Public Trust Board

Lister Education Centre, Lister Hospital, Stevenage

01/11/2023 10:30 - 12:30

Agenda Topic	Presenter	Time	Page
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2. Apologies for Absence For noting	Trust Chair		
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7. Staff Story For discussion		10:35-10:50	
8. Chief Executive's Report For discussion	Chief Executive	10:50-11:00	17
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9. Board Assurance Framework For discussion	Head of Corporate Governance	11:00-11:05	19
STRATEGY AND CULTURAL ITEMS			
10. Digital strategy update For noting	Chief Information Officer	11:05-11:15	51
11. Green Plan	Director of Estates and Facilities	11:15-11:25	61

12.	Strategic transformation update	Director of Improvement	11:25-11:30	71

ASSURANCE AND GOVERNANCE ITEMS

13.	Auditors VFM report	Deputy CEO/Director of Finance	11:30-11:35	82

For noting

14.	Learning from Deaths	Medical Director	11:35-11:40	103

For discussion

15.	Management of complaints and concerns policy	Deputy Chief Nurse	11:40-11:45	112

For approval

PERFORMANCE

16.	Integrated Performance Report	All Directors	11:45-12:05	138

For discussion

16.1	Maternity	Director of Midwifery	12:05-12:15	184

For approval

17.	System Performance Report	Chief Finance Officer & Deputy CEO	12:15-12:20	193

For discussion

COMMITTEE REPORTS 12:20-12:25

18.	Audit & Risk Committee Report to Board - 10Oct2023	Chair of Audit & Risk Committee		237

For noting

19.	Finance, Performance and Planning Committee (FPPC) Report to Board - 26Sept2023	Chair of FPPC		238

For noting

20.	Quality and Safety Committee (QSC) Report to Board - 27Sept2023 & 25Oct2023	Chair of QSC		240

For noting

21.	People Committee Report to Board - 12Sept2023	Chair of People Committee		242

For noting

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For noting

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For noting

24.	Any Other Business	Trust Chair

For noting

25.	Date of Next Meeting	Trust Chair

Wednesday, 17 January 2024

East and North Hertfordshire NHS Trust

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday, 6 September 2023 at 10.30am in the Lister Education Training Centre, Lister Hospital, Stevenage

Present:	Mrs Ellen Schroder	Trust Chair
	Mrs Karen McConnell	Deputy Trust Chair and Non-Executive Director
	Dr David Buckle	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Mr Justin Daniels	Medical Director
	Ms Sarah Lucy James	Deputy Director Cancer Services
	Ms Claudia Montgomery	Deputy Director of Estates and Facilities
	Ms Theresa Murphy	Chief Nurse
	Mr Kevin O'Hart	Director of Improvement
	Mr Thomas Pounds	Chief People Officer
	Mr Mark Stanton	Chief Information Officer
From the Trust:	Mr Stuart Dalton	Head of Corporate Governance
	Ms Eilidh Murray	Assistant Director– Communications and Engagement
	Mrs Debbie Okutubo	Deputy Company Secretary (Board Secretary)

No	Item	Action
23/049	**CHAIR'S OPENING REMARKS** The Chair welcomed Ms Nina Janda, Associate Board member as this was her first meeting and Nick Papé who joined the meeting to present the patient story. The Deputy Trust Chair, commented on this being the last board meeting of the Chair, Mrs Ellen Schroder, as she was leaving to join Great Ormond Street Hospital for Children NHS Foundation Trust (GOSH) as their Chair and thanked her on behalf of the board for all her hard work and contribution to date.	
23/050	**APOLOGIES FOR ABSENCE** Apologies were received from: Mr Jonathan Silver, Non-Executive Director Ms Lucy Davies, Chief Operating Officer Mr Kevin Howell, Director of Estates and Facilities.	

23/051 DECLARATIONS OF INTEREST

There were no new declarations of interest made. Ms Nina Janda was encouraged to file her annual returns online.

23/052 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 7 July 2023 were **APPROVED** as an accurate record of the meeting.

23/053 ACTION LOG

The Board **NOTED** the completed action log.

23/054 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

23/055 PATIENT STORY

Ms Sandra Cruickshank, Senior Clinical Nurse Practitioner introduced Mr Nick Papé, a renal patient with ENHT for many years, who was to present the patient story. Members were advised that he was now with the Cambridge University Hospital NHS Foundation Trust as he no longer lived in this catchment area.

Mr Papé thanked the board for having him and thanked the team who had cared for him over the years when he was a patient with the Trust. Mr Papé narrated his diagnosis of kidney disease in his early 30s and his treatment journey over a 10-year period. During Covid, his kidney function failed, and he was put on the transplant list and started the dialysis procedure.

He received the transplant and 400 days after he was able to raise money for charity from a charity run.

During treatment he was on home dialysis which had its advantages; during Covid however, it was a very lonely experience because, like everyone else, people were unable to travel anywhere and needed to shield.

He suggested that for patients who were on home dialysis it was important to attend events, so that patients could have a community to share their experiences with. He further suggested that the Home Therapy Unit should consider investing in a patient friendly (conducive) place where patients can get together.

Mr Papé commented that as a patient liaison officer he receives a number of calls from patients who say they find the current place oppressive.

