plans to deliver compliance by March 25 (excluding MRI) • Robust plan for long term MRI capacity to bridge gap in demand • Optimise use of community diagnostic capacity • MRI outsourcing now in place with commercial provider	• Sarah James	• March 2025
• Improved theatre utilisation and pre – tci cancellation rate	• Recruitment plans ongoing.	• Claire Moore	Dec 2025

Current Performance – Highlights from the Integrated Performance Report:
• % of 62 day PTL over 62 days • 28 day faster diagnosis • 65 and 52 weeks RTT • Ambulance handovers • ED 4 and 12 hour performance • Diagnostic waits • Patients not meeting the criteria to reside

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
0064	Risk to staff and patients' wellbeing and quality of care delivered due to an increase in mental health patient admissions and attendances and reduced admission spaces/beds	20
0051	Ophthalmology service recovery	16

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 16**
Strategic Risk No.9: **Future of cancer services**		
If the future of cancer services at Mount Vernon and Lister is not resolved promptly by strategic partners	***Then*** there is a risk of unplanned reconfiguration of cancer services and the inability of the Trust to undertake long-term strategic planning that is financially viable	***Resulting in*** fragmented clinical care with the inability to optimise clinical outcomes; material financial destabilisation; the inability of the Trust to deliver its legal duties; and reputational damage.

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	4	16	4	
Current	**4**	**4**	**16**		
Target	2	4	8		

Risk Lead	Chief Operating Officer	Assurance committee	QSC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Clinical Strategy	• Mount Vernon Programme review with NHSE – quarterly (3) • Cancer peer review (3) that reports to QSC • National annual cancer patient experience survey (3)	5
Cancer divisional risk register (up to date with no overdue risks and all risks have mitigation actions)	• RMG monthly and deep dive (1) • Divisional Performance review (1) • Corporate Risk Register to Board (2)	5
Fabric improvement capital investment to address the sites two year backlog maintenance priorities (partial but not a long-term control)	Q&S Committee reports as required (2) NHSE sustainability group (3) – quarterly	4
New Q&S governance structure Mortality and morbidity meeting oversight of risk (Q&S meetings)	Trust Mortality Committee (1) with 30 day SACT mortality data	3
Business Plan approved for joint acute oncology provision and ward at Watford	Mount Vernon Programme Board (3) AOS Steering Group with NHSE and ICB reps (3)	4
Cancer services deep dives to QSC and FPPC	QSC and FPPC reports (2)	4
Standing Board updates on progress with the Mount Vernon transfer	Updates to each Board (2)	4

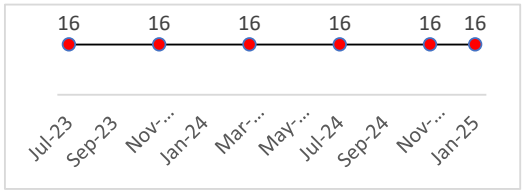
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Clear ownership and roles and responsibilities for making decisions on the future of the current service and ENHT's role in this • Fragmented decision-making between ICB and NHSE which could make	• Add to agenda/ensure continued visibility on joint ICB/NHSE cancer contract meetings to push for prompt decision-making • Add to agenda/ensure continued visibility on joint ICB/NHSE cancer contract meetings to push for prompt decision-making	• NHSE	• April 2025

decision-making more challenging			
• Public awareness of the impact of the delay on quality of services	• Proactive communication plan if gap agreed.	• NHSE/ICB	• Nov 2025
• Access to specialist oncology advice at local DGH sites for those that cannot access Mount Vernon	• Need a clinical oncology strategy for Lister once Mount Vernon transfers	• Sarah James	• April 2025
• Business continuity plan should acute MV services need to close suddenly	• Business continuity/evacuation plan pre-agreed with other cancer providers (UCLH, Circle, Watford, Hillingdon etc)	• Paula Statham	• Dec 2025
• Outcome of service options to NHSE to enable Trust planning	• Obtaining answer from NHSE/ICB about capital and revenue plans to sustain current services	• Lucy Davies	• April 2025
• Lack of a financial mitigation plan for sudden loss of services or significant interim costs whilst awaiting a decision	• Work with NHSE to identify interim funding opportunities that address investment above and beyond NHS contract negotiations	• Martin Armstrong	• Dec 2025
• Assurance gap: Improving QSC oversight of the Mount Vernon strategic plans/patient pathways	• Introduce regular assurance/progress reports to QSC until this risk is resolved	• Justin Daniels	• Nov 2025
• Even if the building is fully equipped it does not fully resolve the issue of fragmented care	• Services need to move to an acute site	• NHSE	• April 2026

Current Performance – Highlights from the Integrated Performance Report:
• 62 and 31 day cancer performance standards • Faster diagnosis standard • 30 day SACT mortality data • COSD cancer data

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3028	Risk of delay in transfer of deteriorating patients [from Mount Vernon] with co- morbidities as a result of inadequate onsite acute facilities to support patient care.	20

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

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	4	16	4	
Current	**4**	**4**	**16**		
Target	4	3	12		

Risk Lead	Chief Information Officer	Assurance committee	FPPC

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Board approved 23/24 Strategic Objectives	• Annual Board review (2)	4
23/24 Digital Strategy and Roadmap	• Digital programme boards (1) • Assurance submissions to NHSE for front line digitization (3) • National benchmarking reports (3)	5
Governance & Performance Management Structures		
Clinical Digital Design Authority (Clinical Decision Committee) with clinical safety review signed off by clinical directors.	• Programme update monthly report to FPPC (2) • Report to Programme Board (1) • Report to Clinical Safety Committee (1)	6
Training and Adoption		
Training and development programme	KPI reporting to Programme Board (1)	2
Learning events, safety huddles and debriefs	Reports to Divisional Boards (1)	2

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Control gaps • Market movement from Perpetual licensing to Software as a Service (SaaS) is preventing the capitalisation of Software licenses and deployment	**Control treatments** • Review Vendor licensing models 1/8/23 • Identify NHS E revenue funding models (not capital) 1/8/23 • Identify Blended Capital/revenue models 1/8/23 • Trust funds identified to fund EPR programme. • Fully mitigated for EPR	Mark Stanton	June 26
• Variation in business-as-usual systems and processes	• Adoption of lean thinking in pathway redesign model as part of the ENH production system for later phases of the project	Mark Stanton	Jan 26

• Improvement training compliance is variable across staff groups and levels of seniority	• Develop a robust training program to include classroom and f2f and communicate requirements with notice via the programme board. Senior stakeholder to share responsibility~~Review of the current model for improvement skills and training following confirmation of Improvement Partner~~	MS~~Kevin O'Hart~~	Feb 25~~Jan 25~~
• Digital Solutions and Delivery team has been historically funded through Capital using contract resource, but new Capitalisation rules mean a move towards revenue, this could significantly reduce the size of the team for Road map deliveries	• Move towards a substantive team to reduce spend • Seek NHS E revenue funding streams	MS	Dec 25
• Training delivery	• Recruitment of a training lead as per the programme plan	MS	Feb 25
• Engagement with the divisions to embed digital as part of learning events, safety huddles and debriefs	• Engagement at appropriate forums to raise awareness and understanding – has started an ongoing	MS	Apr 25
Assurance gaps • Performance data indicates issues with sustaining changes & embedding culture of improvement & learning	**Assurance treatments** • Cultural changes via ENH production System~~Review of current processes for aggregated Trust learning and gap analysis plan to be developed by end Q4 22/23.~~	TGT~~MS~~	Dec 25~~4~~
• Programme milestones and KPIs reflect compliance issues with Trust project management principles	• New strategic project management governance framework established. Ext audit scheduled	MS	Dec 24
• Engagement in the design and adoption of digital systems	• Review of mechanisms to ensure stakeholders have adequate time to engage in design and transformation. • Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions	MS	Ongoing
• Alignment of new transformation portfolio digital requirements with overarching Digital Roadmap	• Executive Programme Board to provide oversight and leadership regarding alignment resourcing and decisions	MS	Dec 24

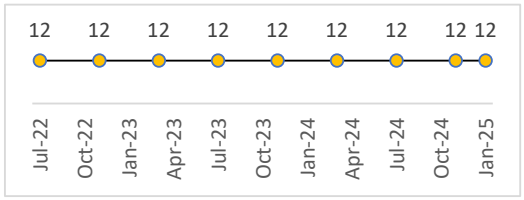
Current Performance – Highlights from the Integrated Performance Report:
• A successful recruitment campaign in Digital has secured a number of Substantive roles ahead of the EPR enhancement programme. • Digital Roadmap presented to FPPC January 2024 • Digital programme commenced April 2024

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
0034	Risk of Cyber Attack	20

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**		**Risk score 12**
Strategic Risk No.11: **ENH Production System delivery**		
If the required leadership and behavioural changes to support the roll-out of the ENH Production System are not prioritised, developed or adopted	***Then*** there is the risk staff will become disengaged and unable to deliver the required improvements at the pace needed	***Resulting in*** missed opportunities to improve performance and outcomes, failure to fully deliver our strategic goals and a deterioration in trust amongst staff.

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

Risk Trend



Risk Lead	Chief Kaizen Officer	Assurance committee	People

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Trust Strategy, Vision and Annual Goals	Board report – annual progress (2)	5
People Strategy	Board report – annual progress (2) People and Culture Committee reports (2)	6
EDI Strategy	Board report – annual progress (2) People and Culture Committee reports (2)	4
Freedom to Speak Up Strategy	Board report – annual progress (2)	6
Operational Systems and Resources		
PSIRF	QSC quarterly updates (2)	4
Governance & Performance Management Structures		
TGT oversight of ENH Production System programme	TGT monthly (2)	5
Staff survey	Board report – annual (3)	4
Improvement Partnership contract management	TGT monthly (2)	5
Executive Value Stream Guiding Teams	TGT monthly (2)	2
Divisional operating model – structure and responsibilities	Reviewed as part of Trust Management Group (1)	4
Core skill and knowledge programmes (management and leadership)	People and Culture Committee reports (2)	5

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Single improvement methodology not established across the organisation	• ENH PS 18-month work plan approved via TGT. • Intro to ENHPS training programme.	• KOH • KOH • KOH	• Mar 25 • Sept 24 • Nov 24

	• Establish 'Report Out' framework to celebrate kaizen successes and spread learning.		
• Leaders acting as coaches and learning to become problem framers, not fixers	• Executive LEIPA development programme. • Deliver three cohorts ENH PS for Leaders. • Positive leadership rounds.	• TP • KOH • KOH	• Oct 24 • Mar 25 • July 24
• Managers understanding their duties and responding to resolve issues and concerns raised by staff (i.e. Freedom to Speak Up framework)	• Management competencies framework and training programme. • Identified as a key priority in response to the staff survey therefore included as part of the 'team talk' discussions where actions are being developed and delivered locally. • Freedom to speak up training included in required learning for all staff on ENH Academy. • Reciprocal mentoring programme in place to develop greater appreciation and understanding of colleagues from different personal and professional background. • Coaching and mentoring framework and guidelines been implemented. • Grow Together reviews and 1-1 conversations.	• NN • TP • TP • TP • TP • TP	• Dec 24 • Dec 24 • Sept 24 • Mar 25 • Mar 25 • Aug 24
• Variation in ward to Board quality governance structures and operational procedures	• Embed new Divisional model and deliver developmental training programme for leadership teams. • Implement daily management via the ENH PS for Leaders programme. • Roll-out weekly Positive Leader Rounds initiative. • Introduction of leader standard work.	• LD • KOH • KOH • KOH	• Sep 24 • Dec 24 • Sept 24 • Dec 24
• Evaluation of ENH Production	• Annual transformation continuum assessment	• KOH	• Mar 25
• Prioritisation of finite KPO resource in the context of multiple competing legitimate demands and the importance of strategic alignment (relates to Executive Value Stream Guiding Teams)	• Kaizen event • Development of Executive values streams • KPO members going through certification process, which takes time	• KOH • KOH • KOH	• Aug 25 • Feb 25 • Jan 25

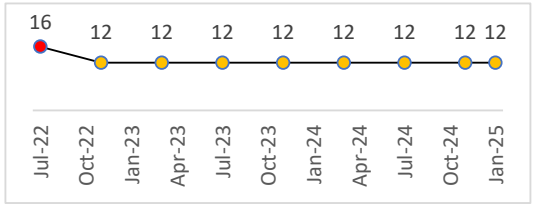
Current Performance – Highlights from the Integrated Performance Report:
• Over 550 staff now attended Intro to ENHPS training session focusing on value, waste and 5S with TGT setting a 10% Trust target for end-March 2025. KPO have scheduled capacity and sessions to meet trajectory. • Three ENHPS for Leaders cohorts involving 60 staff underway with cohort one finishing in February 2025. • Successful RPIW involving ophthalmology team completed in October with 30-day check-in reflecting implementation plan on track. • Intro to ENHPS masterclass facilitated by VMI involving over 60 attendees completed in October. • Planning underway for first two organisational Value Streams involving Cancer Services and Planned Care with 5S event scheduled for Treatment Centre theatres in quarter 4. • TGT completed ENHPS delivery plan reflections in Nov with draft 25/26 delivery plan scheduled for TGT review in December. • Leadership Live event held with over 70 senior leaders in November to review strategic goals and commence early planning for 2025/26 divisional and care group objectives. • New care group structures developmental programme underway with phased approach to address learning and capability building requirements. • TGT team LEIPA exercised completed in November with action plan under development in response to outcomes. • PLRs continue to expand with early work underway to review current practice and alignment with concept of advanced daily management. • KPO Advanced Process Improvement Training cohort 21 due for successful completion in January 2025 which will increase KPO certification by an additional 6 staff.

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

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

	Impact	Likelihood	Score	Assurance
Inherent	4	4	16	5
Current	4	3	12	
Target	4	2	8	

Risk Trend



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

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Quality Strategy	• QSC annual review (2)	6
Clinical Strategy	• QSC approved strategy. Updates needed to QSC. (2)	2
People Strategy	• People Committee reviewed annually (2)	6
Information systems and resources		
Staff survey	• Board and People Committee annually (2)	6
GMC trainees survey	• Education Board (1)	4
GIRFT (addressing unwarranted variation)	• QSC bi-annually (2)	4
ENH academy	• People Committee progress reports (2)	4
Governance and Performance Management Structures		
New operational model introduced in May ’24 that provides additional clinical leadership capacity	• Model approved by Board (2)	2
Rolling half day training	• No independent assurance	N/A
Medical Advisory committee (run by consultants)	• No independent assurance	N/A
Quality Management Processes		
Patient Safety Incident Framework	• QSC each meeting and Board reports (2)	5
ENH Production System	• TGT (1)	5
Training and sharing best practice		
Clinical Directors development Programme	• MEOWG updates (1)	4
Clinical Directors’ Away Days	• MEOWG updates (1)	4

New Consultants development programme	• MEOWG updates (1)	4
ENHPS introduction course	• TGT quarterly reports (1)	5
Leadership and human factors development programmes	• QSC annual report (2)	4
Research and design programmes	• R&D QSC report annually (2)	6
Mentoring for new and existing consultants programme	• MEOWG updates (1)	4
Staff engagement and well being		
Here for you health at Work	• People Committee report annually (2)	5
Freedom to speak up guardian / network (psychological safety)	• Report to Board annually (2)	6
Medical Director's weekly newsletter to all doctors	• No independent assurance	N/A
Regular Clinical Senate meetings	• No independent assurance	N/A
MAC, LNC & JDF	• No independent assurance	N/A
Kindness and Civility Programme	• No independent assurance	N/A
Weekly Positive Leadership Walk rounds (just started)	• TGT (bi-monthly) report (1)	3

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
Skills and knowledge within clinical workforce to learn how to drive change	• Embedding ENH Production system	• KOH	• 2027
Clinical strategy updates to QSC	• New clinical strategy to be written in 2025	• JD	• Dec 2025
Assessment of efficacy of clinical element of new operational model introduced in May '24	• TBC	•	•

Current Performance – Highlights from the Integrated Performance Report:

- Staff survey
- GMC survey
- R&D annual report performance information – number of clinical studies and patients recruited
- Sustained improvement in mortality outcomes

12/24 update

- >400 staff have been trained in the introductory ENHPS methodology, >50 have commenced ENHPS for leaders, first clinical RPIW completed
- Simulation process for learning from incidents shared with TMG in conjunction with the team
- Staff survey engagement increased from 45% in 2023 to 50% in 2024
- GMC survey less good with enhanced support in place for four specialities
- Positive leadership rounds ongoing
- New consultant programme restarted

Associated Risks on the Corporate Risk Register

Risk no.	Description	Current score
	N/A	

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	14
Report title	Maternity incentive Scheme Year 6 – Trust position report.	**Meeting Date**	15 January 2025
Presenter	Director of Midwifery and Lead Divisional Director.		
Author	Director of Midwifery Divisional Medical Director Divisional Director of Operations.		
Responsible Director	Chief Nurse	**Approval Date**	

Purpose (*tick one box only*) [See note 8]	**For information only**	☐	**Approval**	☒
	Discussion	☒	**Decision**	☐

Report Summary:

NHS Resolution is operating year six of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 3 March 2025. The relevant period is from 2 April 2024 until 30 November 2024
https://resolution.nhs.uk/wp-content/uploads/2024/04/MIS-Year-6-guidance.pdf

The purpose of this report is to provide assurance to the Board that the Trust is fully compliant with all ten standards of MIS year 6.

Main Report

1. Purpose

Maternity Services at East and North Hertfordshire NHS Trust are required to evidence the provision of safe, effective, responsive, caring, and well-led services, in line with the Fundamental Standards of Care, as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In line with regulatory requirements and the maternity transformation programme, maternity services engage with a series of externally mandated quality improvement programmes including the CNST Maternity Incentive Scheme (MIS) operated by NHS Resolution. As part of the latter, the Trust must demonstrate compliance with all ten maternity safety actions (Board Declaration form summary of full compliance in year 6 is presented as Appendix 1).

2. Background

CNST is a scheme for handling clinical negligence claims against NHS trusts. 60% of this cost is related to maternity services. The trust pays an annual premium to the CNST scheme, plus an additional 10% towards the MIS. Trusts that can demonstrate that they have achieved all ten safety actions in full, recover the additional 10% of the maternity contribution charged under the scheme.

Trusts that are not compliant with all ten safety actions will not recover their contribution to the CNST MIS but may be eligible for a small discretionary payment from the scheme to help them make progress against actions they have not achieved.

3. Discussion

Evidence to support compliance with each aspect of the maternity safety actions was collated by designated accountable leads for each safety action and monitored through monthly MIS meetings chaired by the Lead Divisional Director.

Evidence of compliance with the evidential requirements for each standard has been submitted to the Trust Quality and Safety Committee throughout the year 6 reporting period as part of the monthly maternity assurance report. Examples of evidence and how they meet each standard are included in the attached presentation (appendix 2).

All evidence has been reviewed in full by the Women's and Children's quadrumvirate leadership team and scrutinised by LMNS representatives and the Chief Nurse for Herts and West Essex ICB who has accepted the submitted evidence and made a recommendation for approval by the Accountable officer for Herts and West Essex ICB as required on the Board Declaration form.

4. Final position against the 10 maternity safety standards.

ENHT can evidence full compliance with all ten safety actions in year 6 of the scheme. Evidence to support compliance with each safety standard is detailed in Appendix 2 of this report.

Within Safety Action 4 (neonatal medical workforce) medical staffing does not currently meet the British Association of Perinatal Medicine (BAPM) national standard. However, the service has been able to demonstrate progress against its action plan to address this which meets the minimum evidential requirement for this standard (included in Appendix 2).

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Monday 3 March 2025.

The Trust's Chief Executive Officer (CEO) must sign the board declaration to confirm that:

- The Trust Board must be satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions as set out in the safety actions and technical guidance https://resolution.nhs.uk/wp-content/uploads/2024/04/MIS-Year-6-guidance.pdf
- There are no reports in relation to the provision of maternity services that provides conflicting information to ENHT declaration (e.g., Care Quality Commission) inspection report, or Maternity and Newborn Safety Investigation program (MNSI formerly known as HSIB).
- The service has been open and transparent with NHS Resolution in years 4 and 5 of the scheme in respect of the short notice CQC inspection of maternity services in October 2022. Following external review and recognition of sustained improvements the

Trust formally exited the National Maternity safety support programme (MSSP) on Thursday 19th December 2024.

The Trust Board is therefore asked to confirm that it is satisfied that the evidence has been provided to meet all 10 safety standards prior to the Chief Executive Officer Sign off of the Trust Board Declaration and final submission to NHS Resolution by 3rd March 2025.

Impact: tick box if there is any significant impact:

Equality (patients or staff)	☒	**Patients / Public benefit or detriment**	☒	**Financial / Resourcing**	☒	**Legal / Regulatory**	☐	**Green Sustainability**	☐

As detailed within the report and evidence log the maternity incentive scheme aims to achieve consistently high-quality services for service users.
Standards 4 and 5 five assurance of available financial / staff resourcing requirements.
Standards 1,2, 7 and 9 all contain equality related standards and measures.

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*

BAF 7 – system inertia
BAF 12 – Clinical engagement change.

Report previously considered by & date(s):

Quality and Safety Committee 18 December 2024

Recommendation

The Board is asked to:
Review and note the content of the report.

- Note that all required evidence has been reviewed at the Women's and Children's Divisional Quadumvirate demonstrating achievement of the 10 maternity safety actions as set out in the safety actions and technical guidance document.
- Note that associated evidence was reviewed and approved by the Quality and Safety Committee at its meeting on 18 December 2024.
- Confirm that it is satisfied that the evidence has been provided to meet all 10 safety standards and give their permission to the Chief Executive Officer to sign the Trust Board Declaration form prior to submission to NHS Resolution by 3 March 2025.
- Note that all evidence is available on request.

To be trusted to provide consistently outstanding care and exemplary service

Appendix 1. Board Declaration form declaring full compliance with the 10 safety action standards for MIS year 6.

Section A : Maternity safety actions - East and North Hertfordshire NHS Trust

Action No.	Maternity safety action	Action met? (Y/N)	Met	Not Met	Info	Check Response	Not filled in
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes	6	0	0	0	0
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes	2	0	0	0	0
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes	3	0	0	0	0
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes	12	0	0	0	0
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes	6	0	0	0	0
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes	6	0	0	0	0
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes	6	0	0	0	0
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes	19	0	0	0	0
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Yes	9	0	0	0	0
10	Have you reported 100% of qualifying cases to the Maternity and Newborn Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Yes	8	0	0	0	0

East and North Hertfordshire NHS Trust

Maternity Incentive Scheme Year 6

Summary of compliance and evidence to support safety standards January 2025

Amanda Rowley: Director of Midwifery

 # ProudToBeENHT

Contents

East and North Hertfordshire NHS Trust

Purpose of the Report

- To provide the committee/Board of the progress being made by the Maternity Service against the ten safety actions outlined in Year 6 Maternity Incentive Scheme
- To provide assurance of compliance through evidence
- To update the committee/Board of current compliance against the ten safety actions and outline the next steps where indicated.

Executive Summary

East and North Hertfordshire NHS Trust

Successes

- The Maternity service has progressed compliance against all safety actions outlined in Year 6 of the Maternity Incentive Scheme.
- The service has led several Quality Improvement projects including the Early Respiratory Distress care bundle, related to Saving Babies Lives care bundle (v3).

Key Themes

- Evidence is being collated into packs to be reviewed by the Safety Champions and ICB to support assurance and signing off the compliance.

Emerging Issues

- The Trust Board is required to sign off at the 15th January 2025 meeting.

This Report includes confirmation of compliance and examples of available evidence. All evidence is available on request.

Safety Action 1

National Perinatal Mortality Review Tool (PMRT)

East and North Hertfordshire NHS Trust

ProudToBeENHT

Requirements of Safety Action One

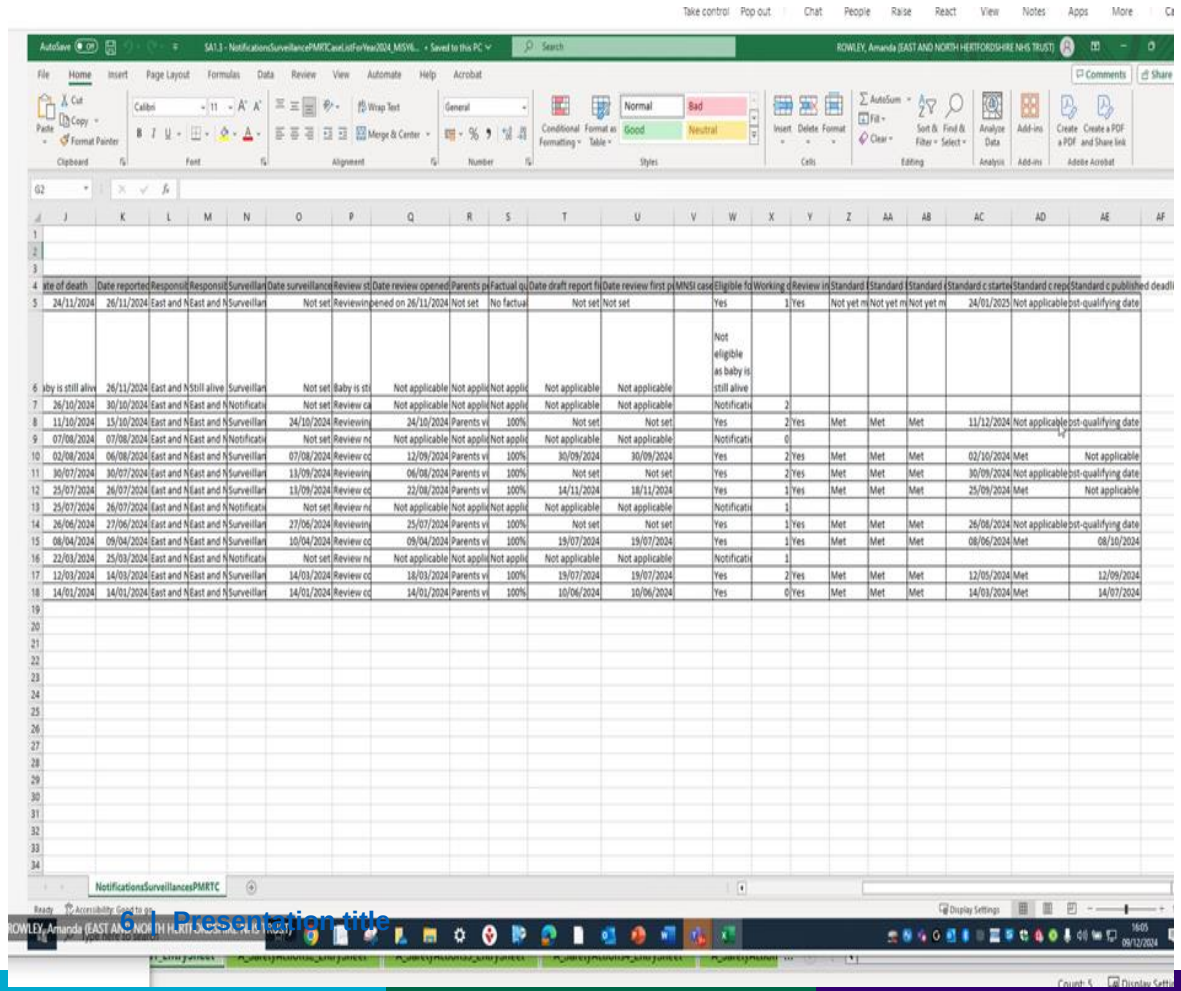
East and North Hertfordshire NHS Trust

Requirement number	Safety action requirements	Requirement met?	Evidence
1	Have all eligible perinatal deaths from 2 April 2024 onwards been notified to MBRRACE-UK within seven working days? (If no deaths, choose NA)	Yes	Excel spreadsheet downloaded from PMRT on MBRRACE website
2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes	PMRT Letter to families template for patient engagement and DoC, example case presentation at PMRT including patient questions, Bereavement QASC reports, Individual cases MBRRACE PMRT tool summaries (on portal)
3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 2 April 2024 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes	Excel spreadsheet downloaded from PMRT on MBRRACE website, Bereavement QASC reports
4	Were 60% of the reports published within 6 months of death?	Yes	Excel spreadsheet downloaded from PMRT on MBRRACE website
5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews, any themes identified, and consequent action plans.	Yes	Bereavement QASC reports
6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes	Bereavement QASC report, Maternity Safety Champion meting minutes, QSC front cover sheet

Recommend that compliance with this safety action has been achieved

5 |

Evidence example :
MBRRACE notifications surveillance PMRT Report



Report Coversheet

NHS East and North Hertfordshire NHS Trust

Meeting	Quality and Safety Committee	**Agenda Item**	5.1
Report title	Perinatal Mortality Review Group	**Meeting Date**	July 2024
Presenter	Amanda Rowley Director of Midwifery		
Author	Rachel Wooldridge, Consultant Obstetrician Josie Reynolds, Lead Midwife for Quality Assurance, Governance & Compliance		
Responsible Director	Director of Midwifery	**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note** ☐	**Approval**	☒
	Discussion ☒	**Decision**	☐

Report Summary:

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to run the national Maternal, Newborn and Infant clinical Outcome Review Programme which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. The aim is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, new-born and infant health services.
The MBRRACE–UK programme of work comprises national surveillance of late fetal losses (22 – 23 weeks gestation), stillbirths and infant deaths and the provision of confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis This report provides the assurance that the maternity services are contemporaneously and continuously monitoring the Stillbirth and Neonatal death rates, by means of the PMRT (perinatal mortality review tool) and provides a summary of the outcomes and actions for the first quarter of 2024/2025 (Apr-Jun). Figures were obtained from the Bereavement Midwife records, Maternity Information System (CMIS) and MBRRACE / PMRT documentation.

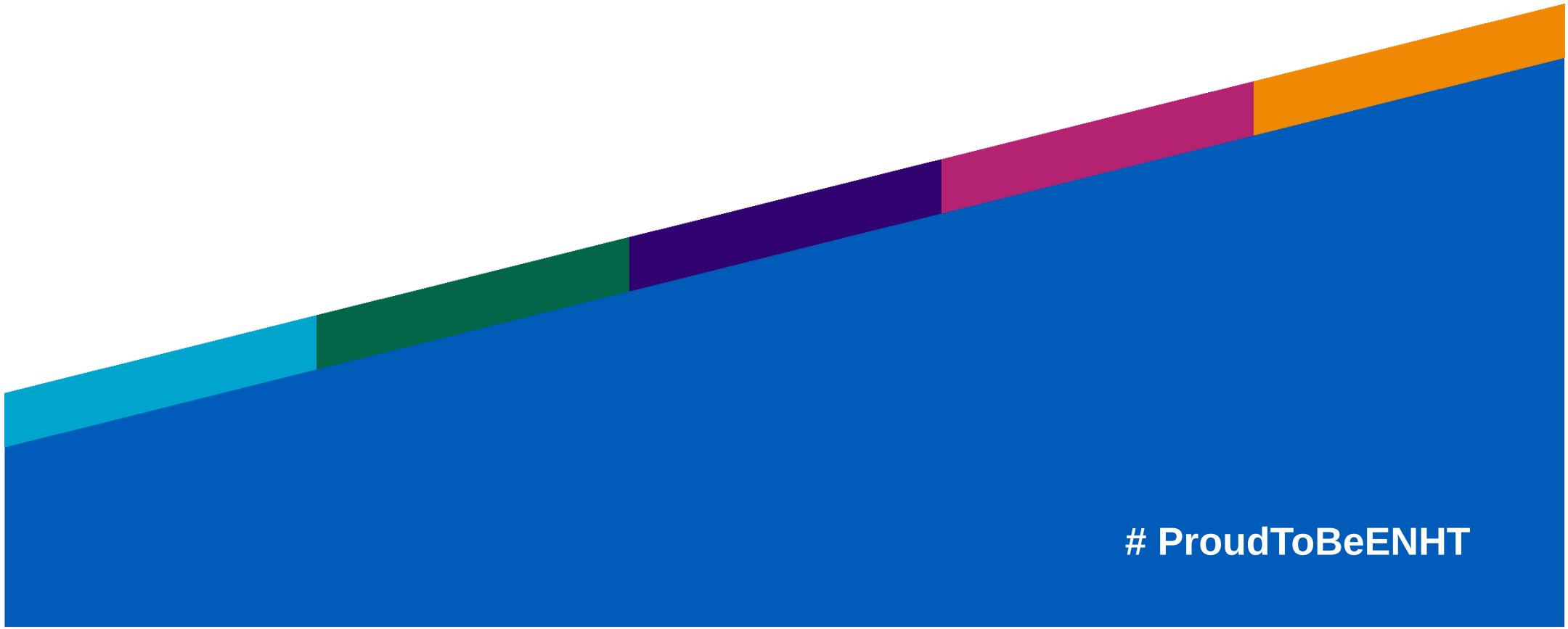
In the first quarter of 2024/2025 (Apr-Jun) there were 1075 babies born.

- **2 stillbirths occurred**
- **0 neonatal deaths occurred**
- **0 late medical terminations (>22/40) of pregnancy resulting in a stillborn baby occurred**
- **0 late medical terminations (>20/40) of pregnancy resulting in a liveborn baby and subsequent neonatal death occurred**
- **1 baby (1 of a set of twins) was transferred out in-utero, was born and died in the neonatal period at another Trust**

Safety Action 2

Maternity Services Data Set

East and North Hertfordshire NHS Trust



East and North Hertfordshire NHS Trust

Requirements of Safety Action Two

Requirement number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence
1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024?	Yes	Screenshot of July scorecard MSDS
2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances (MSD001)	Yes	Screenshot of July scorecard MSDS

Recommend that compliance with this safety action has been achieved.

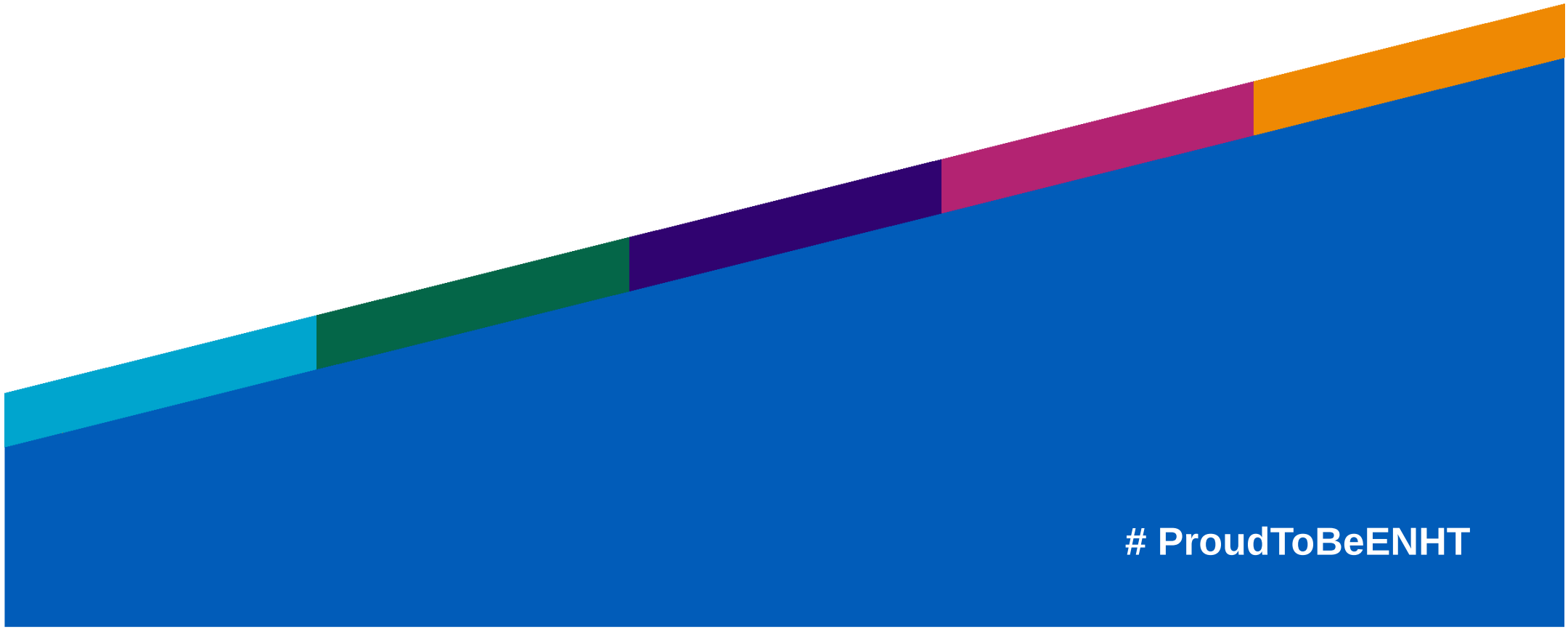
Extract from July Scorecard

Indicator	Data quality rating
Babies readmitted to hospital who were under 30 days old	Passed
Babies that were fully or partially breastfed at 6 to 8 weeks old	Passed
Babies who were born preterm	Passed
Babies with a first feed of breast milk	Passed
Babies with an APGAR score between 0 and 6	Passed
Caesarean section rate for Robson Group 1 women	Passed
Caesarean section rate for Robson Group 2 women	Passed
Caesarean section rate for Robson Group 5 women	Passed
Women who had a 3rd or 4th degree tear at delivery	Passed
Women who had a PPH of 1,500ml or more	Passed
Women who were current smokers at booking appointment	Passed
Women who were current smokers at delivery	Passed
Women with a vaginal birth following a caesarean section	Passed

Safety Action 3

Avoiding Term Admissions Into the Neonatal unit (ATAIN)

NHS
East and North Hertfordshire
NHS Trust



MIS Safety Action Year 6 2024/25

East and North Hertfordshire NHS Trust

Safety action No. 3		
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?		
From 2 April 2024 until 30 November 2024		
Requirements number	**Safety action requirements**	**Requirement met? (Yes/ No /Not applicable)**
1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?	Yes
2	Or Is there a Transitional Care (TC) action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.		
3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.	Yes
4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	Yes

Transitional Care

Date of Report	November 2024
Title	Avoiding Term Admissions into Neonatal units (ATAIN) and Transitional Care report compliance for MIS Safety Action 3
Report for	Women's & Children's Directorate Board meeting Quality and Safety Committee
Report prepared by	Claire Prew: Lead Midwife for Perinatal Quality Improvement claire.prew@nhs.net
Confidentiality	Non-confidential

Purpose of the Report	To advise, alert, assure and update the board. This report provides an overview on the progress with Safety Action Three from the Maternity Incentive Scheme Year 6. Trusts will need to report compliance with the Maternity Incentive Scheme by the 30th of November 2025 and report to Board by 3rd March 2025
Service Provision	The maternity services at ENHT birth rate was 4674 (2023) births pe year. The Local Neonatal Unit (LNU) is a designated level 2 unit, witl 28 cots and 6 Transitional Care cots within the Postnatal Ward.
Key Issues	**Avoiding Term Admission into Neonatal Unit** The ATAIN programme is a national initiative that provides the framework to identify best practice to reduce avoidable term admissions. Learning themes will then inform changes to clinical practice so that term admissions can be reduced, resulting in better family experience. Newborn respiratory distress is the leading reason for admission at East & North Hertfordshire NHS Trust and consequent mother infant separation. The ATAIN multidisciplinary team at ENHT have identified issues which have been incorporated into a themes and trends. An action plan over seen by the MDT to ensure care pathways are robust with an aim to reduce mother and baby separation. An action plan to ensure learn is reviewed weekly at each ATAIN meeting by the MDT. ATAIN reviews include the four key themes, management of maternal infection/ sepsis, management of jaundice, management of hypoglycaemia and respiratory distress. A number of recurrent learning themes have been identified within ATAIN. Themes relating to the identification and escalation of concerns regarding the Cardiotocograph (CTG) in the second stage of labour. In addition the Team has noted babies being taken to the Neonatal Unit when they could have been taken to Transitional Care. Furthermore it has been noted there is theme for possible delays in transfer to theatre for operative birth and caesarean section cases. Learning has been conducted regarding

Issue	Action	Responsible Officer/s	Target Date	Evidence of Progress	Monitoring and Evaluation Group	Completion date of Action
Work stream 1: Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice						
Transitional care area is made available to accommodate staff and equipment	Conduct a site visit with the Estates team by 1st of June date to assess Room 20's adequacy for necessary equipment and staffing. Submit a detailed report with recommendations within one month of the visit.	**Laura Kelly & Hayley De-La-Salle**	**15th July 2024**	**Speciality Report**	**Senior Leadership meeting**	**August 2024**
To ensure Transitional care has correct electrical points before relocation commences	Request correct number of electrical points from the Estates and ensure they are in place	**Hayley De-La-Salle Manuela Ryder**	**1st August 2024**	**Estates meeting**	**MIC**	**October 2024**
Transitional care staffing to remain in Postnatal Ward area to offer ongoing support	Identify and allocate a designated computer-on-wheels for	**Laura Kelly & Jade**	**1st August 2024**	**Speciality Report**	**Neonatal Risk Meeting**	**August 2024**

	one month of the audit's conclusion.					
	Develop criteria for late preterm neonates (34–36 weeks) to receive care in TC by October 30th 2024. Based on recent bed blocking. Implement a trial period with monthly reviews for three months post-implementation.	**Laura Kelly Ather Ahmed Hayley De-La-Salle**	**30th October 2024**	**LMNS report**	**W&C divisional board**	***November 2024 update Jacki Dopran LMNS completed scoping exercise. Awaiting new plan for flow***
Change of practice	Deliver a training program for all neonatal doctors by 15th October 2024 including bedside techniques for cannulation. Measure success through competency assessments completed by at least 90% of doctors within six months.	**Ather Ahmed Caroline Chiutare Laura Kelly**	**15th October 2024**	**Speciality report**	**Maternity Improvement Senate**	**On going**
TC trained staff to provide a 24 hour	Recruited staff members ensure	**Laura Kelly**	**29th November 2024**	**Matron's report**	**W&C divisional board**	**On going**

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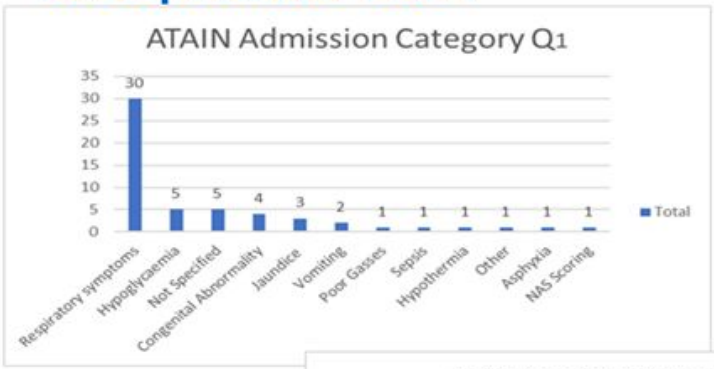
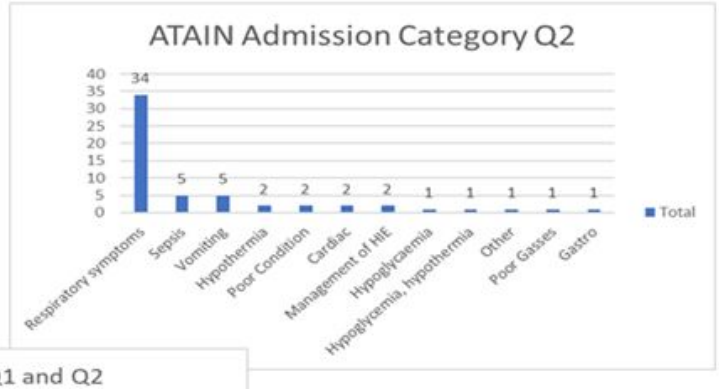
Examples of evidence include a workstream update presented to the divisional quality and safety committee with an action plan in place to support pathways of care into transitional care

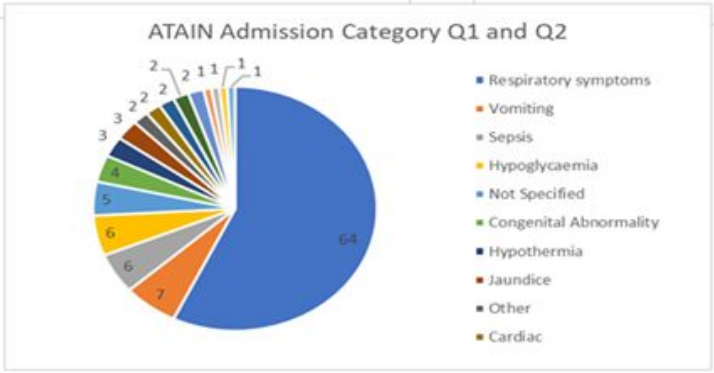
AVOIDING TERM ADMISSIONS TO THE NEONATAL UNIT (ATAIN) Audit data for term babies by admission criteria

East and North Hertfordshire NHS Trust

112 case of term admission have been reviewed April to September 2024







Over 50% of term babies are admitted to Local Neonatal Unit with respiratory conditions

6 | ATAIN RHD AUDIT

Quality Improvement

NHS East and North Hertfordshire NHS Trust

Improvements made to the service for ATAIN

NHS East and North Hertfordshire NHS Trust

- Early respiratory distress pathway. The ATAIN data indicates that a high percentage of term babies are admitted from CLU and many are submitted with respiratory symptoms. The early respiratory distress care bundle aims to keep well babies that have initial respiratory systems within the 1st hour of life with their mothers.

Cannulation without Separation

- A new neonatal cannulation trolley is now available in the CLU so that term babies can be cannulated by the maternal bedside and transferred to transitional care rather that a visit to the neonatal unit.
- In addition babies that require additional care on the postnatal ward can be transferred directly to TC and cannulation can occur in the TC area.

Early Respiratory Care Bundle Proforma & QR code for data collection

East and North Hertfordshire NHS Trust

Patient sticker

Term Early Respiratory Distress Pathway (within 1 hour of birth)

NHS East and North Hertfordshire NHS Trust

Acceptable pre-ductal SpO_2	
2 min	65%
5 min	85%
10 min	90%

Bleep Neonatal SHO / SpR / ANNP

Review within **15 minutes**

Any **risk factors** for sepsis?
If yes – consider need for septic screen

Initial assessment of HR, RR, Sats, Temp, and Work of Breathing

Baby Temp < 36.5C?
If yes – ensure wearing hat, covered in warm blanket and skin to skin

Age <15 min? Remember preductal sats can take 10 min to reach 90%. In a well, vigorous infant born in a low-risk setting, consider early return and review rather than NICU transfer purely based on low O_2 sats.

SEVERE RDS
Sats < 90%
OR
RR>80, HR > 175
OR
Severe ↑WOB

MODERATE RDS
Sats 90-94%
OR
RR 60-80, HR 160-175
OR
Moderate ↑WOB,
Continuous Grunting

MILD RDS
Sats >/= 95%
OR
RR 30-60, HR < 160
OR
Mild ↑ WOB,
Intermittent / No Grunting

Admit to NICU for Short-Stay Observation
(Consider immediate admission if unwell)

Review in **30 minutes**

NEWT observations:
1 hourly for 2 hours
2 hourly for 6 hours.
Call NICU team if concerns.

Symptoms improving?
Sats > 95%
RR < 80
Feeding well

Worse

Better

WORK OF BREATHING:
→ Nasal flaring
→ Tracheal tug
→ Intercostal-subcostal recession → Head bobbing

SCORE:
1 = mild WOB
2 = moderate WOB
> 3 = severe WOB

No change

Blood gas:
pH > 7.25
pCO2 < 8.0

No

Yes

Review within 1 - 2 hours

Better

Worse

Patient sticker

NHS East and North Hertfordshire NHS Trust

Early Respiratory Distress Pathway

For Babies > 37 weeks gestation with signs of respiratory distress **within 1 hour of birth**

DOCUMENTATION ON MATERNAL K2 EPR: Please document as per guidance all care given to the neonate and ensure reference is made to the early respiratory care bundle (i.e. ERDS bundle commenced)

Details to include in documentation:

Issue:
Early respiratory distress
On the Early RDS Pathway

Gestation: weeks+ days
Age: hours

Room Temp:
Baby Obs: (incl Temp, O2 sats)

Examination:

Plan:
(as per Early RDS pathway)

DON'T FORGET!

Scan this QR code and record that you have used the ERD Proforma.

This tool is used by 3 Trust within our region. This will help us to understand how effect the tool is being used within each Trust

Safety Action 4

Clinical Workforce

East and North Hertfordshire NHS Trust

ProudToBeENHT

Requirements of Safety Action Four

Safety action No. 4
Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence
a) Obstetric medical workforce			
1	Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity: Locum currently works in their unit on the tier 2 or 3 rota OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progrssion (ARCP)? OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	y	Policy in place and evidence is audit performed by the medical temporary staffing department. Also supported by monthly exception reports by labour ward lead. Report to Trust Quality and safety Oct 24
2	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance	y	Policy in place and audit by medical staffing department shows compliance. Exception reporting by labour ward lead. Report to Q&S Oct 24.
3	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person.	y	Policy in place and audits in evidence file demonstration compliance and also exception reporting on a monthly basis by labour ward lead. Report to trust Q&S Oct 24
4	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	y	No episodes of non-compliance demonstrated.Report to trust Q&S Oct 24
Do you have evidence that the Trust position regarding question 3 & 4 has been shared:			
5	At Trust Board?	Y	Report to Trust quality and safety Oct 24
6	With Board level safety champions?	Y	Report to Trust quality and safety Oct 24
7	At LMNS meetings?	y	LMNS partnership Board Nov 24
b) Anaesthetic medical workforce			
8	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.	y	Audit of anaesthetic rota and monthly exception reporting by labour ward lead . Paper to Trust Q&S Oct 24.
c) Neonatal medical workforce			
9	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing? And is this formally recorded in Trust Board minutes?	N	Fully complaint except needing 7th consultant. Evidence is action plan for BAMP standards. Paper to Q&S Oct 24. Progress on year 5 action plan and 7th consultant post approved and being appointed to on 13/12/24
10	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	y	Action plan and progress demonstrated at trust quality and safety meeting report Oct 2024.
11	Was the above workforce action plan shared with the LMNS?	y	LMNS Partnership board Nov 24
12	Was the above workforce action plan shared with the ODN?	y	Emailed to ODN 5/11/24 and response
d) Neonatal nursing workforce			
13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	y	
14	If the requirements are not met, Trust Board should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies.	n/a	
15	Was the above workforce action plan shared with the LMNS?	n/a	
6	Was the above workforce action plan shared with the ODN?	n/a	

Obstetric Workforce – Short-Term and Long-Term Locums

East and North Hertfordshire NHS Trust

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	
Report title	Obstetric Medical Workforce MIS year 6 compliance paper 2024		**Meeting Date**	23/10/2024
Presenter	Douglas Salvesen Divisional Medical Director Women's & Children's			
Author	Douglas Salvesen			
Responsible Director	Chief Nurse & Medical Director		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☒	**Decision**	☐

Report Summary:

As part of the NHS Resolution 10 steps to safety MIS year 6 compliance standards, NHS organisations are required to provide assurance to their Boards that we are demonstrating an effective system of clinical workforce planning to the required standard.

For Obstetric Medical Workforce, there are 4 criteria the organisation are required to fulfil.

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
or
c. hold a certificate of eligibility (CEL) to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.

4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an

17 |

ACTION PLAN - SAFETY ACTION 4 Short and Long Term Locums

	Action	Owner	Due Date	Progress	RAG year 5	RAG year 6
1	Short- and Long-term Middle Grade & Long Term Consultant Locum placements in Obstetrics and Gynaecology policy to be reviewed , written and ratified.	DS	Sep-23	We have written the policy and it will be discussed in the next guidelines meeting. Ratified July 23. 2024 remains in date.		
2	Audit of long and short term locums between February - August, including retrospective assessment as to which locums should have had CEL.	MM	Sep-23	Audit in Progress. Audit completed for 2024. 100% compliant.		
3	Trust temporary staffing department to meet and agree processes	DS/MM/KPP/Trust Staffing Dept/T Pounds	Jun-23	DS forwarded RCOG / MIS standards to T Pounds, NHSP and Temporary Staffing. This has been done. We have agreed that we will book locums as per our policy. A check list is created which the staffing will use to book against. Remains in place 2024.		
4	Update labour ward hand over sheet	KM	Jul-23	Completed July 23. Updated 2024.		
5	Update locum induction pack	MM	Jul-23	Completed July 23. Updated 2024.		
6	Provide ongoing assurance and monthly exception reports to the Women's & Children's Divisional Board and the Trust Quality and Safety Committee. Report to indicate in month any new long or short term locums and whether RCOG process followed	KM	Sep-23	Board planner developed with key timelines for reporting, labour ward lead to provide exception report to the governance lead. Monthly exception report agreed July 23. Monthly reports received from labour ward lead 2024.		
7	Fortnightly Maternity Incentive Scheme meetings to be attended by Flexible Workforce, HRBP for Women's and Childrens Division, Medical Resourcing and Academy team to ensure MDT approach	Temp Staffing	Jul-23	Continue 2024		
8	Locum hours to be extended to allow for induction	MM	Jul-23	Completed July 23. In place 2024.		
9	Standard Operating Procedure drafted to ensure compliance of locums booked into Obs & Gynae – including internal checklist for each booking	Temp Staffing	Sep-23	Completed August 23. Completed		
10	Current Temporary Worker Orientation Checklist to be reviewed	Temp Staffing	Aug-23	Updated and complete august 23		
11	Undertake compliance review of all internal bank only and substantive/FTC locums – including recruitment and mandatory training	Temp Staffing	Nov-23	Started August 23. Completed 2024.		
12	Letter / email to be sent to all currently used short term locums to explain current ask. Need CEL from these doctors by Dec 23	MM	Jun-23	Temporary staffing / CD to send letter/email to our current short term locums. Completed July 23 deadline for current locums set as Nov 23. Extension to end ov November for two doctors. Dr Emmanuel Kushanu & Dr Olusola Franklin. Email sent 30/10/23. With extension still meets target of Dec 23. Completed Dec 2023.		
13	Guidance/Template required from service for structured feedback – to ensure these meet RCOG requirement	MM	Nov-23	Completed Oct 23. In place 2024.		

Obstetric Workforce – RCOG Compliance

NHS East and North Hertfordshire NHS Trust

Report Coversheet

NHS East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	
Report title	Obstetric Medical Workforce MIS year 6 compliance paper 2024			**Meeting Date**	23/10/2024
Presenter	Douglas Salvesen Divisional Medical Director Women's & Children's				
Author	Douglas Salvesen				
Responsible Director	Chief Nurse & Medical Director			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☒	**Decision**		☐

Report Summary:

As part of the NHS Resolution 10 steps to safety MIS year 6 compliance standards, NHS organisations are required to provide assurance to their Boards that we are demonstrating an effective system of clinical workforce planning to the required standard.

For Obstetric Medical Workforce, there are 4 criteria the organisation are required to fulfil.

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
or
c. hold a certificate of eligibility (CEL) to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.

4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an

https://www.nhsemployers.org/system/files/2021-06/consultants-on-call-calculation-guide.pdf

8 weeks. **2024 DIARY**

weekdays unpredictable hours 20.30--08.30	Consultant	Date	Details: week days after 20.30 (8:30pm)	premium unpredictable hours 20.30-08:30	Unpredictable Pas 20.30-08:30 3 hrs=1PA	Total Unpredictable PA	record of how may hours after 21:00 just for consideration of compensatory rest needs	Comp rest
M	BA	27/11/2023		0	0	0	0	yes
T	SM	28/11/2023		0	0	0	0	yes
W	MG	29/11/2023		0	0	0	0	yes
T	SE	30/11/2023		0	0	0	0	yes
F	RP	01/12/2023		7	2.33	2.33	7	yes
M	MM	04/12/2023		0	0	0	0	yes
T	HM	05/12/2023		0	0	0	0	yes
W	RP	06/12/2023		0	0	0	0	yes
T	JL	07/12/2023		0	0	0	0	yes
F	MM	08/12/2023		3	1	1	1.5	yes
M	IO	11/12/2023		0	0	0	0	yes
T	IK	12/12/2023		0	0	0	0	yes
W	RP	13/12/2023		0	0	0	0	yes
T	KM	14/12/2023		0.5	0.166	0.166	0	yes
F	BA	15/12/2023		0.5	0.166	0.166	0	yes
M	MM	18/12/2023		1.5	0.5	0.5	1.5	yes
T	DT	19/12/2023		0	0	0	0	yes
W	JL	20/12/2023		0	0	0	0	yes

Sheet1 Sheet2 Sheet3

Anaesthetic Workforce

NHS East and North Hertfordshire NHS Trust

Report Coversheet

NHS East and North Hertfordshire NHS Trust

Meeting	Quality and Safety Committee		**Agenda Item**	
Report title	Anaesthetic medical workforce MIS compliance 2024		**Meeting Date**	23/10/2024
Presenter	Douglas Salvesen, Divisional Medical Director Women's & Children's			
Author	Douglas Salvesen, Dr M Simpson (Obstetric Anaesthetic Medical Lead)			
Responsible Director	Divisional Medical Director Women's & Children's		**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☒	**Decision**	☐

Report Summary:

As per the requirements of CNST Maternity Incentives Scheme year 6, The Trust is required to formally record in their Board minutes, the compliance status against Anaesthetics Clinical Services Accreditation (ACSA) standard 1.7.2.1. The requirement stipulates that a duty anaesthetist is available, 24 hours a day within obstetrics. Maternity services at East & North Hertfordshire NHS Trust are fully compliant with this standard. Evidence provided by a three month rota audit undertaken during the period Feb 2024 - 30th November 2024.

The purpose of this paper is to provide the Board with the information on the provision of Anaesthetic Clinical Services against the required standard as set out in Maternity Incentive Scheme Year 6, Safety Action 4.

Impact: where significant implication(s) need highlighting

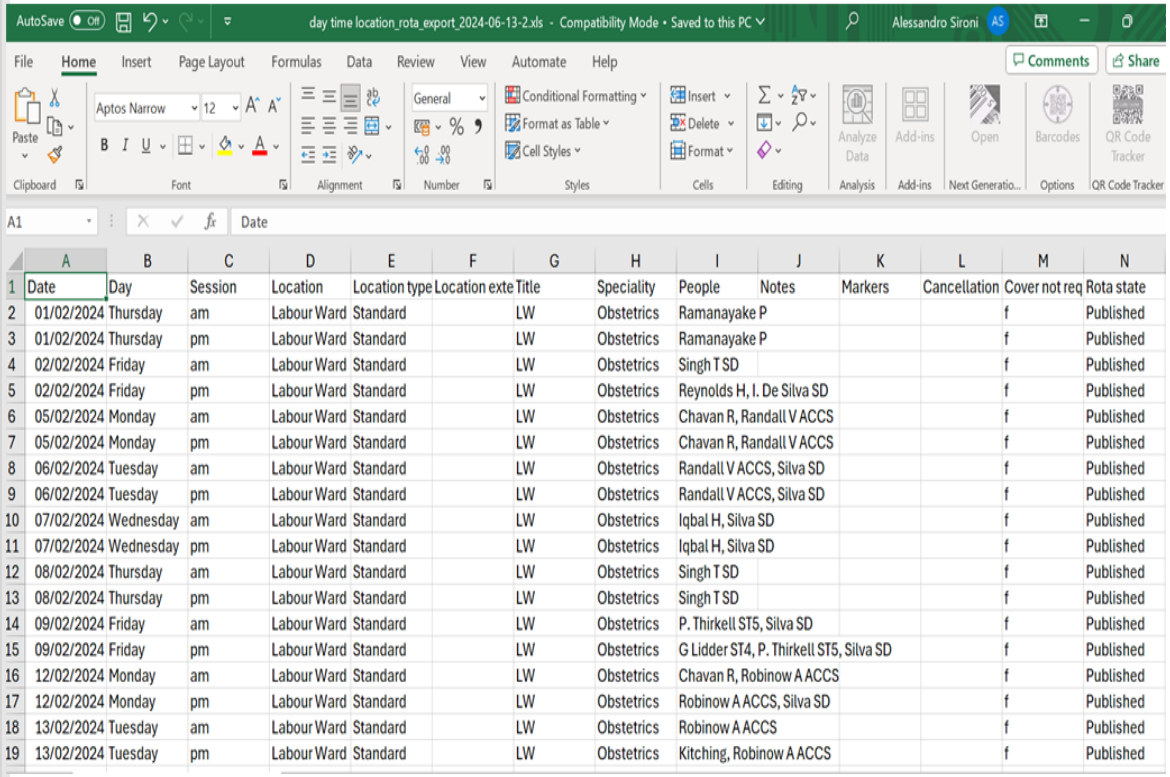
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Risk to patient safety if not sustained.