He made another suggestion that patients should be aware of their treatment patterns which could be in the form of an app that

recorded real time treatment and produced results. When patients attended hospital for either planned or unplanned visits, results were known to all relevant parties including the clinicians and the patients themselves as they would have received them via the app.

There was another suggestion that frequently asked questions (FAQs) could also be uploaded onto the app as this could potentially save time and free up resources. The app can also act as an out of hours clinical help by responding to questions patients might have.

Mr Papé further suggested that accidents do happen, which means that there was the need to be able to get in touch with clinicians when this happened as Accident and Emergency could be a long wait for renal patients and peritonitis could set in.

The Chair thanked Mr Papé and commented that a lot of the ideas worked across the different categories of patients not just those on dialysis. Also, that social intervention was very important as well as having some best practice digitally.

A non-executive director commented that he chaired the hospital charity and would like to speak to Mr Papé outside the meeting to see what improvements they could progress.

It was noted that the National Institute for Health and Care Excellence (NICE) was looking at the evaluation of apps and data sharing in the community. Another non-executive director commented that she chaired the patient experience forum and would like to enact some of the suggestions she had heard.

The Chief Executive stated that the vision of the Trust was that we deliver a good service to patients. He joined the other executive and non-executive directors to thank Mr Papé for doing what he was doing to enable other patients have a good experience.

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

23/056 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

He commented that the Letby trial was a tragedy, and there would be lessons to be learned and once the statutory enquiry

was concluded there will be learning coming out from it.

He commented that he had spent some time in the neo-natal unit and the general feedback was that parents felt their children were safe. Even though in the neonatal ward, it was inevitable that children will die due to their vulnerability.

Following the CQC well led element of the inspection held on 2 and 3 August 2023, the initial feedback had been received and was appended to the Chief Executive's report. In the letter the open culture in the organisation was welcomed.

It was felt that there were strong governance processes in place and that patients with mental illness whilst not always being cared for in the most appropriate place were receiving good care.

It was noted that the draft report was now expected and that there will be the opportunity to comment on it.

People

On the issue of the industrial action, the Chief Executive commented that consultants and junior doctors will have some overlapping strike days. On the strike days the Trust will be providing a 'Christmas day' service. This inevitably meant more delays for patients which was not good. Services, however, needed to remain safe. The Chief Executive thanked staff who had the difficult job of getting in touch with patients to tell them that their planned appointment had been cancelled and needed to be rescheduled.

Another positive area was the recognition of some black and minority ethnic (BAME) staff and nursing staff at award ceremonies.

Seamless service

A new Integrated Heart Failure Service has been developed by colleagues across the East and North Hertfordshire Health and Care Partnership. It was noted that there were currently more than 4,000 people who were registered with heart failure in East and North Hertfordshire; the service would enable patients with heart failure to be monitored and treated closer to home rather than having to come into hospital.

There was the need for alternatives to the emergency department (ED), therefore an urgent treatment centre (UTC) was being created. A same day surgical unit was also being developed.

Continuous improvement

Our new digital patient hub was now live for our Orthotic patients.

This was good use of digital services to give better service to our patients.

Work had started with our improvement partner, the Virginia Mason Institute (VMI) from Seattle and was happening over the over the next three years.

The former CEO of VMI, Dr Gary Kaplan would be visiting us and board members were encouraged to attend some of his sessions.

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

STRATEGY AND CULTURAL ITEMS

23/057 **PEOPLE, COMMITTEE AND CULTURE – Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES)**

The Chief People Officer presented the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) which included a brief analysis of the areas for improvement.

WDES

Members were reminded that the Trust was required to submit the data set using the national format and that it contained 10 metrics. It was noted that staff who declare at appointment and those who declare while employed were both showing positive increases, although declaration rates are still too low. For those that do declare, improvements were required around appointment and career progression.

Also, recruitment and development needed to be more inclusive.

Results in the staff survey shows a deterioration in staff satisfaction linked to bullying and harassment. There has however been an increase in people reporting which is a positive step forward.

Members were advised that there was now an initiative to bring staff who experienced bullying and harassment and the person who was believed to be perpetrating the act together as sometimes the root cause was a lack of insight and or ignorance.

In response to a question, it was noted that on the metrics, Trust wide figures included the consultants, but the model employer did not.

WRES

This showed an increase in our workforce compared to our local

demographics. Career progression amongst BAME staff was also positive as a result of the initiatives the Trust had undertaken.

On the disciplinary front, it was noted that there appeared to be more BAME staff disciplined relative to white staff. Work had started in this area and there was now a panel approach and more informal resolution meetings were being held to try and resolve issues rather than allowing them to escalate.

The Chief People Officer commented that recent initiatives to improve the experience of BAME staff included:

- Actively working on the inclusive strategy, embedding in a sustainable way.
- Having an anti-racism strategy in the eastern region and addressing inequalities.

It was also important to have a representative workforce and to this end, work was ongoing to extend the inclusion ambassador scheme and continue working closely with the staff networks.

It was noted that the reverse mentoring programme was also focusing on race and disability.

Members commented that as numbers of respondents grew the metrics would have more meaning.