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

Risk : 7463

Daytime Rota



day time location_rota_export_2024-06-13-2.xls - Compatibility Mode • Saved to this PC

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Date	Day	Session	Location	Location type	Location exte	Title	Speciality	People	Notes	Markers	Cancellation	Cover not req	Rota state
2	01/02/2024	Thursday	am	Labour Ward	Standard		LW	Obstetrics	Ramanayake P				f	Published
3	01/02/2024	Thursday	pm	Labour Ward	Standard		LW	Obstetrics	Ramanayake P				f	Published
4	02/02/2024	Friday	am	Labour Ward	Standard		LW	Obstetrics	Singh T SD				f	Published
5	02/02/2024	Friday	pm	Labour Ward	Standard		LW	Obstetrics	Reynolds H, I. De Silva SD				f	Published
6	05/02/2024	Monday	am	Labour Ward	Standard		LW	Obstetrics	Chavan R, Randall V ACCS				f	Published
7	05/02/2024	Monday	pm	Labour Ward	Standard		LW	Obstetrics	Chavan R, Randall V ACCS				f	Published
8	06/02/2024	Tuesday	am	Labour Ward	Standard		LW	Obstetrics	Randall V ACCS, Silva SD				f	Published
9	06/02/2024	Tuesday	pm	Labour Ward	Standard		LW	Obstetrics	Randall V ACCS, Silva SD				f	Published
10	07/02/2024	Wednesday	am	Labour Ward	Standard		LW	Obstetrics	Iqbal H, Silva SD				f	Published
11	07/02/2024	Wednesday	pm	Labour Ward	Standard		LW	Obstetrics	Iqbal H, Silva SD				f	Published
12	08/02/2024	Thursday	am	Labour Ward	Standard		LW	Obstetrics	Singh T SD				f	Published
13	08/02/2024	Thursday	pm	Labour Ward	Standard		LW	Obstetrics	Singh T SD				f	Published
14	09/02/2024	Friday	am	Labour Ward	Standard		LW	Obstetrics	P. Thirkell ST5, Silva SD				f	Published
15	09/02/2024	Friday	pm	Labour Ward	Standard		LW	Obstetrics	G Lidder ST4, P. Thirkell ST5, Silva SD				f	Published
16	12/02/2024	Monday	am	Labour Ward	Standard		LW	Obstetrics	Chavan R, Robinow A ACCS				f	Published
17	12/02/2024	Monday	pm	Labour Ward	Standard		LW	Obstetrics	Robinow A ACCS, Silva SD				f	Published
18	13/02/2024	Tuesday	am	Labour Ward	Standard		LW	Obstetrics	Robinow A ACCS				f	Published
19	13/02/2024	Tuesday	pm	Labour Ward	Standard		LW	Obstetrics	Kitching, Robinow A ACCS				f	Published

Neonatal Medical

East and North Hertfordshire NHS Trust

Report Coversheet

Meeting	Quality and Safety Committee	**Agenda Item**	
Report title	Neonatal Medical workforce MIS compliance 2024	**Meeting Date**	23/10/2024
Presenter	Douglas Salvesen Divisional Medical Director Women's & Children's		
Author	Douglas Salvesen, Dr A Ahmed (Neonatal CD)		
Responsible Director	Chief Nurse & Medical Director	**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note** ☐	**Approval**	☒
	Discussion ☐	**Decision**	☐

Report Summary:

As part of the NHS Resolution 10 steps to safety MIS year 6 compliance standards, NHS organisations are required to provide assurance to their Boards that the neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards 2022 for medical staffing. Where the standards are not met, the Trust Board is required to agree an action plan and outline progress against any previously agreed action plans. NHS resolutions also require the reason for non compliance to be specified. The audit of staffing covered 2nd April 2024 to 30th November 2024.

The Neonatal unit at East and North Hertfordshire does not meet all the MIS national medical staffing standards for a local neonatal unit as assessed between 2nd April 2024 and 30th November 2024. Actions are required in order to fully comply with the requirements relating to theTier three rota– Consultant staffing.The Consultant staffing is non complaint as they work on a 1 in 6 rota and the frequency of the consultant rota needs to be no more onerous than 1 in 7 (BAPM 2022).

Current Y6 action plan and progress on the action plan from year 5 are as follows:

1) A paediatric middle grade medical staffing review completed in 2023/24. Additional two middle grade middle doctors funded and recruited to facilitate a split tier 2 rota for acute paediatrics and Neonatology. Fully complaint with BAPM 2018 & 2022 tier 2 standards since March 2024.
2) Funding for a 6th neonatal consultant was approved in 2023/4. 6th Neonatal

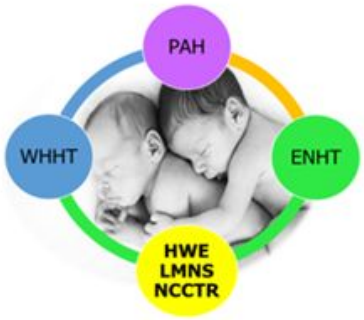
East and North Hertfordshi NHS Tr

NHSR Neonatal medical staffing action plan 2024

	Rota Tier	MIS / CNST / BAPM Standard	Year 3	Year 4	Year 5	Year 6	Comments	Action
MIS / CNST Standards for all LNUs	Tier 1	At least one resident Tier 1 practictioner immediately available dedicated to providing emergency care for the neoantal service 24/7.(2018). Tier 1: Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general					Evidence available from HR / Medical staffing and rota	Fully compliant with standard
	Tier 2	An immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located paediatric unit eg: 09:00-22:00, seven days a week. (2018). Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff (2022)					Year 3: Compliant due to rota changes for Covid 19. Year 4: Non complaint due to returing to pre covid rotas. Tier 2 doctors cover paediatric ward in addition to neonates during weekdays from 1630- 2100. Therefore do not soley cover for neonates 08.30-20.30 hours . For year 4 compliance, middle grade staffing review completed and business case submitted for consideration for funding 2023/24. Business case approved through unplanned board august 2022 and W&C board January 2023. Submitted in Feb 2023 as cost pressures for 2023/24. Year 5: need for x 2 additional middle grades included in Q&S montlhy updates and perfromance meeting escalation May 2023. Need for safe staffing highlighted by CQC report, maternity improvement committee, maternity improvement senate, sixty supportive steps to safety, reports to trust Q&S meeting, risk register. Meeting with finance director and Chief Nurse and MD 31/5/23. Further meeting with MD July 23. Awaiting decision regarding funding for 23/24 or 24/25. Meeting with MD on 06/09/2023 and details of current rota and requirments discussed. Current 2 middle grades on site. One to be clearly nominated as responsible solely for neonates. Additional staff only required to facilitate a 1 in 8 rota. Funding approved for additional 2.5 WTE middle grades (NHSE & UEC). Appointments made Dec 23. Fully compliant from 04/03/2024	Progress on action plan to be made for compliance. Trust decision needed regarding funding for the additional x2 middle grade posts required to have a split rota in 2023/24 or 24/25. As of 08/6/23 awaiting decision regarding funding for 23/24 or 24/25. Meeting with MD, 06/07/2023. One middle grade nominated as solely responsible for neonates. Additional middle grades funded and recruited. As of 04/03/2024 fully compliant.
		LNUs undertaking either >1500 respiratory care days (RCDs) or >600 IC days annually should have immediately available a dedicated resident Tier 2 (ANNP or junior doctor ST4-8) practitioner separate from paediatrics 24/7					These criteria were not met in year 2 but were in year 3 due to rota changes for Covid 19. Now non complaint due to returing to pre covid rotas. ier 2 doctors cover paediatric ward in addition to neonates during weekdays from 1630- 2100. Also cover both areas overnight. Soley cover neonates only 08.30-16.30 weekdays and 08.30-20.30 weekends . Need for BABM standards staffing highlighted by CQC report, maternity improvement committee, maternity improvement senate, sixty supportive steps to safety, reports to trust Q&S meeting, risk register. Meeting with MD & CD for neonates on 06/07/2023 andd etails of current rota and requirments discussed. Current 2 middle grades on site. One to be clearly nominated as responsible solely for neonates. Additional staff only required to facilitate a 1 in 8 rota. From 04/03/2024 1 in 8 rota split from acute paediatric rota. Fully compliant with standards 2018 & now against 2022 standards and evidence of enhanced staffing levels	Progress on action plan to be made: Awaiting Trust decision needed regarding funding for the BAPM medical staffing standards. Additional x2 middle grade posts required to have a split rota in 2023/24 or 24/25. One middle grade nominated as solely responsible for neonates. Additional 2.5 WTE middle grade funding approved and recruited Dec 23. Fully complaint from 04/03/2024.

Neonatal Nursing

NHS
East and North Hertfordshire



HWE LMNS NCCR: Neonatal Nursing Workforce Group

Badger Nursing Report May – July 2024

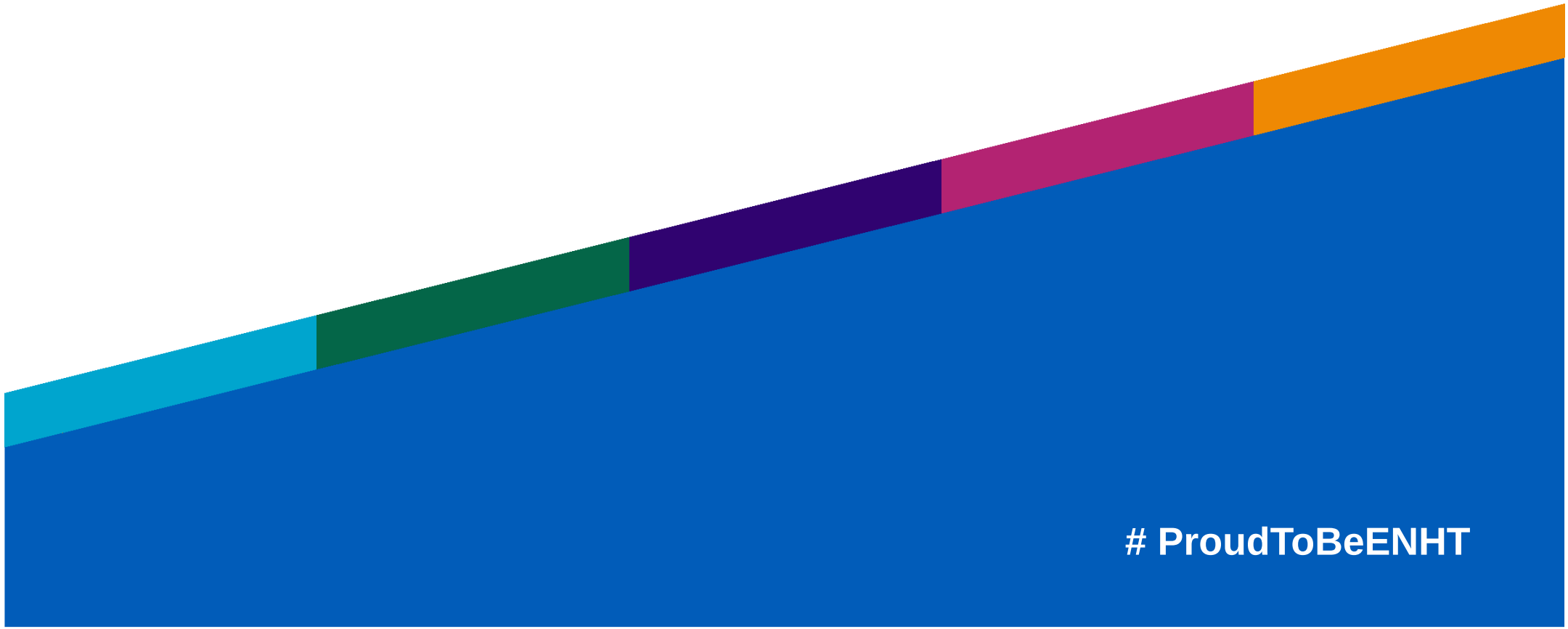
ENHT LNU

Unit	% shifts staffed to BAPM recommo ndations	% shifts QIS to toolkit	% with a team leader	% nursing shifts covered by bank staff	Average nurses on a shift	Base line LNU head count	Average nurses required on shift	Av mean variaince from BAPM	Average median variance	Additional nursing shifts that are need to meet BAPM compliance	Total shifts in timeline	% over time-line of gap in BAPM shift coverage
ENHT	96.1	98.45	92.2	7.58	7.98	10	5.75	2.23	2.23	3.9	66	5.90%
National Av	84.8	73.5	62	9.4		n/a	X	1.26	1.2	X		

Safety Action 5

Midwifery Workforce

East and North Hertfordshire NHS Trust



Requirements of Safety Action Five

East and North Hertfordshire NHS Trust

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 2 April 2024 until 30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence
1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.		Reports for this MIS reporting period submitted to QSC (July and December) .. Business case and staffing establishment review also submitted to Executive committee in July 2024.
2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. If this process has not been completed due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.		BR plus establishment review undertaken in May 2023, reported in October 2023. Business case agreed in July 2024.
3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Meeting midwifery staffing recommendations from Ockenden and evidence of the funded establishment being compliant with outcomes of birthrate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified, the plan to address these findings must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.		Included within bi-annual staffing reports and reported monthly to QSC via the PCQSF tool.
4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.** An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.		Reported in the monthly governance report to QSC.
5	A workforce action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will NOT enable the Trust to declare compliance with this sub-requirement.**	N/A	
6	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashBoard figures demonstrating 100% compliance with the provision of one-to-one care in active labour		
7	A workforce action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. **Completion of the workforce action plan will enable the Trust to declare compliance with this sub-requirement.**	N/A	

Midwifery Workforce

DOC ID: 673

NHS East and North Hertfordshire NHS Trust

Report Coversheet

NHS East and North Hertfordshire NHS Trust

Meeting	Trust Management Group	**Agenda Item**	
Report title	Business case to meet Birth-rate plus based on revised estimated birth rate to achieve an uplift in recruitable headroom and the decoupling of obstetric theatre workforce in line CQC recommendations in maternity.	**Meeting Date**	25/07/2024
Presenter	Amanda Rowley – Director of Midwifery		
Author	Amanda Rowley, Director of Midwifery		
Responsible Director	Theresa Murphy, Chief Nurse	**Approval Date**	
Purpose (*tick one box only*)	**To Note** ☐	**Approval**	☒
	Discussion ☒	**Decision**	☒

Report Summary:

East and North Hertfordshire Maternity services were reviewed by the CQC in October 2022 and were rated inadequate and were placed on the Maternity Safety Support Programme (MSSP).

In May 2024, NHS England (NHSE) reviewed the service and progress against the sustainability action plan. Whilst acknowledging the significant progress made there were three priority areas related to workforce identified.

- 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 AfPP standards.
- Lack of sufficient recruitable headroom to support required training.
- Community caseloads exceed birthrate plus and national recommendations.

The presented business case sets out the workforce changes required to deliver the service which recognise the fall in birth rate over the last 12 months to a predicted birth rate of 4300 alongside a requirement to increase recruitable headroom to 25% to reflect increasing training hours needed to meet national standards.

Changes to the funded establishment and recruitable headroom has identified cost savings that will offset the cost pressure associated with the quality initiative of creating a staffing model for theatres and recovery.

This will enable a staffing model that is compliant with AfPP theatre standards and mitigates any reliance on midwives undertaking scrub duties in theatre.

Escalation and diversion policy for maternity

About this document	
Document ID	673 **Version:** 12
Full review due before	01 November 2027
Document type	Policy
Version type	Full review of document
Usage & applicability	For use Locally by clinical roles only at Lister Hospital

Summary

This policy is to support:

- Early identification and appropriate escalation of capacity and/or staffing concerns which have the potential to impact on the delivery of a safe maternity service
- A proactive rather than reactive response
- Concise and clear actions when:
  - Staffing levels and/or skill mix are insufficient to provide safe care to the people within the service
  - Midwifery Red Flags are triggered including but not exhaustive to:

Midwifery Workforce

NHS East and North Hertfordshire NHS Trust

Maternity Workforce Clinical Risks:

There are currently two risks related to Midwifery staffing on the Women's and Childrens divisional risk register for maternity.

- Risk 3407 - There is to women and newborn babies based upon a collaboration of the current vacancy position within the community midwifery service, the high caseloads and the limited length of appointment time as a result of this. The current risk rating updated on 23/7/24 is 12 with a target rating of 4.
- Risk 7161 . The staffing for maternity theatres and recovery has historically been provided from the midwifery workforce. This poses a significant safety risk in both maternity and theatres due to midwives being deployed from the high-risk CLU to scrub in theatre and non-compliance with AfPP standards for training. The current risk rating updated on 23/07/24 is 14 with a target rating of 8. Work is in progress to resolve this risk and is detailed below:
- Whilst it is not on the risk register, it remains a current challenge to align finance, ESR and Health Roster. Work remains in progress with leads from all areas to address this.

Maternity Theatre Transition to Planned Care:

- Business Case approved in July 2024 for establishment of 17.98 WTE registered nurses and 6.4 WTE unregistered staff.
- Budget currently with Women's and Children's and will transfer to Planned Care when recruitment process is complete.
- Working party formed with representation from Women's and Children's and Planned Care Divisions; this includes HOM, DDON, matrons for both divisions, HR BP's, resourcing lead and operational leads. These meetings have been running weekly since 16/08/24.
- Action Log jointly created and shared via Teams Channel for weekly update – access for all stakeholders
- Information shared with current staff groups regarding shift plans and change of line management – opportunity to discuss with both Matron and DDON; initiated via Microsoft Teams for easy access and scheduled walkarounds.
- Plans for recruitment commenced, supported by resourcing team – with a recruitment trajectory, and development of an agreed competency framework - in progress by Maternity Theatre Manager and Education Lead for Planned Care
- Recruitment Campaign created and commenced for registered posts in October 2024 - two tier approach with a standard advert and an open day which was successfully run on 19/10/24

Number of Red Flags recorded
01/07/2024 to 30/09/2024

Download Results

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	48	71%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	2	3%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	1	1%
RF6	Full clinical examination not carried out when presenting in labour	1	1%
RF7	Delay between admission for induction and beginning of process	5	7%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	1	1%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator unable to maintain supernumerary status - providing 1:1 care	0	0%
RF11	Coordinator unable to maintain supernumerary status - NOT providing 1:1 care	10	15%
TOTAL		68	

Midwifery Workforce

NHS East and North Hertfordshire NHS Trust

Midwifery Staffing Red Flags:

NHS East and North Hertfordshire NHS Trust

The confidence factor for the reporting of Midwifery staffing red flags between 1st April 2024 and 30th June 2024 was 80.22% (against a target of 85%). This reflects the staffing levels and activity during these months.

Processes have been implemented to widen the oversight of this daily, strengthening the reporting and escalation pathway with the aim of increasing the confidence factor and therefore the quality and value of the data extracted.

Supernumerary Status of the Co-Ordinator:

NHS Resolution stipulates:

The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a planned supernumerary coordinator and an ACTUAL supernumerary coordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service.

An escalation plan should be available and MUST include the process for providing a substitute coordinator in situations where there is no coordinator available **at the start of the shift.**

One to One Care in Labour:

NHS Resolution stipulates that ALL women in active labour MUST receive one to one midwifery care throughout labour and birth.

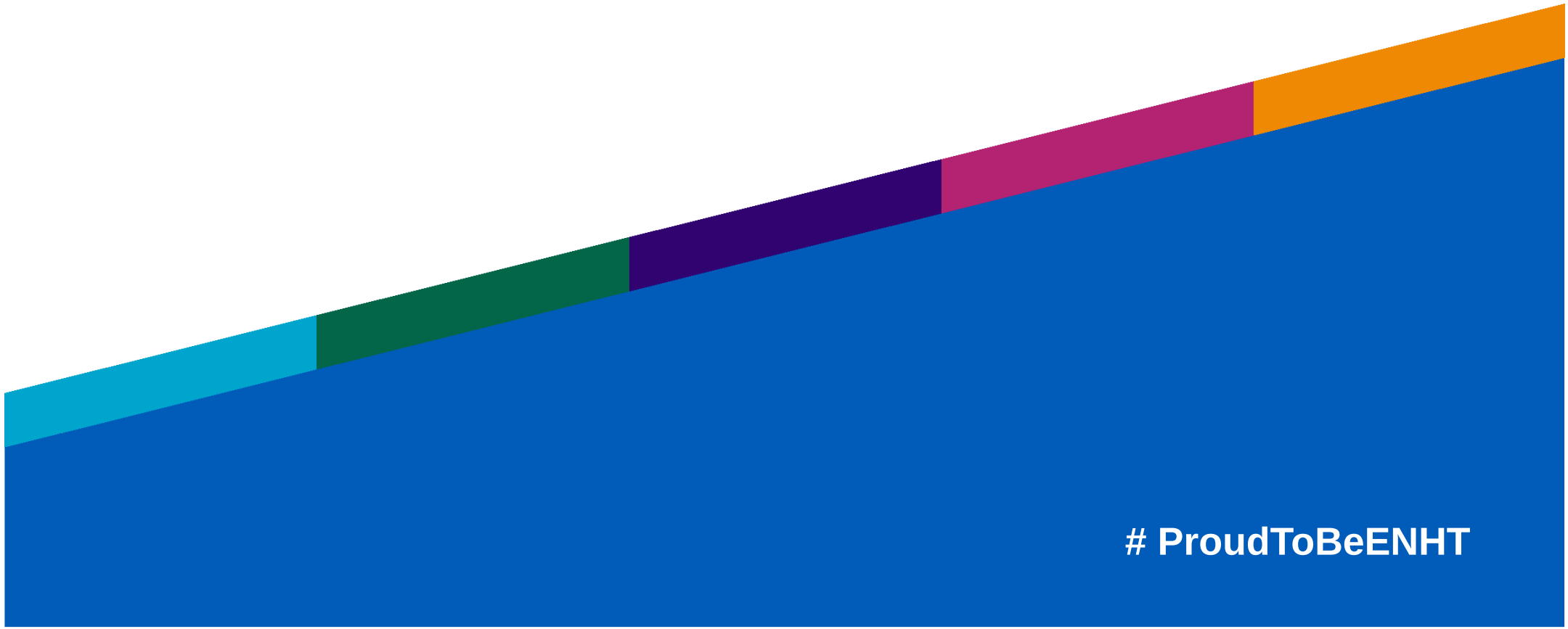
- 1:1 care in labour is an outcome measure linked to safer staffing which is monitored on a monthly basis within both the Division and the LMNS.
- A review of the maternity dashboard for the period 01/04/2024 to 30/06/2024 has identified that 100% of women received 1:1 care in labour. This same data is reflected within the Birthrate Plus ® Acuity reporting Tool.

	Data Source	April 24	May 24	June 24	Exception Reporting
1:1 care in labour excluding BBAs	CMiS	100%	100%	100%	Birthrate Plus® is reviewed and staff are encouraged to incident report any cases where 1:1 care in labour is not provided to enable validation of data on BR+

Safety Action 6

Saving Babies Lives Care Bundle, Version 3 (SBLCBv3)

East and North Hertfordshire NHS Trust



Requirements of Safety Action Six

East and North Hertfordshire NHS Trust

Safety action No. 6

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

From 2 April 2024 until 30 November 2024

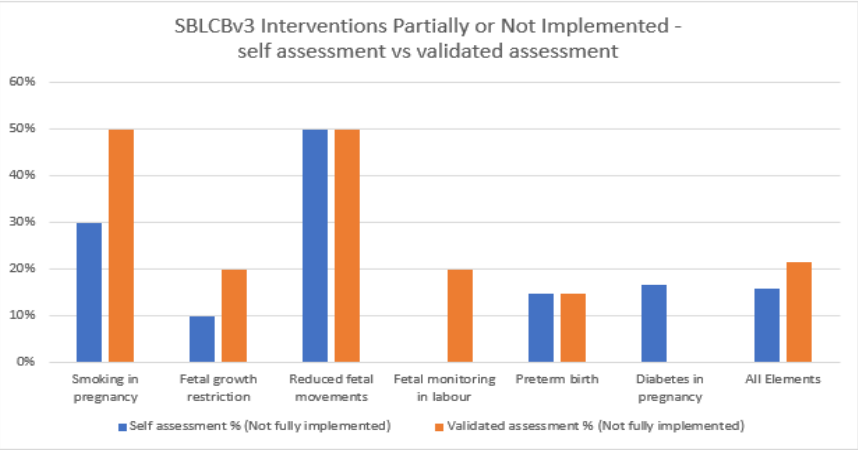
Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you agreed with the ICB that Saving Babies' Lives Care Bundle, Version 3 is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)	
2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**	
3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.	
4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.	
5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**	
6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	

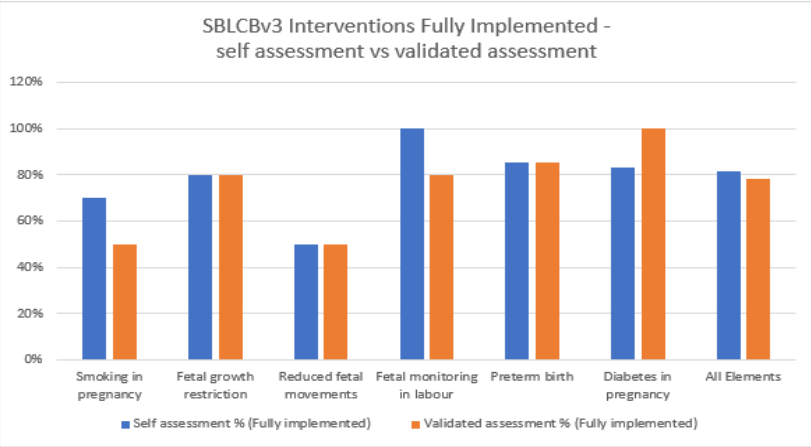
LMNS Dashboard Review – Implementation Progress

East and North Hertfordshire NHS Trust

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemented	50%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	80%	Partially implemented	80%	CNST Met
Element 3	Reduced fetal movements	Partially implemented	50%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Partially implemented	85%	Partially implemented	85%	CNST Met
Element 6	Diabetes	Partially implemented	83%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	81%	Partially implemented	79%	CNST Met





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Recommendation for Safety Action Six

East and North Hertfordshire NHS Trust

- Saving Babies Lives Care Bundle Quarterly reports to LMNS
- Action plan to achieve full compliance with outcome and process metrics in place

See Below:

Recommendation for Safety Action Six:
Saving Babies Lives Care Bundle Quarterly reports to LMNS
Action plan to achieve full compliance with outcome and process metrics in place
Element 1 – Action Plan

East and North Hertfordshire NHS Trust

Element	Sub no.	Our Compliance Assessment	LMNS Complaoince Assessment	Subelement	LMNS Reccomedation of Action	LMNS Suggestion of Improvement	Action
1	1.1	Partially Implemented	Partially Implemented	CO testing offered to all pregnant women at the antenatal booking and 36-week antenatal appointment	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Booking and guideline meet compliance. 36/40 below target/missing data. Will need an improvement plan to measure CO at 36 weeks	Currently 50% paper and 50% K2. Training programme to support staff in improving K2 usage within community setting. Audit of compliance to be conducted on monthly basisi to ensure new tragets are being met.
1	1.2	Partially Implemented	Partially Implemented	CO testing offered at all other antenatal appointments to groups identified within NICE Guidance NG209.	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Compliant Apr/May (6 months ago) no data recorded since then. Improvement plan required to consistently meet> 50%	Smoking cessation lead long term absence. Has now returned to work. Figures gong forward should meet compliance. Monthly meeting set up to ensure data collection on par with expectations.
1	1.3	Partially Implemented	Partially Implemented	Whenever CO testing is offered, it should be followed up by an enquiry about smoking status with the CO result and smoking status recorded.	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Booking status compliant, 36/40 status non-compliant. Improvement plan required to meet >80% at 36/40	Currently 50% paper and 50% K2. Training programme to support staff in improving K2 usage within community setting. Audit of compliance to be conducted on monthly basisi to ensure new tragets are being met.
1	1.4	Fully Implemented	Fully Implemented	Instigate an opt-out referral for all women who have an elevated CO level (4ppm or above), who identify themselves as smokers or have quit in the last 2 weeks for treatment by a trained tobacco dependence treatment adviser (TDA) within an in-house tobacco dependence treatment service.	Fully Implementedy meets standard - continue with regular monitoring of implementation.	Strong compliance over Q1 and most of Q2- last 3 months data missing	Data up to End Sept 2024. Last quarter missing will update when decemeber also avaialble - Smoking cessation lead long term absence. Has now returned to work. Figures gong forward should meet compliance. Monthly meeting set up to ensure data collection on par with expectations.
1	1.6	Fully Implemented	Fully Implemented	The tobacco dependence treatment includes behavioural support and NRT, initially 4 weekly sessions following the setting of the quit date then regularly (as required, however as a minimum monthly) throughout pregnancy to support the woman to remain smokefree.	Fully Implementedy meets standard - continue with regular monitoring of implementation.	Predominantly compliant. Improvement plan needed to address consistency and sustainability then improve beyond target.	Improvement plan by smoking cessation lead to address consistency and sustainability then improve beyond target.
1	1.7	Fully Implemented	Fully Implemented	Feedback is provided to the pregnant woman's named maternity health care professional regarding the treatment plan and progress with their quit attempt (including relapse). Where a woman does not book or attend appointments there should immediate notification back to the named maternity health care professional.	Evidence not in place - improvement required.	No evidence observed to identify this intervention	Evidence in slidepack on elelent 1.7
1	1.8	Fully Implemented	Fully Implemented	Any staff member using a CO monitor, should have appropriate training on its use and discussion of the result.	Focus required on quality improvement intiatives to meet recommended standard.	Consistently not meeting target across all staff groups. Improvement plan required	Training in place. Missing of target predominetly for Trainee Obs in Jun + Aug/Sept 2024. In Novemeber training compiance raised to 100% for Cons Obs and Trainee Obs; and 88% for Midwives. Scoping training schedule to ensure optimal phase rollout through the year
1	1.9	Fully Implemented	Fully Implemented	All staff providing maternity care to pregnant women should receive training in the delivery of Very Brief Advice (VBA) about smoking, making an opt-out referral and the processes within their maternity pathway (e.g., referral, feedback, data collection).	Focus required on quality improvement intiatives to meet recommended standard.	Consistently not meeting target across all staff groups. Improvement plan required	Training in place. Missing of target predominetly for Trainee Obs in Jun + Aug/Sept 2024. In Novemeber training compiance raised to 100% for Cons Obs and Trainee Obs; and 88% for Midwives. Scoping training schedule to ensure optimal phase rollout through the year