Members were advised that alongside the actions which would continue into 2024/25 and the priorities within the NHS equality, diversity and inclusion plan, the Trust was planning to develop a single document to track, monitor, evaluate and bring together all the various inclusion actions to enable the delivery of an inclusive place to work for all.

The Board **RECEIVED** and **NOTED** the WDES and **APPROVED** the WRES.

ASSURANCE AND GOVERNANCE ITEMS

23/058 CORPORATE RISK REGISTER (CRR)

The Director of Quality and the Associate Director of Quality Governance presented this item.

There are 14 open and validated risks on the CRR and they are aligned to the Trust's strategic objectives. Work is ongoing to effectively align operational risks held on the register to the Board Assurance Framework (BAF).

The CRR was presented to the Audit and Risk committee in July 2023 following a review of all risks held by the divisions. An

updated version was presented to the Trust Management Group (TMG) in August 2023 for oversight.

It was noted that through the ongoing transformation work there is better alignment of corporate risks. Conversations are being held about content of their risk and tolerance.

The Chief Executive commended the team and commented that there were a number of risks identified and there was a lot of work to filter this down. This remained work in progress.

Members were advised that there was ongoing work to review all risks held within the register to ascertain current positions and risk mitigations which would support either the increase or decrease of risk scoring and whether risks had progressed sufficiently to support either the closure and/or de-escalation of the risks.

The Chair commented that some items will remain on the CRR and an example was cyber security. She requested that it be considered if risks can be re-categorised into short term, medium term and long-term risks.

Also, that the board assurance framework (BAF) being a live document was a top-down document and the CRR was a bottom-up document.

On audiology, it was noted that the Board had been sighted on the oversight provided and the mitigations in place.

The Board **RECEIVED** and **NOTED** the corporate risk register.

23/059 FREEDOM TO SPEAK UP ANNUAL REPORT

The Director of Quality and the Freedom to Speak up Guardian presented this item.

Reporting numbers have more than doubled over the last year, which is a positive step as it means staff are finding a comfortable space to speak up.

Part of the people promise on the freedom to speak up approach was that staff would have a voice and it will be heard so the next step is to ensure that we ‘listen up’. It was suggested that Managers needed more support on this. Managers needed to develop the skills to listen to difficult conversations and consequently, the proposal was that a management programme be developed for all line managers to listen and learn from their staff speaking up.

The Chair commented that it was excellent that there was trust

and the psychological safety for staff to speak up and seeing it moving to the next level of listening up training for managers was a positive step forward.

Members requested assurance that junior doctors will also get the training. The Medical Director commented that during induction doctors were encouraged to speak up on concerns and this session was followed by the freedom to speak up guardian pointing doctors in the direction of how they can speak up. It was also noted that in addition to encouraging them to speak up they were also told of the importance of kindness. Members commented that this was reassuring as it is an important part of training for leaders.

The Chief Executive commented that the CQC had commented on the recruitment of doctor champions as a good initiative.

On leadership development, the Chief Executive commented that it would be a focus of the partnership with the Virginia Mason Institute (VMI).

It was noted that the Freedom to Speak Up Guardian met regularly with the executive, but they were now looking to formalise this.

Members commented that they found the ongoing work on freedom to speak up encouraging and asked if through the National Guardian's office we could access data to benchmark to other Trusts. This might not be easy but we did have some sight of the work across our ICS and we were in a similar position to our neighbouring Trusts.

The freedom to speak up guardian commented that she did not work in isolation as she had champions across the organisation who worked with her and there was also the staff charter to guide them.

The freedom to speak up board champion thanked the freedom to speak up guardian on her work to date and congratulated her on the 'wins' and for going above and beyond the role.

The Board **RECEIVED, NOTED, SUPPORTED** and **APPROVED** the actions in the freedom to speak up annual report.

23/060 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)

The Director of Quality, the Assistant Director of Quality and Safety & Associate Medical Director for Patient Safety presented

this item.

It was noted that it was a requirement from NHS England to deliver these safety standards for patients. Developing this policy was the beginning of this work as the PSIRF was intended to be used to learn and improve our services.

The policy supported development and maintenance of an effective patient safety incident response process that integrated the key aims of PSIRF with ENHT's values. It also offered the ability to develop a proportionate response to patient safety incidents and safety issues.

Members commented that it was good that this, more holistic, policy was replacing the previous serious incident framework (SIF). Also, members commented that with the evolution of patient safety methodology, the duty of care to patients became a primary factor.

In response to a question, it was noted that it was not possible to write a policy that would answer what a proportionate response was to every case or incident. Local managers therefore had a responsibility to understand cases and respond accordingly.

The Board **RECEIVED, NOTED and APPROVED** the PSIRF Patient Safety Incident Response Framework (PSIRF) plan.

23/061 LEARNING FROM DEATHS

The Medical Director presented this item. The quarterly report summarised the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from learning from deaths work that were on-going processes throughout the Trust.

Members were advised that the recent areas for improvement included cardiology, sepsis, stroke and emergency laparotomy.

Also, that neonatal and paediatrics will be included in the report going forward.