Element 2 and 3 – Action Plan

East and North Hertfordshire NHS Trust

Element	Sub no.	Our Compliance Assessment	LMNS Complaoince Assessment	Subelement	LMNS Reccomedation of Action	LMNS Suggestion of Improvement	Action
2	2.1	Fully Implemented	Fully Implemented	Assess all women at booking to determine if prescription of Aspirin is needed using an appropriate algorithm (for example Appendix C) agreed with the local ICSs and regional maternity team	Fully Implementedy meets standard - continue with regular monitoring of implementation.	Explore cases where women are not being risk assessed and seek to improve	Cases where women are not being risk assessed will be explored by Growth Assessment Lead Midwife to identify reason/root cause to ensure improvement going forward
2	2.7	Fully Implemented	Fully Implemented	Women who are designated as high risk for FGR (for example see Appendix D) should undergo uterine artery Doppler assessment between 18+0 to 23+6 weeks gestation	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Compliance has met, but has tailed off, improvement required to progress and not decline	Growth Assessment Lead Midwife to discuss with lead obstetrics for service and make action plan to ensure no further decline; monthly meetings to have overview of data of action log.
2	2.11	Fully Implemented	Partially Implemented	Staff who perform FH measurement should be competent in measuring, plotting (or recording), interpreting appropriately and referring when indicated. Only staff who perform FH measurement need to undergo training in FH measurement.	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Only received data for 2 months, significantly low compliance. Please discuss challenge and mitigations with LMNS	Identified as part of SBLCB study day that physical compliance was not being recorded after completion. Data now collected at monthly study days therefore compliance will be much improved.
2	2.18	Partially Implemented	Partially Implemented	All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the estimated fetal weight (EFW) is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation.	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit missing next step % of those detected delivered <37+6	Targeted piece of work between quality and safety manager and Growth Assessment Lead Midwife in ensuring data can be captured for monthly audit on K2. At present K2 does not allow this data capture.
2	2.19	Partially Implemented	Partially Implemented	In fetuses with an EFW between the 3rd and	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit missing next step % of those detected delivered <39+6	Targeted piece of work between quality and safety manager and Growth Assessment Lead Midwife in ensuring data can be captured for monthly audit on K2. At
2	2.20	Fully Implemented	Fully Implemented	Fetuses who demonstrate declining growth velocity from 32 weeks' gestation are at increased risk of stillbirth from late onset FGR. Declining growth velocity can occur in fetuses with an EFW >10th centile. Evidence to guide practise is limited and guidance (see Appendix D) is currently based on consensus opinion. In fetuses with declining growth	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Audit adherence to guideline for next quarter	Audit will adhere to guideline in next quarter
3	3.2	Partially Implemented	Partially Implemented	Use provided checklist (page 40) to manage care of pregnant women who report RFM, in line with national evidence-based guidance (for example, RCOG GreenTop Guideline 57)	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Please provide audit detailing percentage of women with recurrent RFM who have received a USS the next working day	Audit uploased to NHS Futures Platform

Element 4 – Action Plan

East and North Hertfordshire NHS Trust

Element	Sub no.	Our Compliance Assessment	LMNS Complaoince Assessment	Subelement	LMNS Reccomedation of Action	LMNS Suggestion of Improvement	Action
4	4.1	Fully Implemented	Partially Implemented	All staff who care for women in labour are required to undertake annual training and competency assessment on knowledge and skills required for effective fetal monitoring via Intermittent auscultation (IA) [Midwives] and electronic fetal monitoring [Midwives and Obstetricians].	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	19.12.2023 - Complete	Training compliance at 90% at present
4	4.3	Fully Implemented	Fully Implemented	Regular (at least hourly) systematic review of maternal and fetal wellbeing should be agreed and implemented. This should be accompanied by a clear guideline for escalation if concerns are raised using this structured process. All staff to be trained in the review system and escalation protocol	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Compliance met in most instances, often inconsistent. Adress reasons for inconsistencies in improvement plan	Inconsistencies regarding K2 documentation with multiple areas to document and no mandated fields. K2 education programme to be led by new digital lead midwife to ensure consistency in documentation. Monthly audits from January to ensure improved compliance.
4	4.4	Fully Implemented	Fully Implemented	A buddy system should be used to help provide an objective holistic review for example 'Fresh Eyes' – this should be undertaken at least hourly when CTG monitoring is used and at least four hourly when IA is utilised, unless there is a trigger to provide a holistic review earlier.	Fully Implementedy meets standard - continue with regular monitoring of implementation.	Compliance met in most instances, often inconsistent. Adress reasons for inconsistencies in improvement plan	Inconsistencies regarding K2 documentation with multiple areas to document and no mandated fields. K2 education programme to be led by new digital lead midwife to ensure consistency in documentation. Monthly audits from January to ensure improved compliance.

Element 5 – Action Plan

NHS East and North Hertfordshire

Element	Sub no.	Our Compliance Assessment	LMNS Complaoince Assessment	Subelement	LMNS Reccomedation of Action	LMNS Suggestion of Improvement	Action
5	5.13	Fully Implemented	Fully Implemented	Every provider should have referral pathways to tertiary prevention clinics for the management of women with complex obstetric and medical histories. This should include access to clinicians who have the expertise to provide high vaginal (Shirodkar) and transabdominal cerclage. These procedures are performed relatively infrequently and therefore are best provided on a supra-regional basis in order to maintain expertise.	Fully Implementedy meets standard – continue with regular monitoring of implementation.	Please upload MMN referal pathway/guideline	Maternal Medicine Guideline to be updated to include cervical circlage pathway.
5	5.14	Partially Implemented	Partially Implemented	Midwifery Continuity of Carer (CoC) models, with a focus on individualised risk assessment and care pathways, may prevent preterm birth and save babies' lives. Ref B0961_Delivering-midwifery-continuity-of-carer-at-Fully Implemented-scale.pdf 48 (england.nhs.uk). Local implementation plans for midwifery CoC models should ensure prioritisation of women from the most deprived groups in line with Core20+5. However, Midwifery CoC must be supported by safe staffing levels to preserve the safety of all pregnant women and families	Focus required on quality improvement intiatives to meet recommended standard.	Nationally Paused	
5	5.16	Partially Implemented	Partially Implemented	Ensure the neonatal team are involved when a preterm birth is anticipated, so that there is time to meet as a perinatal team to discuss care options with parents prior to birth. This is especially important at earlier gestational ages. In the case of extreme prematurity where complex decision making is required (active survival focused care or comfort care), management should be as outlined in the 2019 BAPM Framework for Practice regarding Perinatal Management of Extreme Preterm Birth before 27 weeks of gestation: "Conversations with parents should be clearly documented and care taken to ensure that the agreed management plan is communicated between perinatal professionals and staff shifts. Decisions and management should be regularly reviewed before and after birth in conjunction with the parents; plans may be reconsidered if the risk for the fetus/baby changes, or if parental wishes change." https://www.bapm.org/resources/80-perinatal-management-of-extreme-pretermbirth-before-27-weeks-of-gestation-2019	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Please investigate why compliance has reduced	Since K2 has been implemented decline in documentation has been noted. Targetted piece of work by the digital midwife for the neonatal team is on education plan. Mitigation, is current pro-forma added to maternal drug chart however not robust system.
5	5.17	Partially Implemented	Partially Implemented	Women identified to be potentially at increased risk of imminent preterm birth, where active survival focused care is planned, should be made aware of optimisation interventions that may be offered. Families should also be offered information and support for families from charities such as Bliss	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	If optimisation discussion is the same audit as 5.16, please review why compliance has reduced.	Since K2 has been implemented decline in documentation has been noted. Targetted piece of work by the digital midwife for the neonatal team is on education plan. Mitigation, is current pro-forma added to maternal drug chart however not robust system.
5	5.25	partially Implemented	Partially Implemented	Early maternal breast milk (MBM) Babies born below 37 weeks gestational age should receive their own mother's milk, ideally within 6 hours, but aiming always within 24 hours of birth (except in rare situations where there are contraindications to MBM). Perinatal teams should work together to ensure consistent delivery of antenatal advice about MBM, with support (equipment, education, help) for mothers to express within two hours of birth. https://www.bapm.org/pages/196-maternalbreast-milk-toolkit	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Not consistently at 80%	Collaborate with perinatal teams to create a QI plan with infant feeding midwife support.
5	5.26	Partially Implemented	Partially Implemented	Volume-Targeted Ventilation For babies born below 34 weeks' gestation who need invasive ventilation, use volume-targeted ventilation (VTV) in combination with synchronised ventilation as the primary mode of respiratory support. This reduces the chance of death or bronchopulmonary dysplasia by 27% and intraventricular haemorrhage (grades 3–4) by 47% compared with pressure-limited ventilation modes. *NB – For preterm babies who do not need invasive ventilation, consider nasal CPAP or nasal high-flow therapy as the primary mode of respiratory support. https://www.nice.org.uk/guidance/qs193/chapter/Quality-statements https://www.gettingitrightfirsttime.co.uk/medical-specialties/neonatal-intensive-care/	Fully meets standard – continue with regular monitoring of implementation.	Data not available through HWE Systems	Collaborate with Jacki Dopran

Element 6 – Action Plan

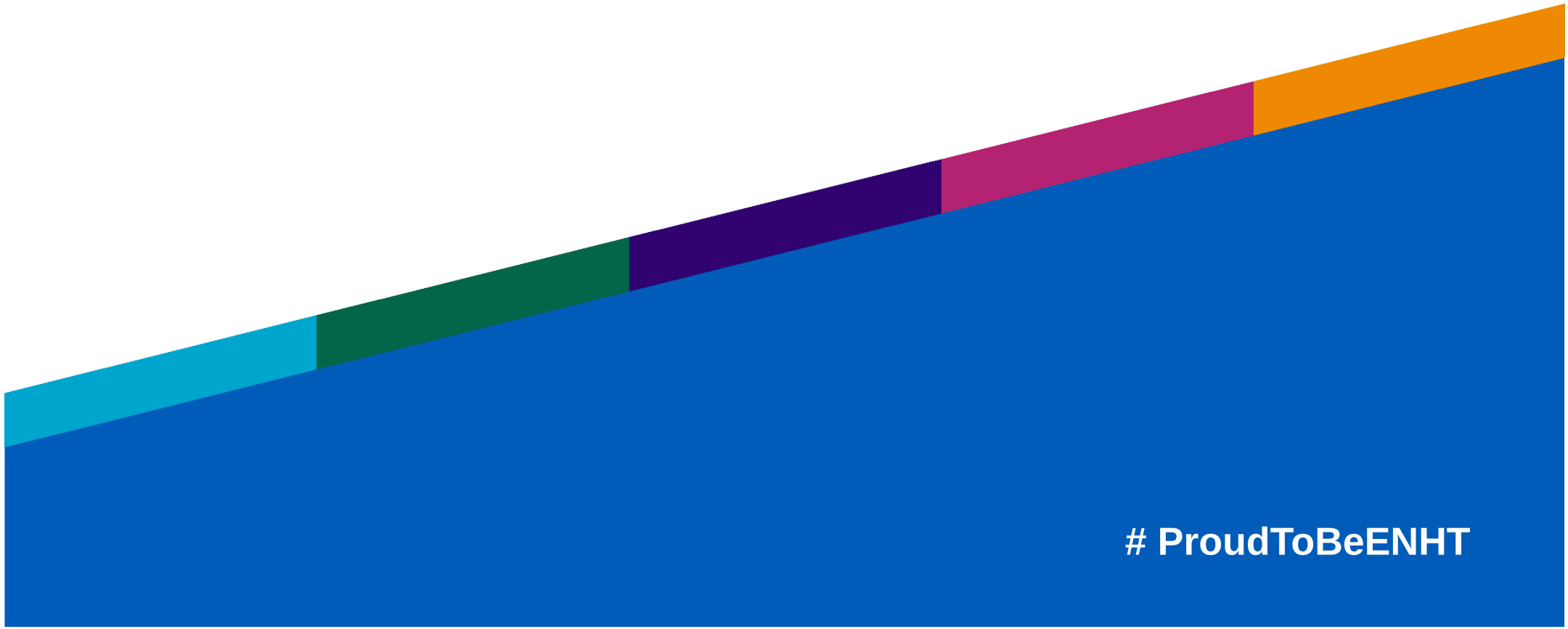
East and North Hertfordshire NHS Trust

Element	Sub no.	Our Compliance Assessmen	LMNS Complaoince Assessment	Subelement	LMNS Reccomedation of Action	LMNS Suggestion of Improvement	Action
6	6.3	Fully Implemented	Fully Implemented	Women with type 2 diabetes should have an objective record of their blood glucose recorded in their hospital records/EPR and be offered alternatives (e.g., intermittently scanned CGM) to blood glucose monitoring if glycaemic targets are not achieved	Fully meets standard – continue with regular monitoring of implementation.	Discussions around funding for poorly controlled T2 women will need to take place to ensure compliance at next Qtr	Discussions commenced to unpick challenges regarding funding.
6	6.6	Fully Implemented	Fully Implemented	Recognising the very high risk of fetal death (stillbirth rate 160 per 1,000 births) associated with diabetic ketoacidosis (DKA), all pregnant women presenting to secondary care with DKA should have ongoing multidisciplinary Consultant input and be cared for in line with the jointly agreed trust policy.	Fully meets standard – continue with regular monitoring of implementation.	Please also upload MMN referral pathway/guideline	MMN added to 6.6 on NHS Futures

Safety Action 7

Maternity and Neonatal Voices Partnerships - MNVP

NHS
East and North Hertfordshire
NHS Trust



Requirements of Safety Action 7

East and North Hertfordshire NHS Trust

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 2 April 2024 until
30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence
1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes	Ethnicity data report. MNVP listening charity reach. Stevenage equities commission. LMNS equity and Equality action plan
2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as:** • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee	Yes	ToR and minutes meetings within this MIS reporting period.
3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost	Yes	MNZP updates and minutes. MNVP engagement table.
4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A	
5	Show evidence of a review of annual CQC Maternity Survey data, such as the documentation of actions arising from CQC survey and, if available, free text analysis, such as an action plan.	Yes	Maternity survey action plan.
6	Has progress on the coproduced action above been shared with Safety Champions?	Yes	Action plan shared at PACE committee.
7	Has progress on the coproduced action above been shared with the LMNS?	Yes	LMNS partnership board minutes

Evidence as Provided By MNVP leads

East and North Hertfordshire NHS Trust

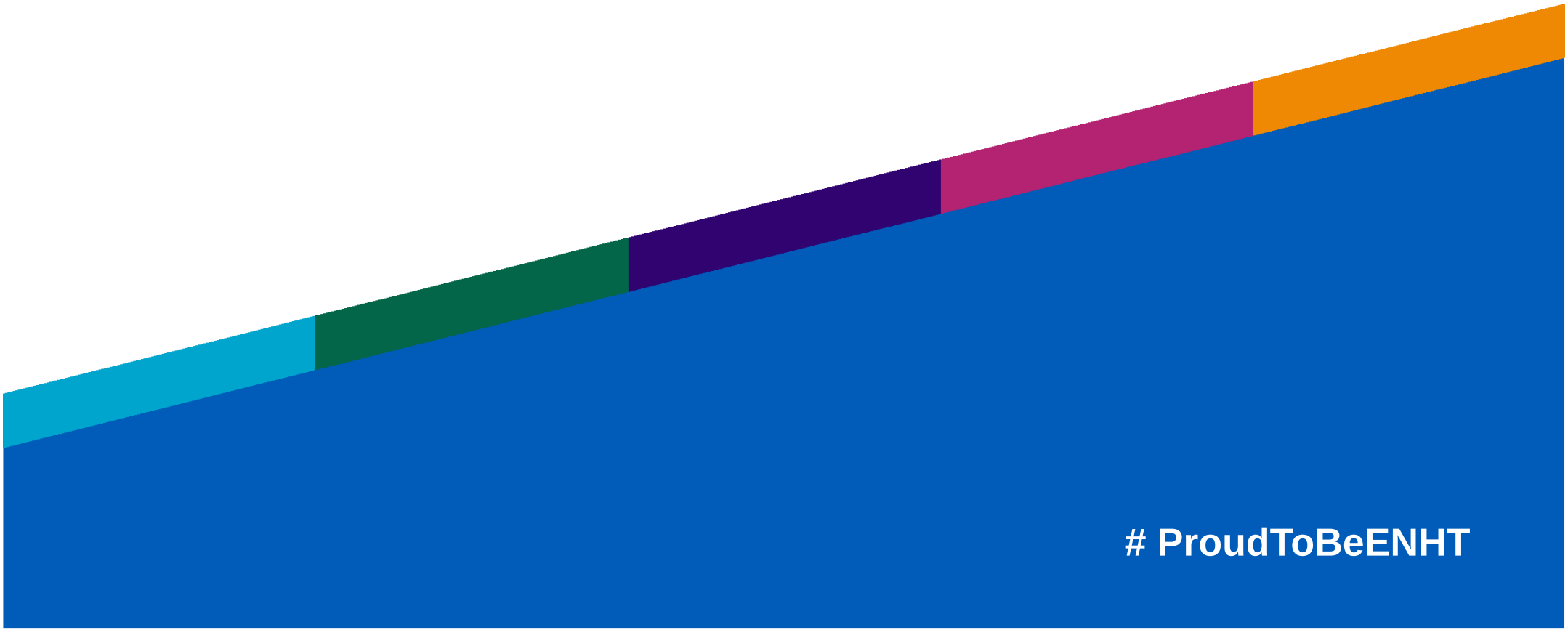
Recommendations

- The LMNS has reviewed the financial budget and terms of conditions of employment for the MNVP chairs with both the neonatal and maternity chairs now having substantive contracts with appropriate renumeration. - Both neonatal and maternity and MNVP chairs formally recruited in November 2024
- All actions complete

Safety Action 8

Education, Training and Development

East and North Hertfordshire NHS Trust



Requirements of Safety Action 8

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 2 April 2024 until
30 November 2024

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
Can you demonstrate the following at the end of 12 consecutive months ending 30 November 2024?		
	Fetal monitoring and surveillance (in the antenatal and intrapartum period)	
1	90% of Obstetric consultants?	Yes
2	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	Yes
3	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres?	Yes
	Maternity emergencies and multiprofessional training	
5	90% of obstetric consultants	Yes
6	90% of all other obstetric doctors (commencing with the organisation prior to 1 July 2024) including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	Yes
7	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
8	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	Yes
9	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	Yes
10	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	Yes
11	90% of all other obstetric anaesthetic doctors (commencing with the organisation prior to 1 July 2024) including anaesthetists in training, SAS and LED doctors who contribute to the obstetric anaesthetic on-call rota. This updated requirement is supported by the RCoA and OAA.	Yes
12	For rotational anaesthetic staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
13	At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff	Yes
	Neonatal basic life support (NBLS)	
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	Yes
15	90% of neonatal junior doctors (commencing with the organisation prior to 1 July 2024) who attend any births	Yes
16	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	N/A
17	90% of Neonatal nurses (Band 5 and above)	Yes
18	90% of advanced Neonatal Nurse Practitioner (ANNP)	Yes
19	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Yes

Evidence

NHS East and North Hertfordshire NHS Trust

Final Training Compliance SA8

NHS East and North Hertfordshire NHS Trust

PROMPT	Obs Cons	Obs Trainees	FY1s GPs	Anaes Cons	Anaes Trainees	Midwives	Support Staff
Current	100%	100%	100%	100%	95.4%	99.0%	96.1%

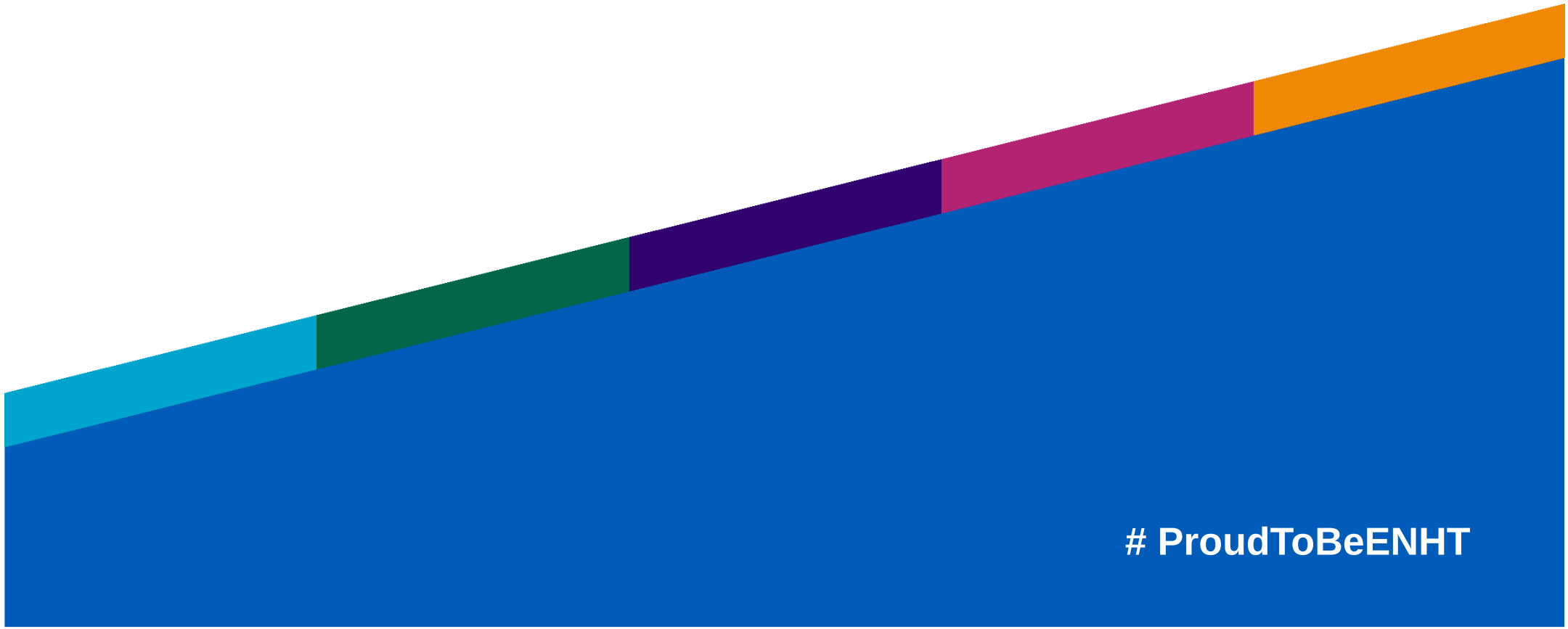
Fetal Monitoring	Obs Cons	Obs Trainees	Midwives
Current	100%	95.7%	97.7%

NBLS / NLS	Midwives	Neonatal Nurses	ANPs	Neonatal Cons	Neonatal Drs
Current	95.4%	96.1%	100%	100%	100%

Safety Action 9

Safety Champions

East and North Hertfordshire NHS Trust



Requirements of Safety Action 9

Safety action No. 9

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

East and North Hertfordshire NHS Trust

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	
1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes	Reported by Governance to QSC
2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?	Yes	Compliant
3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes	PQSM reported every month to QSC
4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes	PQSM reported every month to QSC
5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes	LMNS Quality and Safety Reports
6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes	Monthly MNSC walkabouts reported to Governance and QSC. Enhanced by
7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes	Presented at TWNQSC Sept and Nov 202
8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes	Trust board Minutes
9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes	QSC and Trust Board Minutes

Recommend that compliance with this safety action has been achieved

Evidence

East and North Hertfordshire NHS Trust

SAFETY CHAMPIONS MEETING
MINUTES OF THE MEETING HELD ON 26.11.2024.
14:00 – 15:30 – via Teams

Present:
Josie Reynolds (JR), Nina Janda (NJ), Theresa Murphy (TM), Douglas Salvesen (DS), Rebecca Wilkie (RW), Vanessa Tingey (VT), Shamila Ghouse (SG), Helen Mansfield (HM), Frances Kilmurray (FK), Kanta Temba (KT), Claire Prew (CP), Inibiokun Orangun (IO).

Actions Log:

Meeting Date	Action	Update	Action Owner
26/11/24	Discuss whether safety champions meetings is the best forum for capturing stay interview themes.		JR/KT

Agenda Item	Notes
Apologies for absence	Apologies for absence were received from Amanda Rowley, Mona Modi, Lesley Overy, Lucinda Berry and Sophie Williams.
Minutes from the last meeting and Actions Log	The minutes from the previous meeting were approved. There were no actions from the previous meeting to update.
Claims Incident Complaints Q2 triangulation report	It was noted that the claims incident complaints Q2 triangulation report had already been presented at the Women's and Neonatal Quality committee on 25 November 2024. TM asked about the line of sight of how incidents and claims have impacted black and ethnic minority women within the demographics. JR was unable to provide assurance that there is accurate data of these groups of people within our claims, incidents and complaints. A lot of the data is contained within Lorenzo, however K2 cannot accurately provide the data for patient safety incidents. JR has been liaising with the complaints team regarding

44 | Presentation title

East and North Hertfordshire NHS Trust

Triangulation of maternity claims scorecard, incident and complaint data: information and update

East and North Hertfordshire NHS Trust

Meeting	TWNSQC		**Agenda Item**	Maternity Scorecard, Incidents and Complaints Update
Report title	SA9 Maternity Scorecard, Incidents and Complaints Update		**Meeting Date**	11 October 2024
Presenter	Josie Reynolds, Sophie Williams, Katie Moore, Lucinda Berry			
Author	Josie Reynolds, Sophie Williams, Katie Moore, Lucinda Berry			
Purpose *(tick one box only)*	**To Note**	☒	**Approval**	☒
	Discussion	☒	**Decision**	
Report Summary:				

Action required by the Committee:

The Committee is asked to:

- Review and accept the presentation detailing the most recent Trust claims scorecard data for the period as being in line with the Maternity Incentive Scheme Year 5 Safety Action 9 (May 2024);
  The trust must show evidence of triangulation of claims using the claims' score cards, complaints, and incidents. Using this process the trust can identify areas of improvement for the treatment and care of patients through in-depth reviews of services, benchmarking and presenting a data-driven evidence based to support change. These discussions must be held at least twice in the MIS reporting period at Trust level quality meetings.
- To review the claims, complaints and incident data for the period 1 January 2024 to 30 June 2024
- Note the themes identified and ongoing actions in progress
- Approve the slide deck to present triangulated data moving forwards.

Requirements of Safety Action 9

East and North Hertfordshire NHS Trust

- The service has had active involvement by a maternity NED throughout the 2023-2024 reporting period. A new NED was appointed in September 2024.

- A monthly report of the maternity and neonatal safety champion's activity is included in the governance monthly report that is presented to the Division and Quality Safety Committee.

- Service to Board governance has been strengthened with monthly governance reports that incorporate all elements of the national Perinatal Quality Surveillance model which is fully in place.

- CNST Scorecard and legal positions has been discussed at safety champions meetings and included in the October TWNSQC and QSC report.

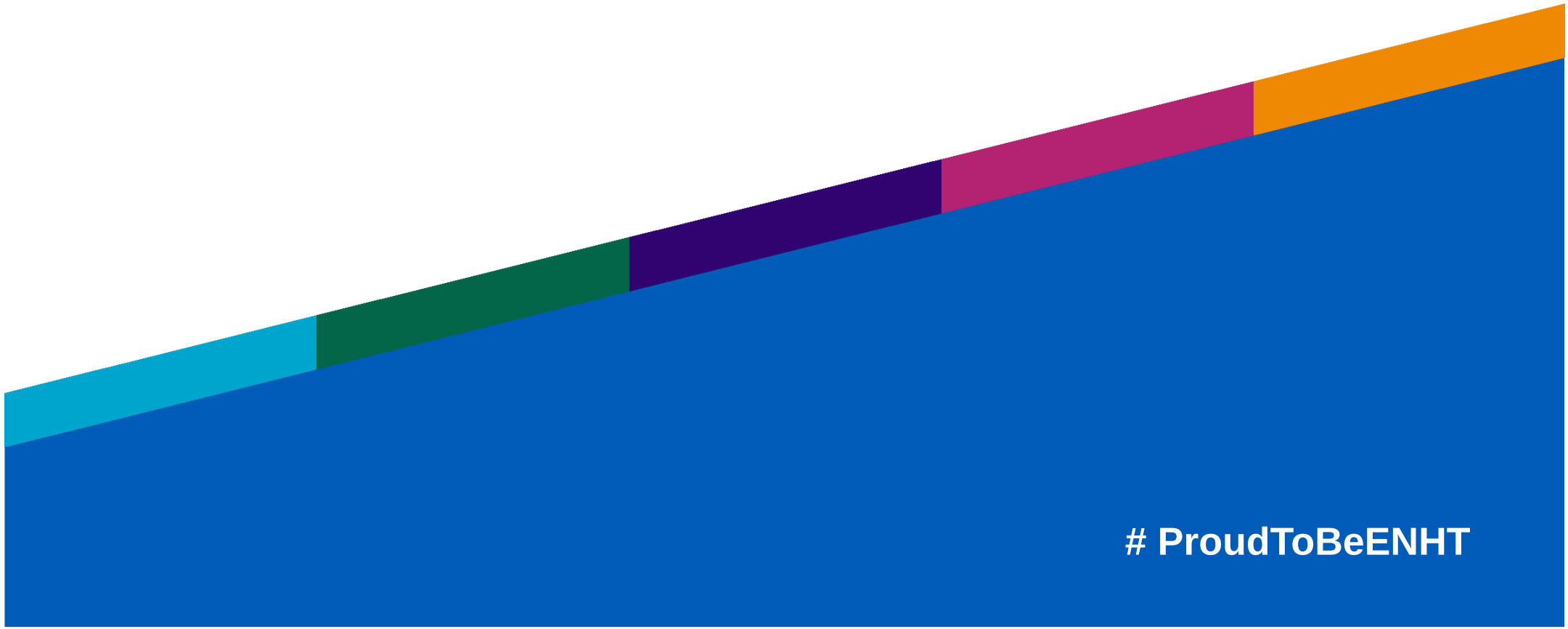
45 |

Recommend that compliance with this safety action has been achieved

Safety Action 10

Maternity and Neonatal Safety Investigations (MNSI - former HSIB)

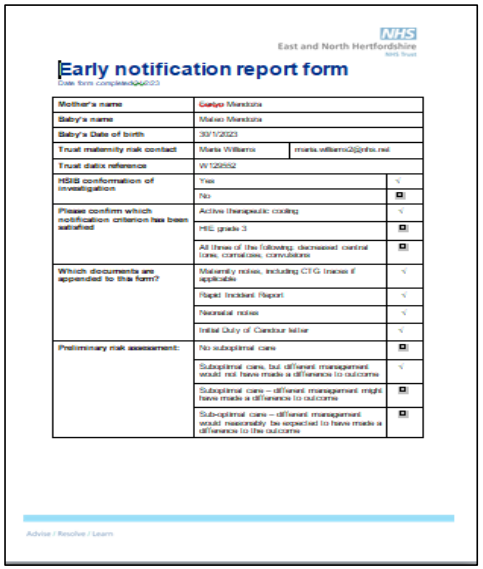
East and North Hertfordshire NHS Trust



Requirements of Safety Action 10

East and North Hertfordshire NHS Trust

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)	Evidence
1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	Yes	MNSI case spreadsheet (Three cases, 2 rejected)
2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.	Yes	MNSI case spreadsheet (Yes for the one accepted case)
3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes	MNSI case spreadsheet (Yes all referred cases)
4	Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	Yes	MNSI case spreadsheet (Yes all referred cases)
5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	Yes	All cases presented via QSC as part of Governance report and at Trust Board following investigation completion (one case)
6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes	Included in monthly perinatal report
7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes	Includedin monthly perinatal report
8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes	Claims report



MNSI Maternity & Newborn Safety Investigations

47 |

Recommend that compliance with this safety action has been achieved

Hertfordshire and West Essex Integrated Care System

HWE ICS Performance Report

November 2024

Working together
for a healthier future

Executive Summary – KPI Risk Summary

Further information regarding high level risks can be found within the accompanying Risk Report

Highest Risk	Programme
CHC Assessments < 28 Days	Community
Community Waits (Children)	Community
6 Week Waits	Diagnostics

Lowest Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
28 Day Faster Diagnosis	Cancer
CHC Assessments in Acute	Community

Low Risk	Programme
2 Hour UCR	UEC
NHS 111 Calls Abandoned	UEC
No Criteria to Reside (NCTR)	UEC
Day Case Rates	Elective
Community Waits (Adults)	Community

Variable Risk	Programme
% of on the day GP Appointments	Primary Care
% of <14 day GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
Ambulance Handovers	UEC
ED 4 Hour Standard	UEC
Patients discharged before Noon	UEC
Talking Therapies	Mental Health
Severe Mental Illness (SMI) Health Checks	Mental Health
31 Day Standard	Cancer
62 Day Backlog	Cancer
62 Day Standard	Cancer
RTT 78 Week Waits	Elective
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective

High Risk	Programme
Ambulance Response Times	UEC
Out of Area Placements	Mental Health
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
Community MH - Adult Waits for 2nd Appt	Mental Health
Theatre Utilisation	Elective
Autism Spectrum Disorder (ASD)	Community
Attention Deficit Hyperactivity Disorder (ADHD)	Community

Moved to lower risk category **Moved to higher risk category** **No change to risk category** **New KPI added this month**

Executive summary

URGENT CARE	**4 Hour Performance**	**Region: HWE better than average**	**National: HWE better than average**

- Hours lost to handover >15mins continues a trend of improvement. 1,845 hours were lost in Sept, which was slightly behind our fair shares handover target
- Sept saw a slight downturn in 4-hour ED performance at 75.6%; variation by Provider with PAH remaining the most challenged, however WHTHT continue to deliver above 80% and held be up as a national exemplar
- NHS 111 abandoned call performance has continued to improve and is now achieving the 3% national standard, with an abandonment rate in September of 1.6%
- Following an improvement in August, Cat 2 ambulance response times increased in Sept at 48 mins; this remains adrift of the national 30-minute standard and the regional average, which was 41 minutes in Sept

PLANNED CARE	**18 Week RTT**	**Region: HWE better than average**	**National: HWE worse than average**

- The overall elective PTL size remains high, however five months of continuous growth came to an end in August. The increase this year is largely due to PAH converting Appointment Slot Issues (ASIs) to the live PTL
- 78-week waits continue at low numbers, with 17 reported across the ICS for August; full clearance is expected by end of October
- 65-week waits have improved over the last two months with WHTHT the best performing in region at end of September with 3 breaches. The latest end of October forecast for HWE is 82: ENHT 40, WHT 26, ISP 16 Full clearance of 65ww is expected before the end of December, as per national requirement

DIAGNOSTICS	**6 Week Waits**	**Region: HWE worse than average**	**National: HWE worse than average**

- 6-week wait performance continues at declined levels at 56.1% in August. A return to reporting of the challenged paediatric audiology service at ENHT in June 24 has driven a step change decline in performance

CANCER	**28 Day FDS / 31 Day / 62 Day**	**Region: HWE better than average**	**National: HWE better than average**

- 28-day Faster Diagnosis Standard (FDS) performance continues to meet this year's ambition of 77%, achieving 80% in August
- 62-day performance continues to meet the 70% target, but with notable variation by Trust (ENHT 87.5%; WHTH 74.9%; PAH 59%). 31-day performance continues to fluctuate but met the national std of 96% in Aug

MENTAL HEALTH / LD	**Community MH (2nd Appt)**	**National: HWE better than average (Adult)**	**LDAHC**	**Regional: HWE worse than average**

- Learning Disability Annual Health Check (LDAHC) performance remains strong with all Places exceeding their equivalent 23/24 positions. Performance is 1.4% behind EOE average but on track to achieve by year end
- Increases in Out of Area Placements (OAPs) across last two months; 35 in Aug against plan of 8. Lister's Aston Ward re-opened for phased returns early Oct and should have positive impact on OAP numbers from Nov
- Community Adult MH median waits for a 2nd contact increased in the quarter to August at 66 days, however this still benchmarks well against the national average of 122

CHILDREN	**Various**	**Community 18 Week %: HWE worse than national**	**Community MH 1st Appts: HWE better than national**

- The total number of children on community waiting lists remains very high but has plateaued over the last 14 months. Longest waits have increased further to 136 weeks; this compares to 58 weeks for adults
- 18 week % for children's community waits continues to decline; at 40% in Aug compared to the national average of 54%. The main pressure areas continue to be Community Paeds, 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
- The 28-day CAMHS access standard in Hertfordshire has not been achieved since 2021. Performance has declined for three consecutive months with c.45% achieved in September. Vacancy rates continue to impact
- Children's waits for a Community MH 1st appointment continue to better the national average. However median waits are 165 days, compared to 66 days for a 2nd contact in adult services

COMMUNITY (Adults)	**% <18 Weeks**	**National: HWE better than average**	**Adult waiting times better than CYP**

- The % of adults waiting <18 weeks remains strong at 90.4% compared to the national average of 84%

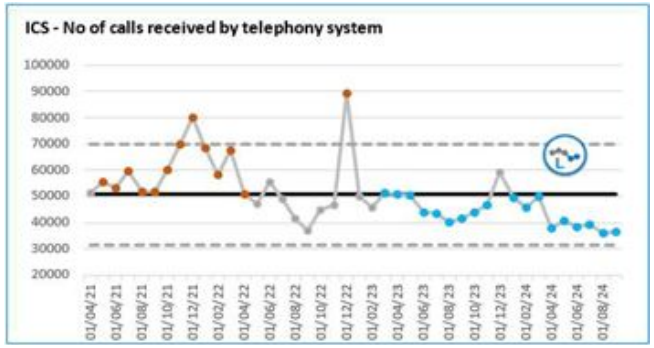
PRIMARY CARE & CHC	**CHC Assessments Within 28 Days:**	**HWE worse than regional and national average**

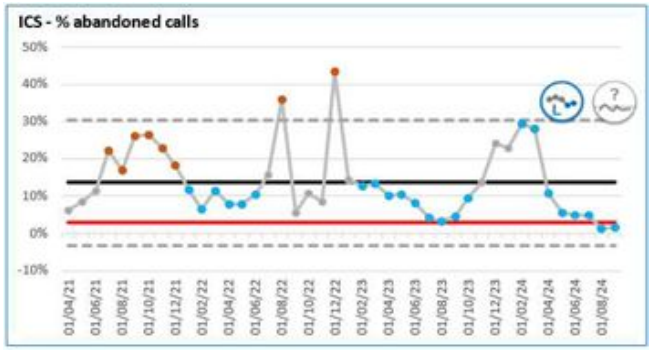
- The % of appointments seen on the same day remains within common cause variation limits. The % seen within 14 days of booking continues along the mean and is marginally below this year's plan of 89%
- CHC assessments within 28 days remains significantly challenged, most notably in South & West Hertfordshire with performance at 24% in August against 80% target; this remains an area of highest risk

Performance by work programme

Hertfordshire and West Essex Integrated Care System

NHS 111

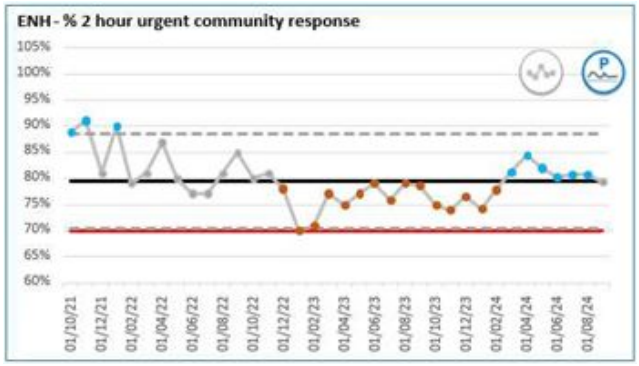


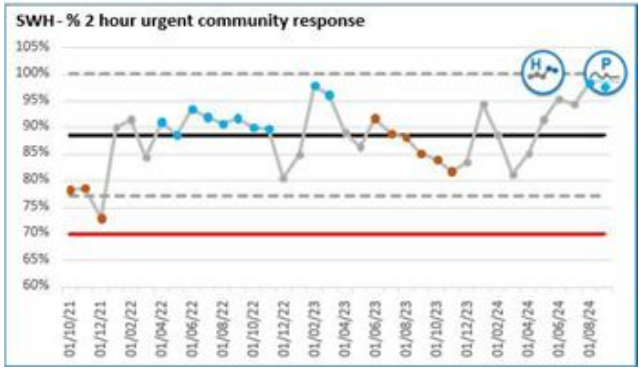


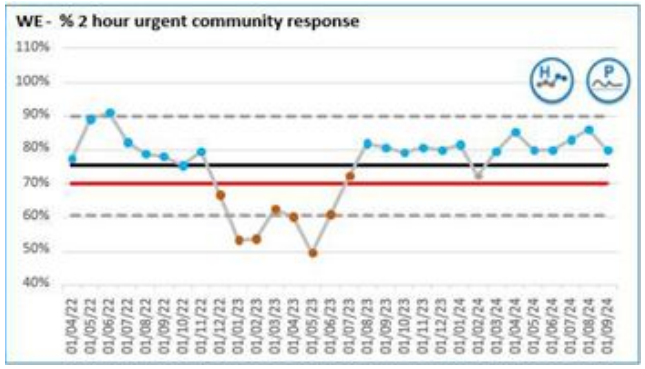
ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have been consistently trending below the historic mean since 2022 • Significant improvement in abandoned call rates with the 3% national standard being achieved in both August and September	• Recruitment continues to be challenging, particularly for evening / weekend shift patterns as these are not desirable • National shortage and delays in issuing of smartcards continues. This has increased the average handling time for new starters, of which c.31% are in their probation period	• Escalation of smartcard shortage issue to NHSE • Targeted assessment days in September to improve staffing ahead of winter • Cross-site networking remains in place as HUC moves to a pan-HUC model to increase efficiencies and resilience. This has supported improved rota fill which continues to improve against current expected establishment • Improved internal processes to support with average speed to answer and average handling times, including call flow scripts, wrap up times and additional non-clinical floor walkers (NCFWs) • Deep dive into HUC-wide rotas to ensure sufficient capacity to meet demand spikes, including review of seasonality forecasting. Also reviewing “shrinkage”, including break usage etc, and how these can be managed to improve efficiencies across HUC sites

Hertfordshire and West Essex Integrated Care System

Urgent 2 Hour Community Response (UCR)







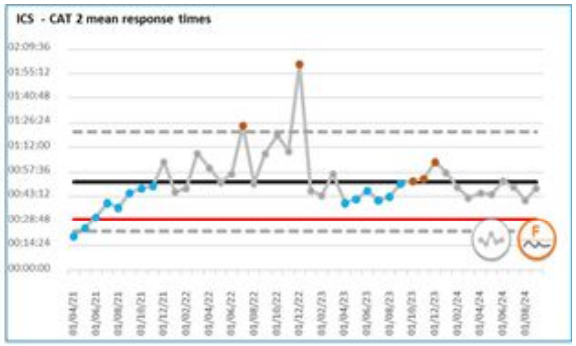
Referrals	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
West Essex	399	453	344	301	313	317	412	397	416	391	461	386	454
East & North Herts	693	643	631	650	709	568	707	736	691	621	659	676	657
South & West Herts	175	180	158	157	213	212	209	237	217	246	204	197	176

ICB Issues, escalation and next steps

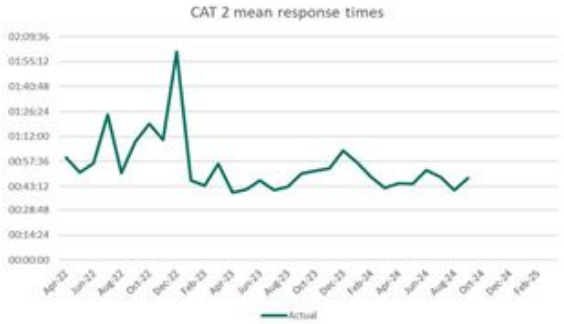
- The ICS and all 3 Places continue to achieve the 70% standard
- Although CLCH is achieving the 2hr target, activity remains low when compared to EPUT and HCT. Further system work is required to ensure like for like is being reported

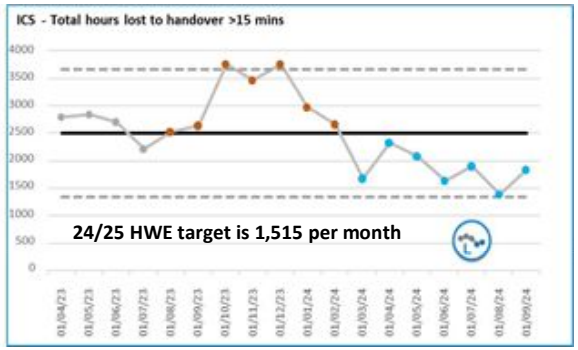
Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC) - Ambulance Response and Handover



Recovery Trajectories





What the charts tell us

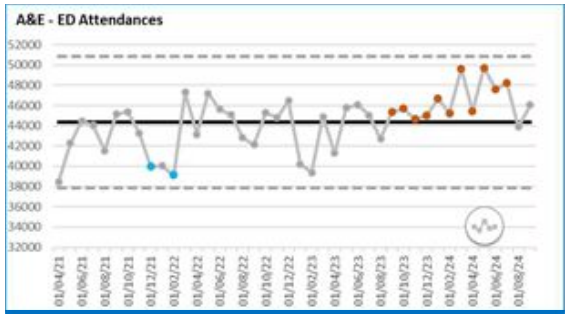
- The mean Category 2 ambulance response time was 48 minutes in September. This remains significantly adrift of the national 30-minute standard
- The performance trend has been largely flat since Jan-23
- Mean C2 response times in HWE are consistently longer than the regional average, which in Sep-24 was 42 minutes
- Hours lost to handover >15 mins have decreased significantly from a peak of 3,757 in Dec-23 to 1,845 in Sep-24. This is slightly worse than the trajectory of 1745 hours for Sep-24

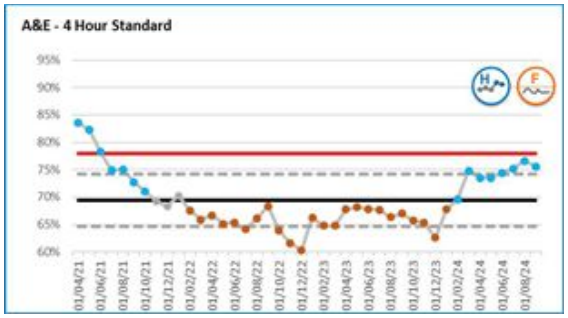
ICB Issues and actions

- Ambulance incidents were 3.4% higher in Sep-24 compared to Sep-23
- There are c.80 x WTE vacancies at EEAST in the HWE region
- This means that the number of deployed staffing hours per ambulance incident was 4.2 in HWE in compared to 5.0 across the region as a whole
- Current plans are for EEAST to reduce the vacancies in the HWE sector from 78 to 27 by Mar-25
- EEAST has introduced some joining incentives in HWE and has a policy to not allow transfers out of the HWE sector to other EEAST sectors
- Since September, EEAST has been a Tier 1 organisation and subject to Tier 1 meetings with NHSE. This is primarily in response to EEAST's CAT 2 mean response time performance

Hertfordshire and West Essex Integrated Care System

UEC – Emergency Department



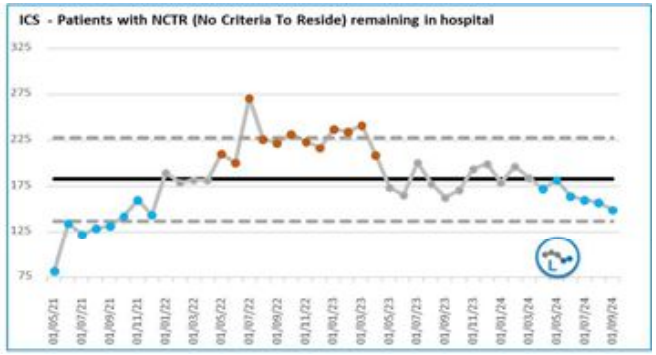


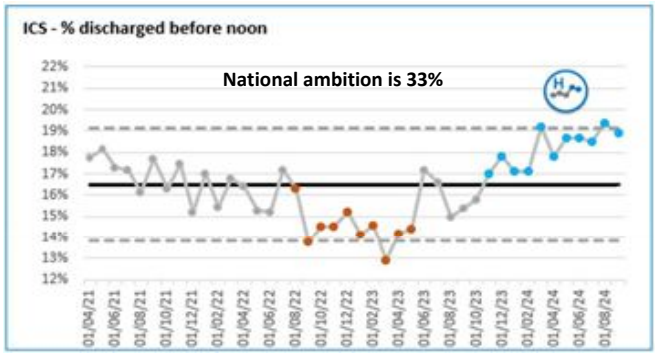
Recovery Trajectory

What the charts tell us	Issues	Actions

• The significant improvements in ED performance between Dec-23 and Mar-24 have been maintained at a system level, and there have been seven consecutive months where performance has been close to the upper process limit
• In Sep-24, ED performance was 75.6% which is just below the system target of 77% for Sep-24
• The number of attendances remain high and have been above average for 12 of the last 13 months
	• There is significant variation at place level and the gaps between places have increased. In September:
	  ○ SWH = 81.7%
	  ○ ENH = 76.2%
	  ○ WE = 66.2%
	• Continued high demand: ED attendances across the system were 1.6% higher in Sep-24 than they were in Sep-23
	• Mental Health (MH) presentations at ED remain high, coupled with a shortage of beds / assessment space. 19.4% of MH patients spent >12 hours in ED in Sep-24, compared to 8% for patients overall
	• Hospital flow remains challenging with high occupancy rates, especially at PAH where average bed occupancy in September was 98.1%
		System
		• Single point of access and SDEC task and finish group established. Focusing on getting a GP in the UCCH during winter and how this will be most effective, and straight to SDEC pathway for EEAST crews
		East and North Herts
		• CDU expansion to 10 chairs was implemented in Sep-24
		• Successful MADE week took place during Sep-24
		• New Combined Streaming & Triage (Striage) process expected to implemented in Nov-24
		• Lister UTC opening hours extending to 12am in Dec-24
		• ED admitting rights work ongoing for some defined pathways – e.g. NOF direct to ward
		West Essex
		• Mega MADE event planned for Oct-24 with >85% ambition
		• IUATC utilisation - incremental improvements in Aug-Oct but plan to strengthen workforce during winter
		• Medical SDEC – PDSA re extending referral acceptance time from 4pm to 5pm
		• Medical SDEC – collaborating with ED to identify patients earlier in their journey
		• "Golden Patient" project to identify patients for discharge the following morning
		South and West Herts
		• Oct-24 – trial for ED clinician support in the care coordination centre
		• Oct-24 – support task related to HAARC car utilisation

UEC – Discharge & Flow

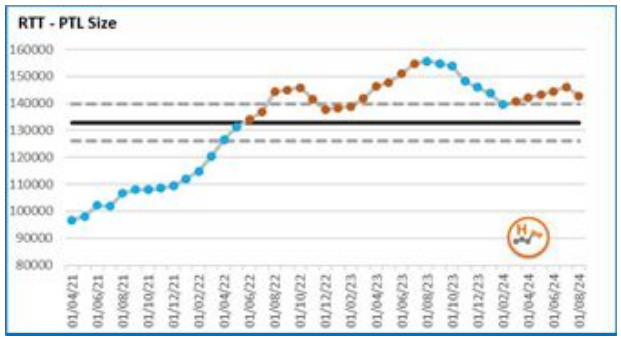


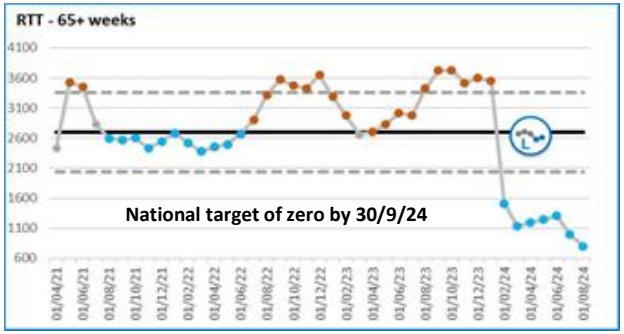


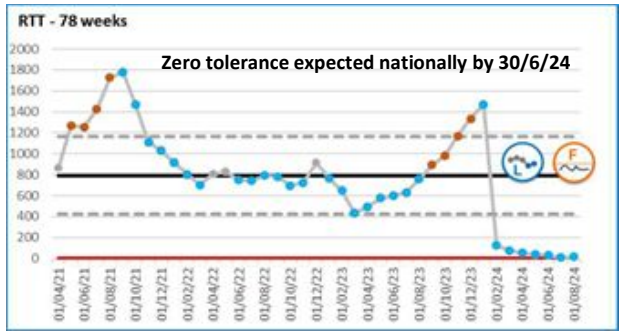
What the charts tell us	Issues	Actions
• The system-level daily average number of patients with no criteria to reside remaining in hospital has been reducing over the last two years • The Sep-24 figure of 150 patients per day is the lowest since Dec-21 • The % of patients discharged before noon is improving and reached 18.9% in Sep-24	• There remains significant variation across the three HWE acute trusts for the % of patients discharged before Noon. In Sep-24: ○ ENHT – 18.8% ○ WHTH – 22.9% ○ PAH – 12.8% • The issues are typical discharge challenges, including: ○ Availability of out-of-hospital capacity ○ Complex discharges ○ Internal process challenges	**East and North Herts** • Successful MADE week took place between 9th -13th September 2024 with positive trial of extended opening of SDEC to 10pm and Frailty Assessment Unit (FAU) beds in CDU • New complex care pathway implemented **West Essex** • New community bed model for Winter. Repurpose of 22 beds to support complex care patients. Target go live in Nov. • New referral process agreed to manage EPUT/HCT H@H referrals from PAH via the PAH TOCH which is aligned to WE CCC. Referrals processed as pathway 1 discharge in accordance with the national D2A guidelines • Mega MADE event scheduled for October with a target of <80% occupancy for that week • Failed discharge review by ward has been undertaken – action plan to be developed **South and West Herts** • Oct-24 – Discharge Improvement Programme first working group set up with a focus on a new SOP • Oct-24 – Discharge-to-Assess overstayers – developing a plan for reducing the number of patients waiting for a continuing healthcare assessment

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

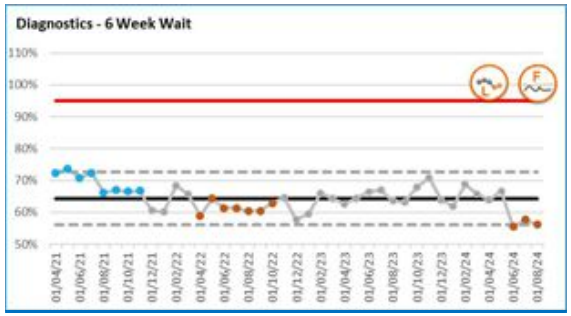
Planned Care – PTL Size and Long Waits

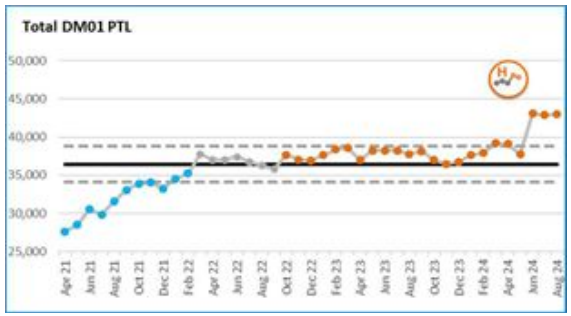
ICB Area	What the charts tell us	Issues	Actions

HWE	• August saw a decrease in 78ww long wait breaches. WHTH reached zero in April, PAH reached zero breaches in July and ENHT forecasted to reach zero by end of October
	• The overall number of patients waiting >65 weeks has decreased over the last two months, but there remains variation at place level
	• Excluding Community Paediatrics, the number of patients waiting >52 weeks has shown a decreasing trend over the last seven months
	• The overall PTL size remains high. August showed a slight decrease, reversing a trend of increases over the previous four months
	• 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 increase in the PTL this year is largely due to PAH converting Appointment Slot Issues (ASIs) to the live PTL
		• The system is forecasted to reach the zero target for 78ww breaches by the end of October (as of 15/10)
		• The 65ww target of reaching zero by the end of September has not been achieved, although it should be noted that this has not been met by any ICB nationally
		• The end of September 65ww actuals at HWE were 244:
		  • ENHT: 70
		  • WHTH: 3
		  • PAH: 150
		  • ISP: 21
		• The end of October 65ww forecast (as of 15/10) is 82
		• Trauma and Orthopaedics (T&O) remains the main specialty under pressure, with ENT also a notable risk
		• Staffing remains a challenge
			• 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 >65 weeks, with regional and national oversight
			• Demand, capacity & recovery plans are in place to monitor 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
			
			Increasing capacity and improving productivity
			• Repair works completed on the two previously closed PAH theatres. Operating recommenced mid-September
			• 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
			• Six area have ICB wide GIRFT programmes to improve productivity: Theatre Utilisation, Ophthalmology, MSK, Urology, Gynae and ENT
			• PAH Vanguard theatre live on 19th August and managing Ophthalmology procedures. Cataract waiting list reduced by 49% and additional capacity released in main theatres for cancer recovery

Hertfordshire and West Essex Integrated Care System

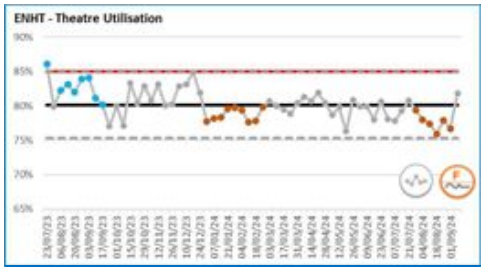
Planned Care – Diagnostics

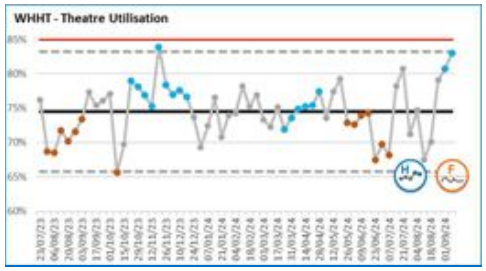


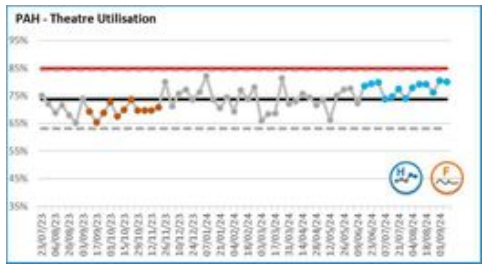


What the charts tell us	Issues	Actions
• 6-week wait performance across the ICS has been at c.56% for the last 3 months • Decline since May driven by the inclusion of ENHT Audiology data • August performance improved at WHTH, but dipped slightly at PAH and ENHT • After a period of stability there was a sharp increase in the overall PTL in June, again due to the inclusion ENHT Audiology data	• Significant variation in Trust performance: ENHT – 41.3% / WHTH – 92.1% / PAH – 69.2% **ENHT** • The significant drop in % of patients waiting <6 weeks has been caused by Audiology returning to reporting. There are notable capacity issues within the service • Excluding Audiology, the % of patients waiting <6 weeks was 58.5% which is lower than peers • Excluding Audiology, the longest waits remain in DEXA and MRI **PAH** • Non-Obstetric Ultrasound (NOUS), Echocardiography, Cystoscopy and Audiology remain the key challenges at PAH **WHTH** • In September, the lowest performing services were Cystoscopy and Neurophysiology	**ENHT** • Adult Audiology: exploring outsourcing options; waiting list cleansing exercise under-way • Paediatric Audiology: mutual aid is being provided by CUH, MSE and CHEAR; band 7 Audiologist starting in October; insourcing companies being explored but there are issues with the suitability of the rooms at ENHT • ENHT is progressing with several initiatives to increase imaging capacity, including: o Continued outsourcing MRI to Pinehill and utilising a mobile scanner on the Lister site o CT increasing capacity for evening / weekend sessions o DEXA increasing capacity through return to work of 0.4 x WTE and DEXA lead post out to advert o New Ultrasound sonographer moved to 8 sessions per week at the end of July **PAH** • NOUS: New locum Sonographer and entry level Sonographers; Additional sessions continue at agreed rates; Scoping weekend Locum opportunities • Echocardiography: 2 recent offers - 1 x Band 7 and 1 x Band 6 development post. sponsorship and visa requirements will impact timeline • Cystoscopy: Insourcing commenced 18/10 – additional 60 slots per week; Revised recovery trajectory for compliance in January • Audiology: Recruitment to 3 WTE posts. Additional capacity expected in November **WHTH** • There is improvement month on month with the recovery trajectory on track