The Medical Director made reference to the Papéer that had been written on the Trust response to the extremely sad neonatal death in Chester. His view was that a key issue was that neonatologists in Chester felt unable to contact the police when their concerns were not taken seriously. His view was that this would not be the case were a similar event to take place locally.

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

23/062 MATERNITY ASSURANCE

The Director of Midwifery presented this item. The report described the ongoing work in the service to strengthen leadership and provide assurance to the board on the extent of the maternity improvement and transformation programme and ~~to~~ how the Trust will meet the requirements of NHS resolutions (NHSR) in the context of the requirements of the clinical negligence scheme for trusts (CNST).

Members were reminded that following the inspections on 4 and 5 October 2022 and the reinspection on the 20 – 22 June 2023, the divisional leadership team had been working with the maternity improvement advisors as part of the maternity safety support programme. Currently, in the unit staffing was still below the funded establishment, the vacancy rate for July was 13% based on 21% headroom.

On the Letby case, the safety actions which formed part of the assurance process and measures within the perinatal services were discussed with the board. This included monthly walkarounds across maternity and neonatal services by the board level maternity and neonatal safety champions to hear concerns from staff.

The Board **RECEIVED** and **NOTED** (1) the Midwifery workforce report for July 2023, (2) that Maternity services monitored the Stillbirth and Neonatal death rates, by means of the perinatal mortality review tool (PMRT) and (3) the maternity and neonatal assurance.

23/063 PERFORMANCE

INTEGRATED PERFORMANCE REPORT

The Deputy Chief Executive & Director of Finance introduced the Integrated Performance Report for month 4.

A scorecard of the various work programmes was presented, with the various directors talking to their respective service areas.

The Board received the new maternity dashboard and noted its contents. Members commented that the executive summary was positive and gave assurance on the ongoing oversight in place through the governance of the saving babies lives working group and the governance pathway.

On pre-term births, it was noted that 69% of the pre-term births

were over 34 weeks gestation which included three sets of twins.

The midwifery team were thanked. The Chief Nurse commented that the community midwifery care unit was the next service they would be working with as there was always room for improvement.

The board were advised that due to the new Covid variant recently discovered, the vaccination programme was being brought forward.

The Board **NOTED** the issues, actions and mitigations put in place for the areas covered in the report, the respective work programmes including the maternity dashboard.

BOARD COMMITTEE REPORTS

23/064 AUDIT AND RISK COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Audit and Risk Committee meetings held on 11 July 2023.

23/065 FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and Planning Committee meetings held on 25 July 2023.

23/066 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on 26 July 2023.

23/067 PEOPLE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on 18 July 2023.

23/068 ANNUAL CYCLE

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

23/069 ANY OTHER BUSINESS

No other business was raised.

East and North Hertfordshire NHS Trust

23/070 DATE OF NEXT MEETING

The next meeting of the Trust Board will be on 1 November 2023.

Mrs Ellen Schroder
Trust Chair
September 2023

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

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 6 September 2023

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
5 July 2023	23/040	Inviting the Chair and Chief Executive Officer of the ICB to the September meeting.	The Trust Chair to liaise with the Integrated Care Board (ICB) and invite them to the meeting.	The ICB Chair and CEO will attend the board seminar in December as they were not available to attend the September Trust board meeting.	Trust Chair	*December 2023

East and North Hertfordshire NHS Trust

Chief Executive's Report

November 2023

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

Quality

We have received a draft report following the full inspection of core services at the Lister Hospital by the Care Quality Commission (CQC). We have responded on matters of factual accuracy and await a response and a date for publication of a final report.

The CQC has now published its State of Care 2022/23 report, details of which can be found on its website. State of Care is its annual assessment of health care and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve.

The Endoscopy team, at the end of September, had no outstanding urgent referrals. This means any patients referrals on the urgent pathway will have their procedure within 2 weeks, or as a critical referral.

At the start of the year, patients referred on an urgent pathway were having their diagnostic procedure on average of 15 to 16 weeks and routine referrals 24 weeks. In addition to this, there were over 500 referrals to be added onto the system.

Thriving people

In September, the The Working Party on Sexual Misconduct in Surgery published a report raising awareness of sexual misconduct in Surgery in the UK. As a Trust we responded to this by holding forums with leaders and staff to discuss the wider issue of sexual safety at work and supported by a video featuring Miss Marie Lyons, Division Medical Director for Planned Care, made a clear statement that sexual misconduct must be rooted out and appropriately dealt with in the Trust.

Preterm Birth Specialist Midwife Dede Thorpe won the BAME Midwife of the Year at the National Health and Care BAME Awards.

The National BAME Health and Care Awards celebrate BAME staff and networks across British health and social care who are making significant improvements in BAME career development support and forging better healthcare initiatives for their communities.

Two members of staff at the Trust have been nominated for an award at The Society for Cardiological Science and Technology (SCST) annual ceremony, for their hard work which has "raised the standards and profile of the cardiac workforce as a whole."

Ambulatory Supervisor Juliana Dias and Lead Invasive Physiologist Michelle Irvine have both been individually nominated for The Dave Richley Award for Outstanding Education.

Seamless services

Last month I met with chief executive of NHS England, Amanda Pritchard, and Karen Taylor, chief executive of Hertfordshire Partnership NHS Foundation Trust with a major topic of conversation being how to better support patients who attend or are brought to our emergency department in a mental health crisis.

I know how hard our staff in ED and assessment are working to care for patients in mental health crisis, and the challenges faced in keeping them as safe as possible. The mental health Trust is also working hard to try and support these patients better, and we are working closely together to fast track a number of projects to improve the experience of these patients, and our staff who provide the best care possible often in challenging circumstances.

Round tables have taken place with all system partners including the police to try and find better solutions and Amanda Pritchard is keen to keep abreast of our progress.

The Hospital at Home service that helps monitor patients in the comfort of their own homes has reached the milestone of more than 1,000 people in East and North Hertfordshire. The service seeks to provide hospital-equivalent care and safely monitor patients remotely using state-of-the-art technology. Tech-enabled virtual wards are one of the key elements of Hospital at Home.

Achieving this key milestone is part of a national ambition to deliver more virtual wards – NHS England recently published data showing that there are now more 10,000 virtual ward beds available across England, treating more than 240,000 patients.

Continuous Improvement

Our work with the Virginia Mason Institute (VMI) from Seattle has progressed over the last month. On October 2nd Dr Gary Kaplan, the former CEO of the Virginia Mason Medical Centre (VMMC), visited the Trust to share his experience of developing and implementing their quality management system. Many members of staff as well as our system partners were able to join one of five sessions throughout the day with others watching online subsequently.

The partnership contract from VMI includes the expectation that the ‘Trust Guiding Team’ visits the Medical Center early in the programme to meet clinical and managerial staff with deep experience of their approach and to start to understand the underpinning principles of why it has been so successful. This took place for three days during October and was invaluable in seeing and discussing the impact on patients and staff first hand.

Over 600 members of staff contributed to a ‘cultural assessment’ of the Trust, the output of which we will share widely with staff, and this forms the basis for the development of the implementation programme during November.

Adam Sewell-Jones
Chief Executive

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	9
Report title	**Board Assurance Framework (BAF)**	**Meeting Date**	1 November 2023
Presenter	Stuart Dalton, Head of Corporate Governance		
Author	Stuart Dalton, Head of Corporate Governance		
Responsible Director	Martin Armstrong, Deputy CEO	**Approval Date**	

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

Report Summary:

Key points to highlight are:

- For the first time, corporate risks from the Corporate Risk Register presented at September's Board have been mapped to the closest relevant BAF risk to help the Board and Committees better triangulate strategic and corporate risk. These are added as tracked changes at the bottom of each BAF, where a Corporate Risk is linked to that BAF risk.
- Whilst has been some significant mitigation to some BAF risks, there are no proposed risk score reductions. Equally, positively, no BAF risk scores have increased.
- Some risks have seen more progress than others. Progress to highlight is:
  - Risk 2 *(Population/stakeholder expectations).* There has been some excellent progress: Equity of care mapping stratification to waiting lists to help tackle health inequalities; Patient Safety Incident Response Framework policy approved; Referral To Treatment tier 1 rating is moving to a tier 2 rating; Patient safety partner recruitment progressing.
  - Risk 9: *(Trust and system financial flows and efficiency).* A system wide financial recovery plan has been developed.
  - Risk 10 *(Digital Transformation).* Electronic Patient Record (EPR) work, including successful negotiation with EPR providers to establish licence models compliant with the Capital revenue mix available to the Trust.
  - BAF risk 11 *(Enabling innovation).* Virginia Mason Institute rollout.

Impact: where significant implication(s) need highlighting

Covered above

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

N/A - BAF

Report previously considered by & date(s):

July Board and leads Committees between September and October (People; Finance, Performance & Planning Committee; Quality & Safety Committee)

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

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.	**Workforce requirements**	Chief Nurse (Medical Director) (Chief People Officer)	Quality & Safety	12	⟷
2.	**Population/stakeholder needs**	Chief Nurse (Medical Officer)	Quality & Safety	12	⟷
3.	**Financial constraints**	Chief Financial Officer	Finance, Performance & Planning	20	⟷
Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability					
4.	**Workforce shortages and skills mix**	Chief People Officer	People	12	⟷
5.	**Culture, leadership and engagement**	Chief People Officer	People	16	⟷
6.	**Autonomy and accountability**	Chief Operating Officer	Finance, Performance & Planning	16	⟷
Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners					
7.	**Immature place and system collaborative processes and culture**	Deputy Chief Executive (CFO)	Finance, Performance & Planning	16	⟷
8.	**Improving performance and flow**	Chief Operating Officer	Finance, Performance & Planning	16	⟷
9.	**Trust and system financial flows and efficiency**	Chief Financial Officer	Finance, Performance & Planning	12	⟷
Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities					
10.	**Digital Transformation**	Chief Information Officer	Finance, Performance & Planning	16	⟷
11.	**Enabling Innovation**	Director of Transformation	People	12	⟷
12.	**Clinical engagement**	Medical Director (Chief Nurse)	Quality & Safety	12	⟷