Planned Care – Theatre Utilisation / Productivity



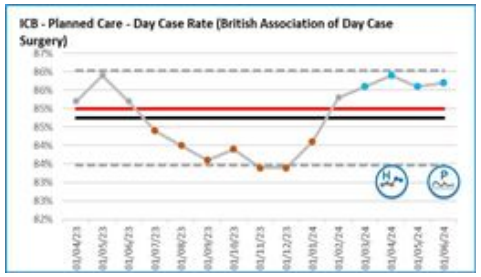


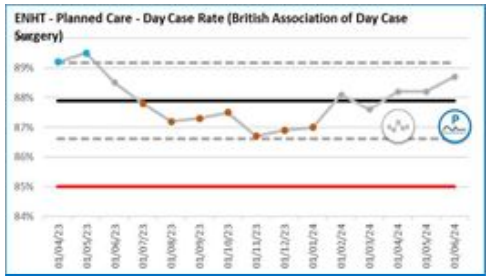


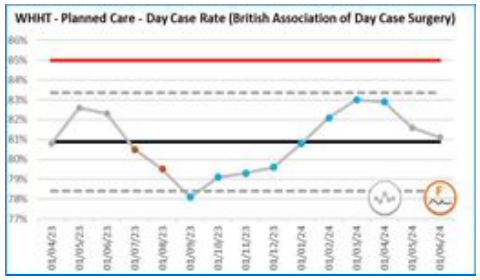
ICB Area	What the charts tell us	Issues	Actions
HWEICB	• ICB theatre utilisation is 82% against the 85% target • Comparable performance v. peers for most aspects except late finishes and early starts where HWE have a worse position **Other data** • Average cases per session for the ICB (2.5) are slightly better than peers (2.4), although PAH is below average at 2.0 • For sessions finishing early, the average minutes lost was 42 for the ICB, which is worse than peers who have an average of 39 minutes, but higher than the expected 15-30 minutes	• Overall productivity has improved in August, with a significant improvement at WHTH and ENHT, whereas PAH has remained relatively static • ENHT – although generally good performance, capped utilisation has yet to achieve the national target of 85% and is currently 81.8% • PAH – although capped utilisation dropped slightly in August reaching 80%, it had improved during June and July and is therefore relatively high and on an improving trajectory • WHTH - capped utilisation rates improved significantly in June, July and August reaching 83%	• 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 demonstrated in the improved numbers • Active theatre improvement programmes at each of the acute providers • There is a GIRFT review planned for H3

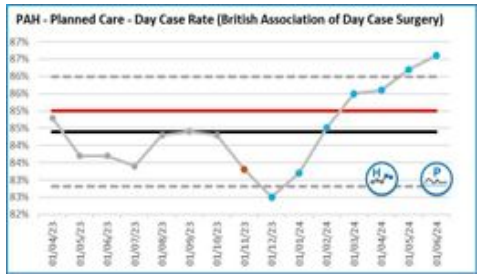
Hertfordshire and West Essex Integrated Care System

Day Case Rates





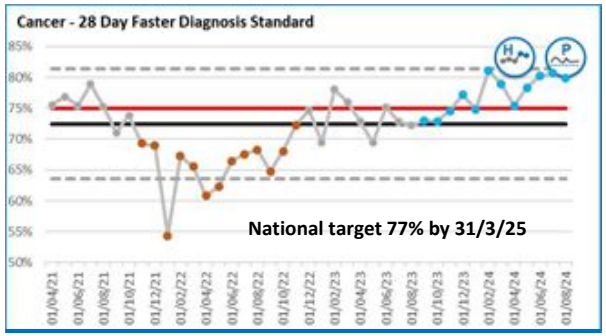


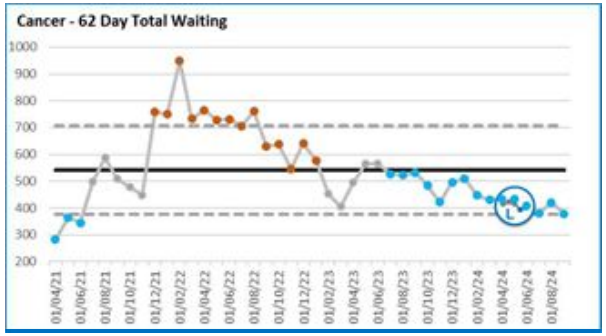


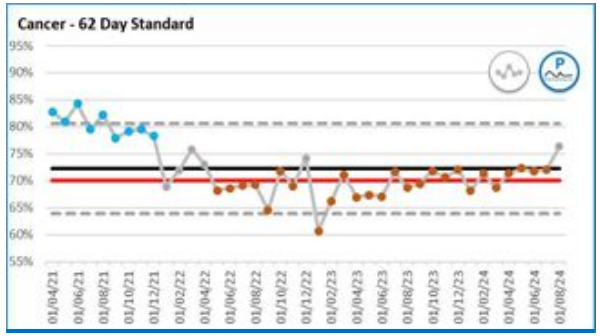
ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Day case rates at the ICB were 86% during July, which is above the 85% national target • There is variable performance across the system. ENHT and PAH are performing above the national target, and WHTH slightly below at 81%	• Specialities where BADS is less than national / peer average are Orthopeadics, Urology and Vascular. This may be attributed to the complexity of patient pathways • Issues with not listing the intended procedure correctly (listing day case rather than inpatient and vice versa) create inconsistency and incorrect data. Model Hospital measures the intended procedure (rather than the actual), which leads to under recording of the true day case rate • Conversion from day case to inpatient stay is high in some specialities due to incorrect listing, complications during surgery, poor pre-operative assessment and management	• Improvements to administrative processes are underway to support the correct listing of procedures through process review, training and education • Further investigation into reasons for high conversation rate between day case to inpatient required with a possible review of patient pathways • Improvements to the pre-operative process to ensure patients are listed correctly and fully optimised for their procedures

Hertfordshire and West Essex Integrated Care System

Cancer







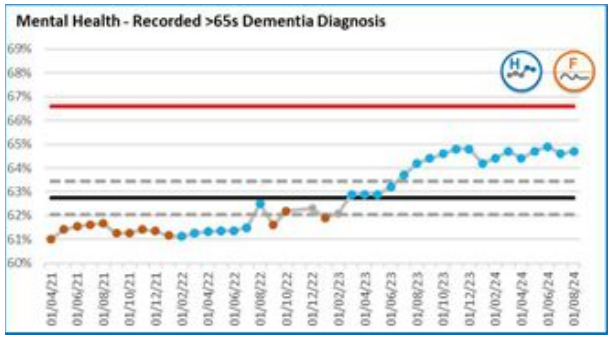
Hertfordshire and West Essex Integrated Care System

Cancer

What the charts tell us	Issues	Actions

• 28-day Faster Diagnosis Standard (FDS) performance dipped slightly in August but is above the target at 79.9%
• All three acute Trusts surpassed the 77% FDS standard in August
• The 31-day target was reached collectively in August, although PAH missed the target
• Performance against the 62-day standard improved significantly in August and although remains below the national target, it is surpassing the 70% standard expected in the 24/25 National Planning Guidance
• Each Trust has improved over the last three months but there is significant 62-day variation between Trusts:
  ○ ENHT 87.5%
  ○ WHTH 74.9%
  ○ PAH 59.0%
• The 62-day backlog is variable but with a generally improving trend
	ENHT
	• All three standards were met by ENHT for both July and August
	• However, there remain some challenged pathways. For example, for the Urology pathway in August, only 40.3% of patients met the faster diagnosis standard
	• For the week ending 13th October, there were 200 patients waiting longer than 62-days following an urgent cancer referral. This is above the Trust's recovery trajectory of 170
	
	WHTH
	• 28-day FDS Improvement seen overall, however some smaller volume pathways are not meeting the standard (Haematology, Head & Neck, Urology)
	• 31-day has continual under performance in Breast
	• 62-day improvement with Urology, Haematology and Head & Neck having the most challenged pathways
	
	PAH
	• Urology remains the biggest challenge in terms of FDS performance, with 24.2% achieved in August
	• Urology and Skin remain the biggest challenges in terms of the greater than 62-day waits, collectively accounting for 75% of the overall patient backlog
		ENHT
		• The Urology two-stop service has been introduced in September and there is currently an MRI van supporting the pathway
		• Breast radiology delays continue due to a Radiologist leaving in June. ENHT is currently organising waiting list initiatives and a locum in order to meet capacity requirements
		• Head & Neck – Increased one stop service to 8 slots per week at the end of July
		• Gynaecology – pathway analyser work completed
		
		WHTH
		• Cancer Improvement Programme Board continues to oversee service level plans and service developments
		• Cancer Alliance review underway of Gynae patient pathways. Local and specialist MDT processes in WHTHT and ENHT at the request the provider organisations
		• Pathway analyser work carried out on Urology pathways and to be undertaken for Haematology, H&N and UGI Pathways
		• Development continues on a one-stop diagnostic pathway for Urology, using Cancer Alliance transformation funding. Workforce model adjusted due to challenges recruiting an Advanced Practitioner. Go live delayed due to workforce challenges
		• Redistribution of transformation funding agreed in response to workforce recruitment challenges
		• Planning continues for transformation of Acute Oncology Service (AOS) and the establishment of a cancer / Haematology ward (Granger) at WGH
		
		PAH
		• Princess Alexandra Hospital remains in Tier 2 of the national oversight and support infrastructure for Cancer recovery, with the focus being on 62-day recovery
		• Significant progress during September in reducing the >62-day backlog. PAH has now achieved its national "fair shares" target, including in Urology
		• September's unvalidated 62-day performance is currently 49.2% which is a direct consequence of the backlog reduction in month. Now that the backlog is more manageable the trust will direct focus to achievement of the 62-day standard
		• Vanguard theatre now being utilised for all Ophthalmology patients, freeing main theatre and day unit capacity for cancer procedures

Mental Health – Dementia Diagnosis in Primary Care



ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care	• September data shows a further small increase to 64.8%, but is still short of the national target of 66.7%, and is not meeting our August plan of 65.4% • Performance does however better the EOE average of 64.0% • Both Hertfordshire places are achieving 62.6% • West Essex continue to achieve the standard at 72.8%	• High demand for memory assessment services with significant waiting lists (especially in Herts). In Hertfordshire, a trajectory is in place to reduce the waiting list and therefore recover performance against the 12 week wait to diagnosis KPI by the end of Q4 • Estimated prevalence rate of people with dementia rises month on month • Coding exercise and case finding needed in primary care, but is not being prioritised due to GP capacity and not mandated in ECF	• Monthly meetings continue to monitor HPFT progress in Hertfordshire. Monthly performance report is produced • Hertfordshire memory service currently on track to recover their KPI in Q4 • Hertfordshire memory service is currently reducing waiting lists through increased capacity. Intention is to offer up to 129 appointments per week in line with the Q4 trajectory • Diagnosis remains a key focus of the Hertfordshire Dementia Strategy, with a subgroup progressing actions to improve diagnosis • Conversations continue to resolve the challenges with Primary Care and to agree actions

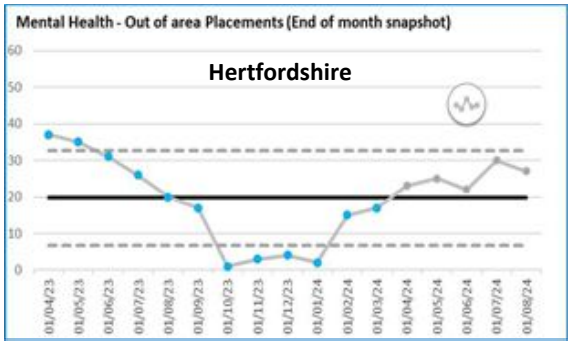
Hertfordshire and West Essex Integrated Care System

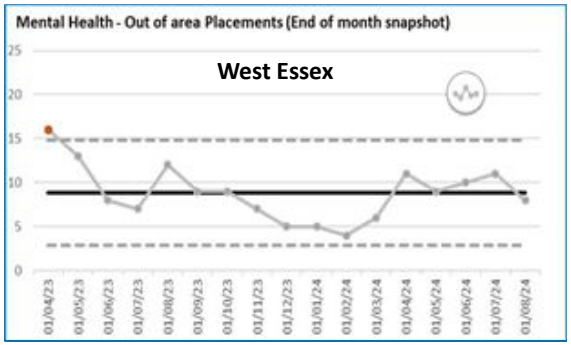
Mental Health – Out of Area Placements (OAPs)

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

HWE August total out of area placements: 32 vs. 5 plan

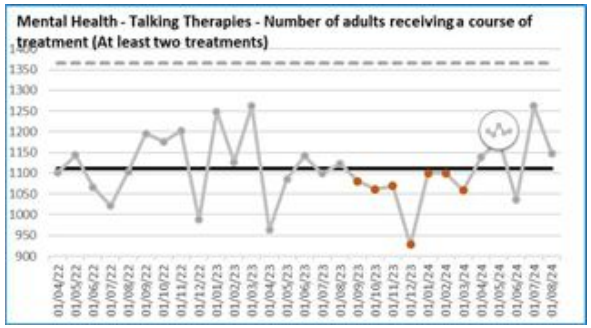


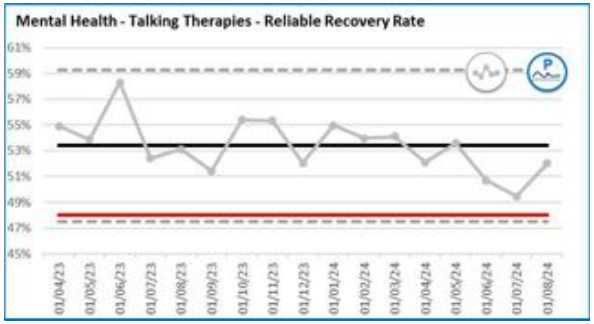


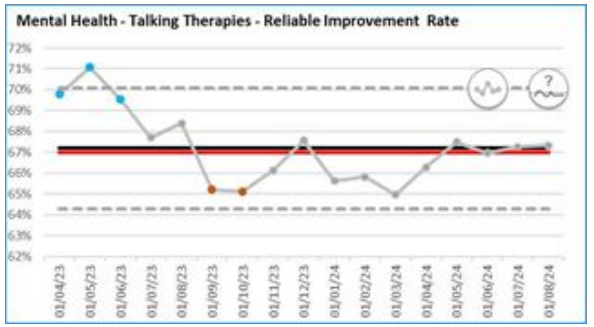
ICB Area	What the charts tell us	Issues	Actions
West Essex	• There has been a reduction in the number of out of area placements, however further work needs to continue to achieve national ambition	• A national shortage of MH beds and increased pressures on service use of inappropriate OOA beds is likely to continue • Essex risk share of inpatient beds, with increased usage of beds at place by Essex wide footprint	• Essex wide review of all inpatient beds as well as at place (West Essex) • EPUT MADE event with system partners during October 2024 • Full review of MADE event in November to identify next steps in conjunction with NHSE • Review of West Essex Community Rehab has seen an increase in discharges at place to support repatriation • Weekly system DTOC calls and ongoing focus on 'time to care and purposeful admissions' • Continued engagement with national GIRFT programme to identify areas of improvement • Full review of 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 early 2024 due to a combination of increased demand and delayed transfers, as well as the closure of Aston ward (20 beds) at Lister site due to Water Safety Incident	• Reduced capacity due to closure of Aston Ward; the ward re-opened for phased returns on 7th October • Hertfordshire low number of beds per population – now supported by provision of additional block beds • National shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Placement challenges for service users with complex needs who are ready for discharge • Inpatient and Community recruitment	• Phased re-opening of Aston Ward - estimated to return to full capacity in 4-5 weeks. This should start to have an impact on OAPs by mid-November 24 • Further alternatives to admission – Crisis House – in place • 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 and continues to be developed • A group from across the system established to review and oversee some of more complex discharge issues • Invitation letter from DHSC and NHSE for an information gathering visit to Hertfordshire ICS to help develop future policy and plans on discharge from mental health settings – initial meeting on 4 Sep 2024. Since this date HPFT have been able to re-open Aston ward that was closed for a number of months and have also held a "perfect week" to support the ongoing flow.

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





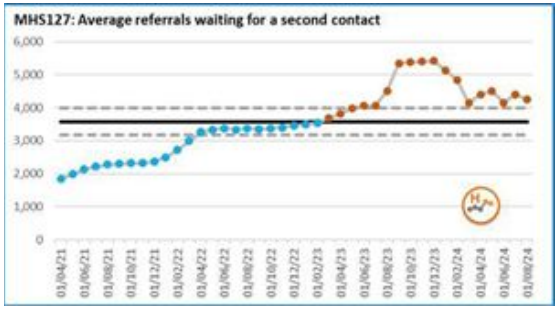


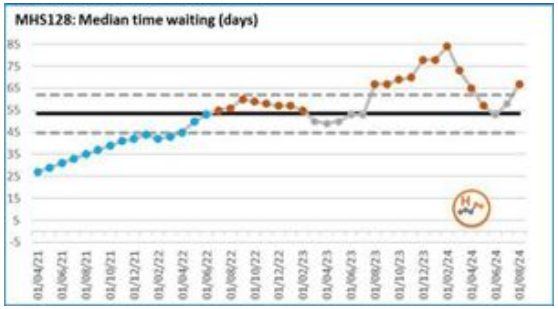
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• Treatments reduced in August; however national trends demonstrate a decline through summer months • The number of people completing a course of treatment is still within expected common cause variation limits • The System and Places are consistently achieving the reliable recovery 48% standard • The reliable improvement standard has been met for 3 of the last 4 months	• Understanding and interpreting the new national targets to ensure consistency of data collection and quality across the system • Continuing 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 was access / first appointments • Potential risk in Hertfordshire that procurement process not successful with building capacity to support 'counselling for depression'. Currently delay to procurement process • Reliable improvement rate for those completing a course of treatment in Hertfordshire requires slight improvement. Q2 reflecting 65.75% HPFT	• Ongoing partnership working across the system with NHSE to provide support clarity and data validation • Ongoing conversation with NHSE regarding additional trainee posts for services in line with workforce planning ICB wide • Procurement of counselling providers in Hertfordshire by 2025, leading to an improvement of pathways and ensuring right modality in place for service users • Scope to provide extension liaising with SPG and legal • NHS England representation embedded within West Essex contract meetings

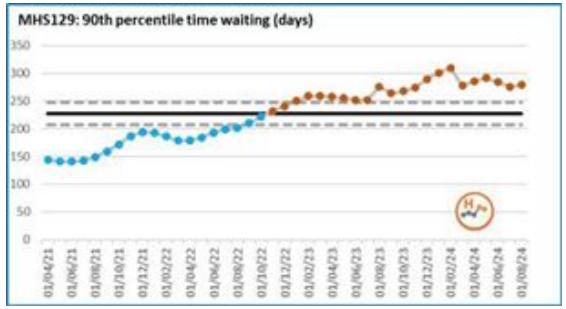
Hertfordshire and West Essex Integrated Care System

Mental Health – Community Waits

Adults and Older Adults – time still waiting for second contact





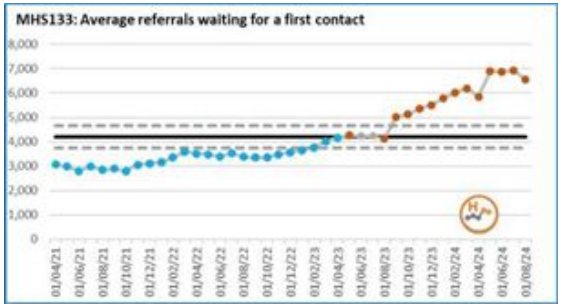


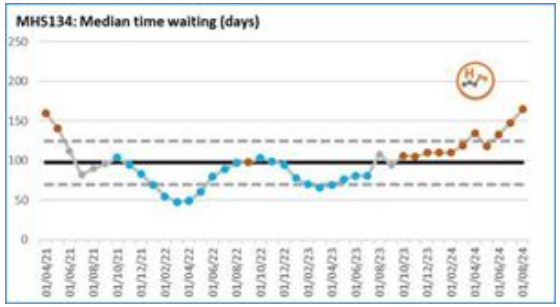
ICB Area	What the charts tell us	Issues	Actions

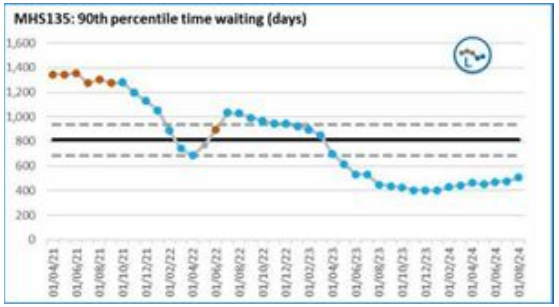
Hertfordshire & West Essex	• Median waiting times for a 2nd appt. for the quarter to August were 66 days
	• 66 days benchmarks well against the national average of 122 days, but has increased in the last two months
	• Within the system there is variation of between 48 and 68 days:
	  • East & North Herts 66 days
	  • South & West Herts 68 days
	  • West Essex 48 days
	• 90th percentile waits for the quarter to August were 279 days
	• 279 days benchmarks well against the national average of 794 days, however there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 258 & 290 days:
	  • East & North Herts 265 days
	  • South & West Herts 290 days
	  • West Essex 258 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 there is variation from local data sets to nationally published data. An improved performance position is expected with complete data; current waits reported are for specialist services only that have longer waiting times.
		• 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. Service lines have incorporated the new waiting times into their transformation work. SNOMED codes have been re-mapped on the HPFT EPR, PARIS, and continue to be reviewed as changes are made at National level. Internal reporting continues to prove challenging and working with Regional colleagues to better understand NHSE scripts
			• A Trust-wide waiting times steering group is in place to ensure the care and safety of all people waiting for services
			• 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 People-s services to ensure that refs and treatment are recorded as for adults
			• All ICBs working with mental health Trusts to review 104 week waits as requested by NHS England

Mental Health – Community Waits

Children – time still waiting for a first contact



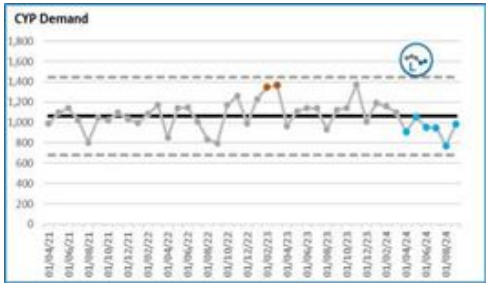


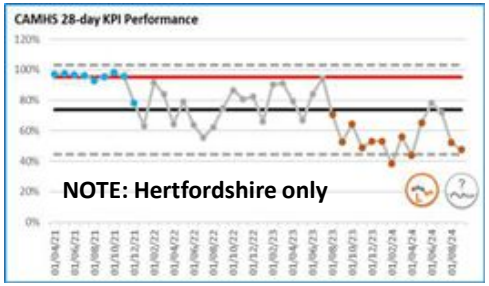


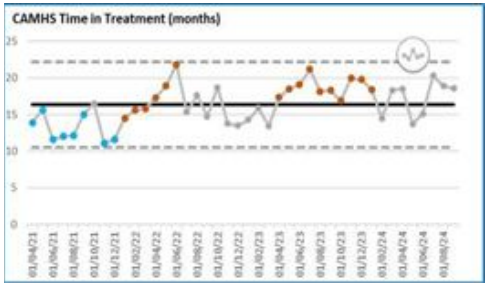
ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times increased to 165 days and have been trending above the historic mean since August 23
	• 165 days benchmarks well against the national average of 240 days
	• Within the system there is variation of between 68 and 192 days:
	  • East & North Herts 68 days
	  • South & West Herts 192 days
	  • West Essex 111 days
	• 90th percentile waiting times for the quarter to August were 507 days, and on a long-term trend of improvement
	• 507 days benchmarks well against the national average of 789 days
	• Within the system there is variation of between 317 & 543 days:
	  • East & North Herts 317 days
	  • South & West Herts 543 days
	  • West Essex 415 days
		• The biggest impact on the Hertfordshire waiting list and long waiters is Autism & ADHD backlogs / waiting lists for diagnostic pathways
		• South & West Hertfordshire data is reflective of the historically longer waiting times in the patch, due to ASD / ADHD backlogs (for East & North these services are delivered by ENHT not HPFT/HCT)
		• The 18+ week waiters within West Essex (NELFT) are predominately within the Getting Help element of the Thrive model. As @ end of August there were 7 x 18+ week waiters in the service, equating to 2.7% of all waiters
			• CAMHS services are incorporating the new waiting times in their transformation work and service design. SNOMED coding has been re-mapped on the HPFT EPR, PARIS and internal reporting is under development with support from Regional colleagues
			• A Trust-wide waiting times steering group is in place to ensure the care and safety of all people waiting for services
			• Local provider dashboards in place assessment & treatment activity, caseloads and waiting times. Average waits not always reflective of challenges experienced by service, but recovery action plans in place where applicable and closely monitored by commissioning leads
			• Commissioners, HPFT and now an HCT representative are linked into EOE waiting times standards group. Now focus is on 104 weeks waiters report to NHSE due by 8/11/24. Long waiters only in HPFT all relate to ADHD backlog.
			• In NELFT Team Managers monitors their >18-week waiters on a weekly basis. All waiters >18 weeks have a clinical harm review in place and the teams will be working towards seeing all longest waiters as soon as possible. Team will continue to review the >18- week waiters and if there increase in risk, allocation for treatment will be considered as per team capacity and escalated via the Clinical Harm Audits

Mental Health – CAMHS Services







What the charts tell us	Issues	Actions
West Essex • West Essex does not have a formal KPI for 28 days, but this is monitored at monthly provider meetings • Decrease in demand at SPA during Q2 2024/25 which is seasonal variation • Slight decrease to caseload as @ end of Q2 2024/25 when compared to end of Q1 **Herts – HPFT only** • Demand into the service has reduced, as expected over summer months • Caseloads are steady and tracking around the historic mean • 28-day performance has fallen for 3 consecutive months • Time in treatment is variable, close to the historic mean	**West Essex** • Challenges continue with recruitment to specialist community eating disorder team manager and clinical lead roles **Herts – HPFT only** • Clinicians have reported increased acuity / complexity of caseloads • Active issue regarding recruitment to vacancies impacting on capacity and performance • Acquiring highly skilled CAMHS clinicians remains difficult. Non-health support roles being used to bolster teams • Forecast recovery by the end of Q3 will not be achieved due to capacity issues within the Herts Quadrant Teams. Work on current and future capacity models is being undertaken to determine expected recovery timescale	**West Essex** • Recruitment drives ongoing in NELFT with rolling advertisement for ED team manager and clinical lead roles. Support to the CYP ED team provided from within the wider organisation to minimise any impact on CYP engaged with the service; progress monitored at contract meetings **Herts – HPFT only** • MH Leads meeting with HPFT on 7th November to review revised safety and recovery plan / trajectory • Continuous improvement methods introduced to support the quality of clinical reporting, achieve data accuracy and optimise the trajectory. 28-day KPI doesn't include all CYP waiting – commissioners have requested waiting list position for all CYPs • West & East CAMHS quadrants are indicating improvements against localised & deliverable recovery actions • Visible & accessible operational leadership support to help sustain progress in above now in place • All quadrants are engaged with the recovery plan inclusive of care of waiter and demand & capacity initiatives; CQI projects (access & flow improvement) • Resource under review across all quadrants to improve equity & flow of service delivery. Test of shared resource where most practical to improve integrative working – initial focus on entry/access points • HPFT/HCT SLT partnership initiative progressing to support equity, better communication, improve relations and system working • Divisional Director continues to lead & monitor recovery, including vacancy management, delivering value and job planning for individual care professionals • Workforce Skill analysis & local plans informing recruitment activity with valued based & targeted short-term agency backfill

Mental Health – Learning Disability (LD) Health Checks

LD Health Checks July 2024	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to July 2023
NHS Hertfordshire and West Essex ICB	**7,742**	**1,219**	**23**	**6,500**	**15.7%**	**14.0%**
East & North Hertfordshire	3,202	558	4	2,640	**17.4%**	**15.2%**
South & West Hertfordshire	3,380	490	14	2,876	**14.5%**	**12.4%**
West Essex	1,160	171	5	984	**14.7%**	**12.9%**

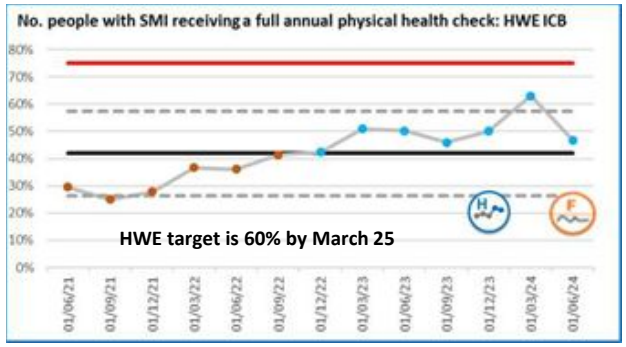
*** 75% Year End Target**

ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• All three places achieved the 75% standard in 23/24 • July 24 data shows the ICB and each place ahead of the equivalent 2023 position at this point in the year • August data is not available at the point of writing	• It is challenging to forecast end of year performance against the 75% LD Health Checks standard, as a large proportion of health checks are carried out towards the end of the year, and particularly in Quarter 4	• Ongoing work between HWE Team and NHSE to cross check local data against national systems