Section 2 Strategic Risk Heat Map

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

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

Risk Scoring Guide

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

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

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

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

NHS East and North Hertfordshire NHS Trust

Our Trust mission

Providing high-quality, compassionate care for our communities

Our guiding themes

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

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

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

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

Objectives 2023-24

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

Vision to 2030

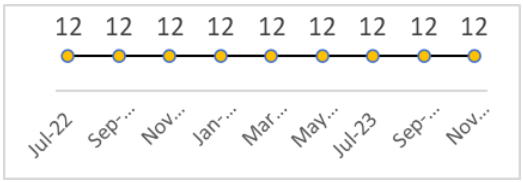
To be trusted to provide consistently outstanding care and exemplary service

Section 3 –Strategic Risks

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

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

Risk Trend



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

Controls	Assurances reported to Board and committees
Strategies and Plans • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans • Thematic review of complaints relating to staffing **Operational Systems and Resources** • Local recruitment and retention plans • Detailed establishment reviews across Nov/Dec 2022 • International recruitment plans • Training needs analysis reviews (capability building) • Fill rates and reviews • GROW appraisal and talent system weekly review via hot topics for nursing and midwifery/AHPs • Apprenticeship schemes • Change policy and toolkit • Pre and post reg training programs • Training on appraisals **Governance & Performance Management Structures** • Accountability and Review Meetings (ARM) • People Committee	**Internal Committee-level assurances** • Integrated performance report key indicators • Deep Dive recruitment briefs and reviews reports • Freedom to Speak up prevalence thematic analysis reports • Positive leadership rounds (January 2023) • Board members walk rounds to be piloted with positive leadership rounds (April 2023) • Deep dives for each division to establish staffing plans/budgeted WTE – ED, maternity and planned care. Check and challenge sessions for on rota staffing reviews due March 2023. • Safer staffing paper quarterly to QSC/TMG **Third line (external) assurances** • Staff survey results • External benchmarking with Integrated Care Partnership, Integrated Care Board and other partners • Ad hoc feedback: Health Education England / Professional Bodies / Academic body (pre and post reg) partners feedback • Care Quality Commission engagements session feedback reports • Patient feedback (national) survey
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
No substantive care support worker development programme	Redesign of service delivery pathways and development of new roles including 'grow your own' skills/talent - *by end of Q4 2023/24* - Heath care support worker care certificate programme in progress at onboard phase. BEECH course now in progress for CSW management of the deteriorating patient

Recruitment and retention plans required for professional groups with identified high vacancy rates, e.g. pharmacy, administration	• Ongoing review of establishments in progress in relation to shift patterns and budget alignment ~~*due by Q1 2023/24.*~~*started and will continue* • E-roster establishment review ongoing – ~~by end Q2 23/24~~started and in progress • Plans to continue collaboration with the ICS for international nurse recruitment for ~~2223~~/~~2324~~- ~~bid successful March 2023, recruitment plans TBC~~recruitment plan in progress • ~~Virtual training sessions and drop in events continue to take place in April and May 2023 and are set to continue during the appraisal cycle to support GROW conversations~~Grow together training and conversations completed as part of annual appraisal framework *[moved to controls]* • Scoping with university to deliver ward managers development programme– aim to deliver Q4 2023/24 • ~~CPO and CNO supporting deep dives in safer staffing across CNO safer staffing paper was presented to TMG March 2023 and QSC April 2023.~~Safer staffing paper will continue to be shared Quarterly in TMG and/or QSC *[moved to assurance]*
National and local cost of living and employment picture, which may make recruitment more challenging	National workforce strategy to be published by end of 2023. Support for staff with cost-of-living bundle of interventions already in place (community shop; blue light card refund; discounted vouchers, discounted fuel & increased excess mileage rate, lunch vouchers etc) – keep under review

Current Performance - Highlights

The following points are highlighted from the Integrated Performance Report:

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

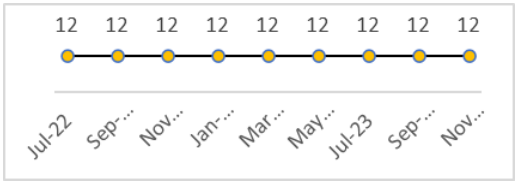
Associated Risks on the Board Risk Register

Risk no.	Description	Current score
0051	Risk of irreversible sight loss due to delay in the ophthalmology service recovery which has been exacerbated post COVID.	16
1127	There is a risk to babies care and treatment as a result of insufficient numbers of Consultant and Middle Grade Neonatologists which would impact compliance with BAPM (British Association of Perinatal Medicine standards)	15

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

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

Risk Trend



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

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

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

Patient-centred decision-making	Patient co-design and engagement plans in progress, scoping underway to imbed in patient co-design framework, ~~aim Sept 2023~~embed within PSIRF by Q4 2023/24

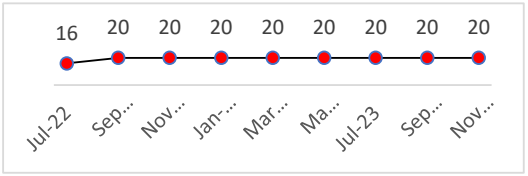
Current Performance - Highlights
The following points are highlighted from the IPR most recent Board report: • On average 94% of complaints are acknowledged within 3 working days • Overall complaints responded to within agreed timeframe remain below agreed target and a priority for improvement