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

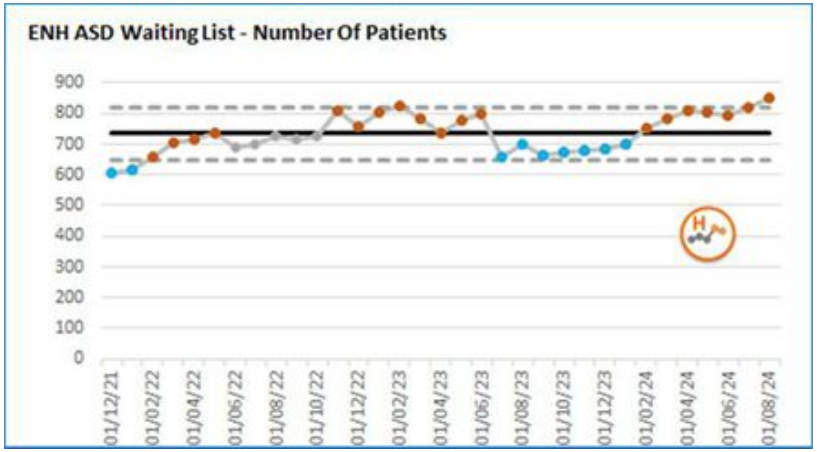


	2021/22				2022/23				2023/24				2024/25
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
East and North Herts Place	19.6%	11.9%	15.1%	25.8%	24.0%	36.3%	40.4%	45.9%	49.7%	47.7%	49.4%	60.5%	52.3%
South West Herts Place	39.4%	38.2%	39.5%	47.5%	44.6%	46.4%	43.6%	55.9%	51.0%	44.8%	52.2%	66.9%	38.9%
West Essex Place	28.9%	24.5%	30.6%	36.5%	38.5%	38.9%	44.0%	50.4%	49.4%	44.8%	46.4%	59.2%	52.1%
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%**	**46.8%**

- The systems for submitting and reporting of SMI Health Checks data has changed for 24/25
- Health Checks undertaken in Secondary Mental Health Services may not currently be fully captured, and therefore a direct comparison to last year's data is not possible at present. This is a known national issue

What the charts tell us	Issues	Actions
• As described above, current data is not capturing all health checks undertaken in secondary care MH services • Notwithstanding the incomplete datasets, East & North Hertfordshire and West Essex Q1 performance is still ahead of their equivalent 23/24 positions • The position in South & West Hertfordshire is notably lower at 38.9%	• Data quality issues as described to be resolved • SDF funds for secondary mental health services to support primary care ceased in 24/25 • 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	• The data is being extracted from General Practice Extraction Service (GPES), an alternative system this year in Primary Care. There is a piece of work that needs to take place in order that the GPs are recording the data for health checks undertaken in primary care, as well as those carried out when a person is under the care of the MH Trust. This is a known national issue • Work with ICB BI leads and Provider leads to understand reporting requirements of secondary mental health services and primary care QOF data to ensure clear guidance and responsibilities, in line with the NHSE reporting procedures • Action to standardise record checking across secondary care and primary care to ensure the SMI lists for QOR and open to HPFT are defined and agreed • Outreach physical health check pilot funding agreed to March 2025. A pan-HWE business case will now be developed • HCP place meetings in SW and ENH diarised to present current support offer to GPs and identify further actions to support programme of work • Support the improvement of interoperability and provider electronic care records and information systems to enable monitoring of performance against equity of access to care • Working with Regional MH Team support and feedback to the NHS England regional and national teams • Working with Regional MH Team to look at shared care protocols to detail who is responsible for the physical health check, and how support for people who only engage with secondary care and not primary care will be captured • Working with the Trust to look at SMI registers in Primary Care and advise who is open to community services and who is responsible undertaking the health check

Autism Spectrum Disorder (ASD) – East & North Hertfordshire



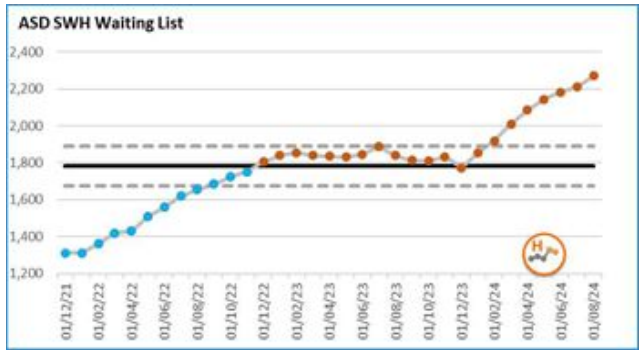
- In ENH, patients have a first appointment with Community Paediatrics. If the clinician, then considers that the patient requires an ASD assessment then they are added to the ASD waiting list
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments 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 Jun-24):

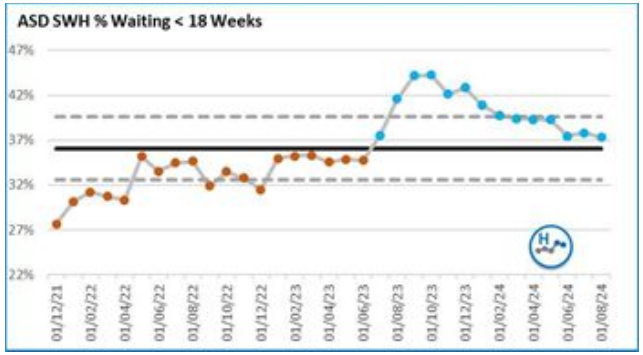
Waiting list bucket	Number of patients (Jul-24)	Number of patients (Aug-24)
<18 weeks	109	143
18 – 65 weeks	471	475
66 – 78 weeks	82	79
>78 weeks	157	156

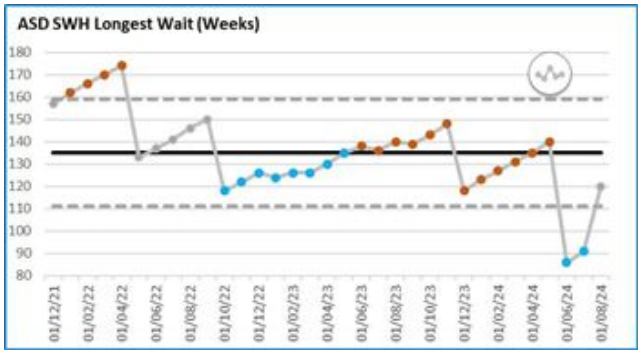
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting backlog waiting list continues to increase and reached 853 patients in Aug-24 which is the highest recorded level • The number of patients waiting >78 weeks for an ASD assessment has risen from 86 in Dec-23 to 156 in Aug-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 and 2025/26 • Neurodiversity support hub needs agreement on funding post March 2025 by end of October to enable procurement to proceed and ensure no gap in service	• Procurement process to outsource assessments for autism paused as funding has been stopped due to lack of funding • 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 • A business case has been developed and is going through governance to enable procurement process to proceed for service beyond March 2025 for the Neurodiversity Support Centre • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through clinical governance and agreed by operational teams. The business case is complete and agreement on governance route and funding is being confirmed in the ICB • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in 2024 / early 2025 • Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB and HCC was successful. The programme has begun with the 25 selected schools

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	2210	2270	↑	37.78%	37.31%	↓	91	120	↑	August



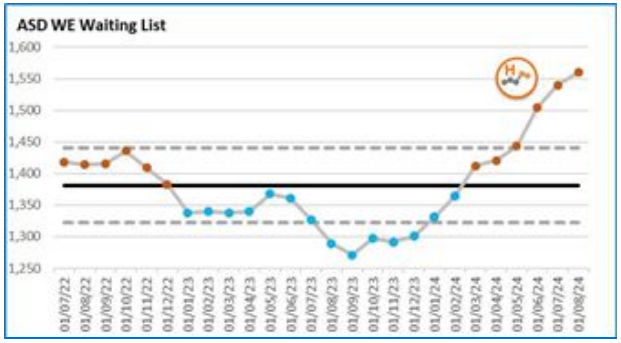


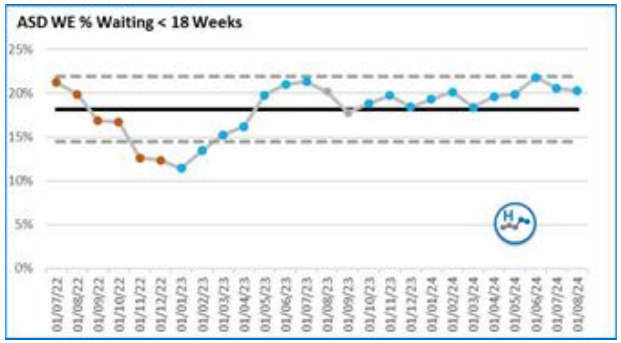


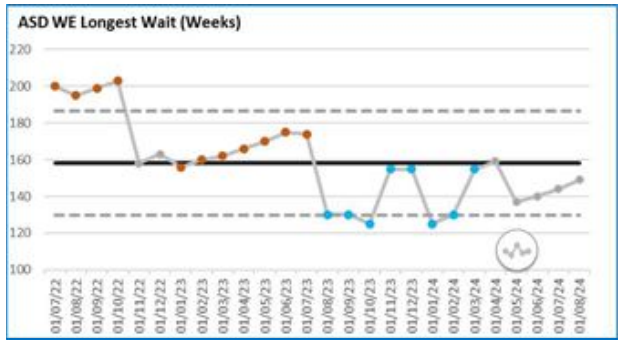
ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The overall waiting list remains consistently above the historic mean and increased further to its highest level in August • The % of ASD waiters < 18 weeks remains just above the historic mean, but has fallen by c.8% since October • The longest waits are variable but within common cause variation limits	• Capacity in existing services does not meet demand • Further increases in demand predicted • Payment will be based on activity in 2024/25 • Awaiting confirmation of investment into the service for 2025/26 • Neurodiversity support hub needs agreement on funding post March 2025 by end of October to enable procurement to proceed and ensure no gap in service	• 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 • A business case has been developed and is going through governance to enable procurement process to proceed for service beyond March 2025for the Neurodiversity Support Centre • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through clinical governance and agreed by operational teams. The business case is complete and agreement on governance route and funding is being confirmed in the ICB • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in 2024 / early 2025 • Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB and HCC was successful. The programme has begun with the 25 selected schools

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	1540	1560		20.58%	20.26%		144	149		August







ICB Area	What the charts tell us	Issues	Actions
West Essex	• The ASD waiting list continues to increase and is now at its highest reported level • The number of ASD waiters <18 weeks remains low, but is consistently above the historic average • The longest wait increased further to 149 but remains just below the historic mean • 262 of the 1,560 total waiting list are >104 weeks	• Average monthly referral rate continues to be 75-100% greater than commissioned capacity, for Q2 this was an average of 71 per month against capacity for 40 • 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. Awaiting release of identified ICS wide funding • 'Waiting well' workstream continues with local partners at Place, led by HCRG, also linking in with Essex wide joint commissioning initiatives

Hertfordshire and West Essex Integrated Care System

Attention Deficit Hyperactivity Disorder (ADHD)
West Essex & East & North Hertfordshire

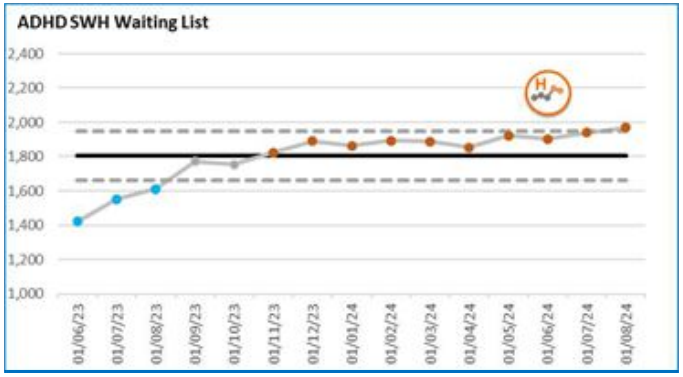
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	ENHT Paediatrics Service	Children	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	August
WE	HCRG	Children	310	311	↑	79.68%	70.42%	↓	48	52	↑	August

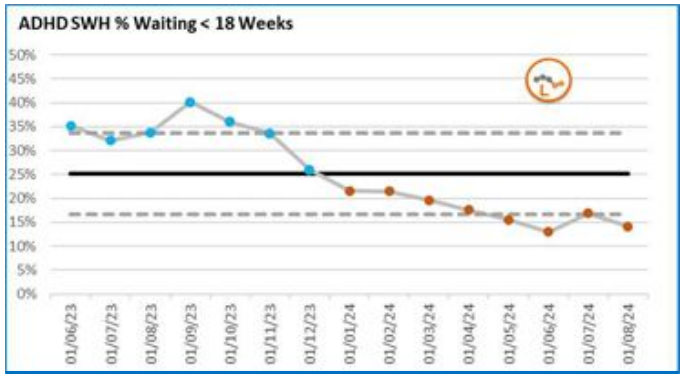
ICB Area	What the charts tell us	Issues	Actions
West Essex	• West Essex waiting lists in August were broadly similar to July • The % of children waiting <18 weeks fell by a further 9% in month • The longest wait in West Essex increased by 4 weeks to 52 weeks • ENHT is not currently able to report on waiting times / waiting list sizes for patients waiting for an ADHD assessment	• Partial reporting of the Essex ADHD Minimum Dataset whilst pathway improvements continue, aiming for completion during Q3 • Referral rates continues to rise, resulting in risk to maintaining waiting list performance	• 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. In the interim, manual ADHD has been included in this report

Hertfordshire and West Essex Integrated Care System

Attention Deficit Hyperactivity Disorder (ADHD) – South & West Hertfordshire

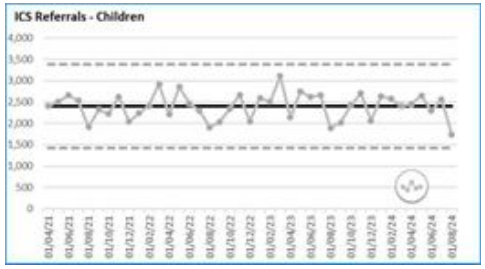
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HPFT	Children	1940	1968		16.86%	14.18%		163	173		August

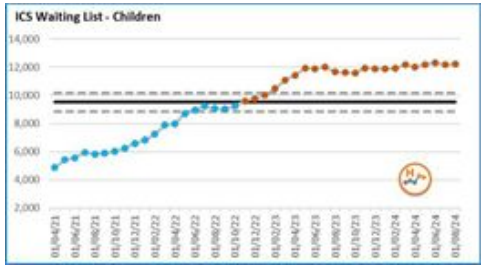


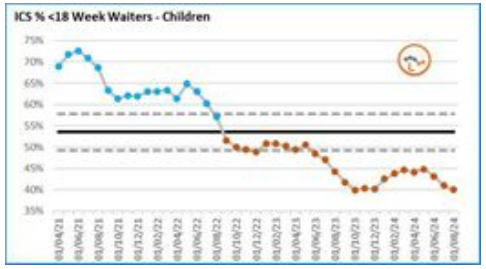


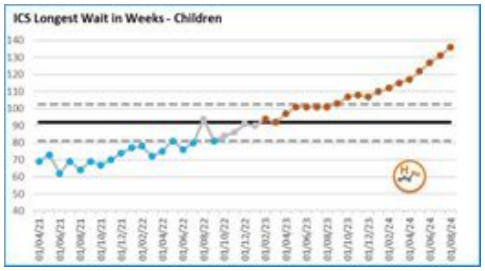
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Overall waiting list is relatively stable but has been consistently above the historic mean for the last 10 months • The % of ADHD waiting <18 weeks continues to be of concern at 14.2% for August	• Payment will be based on activity in 2024/25 • Awaiting confirmation of investment into the service for 2025/26 • Neurodiversity support hub needs agreement on funding post March 2025 by end of October to enable procurement to proceed and ensure no gap in service	• 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. The business case is complete and agreement on governance route and funding is being confirmed in the ICB • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in 2024 / early 2025 • Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB and HCC was successful. The programme has begun with the 25 selected schools

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	2565	1735		12162	12244		40.96%	39.99%		131	136		August
Place	Provider													
ENH	HCT	376	300		817	767		75.89%	80.18%		52	46		August
ENH	AJM/Millbrook	13	27		147	142		65.31%	59.86%		48	53		August
ENH	ENHT Community Paeds.	345	169		5964	6154		15.69%	15.75%		131	136		August
ENH	**All**	**734**	**496**		**6928**	**7063**		**23.85%**	**23.63%**		**131**	**136**		**August**
Place	Provider													
SWH	HCT	1378	890		4190	4049		57.61%	55.50%		73	79		August
SWH	AJM/Millbrook	23	17		154	144		63.64%	59.03%		44	48		August
SWH	**All**	**1401**	**907**		**4344**	**4193**		**57.83%**	**55.62%**		**73**	**79**		**August**
Place	Provider													
WE	EPUT - Wheelchairs	12	16		23	23		100.00%	100.00%		29	13		August
WE	HCRG / Virgin	418	316		867	965		91.70%	90.36%		26	36		August
WE	**All**	**430**	**332**		**890**	**988**		**91.91%**	**90.59%**		**29**	**36**		**August**

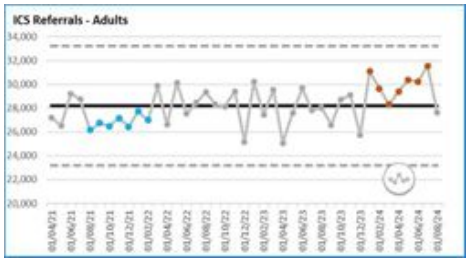
Hertfordshire and West Essex Integrated Care System

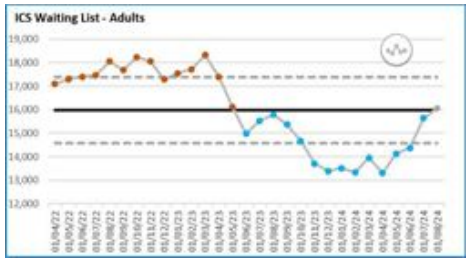
Community Waiting Times (Children)

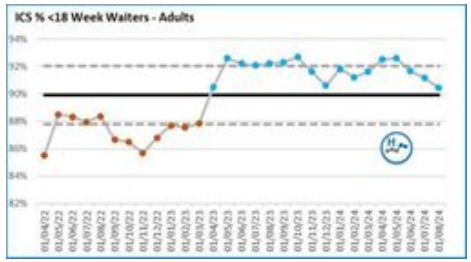
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18-week target for an overall view of waiting time performance.

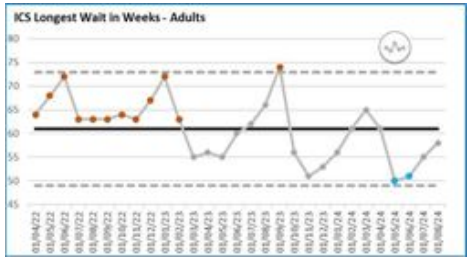
ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall referrals to all services continue to fluctuate within expected common cause variation limits • The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 has fallen for the last 3 months and is now at 40%, compared to the national average of 54% • The longest waits are within the ENHT Community Paediatrics Service at 136 weeks. There are also long waits of up to 79 weeks within HCT services in South & West Hertfordshire • Consultant led 18-week RTT performance: SWH Community Paediatrics – 47.4% SWH Children's Audiology – 46.3% ENH Community Paediatrics – 15.8% WE Community Paediatrics – 95.0%	**Hertfordshire** • Most HCT children's specialist services are seeing a marked increase in demand • Waiting times in the SWH HCT Community Paediatrics service are improving, with a decreasing number of long waiters and an improvement trend since August 2023 • There are continued waiting time pressures in Paediatric Audiology in SWH, but there has been improvement with a 26% decrease in total waiters since a high point in June 2023. 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)** • Referrals to CYP services fell slightly in some services over the summer months. This follows the annual profile with family holidays and school closures • Most services at or slightly below plan for activity levels due to staff leave	Joint system review of community waits for children and young people to be undertaken with the aim to reduce overall waiting times and backlogs, mitigate further growth and support patients well. **Hertfordshire** • For HCT services the number of over 52-week waits has reduced from 494 in September 2023, to 94 in September 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 • Waiting list initiatives in place for some services to achieve no 65+ week waiters each month • Community Paediatrics in SWH is receiving non-recurrent additional investment to increase workforce capacity and introduce new specialist nursing posts. Service working at fully established WTE • 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, now being rolled out to other localities • EHCP dashboard developed to improve waiting list management **Community Paediatrics ENHT** • Referrals have increased by 30% since FY1920 but activity has only increased by 17% (28% increase in follow-up activity but a 15% decrease in new activity) • Ongoing recruitment attempts have been unsuccessful and there is little appetite for waiting list initiatives in the service • Development of a single model of care for neurodiversity in Hertfordshire is progressing. Proposed service will include a single point of referral for all ADHD / ASD referrals in Hertfordshire and make full use of the MDT for pathways that don't need to be Consultant led **West Essex (WE)** • Focus on caseload cleanse for a number of services over the quieter summer period • Considering a PIFU approach in Dietetics. Vacancy remains • Awaiting release of identified CYP funds from the ICB • Preparation for recommissioning of HCRG contract ongoing

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	31541	27662	↓	15642	16057	↑	91.16%	90.43%	↓	55	58	↑	August
Place	Provider													
ENH	HCT	9657	7559	↓	8573	9169	↑	91.19%	90.97%	↓	55	58	↑	August
ENH	AJM/Millbrook	156	112	↓	637	633	↓	67.03%	63.98%	↓	50	54	↑	August
ENH	**All**	**9813**	**7671**	↓	**9210**	**9802**	↑	**89.52%**	**89.23%**	↓	**55**	**58**	↑	**August**
Place	Provider													
SWH	CLCH	7512	6870	↓	1604	1833	↑	99.69%	98.96%	↓	19	23	↑	August
SWH	Circle	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	August
SWH	HCT	907	857	↓	1106	1102	↓	83.45%	83.12%	↓	53	55	↑	August
SWH	AJM/Millbrook	139	125	↓	729	716	↓	69.00%	61.59%	↓	55	58	↑	August
SWH	**All**	**8558**	**7852**	↓	**3439**	**3651**	↑	**87.96%**	**86.85%**	↓	**55**	**58**	↑	**August**
Place	Provider													
WE	EPUT	13058	12028	↓	2873	2469	↓	99.90%	100.00%	↑	27	18	↓	August
WE	EPUT - Wheelchairs	112	111	↓	120	135	↑	100.00%	99.26%	↓	24	19	↓	August
WE	**All**	**13170**	**12139**	↓	**2993**	**2604**	↓	**99.90%**	**99.96%**	↑	**27**	**19**	↓	**August**

NOTE: Circle Health MSK data is currently unavailable following reprocurement of the service. Historic Connect data has been removed for consistency.

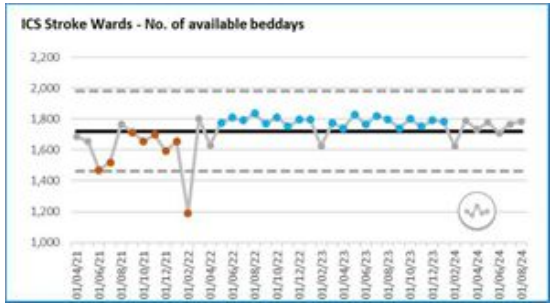
Hertfordshire and West Essex Integrated Care System

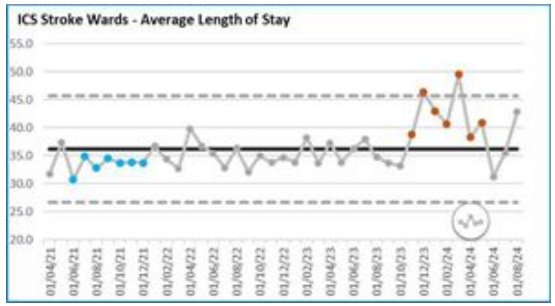
Community Waiting Times (Adults)

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.

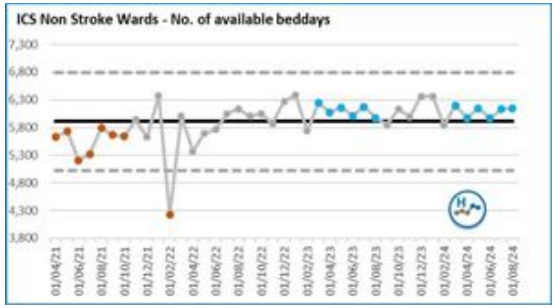
ICB Area	What the charts tell us	Issues	Actions
ICB	• **SWH MSK data excluded from reporting following DQ issues in April data after award of new contract to Circle** • Overall referrals are within common cause variation limits, but have been above the historic average throughout 2024 to date • The % of patients waiting less than 18 weeks has fallen for the last 3 months, but remains comparatively strong at 90.4%, compared to the national average of c.84% • Overall waiting lists are within common cause variation limits, but have increased for the last 4 months driven by high referrals and transfer of iMSK patients to EPUT in WE • Longest waits are within HCT services in East & North Hertfordshire • Consultant led 18-week RTT performance: ENH Skin Health – 90.8% SWH Respiratory – 98.9% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Referrals have increased compared to 2022/23 • Slight reduction in the 'waiting within target' performance in recent months when compared to the pre-pandemic baseline **South & West Hertfordshire (SWH)** • MSK services previously delivered by Connect have been reprocured with Circle. Work continues to resolve a number of data quality issues before incorporation into this report • Slight decrease in referrals at CLCH • CLCH longest waiter has increased from 19 to 23 weeks • Total number of patients waiting has increased **West Essex (WE)** • SLT maximum wait time has increased to 13 weeks due to vacancy and non-availability of bank/agency • Podiatry maximum wait time has increased to 12 weeks, again due to staffing gap • MSK breaches and increased PTL following transfer of iMSK patients from Stellar Healthcare on contract termination	**East & North Hertfordshire (ENH)** • All waits are closely monitored and subject to robust internal governance • Service productivity initiatives continue • 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 and analysis has allowed the Trust to compare waiting times and DNA rates for those living in relative deprivation versus those that do not. 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 • External provider support will be coming to an end over the next few weeks. Services working on plans to ensure waiting times positions are maintained • Divisional weekly waiting times group remains in place which also feeds into Trust group • Division specific recruitment day held in Hemel in October • Trajectories now in place for all services of concern. These are reviewed and monitored weekly **West Essex (WE)** • Successful recruitment to SLT vacancy. Position will improve over October / November. High risk patients being prioritised • Podiatry locum support secured – commenced November • iMSK recovery plan agreed with full recovery expected by March 25. Trajectory TBC

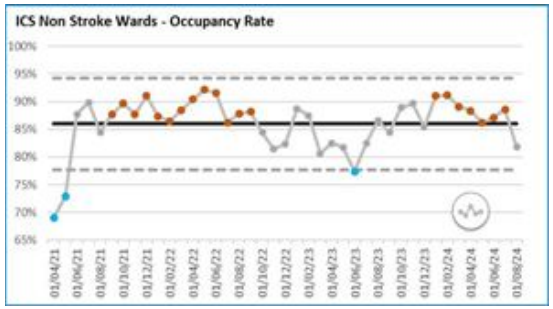
Community Beds (Stroke & Non-Stroke)

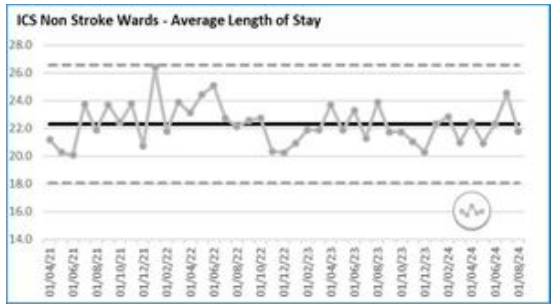




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	744	744	⇨	87.23%	70.30%	↓	35.6	33.4	↓	August
SWH	CLCH	589	606	↑	98.47%	98.51%	↑	27.0	51.0	↑	August
WE	EPUT	434	434	⇨	85.48%	81.11%	↓	48.6	43.0	↓	August
ICS	**All**	**1767**	**1784**	↑	**90.55%**	**82.51%**	↓	**35.5**	**42.8**	↑	**August**







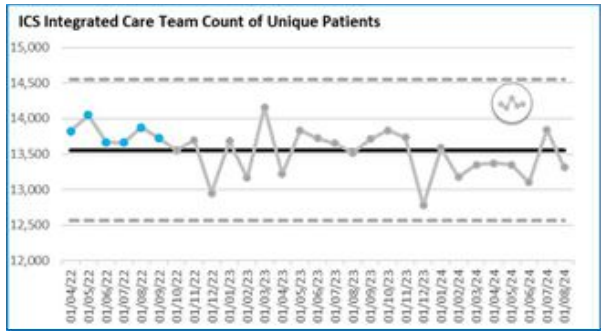
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1643	1643	⇨	84.36%	71.70%	↓	24.7	21.9	↓	August
SWH	CLCH	2224	2241	↑	92.54%	91.74%	↓	26.0	23.5	↓	August
WE	EPUT	2263	2263	⇨	87.85%	79.28%	↓	22.9	19.6	↓	August
ICS	**All**	**6130**	**6147**	↑	**88.61%**	**81.80%**	↓	**24.5**	**21.8**	↓	**August**

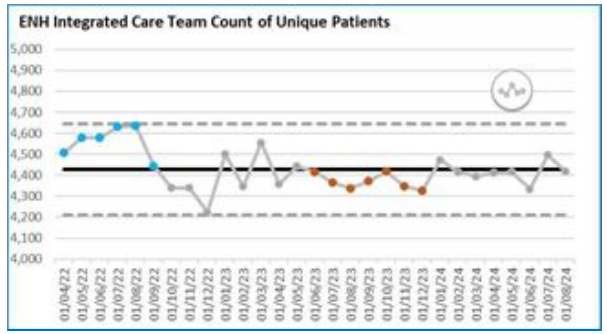
Community Beds (Stroke & Non-Stroke)

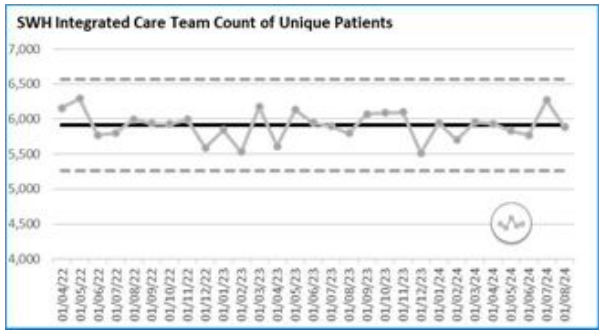
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds Days** • Available stroke bed days remain stable • Overall stroke bed occupancy rates significantly reduced during July and August, most notably at HCT (70.3%) • CLCH occupancy remains very high at 98.5% • Overall length of stay is within common cause variation limits, but has been largely above the historic average during 2024 • Length of stay at CLCH was significantly up in August (51 days) **Non-Stroke Beds Days** • Available non-stroke bed days remain consistent at c.6,100 per month • Overall occupancy rates reduced across the system and in each place in August, most notably at HCT (71.7%) and EPUT (79.33%) • Overall length of stay remains within common cause variation limits	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 94% over the past 12 months. Herts & Essex and QVM have an average occupancy of 81% and 83% respectively • Average length of stay over the past 12 months for Herts & Essex averaged 25 days, and 28 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 19, and Herts & Essex averaging 32 **South & West Hertfordshire (SWH)** • Continued high occupancy rates across stroke beds due to supporting system flow and admitting higher acuity patients • However slight reduction in non-stroke bed occupancy • Average length of stay increased in August for stroke beds, but reduced in non-stroke beds **West Essex (WE)** • Length of stay on stroke ward continues to be impacted by a complex patient. Extension to stay has been agreed with ICB commissioners • Non-stroke bed occupancy remains low	**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 • Review of Transfer of Care HUB with system partners currently underway • In partnership with social care colleagues, currently reviewing escalation plan **West Essex (WE)** • Daily escalation calls in place to support all delayed discharges • West Essex HCP + Essex County Council plan to use bed capacity to support Discharge to Assess (D2A) patients from November 2024

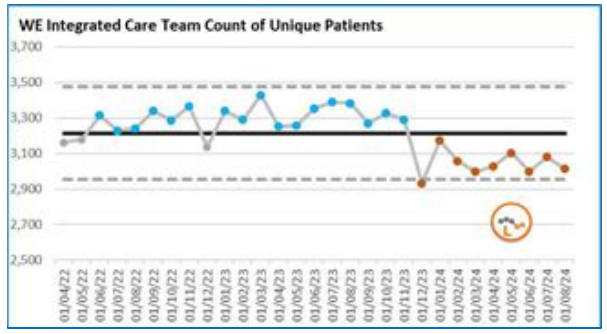
Hertfordshire and West Essex Integrated Care System

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	4497	4418		7.1	7.0		August
SWH	CLCH	All	6268	5884		9.1	8.5		August
WE	EPUT	All	3081	3014		9.2	9.0		August
ICS	**All**	**All**	**13846**	**13316**		**8.4**	**8.0**		**August**

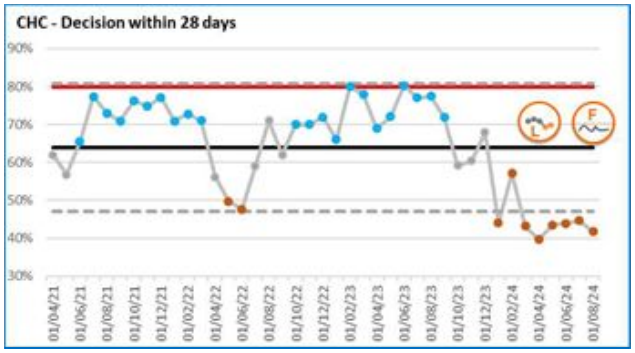
Hertfordshire and West Essex Integrated Care System

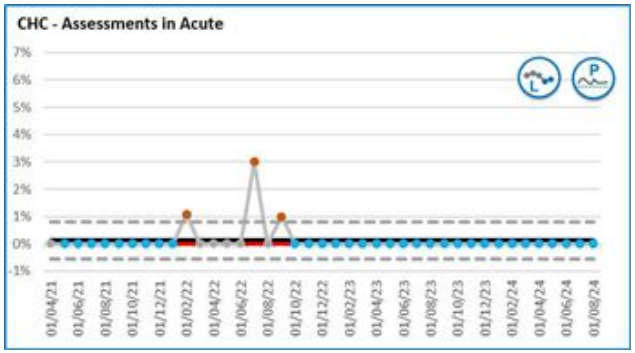
Integrated Care Teams (ICT)

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 have trended below the historic mean for the last 9 months	**East & North Hertfordshire (ENH)** • The number of individuals rereferred to the ICT is similar to pre-pandemic • Contacts per month are lower than pre-pandemic (linked to increasing complexity) and there is an increase in the first-to-follow-up appointment ratio • The net effect of these factors is that the overall caseload is much higher than in 2019/20 across all localities • Patient complexity is increasing, with more intensive treatments required. e.g., numbers of intravenous antibiotics (IV) and End of Life (EOL) patients • 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, suggesting an increase in acuity of patients receiving care in the community	• Care Closer to Home programme 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 • A comprehensive transformation programme in place focused on workforce, wound care and diabetes management with the ICT • SystmOne optimisation project underway aiming to streamline use of clinical systems with a prospective productivity gain. Some promising initial progress in relation to revised design • The Hospital at Home service appears to be effectively supressing Acute demand **West Essex (WE)** • Work progressing to support development of Integrated Neighbourhood Teams of which the ICTs are integral, alongside socialisation of the new HWE care closer to home model of care. Proactive care model for segments 4 & 5 to support reduction on NELs by 25%

Hertfordshire and West Essex Integrated Care System

Continuing Health Care (CHC)



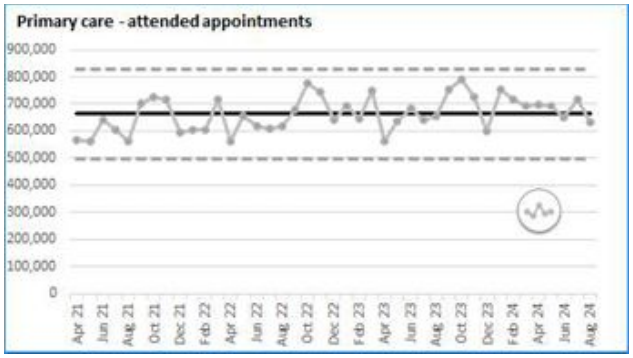


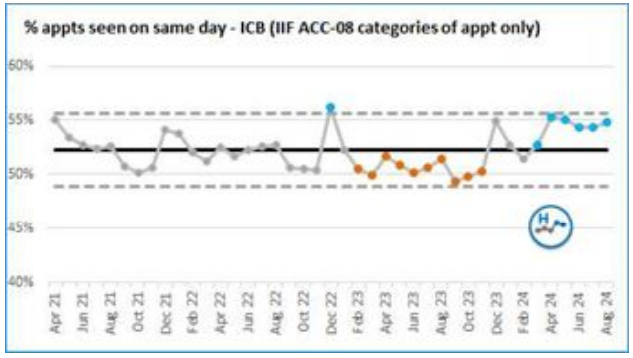
	What the charts tell us	Issues	Actions

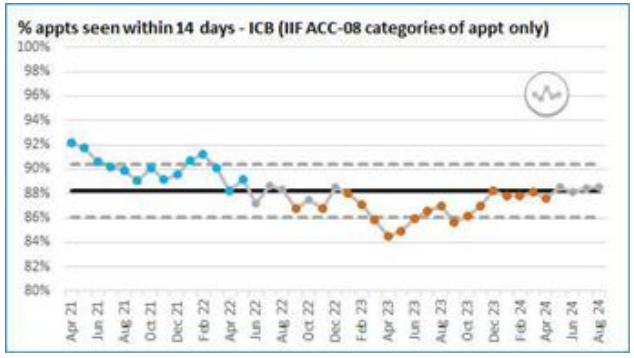
HWEICB	• The 28-day standard continues to present a significant challenge, most notably in South & West Hertfordshire
	• Performance is trending below the historic mean, however ICB projections for the quarter have been met (>=40% to 49.9%)
	• August overall performance is slightly worse compared to July as below, with further slippage in ENH and SWH:
	  ○ Overall ICB – 42%
	  ○ West Essex – 67%
	  ○ ENH – 64%
	  ○ SWH – 24%
	• 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
		• ENH 28-day performance is 7% worse in Aug vs. July, and SWH performance is 4% worse in Aug vs. Jul. Key issue is delays in allocation of social workers from HCC due to resource challenges, as well as workforce issues around sickness and leave across the service
			• 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 is being implemented moving forwards
			• More robust Induction and training packs being developed for new starters to ensure they can become as involved with day-to-day operations as quickly as possible

Hertfordshire and West Essex Integrated Care System

Primary Care







NOTE: %s in the above charts are based on appointments made, not requests received

What the charts tell us

- GP appointments attended each month remain within expected common cause variation limits. However, there are indications of an overall growing trend in attendances, with only 3 of the last 12 months being below the mean line
- The % of appointments seen on the same day of booking has been above the long-term mean for the last six months, suggesting that there has been a sustained improvement in the % of appointments seen on the same day. 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 (IIF ACC-08 categories of appointment)
- The % of appointments which were seen within 14 days of booking has been consistently below the mean since Jan-23. 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 (IIF ACC-08 categories of appointment)

Hertfordshire and West Essex Integrated Care System

Primary Care

ICB Area	Issues	Actions
ICB	• National contract for 24/25 imposed without agreement from and Collective Action in Primary Care added to the risk register • General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • 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** • Logging local intelligence on practices taking part in collective action and ongoing work with HETCG and liaison with LMC to identify and mitigate any issues arising • Annual GP Patient Survey (GPPS) now published (data collected Jan –Mar 24). Overall slight improvement and PCCC and Primary Care Board oversight of results. Action plan developed through the Access MDT Group. BI and primary care teams looking at data which will be presented at Primary Care Transformation Committee and STQIC. Triangulation with other data held does not show any strong correlation e.g. number of appointments, digital telephony etc. • GPPS 2024 Dental Access results shows HWE as best performing in East of England • 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 • 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 • National GP Improvement Programme - 30 practices & 4 PCNs participated in this nationally supported facilitated programme • 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 • Many practices are now actively moving towards full enablement of prospective records access; almost 700k patients across HWE have access to their records; 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 • Communications 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 • Local CAIP - 21 of 25 PCNs have submitted their self-declaration based on the PCN's progress in implementing the Modern General Practice Access (MGPA) model and specifically in delivering against three priority domains. Specifically, these are Better Digital Telephony – 21 PCNs; Simpler Online Requests – 16 PCNs; Faster Care Navigation, Assessment and Response – 19 PCNs. PCNs can submit their self-declaration up to 31 March 25 • Transition Cover – 108 practices supported with further funding to implement modern general practice **Other** • Funding for Additional Capacity via PCNs over Winter agreed locally as no National funding this year – action to review PCN plans against 2 agreed priorities - Prevention (frailty, LTC, EOL) or Same day access – submissions by 18/10/24 • 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 • 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. 24/25 Operational Plans – Month 5

Area	Description	Year To Date				Performance	Latest Data
		Plan	Actual	Variance to Plan	Variance to Plan %		
Planned Care	Elective day case spells	64,534	66,314	1,780	2.8%	↑	Aug-24
	Elective ordinary spells	5,754	5,966	212	3.7%	↑	Aug-24
	Outpatient procedures	114,619	127,719	13,100	11.4%	↑	Aug-24
	Percentage outpatients follow-up without a procedure	49.5%	47.6%	-1.9%		↓	Aug-24
	Total outpatient attendances	669,701	703,366	33,665	5.0%	↑	Aug-24
	Incomplete (RTT) pathways 65 weeks+	145	801	656	452.4%	↑	Aug-24
	The number of incomplete Referral to Treatment (RTT) pathways	140,779	142,736	1,957	1.4%	↑	Aug-24
	Diagnostic test waiting list over 6 weeks - All Planning Modalities	8,100	17,870	9,770	120.6%	↑	Aug-24
Cancer	Percentage patients seen within 62 days	76.3%	72.7%	-3.6%		↓	Aug-24
	Percentage cancer 28 day waits (faster diagnosis standard)	73.9%	78.9%	5.1%		↑	Aug-24
UEC	Type 1, 2, 3 A&E attendances	213,515	218,258	4,743	2.2%	↑	Aug-24
	Percentage Type 1, 2, 3 A&E attendances < 4 hours	75.0%	72.7%	-2.4%		↓	Aug-24
	Non-elective spells - 0 days length of stay	13,818	19,801	5,983	43.3%	↑	Aug-24
	Non-elective spells - 1+ days length of stay	35,256	35,553	297	0.8%	↑	Aug-24
Primary Care	Percentage of appointments seen within two weeks	89.2%	88.2%	-0.9%		↓	Aug-24

Key	
↑	Value is above plan
↓	Value is below plan
	Variation of a positive nature
	Variation of a negative nature

Mental Health Performance v. 24/25 Operational Plans – Month 5

MONTHLY METRICS

Area	Description	Latest month		Year To Date				Performance	Latest Data
		Plan	Actual	Plan	Actual	Variance to Plan	Variance to Plan %		
OAPs	Active inappropriate adult acute mental health OAPs	8	35	53	176	123	**232.1%**	↑	Aug-24
Talking Therapies	Percentage of patients that achieved reliable recovery	48.5%	52.0%	48.5%	51.6%	**3.1%**		↑	Aug-24
	Percentage of patients that achieved reliable improvement	67.1%	63.7%	67.1%	63.1%	**-4.0%**		↓	Aug-24
Dementia	Estimated prevalence of dementia based on GP registered populations	65.1%	64.7%	64.7%	64.7%	**0.0%**		↓	Aug-24
CYP	Number of CYP supported through NHS funded mental health services receiving at least one contact	19,057	10,735	93,376	55,345	-38,031	**-40.7%**	↓	Aug-24

QUARTERLY METRICS

Area	Description	Latest month		Year To Date				Performance	Latest Data
		Plan	Actual	Plan	Actual	Variance to Plan	Variance to Plan %		
Learning Dissability	% of AHCs carried out for 14+ year olds on the QOF Learning Disability Register	18.8%	23.7%	18.8%	23.7%	**4.9%**		↑	Q1
	Learning Disability Inpatient Rate per Million ONS Resident Population	29.01	-	29.01	-	-		-	Q1
	Learning Disability Inpatient Rate per Million ONS Resident Population	15.09	-	15.09	-	-		-	Q1
SMI	Percentage of people with severe mental illness receiving a full annual physical health check	48.7%	46.8%	48.7%	46.8%	**-1.9%**		↓	Q1

Key	
↑	Value is above plan
↓	Value is below plan
	Variation of a positive nature
	Variation of a negative nature

Appendix A: Performance Benchmarking

August 2024		Hertfordshire and West Essex ICB					
Area	Activity	Latest published data	Data published	Trend *1	NATIONAL position National vs (ICB)	REGIONAL position EoE Region vs (ICB)	ICB Ranking
111	Proportion of calls answered < 60 secs	92.4%	September 24	✗ -1.38%	85.42% (Better)	87.84% (Better)	6
	Proportion of calls abandoned	1.6%	September 24	✗ 21.70%	2.33% (Better)	2.10% (Better)	5
A&E	% Seen within 4 hours	75.6%	September 24	✗ -1.279%	74.22% (Better)	73.07% (Better)	11
	12 Hour Breaches	138	September 24	✗ 13.04%	38,880 (0.35%)	2,702 (5.1%)	5
Cancer	28 days Faster Diagnosis	78.2%	August 24	✗ -0.84%	75.55% (Better)	73.27% (Better)	11
	31 days	91.7%	August 24	✗ -2.23%	91.67% (Better)	88.72% (Better)	24
	62 days	71.2%	August 24	✓ 3.56%	69.16% (Better)	66.06% (Better)	15
RTT	Incomplete Pathways <18 weeks	56.7%	August 24	✗ -0.97%	58.27% (Worse)	54.40% (Better)	30
	52+ weeks as % of total PTL	3.77%	August 24	✓ -7.62%	3.70% (Worse)	4.99% (Better)	25
	65+ weeks as % of total PTL	0.58%	August 24	✓ -24.87%	0.60% (Better)	0.92% (Better)	25
	78+ weeks as % of total PTL	0.03%	August 24	✗ 80.28%	0.04% (Better)	0.07% (Better)	24
Diagnostics	6 week wait	39.0%	August 24	✗ 7.50%	23.93% (Worse)	35.44% (Worse)	40
Mental Health	Dementia Diagnosis rate	64.8%	September 24	✓ 0.15%	65.5% (Worse)	64% (Better)	23
	OOA placements	35	August 24	✗ -17.14%	n/a	n/a	n/a
CHC	% of eligibility decisions made within 28 days	41.7%	August 24	✗ -7.04%	72.49% (Worse, at 55.21%) *2	68.56% (Worse, at 55.21%) *2	36
	% of assessments carried out in acute	0.0%	August 24	= 0.00%	0.34% (Worse, at 0.66%) *2	0.19% (Worse, at 0.66%) *2	34

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

*1 Trend against last month's performance.

*2 **Benchmarking and ranking for CHC** is based on quarterly data only. The latest data is for Q1 for 2024/25 (covering Apr - Jun 2024).

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	Audit and Risk Committee 20 November 2024 highlight report			**Meeting Date**	15 January 2025
Chair	Karen McConnell – Committee Chair and Deputy Trust Chair				
Author	Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Internal Audit Plan and Strategy
- Internal Audit recommendation tracker
- Local Counter Fraud Specialist Progress report
- Risk Oversight Report/KPIs
- Board Assurance Framework
- Data quality and clinical coding report
- Digital Submission – Cyber Security update
- Anti-Fraud and Bribery policy
- The Handling of Claims policy
- Governance of Quality Governance
- Audit and Risk Committee effectiveness.

Alert:

- Data security and protection toolkit (DSPT) had changed to cyber assessment framework (CAF). CAF is a national approach to risk, but guidance has not yet been issued so the work required could not be completed.
- Delays in responding to Freedom of Information (FOI) requests were discussed. Steps to be taken to improve performance including the appointment of a FOI/Information Governance Administrator from November 2024.

Advise:

- The Committee discussed the BAF and noted that an Internal Audit of the risk management and assurance framework was due to commence in January 2025.
- On emerging risks the Audit Committee noted that the Executive planned to provide oversight with divisions identifying mitigations and actions. Deep dives are to be undertaken to help improve processes.
- The Committee noted progress on the development of a framework for the Governance of Quality using the published Quality Governance Standards Framework. An initial pilot had been conducted with the Cancer Services Division. The learning from this process is to be used to inform the approach with an annual workplan across all 4 divisions.
- The Director of Quality will consider actions to help mitigate and respond to any data breaches with the Caldicott guardian.

Assurance:

- The Committee approved the Internal Audit Plan and Strategy. The Committee noted the improvement in performance on Internal Audit open actions as none were now overdue. The need to sustain this improved performance was noted.
- The Committee noted the Local Counter Fraud Specialist (LCFS) progress report. Work was on track.

• Good progress was being made on the declarations of interest with the full range of decisions makers as the Trust was currently 88% compliant. Plans are in place to ensure outstanding declarations are received. • The Committee approved the Handling of Claims Policy subject to some minor amendments. • The Committee approved the Anti-Fraud and Bribery policy.
Important items to come back to committee (items committee keeping an eye on):
• The governance framework and timetable for planned changes across the ICS impacting the Trust and with the introduction of an Acute provider collaborative be brought back to the meeting by April 2025.
Items referred to the Board or a committee for a decision/action:
• The People and Culture Committee to monitor outcomes on the implementation of agreed management actions from the Doctor's Rostering Audit and update the Audit Committee on progress over the next six months.

Recommendation	The Board is asked to **NOTE** the Audit and Risk Committee report.

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	17
Report title	Finance Performance and Planning Committee – Highlight October report 2024	**Meeting Date**	15 January 2025
Chair	Richard Oosterom - Committee Chair and Non-Executive Director		
Author	Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Clinical Productivity Improvement Workstream- Update and Delivery Plan
- Finance Position Month 6
- CIP
- Outturn Forecast/including system position
- MFFP & 25/26 plan negotiations
- PWC- Review of system financial improvement
- Winter Preparedness
- Productivity and ERF report
- Performance report
- IT/Digital update
- Board Assurance Framework

Alert:

- The Trust's half-year deficit was £1.3 million. Industrial action and a shortage of funds to offset lost income and activity were highlighted as key drivers of the reported deficit. However, the Trust also had to allocate non recurrent reserves funding to cover a range of unplanned pay and non-pay impacts. In addition, the pace of ERF delivery has remained a concern.
- The committee discussed financial performance across the ICS, and the steps that the Trust is taking to support achievement of the 24/25 financial plan. There was considerable around the scale of non-recurrent resources that have been utilised this year and the need to significantly improve divisional exit run rates.
- The Committee noted that M7 UEC performance had shown slight improvement compared to previous months, however, it was advised that for November the Trust had not been able to keep that position.

Advise:
• The Clinical Productivity report provided an update in respect of additional tactical in year savings that had been identified. • It was acknowledged that a number of opportunities identified in the recent PWC system review have already commenced. • A recent GIRFT review had taken place in the Emergency Department and finding and observations were presented to the Committee. • It was noted that demand and capacity modelling within the audiology service had commenced with the validation process nearly completed.
Assurance:
- Stroke had maintained their category B position.

Important Items to come back to committee:	
Items referred to the Board or a Committee for decision or action:	-

Recommendation	N/A

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	17a
Report title	Finance Performance and Planning Committee – Highlight November and December report 2024	**Meeting Date**	15 January 2025
Chair	Richard Oosterom - Committee Chair and Non-Executive Director		
Author	Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

November:

- Performance Report
- IT/Digital update
- Acute Provider Collaborative Update
- Consultant Job Planning
- Finance Position Month 7
- Capital Plan update
- Productivity and ERF Report
- CIP
- Outturn Forecast/ Review Financial Recovery Programmes
- Procurement Delivery Update
- Committee Effectiveness Review

December:

- Performance Report
- IT/Digital Update
- UEC Post Project Evaluation Work
- T&O Deep dive and Plan
- Finance Position month 8
- Productivity and ERF report
- CIP
- Outturn Forecast/ Review Financial Recovery Programmes
- Inventory Management Business Case
- Board Assurance Framework
-

Alert:

November :

- Due to the decline UEC performance, a back-to-basics strategy was deployed across emergency department with the goal of better communicating the new

delivery, pathway and governance structures. Workshops had been arranged to assist staff with the changes at UEC.
- Cultural concerns had been conveyed regarding relationships within UEC teams, and it was stated that doctors, nurses, and operational managers in the ED were not always working closely together.

December:

- In relation to RTT performance the Trust was forecasting 30 to 40 65-week breaches for December within T&O gastro and oral, however, it was highlighted that there had been a number of patient choice cancellations.
- Maternity costs remained a concern with significant bank and temporary staffing usage within the department.

Advise:

November:

- At M7 there was YTD a £0.3m actual surplus with the Trust being £0.7m adverse to plan. Industrial action and a shortage of funds to offset lost income and activity were highlighted as key drivers of the reported deficit. However, the Trust also had to allocate non recurrent reserves funding to cover a range of unplanned pay and non-pay impacts. In addition, the pace of ERF delivery has remained a concern.
- It was noted that M7 actual financial performance was at variance from expected recovery action plans, however it was acknowledged that ERF activity delivery levels had improved. In addition, the additional focus on exit run rates was encouraging.
- It was reported that the YTD capital expenditure was £7.16m against a plan of £12.63m

December:

- A formal mutual aid request had been submitted in relation to Paediatric audiology to the ICB and the Trust now awaited a response.

Assurance:

November:

- Stroke had maintained their category B position.
- T&O activity went up significantly in October and that the average cases per list had improved from 1.7 to 1.9.
- Paediatrics, breast surgery and diagnostics were reporting a positive improvement. It was also reported that non elective & ED activity had increased.
-

December:

- Ambulance handovers, ED-related harm, UTC performance, and time spent in the department, had seen positive developments.
- The GIRFT Emergency Medicine Indicator ranking, which incorporates Type 1 four-hour performance, ambulance handover, and 12-hour wait times, significantly improved.

Important Items to come back to committee:	
Items referred to the Board or a Committee for decision or action:	- Exit Run rates.

Recommendation	N/A

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	Quality and Safety Committee 18 December 2024 - highlight report			**Meeting Date**	15 January 2025
Chair	Dr David Buckle - Committee Chair and Non-Executive Director				
Author	Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Safe, Care, Effective update
- Renal PSII
- Maternity Assurance
- Quarter 2 - Patient Experience report
- Learning from death
- Incident and Complaints Triangulation report
- Integrated compliance report- incident, compliance and risk report
- Litigation Annual report (note the annual clinical negligence claims against NHS Trust (CNST) is now £21m)
- Board Assurance Framework
- Safeguarding Adults and Children Annual report
- Health Inequality update.

Alert:

- The renal PSII report and the Trust response is to be summarised and presented at the next public Board meeting by the Medical Director. The Committee wanted the full Board to be clear about the causes, consequences and changes which the report described.
- Duty of candour targets are not being met. Compliance stage 1 is 45% and stage 2 is 12%. (Rolling 12-month figure) QSC accepts the poor figures are mainly due to documentation but cannot be assured until this is resolved.

Advise:

- All Non-Executive Directors to be sent the Renal PSII report.

Assurance:

- The Committee continues to monitor the Trust response to sepsis. The Sepsis six standards are not being fully met and yet a range of actions have been previously discussed. The work would continue whilst we only had partial assurance.
- Our PALs service continues to receive a high level of requests and consequently the service is considered to be fragile. Further assurance was requested by the committee.

Important items to come back to committee (items committee keeping an eye on):

- Board Assurance Framework (BAF) alongside the corporate risk register.
- The Annual cycle is being reviewed in depth now there are nine meetings a year rather than 11.
- The Committee is also reviewing the considerable volume of information it receives. The aim is to improve the assurance and the analysis' it provides to the Board. To deliver this the committee is debating what it needs in order to adequately inform its members, yet not obscure the key issues with a volume of data that is hard to assess.

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• The non-executives see excellent examples of good papers which can be used to improve the quality of all cover sheets and executive summaries.	
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.

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	20
Report title	Charity Trustee Committee – Highlight report December 2024	**Meeting Date**	15 January 2025
Chair	Dr David Buckle – Committee Chair and Non-Executive Director		
Author	Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Meeting preparation for 2025
- Major Projects update
- Charity Finance Report
- 23/24 Charity Accounts
- Investment Portfolio Rathbones
- Approvals in Excess of £5000
- Charity Highlight Report
- Committee Effectiveness

Alert:

- The sunshine appeal (ITU patient terrace) is delayed. In early 2024 regulatory fire safety rules were introduced as a consequence of the Grenfell Tower fire disaster. It is understood that our plans for a patient open air terrace fall within the scope of these new regulations. We expect to know soon if any mitigation is required so that we can then proceed.

Advise:

- Total income at the end of October 2024 (730k) was £10k below budget. Expenditure at the end of the period (£846k) was below budget by £405k. This resulted in a deficit of £16k against a budgeted deficit of £511k.

- Fundraising income (£612k) was £52k ahead of budget.

- The following requests for funding were agreed: -

Unplanned	Speciality walking hoist with treadmill and gait analysis for stroke rehabilitation	£36,500	Donating of £25k plus gift aid received, shortfall met from charity general funds or funds left over from stroke kitchen project.	Unplanned
Cancer	Funding to buy abdominal compression belts for stereotactic body radiotherapy (SABR)	£10,731	Chirag Lakhani	Funding Secured
Cancer	Funding was requested to extend the fixed term contracts of 2x 0.4 WTE complementary therapists , (band 5) current fixed term contracts end in March and June 2025 funding was requested to extend the contract of existing staff from those dates for 6 months (reduced from 12)	£20,700	Gennie Abubakar	LIMC or MVCC general funds.
Cancer services	14 treatment chairs for patients having SACT in the Mount Vernon Cancer Treatment Suite	£32,928	Dean Weston	To fundraise for one by one.
Cancer Services	Patients furniture in JBS	£6,892	Michael Glynn	Charity funding via comfort funds

Assurance:

-

Important Items to come back to committee:	N/A
Items referred to the Board or a Committee for decision or action:	N/A

Recommendation	The Board is asked to **NOTE** the Charity Trustee Committee report.

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Board Annual Cycle 2024-25

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	Jan 2025	Feb 2025	Mar 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Standing Items															
Chief Executive's Report	X		X		**X**		**X**		**X**		**X**		**X**		**X**
Integrated Performance Report	X		X		**X**		**X**		**X**		**X**		**X**		**X**
Board Assurance Framework							**X**		**X**		**X**		**X**		**X**
Corporate Risk Register			X				**X**				**X**				**X**
Patient/Staff Story (Part 1 where possible)	X		X		**X**		**X**		**X**		**X**		**X**		**X**
Employee relations (Part 2)	X		X		**X**		**X**		**X**		**X**		**X**		**X**
Board Committee Summary Reports															
Audit Committee Report	X		**X**		**X**		**X**		**X**		**X**		**X**		**X**
Charity Trustee Committee Report	X		X		**X**		**X**		**X**		**X**		**X**		**X**
Finance, Performance and Planning Committee Report	X		X		**X**		**X**		**X**		**X**		**X**		**X**
Quality and Safety Committee Report	X		X		**X**		**X**		**X**		**X**		**X**		**X**
People Committee	X		X		**X**		**X**		**X**		**X**		**X**		**X**
Strategic reports															
Planning guidance	X												**X**		
EPR implementation to Lorenzo			**X**												X
Smoke free sites			**X**												
Trust Strategy refresh and annual objectives			X												**X**

Board Annual Cycle 2024-25

Items	Jan 2025	Feb 2025	Mar 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Strategy delivery report	X						X						X		
Strategic transformation & digital update			X				X				X				
Integrated Business Plan											X				
Annual budget/financial plan			X												
System Working & Provider Collaboration (ICS and HCP) Updates	X		X		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)	X												X		
Estates and Green Plan															
Workforce Race Equality Standard	X												X		
Workforce Disability Equality Standard	X												X		
People Strategy	X												X		
Enabling Strategies															
Estates and Facilities Strategy											X				
Green Strategy											X				
Quality Strategy			X												X
Clinical Strategy (Autumn 2025)															
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 2024-25

Items	Jan 2025	Feb 2025	Mar 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
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															
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										
Learning from Deaths	X				X		X				X		X		
Nursing Establishment Review	X										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															
Trust Values refresh							X								

Board Annual Cycle 2024-25

Items	Jan 2025	Feb 2025	Mar 2025	April 2025	May 2025	June 2025	July 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026
Freedom to Speak Up Annual Report							X								
Equality and Diversity Annual Report and WRES									X						
Gender Pay Gap Report					X										
Shareholder / Formal Contracts															
ENH Pharma (Part 2) shareholder report to Board							X								