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3027	Risk of Regulatory Non-compliance within Audiology Service	16
1923	Risks to patient safety and staff well-being due to overcrowding in the Emergency Department (ED) and lack of assessment space including waiting room care	15
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.	16
1273	Delays in Reporting of diagnostic scans in the Paul Strickland Scanner Centre (PSSC) leading to a greater risk of delay in treatment to cancer patients.	12
0061	Risk of sight loss due to delay of identification of sight threatening diabetic retinopathy as a result of ageing screening cameras.	20

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

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

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Approved 23/24 Revenue, Capital, CIP & Activity Plan **Operational Systems and Resources** • Financial Reporting Systems – Finance Qlikview Universe • Detailed monthly CIP performance reporting • Monthly ERF & Productivity Report to FPPC • Monthly Finance Reports • Outturn Forecast report to TMG, FPPC and System • Detailed bridge analysis of performance drivers **Governance & Performance Management Structures** • Monthly FPPC & Exec Committee Reporting • Monthly Divisional Finance Boards meetings • Monthly Capital Review Group • Weekly D&C / ERF delivery meetings • Monthly cost-centre / budget holder meetings • Bi-weekly ICS Director of Finance meetings • Bi-weekly Coding Improvement Group • Monthly Workforce Utilisation & Deployment Group • MEOG medical staffing group • Ratified SFI's and SO's, Counter Fraud Policy • Consolidated ICS Procurement Service & Governance	**First and second line (internal) assurances)** • Monthly Finance Report / Key Metrics to FPPC • CIP report & productivity report to FPPC • Outturn Reports to TMG, FPPC and Board **Third line (external) assurances** • 23/24 Financial plan submitted to and approved by NHSE • Monthly financial reporting to NHSE & HWE System • Monthly system finance oversight meeting with NHSE • Bi weekly System CEO / CEO finance review meetings • External / Internal audit review of key financial systems and processes • Model Hospital / GIRFT / Use of Resources benchmarking
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
~~• Risk to delivery of CIP savings at the level planned, placing financial pressure on the Trust and its system partners~~ ~~• Failure to remove COVID related cost investments in parallel with reductions in COVID income funding~~ • Risk that Industrial Action significantly reduces the volume of elective activity performed, income earned and increases unplanned medical staffing costs.	~~• Monthly CIP report to Finance Committee and review at monthly divisional finance performance reviews.~~ • ~~Programme of establishment review sessions to recommence in July.~~The Trust has established mechanism to capture the cost of additional IA costs incurred and estimate the impact of lost income and activity. This has been incorporated into the Trust's outturn position.
• Risk of non-payment of ERF overperformance by ICB and NHSE	• Weekly ERF delivery sessions with divisions in place. • Productivity framework in development, reporting to FPPC monthly

• Risk of significant overspend against elements of the Trust's workforce establishment~~.~~ – mainly CSW budgets and also significant overspends pertaining to medical staffing budgets	• Utilisation and Recruitment tools developed for use by nursing managers. • Allocate rostering system review to take place in July • Weekly and Monthly deployment framework will be included in July • Medi-rota management reporting development to commence in July
• Risk around absence of a short- and long-term financial strategy for the system and stakeholders to address underlying deficit	• ~~Work plan proposed to ICS DoFs – 9th June setting out programme of activities~~The Trust has generated a medium terms financial plan based upon agreed national and local assumptions. This has been discussed at the September FPPC and will act as a jump off point in respect of 24/25 financial planning.
• Significant reductions in Trust productivity 3 vs pre-pandemic levels. Significant increases in staff volumes and costs not related to activity change.	• The Trust has undertaken extensive run rate and associated bridge analysis. • This has framed areas for review and restatement for 23/24. This is formalized in a specific strand of budget setting activity. Further 'Establishment Growth' review sessions during ~~July~~October. • Productivity report, with an emphasis on the development of a 'Productivity Index, to FPPC

Current Performance – Highlights
The following points are highlighted from the Integrated Performance Report: • The Trust reports a YTD deficit of £~~4.8m~~7.0m, this is broadly in line with the financial plan. • As at Month ~~2~~6 the Trust CIP plan is on track • Variable SLA income is ~~behind~~ahead of plan at Month ~~2~~6 • The Trust has developed an internal Financial Recovery Plan to support achievement of year end targets

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
0025	Risk of non-delivery/ failure to achieve agreed Financial Plan and Cost Improvement Programme (CIP)	20
0066	Risk of microbial colonisation due to inadequate hot water temperatures as a result of equipment failure & temperatures falling below required levels	16
3026	Risk of potential delays to patient care as a result of unavailability of safe medical equipment/ devices which may impact timely patient care pathways	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
0044	Risk of harm to patients due to delays in delivery of emergency surgery caused by a lack of Emergency General Surgery list capacity	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 skill mix**		
If global and local workforce shortages in certain staff groups persist or increase combined with not having the right skill mix	***Then*** the Trust may not have the required number of staff with the right skills in the right locations	***Resulting in*** a negative work experience for staff due to increased work burden and gaps in skills to deliver services

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

Risk Trend

Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • Data accuracy between ESR and finance systems • Clinical Strategy 2022-2030 • People Strategy • Annual Divisional workforce plans and local Skill mix reviews • GROW and Succession plans • Tailored approach to nursing and medical and administration hotspots, with UK based campaigns supported by international recruitment plans • National workforce strategy **Learning and Development** • 'Grow our own' through Apprenticeship schemes • Leadership and Manager Development programmes • CPD funding – short course and Higher education qualifications - upskilling of staff • Clinical skill development and clinical education **Recruitment and Retention** • Workforce Plans • NHSP and international recruitment • Various return to work schemes e.g. retire and return • Drive for 5% - recruitment and retention steering group • ICS retention pathfinders working groups **Staff Engagement & Wellbeing** • Thank you and engagement interventions • Staff Survey • Absence and referral rates • Take up of wellbeing services **Governance & Performance Management Structures** • Medical establishment oversight working group • Clinical oversight working group • Recruitment and retention group	**First and second line (internal) assurance** • IPR – to board and People Committee, including vacancy and turnover rates • WDES/WRES reports - to board and People Committee • Recruitment and Retention deep dives and reports – People Committee, ARM, Divisional Boards • Deep dives with focus on specific workforce areas **Third Line (external) assurances** • Equality data for workforce (WRES/WDES) • Staff survey results • EDS 2 Assessment

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

Current Performance - Highlights

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

- Plans to continue collaboration with the ICS for international nurse recruitment for 23/24
- Development in system for GROW Together conversations completed and new cycle commences from April 2023
- Refreshed and reviewed induction programme in place for new joiners to ENHT with clearer development and work continues to enable early access to systems for e-learning to achieve day 1 ready in the future
- New roles and pathways exist, health care support worker pathways, nurse prescribing roles, Advanced Clinical practitioners (ACPs) with some under development e.g. physician associates,

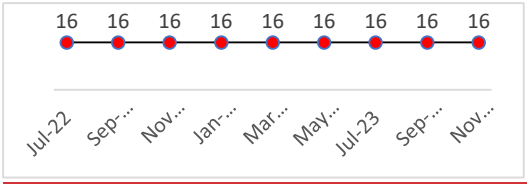
Associated Risks on the Corporate Risk Register

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

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

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

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People Committee

Controls	Assurances reported to Board and committees
Strategies and Plans • People Strategy • ENHT Values • People policy reviews • Speak Up approaches • EDI Strategy • Leadership Development Plans **Learning and Development** • Core skill and knowledge programmes (management and Leadership) • Healthy Leadership, care support pyramid • Civility Matters • East of England Hub- Mentoring and coaching programmes • Mandatory learning around inclusion, management and development of people • Speak up training • Grow Together training and support **Recruitment and Retention** • Values assessment undertaken at application stage for senior roles and in shortlisting criteria • Pulse surveys • Feedback through local induction processes • Grievance and raising concerns policy and guidance **Staff Engagement & Wellbeing** • Core offer of support available linked to financial, physical, mental, spiritual and social wellbeing for all staff • Annual days to raise awareness of specific topics • Staff networks /Freedom To Speak Up/ Meet the Chief Executive • We have submitted our SEQOHS application for Health@Work services • Internal communications - all staff briefing, in brief and newsletter	**First and second line (internal) assurance** • Regular reports on progress against People Strategy • IPR • Staff survey results and deep dives on action plans in divisions **Third Line (external) assurances** • National staff survey results • EDS2 return • WRES/WDES • Published equality data

Governance & Performance Management Structures • People Committee, staff side, Local Negotiating Committee • Divisional boards • Grow together reviews and talent forums • Staff networks	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
• Capacity to undertake support and development in identified areas to improve leadership practice and engagement • Challenges in the level of organisational engagement across ENHT to make things happen and embed sustainable change	• Prioritise approaches for service areas and deliver development work by end of Q4. Healthy Teams work is being implemented in Gynae, Theatres, (will add others) 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 • Cultural development work continues with senior leadership team - CQ workshops have completed and Reciprocal mentoring due to launch from July 2023 with first cohort
• Capacity to release staff and leaders to participate in development alongside day-to-day priorities	• Creative delivery and support to enable release and participation e.g. protected time; forward planned events and team talks - introduction of grand rounds in the LEC since Jan 23, to capture medical and non-medical staff, increased numbers of courses on ENH Academy in 22/23 e.g healthy leadership modules, skills boosters, project mgt courses, learning delivered at meetings e.g. leadership forum, quality huddles • Dedicated agreement organisationally of time to develop e.g. to complete mandatory training in 23/24 Q2 - Joint full day training days being delivered ensuring a higher % of courses can be completed in one sitting. The amount of time each online course takes to complete now included on ENH Academy.
• Ability to resolve staff complaints quickly and easily	• People Policy reviews will be complete by March 2023 and a rolling programme for training managers in investigation, reports and hosting challenging conversations will follow during 2023/24 – Delay in publication corporate policy group some policies not yet published Communication on policies commences in July 2023 and further work on revising and redeveloping people policies continues
• Investment and support levels organisationally for EDI programmes and resources restricts progress	• EDI strategy produced by June 2023 A draft EDI strategy is available and work in July/August will lead to publication in September 2023 • EDS2 published Mar 23 with action plan to be delivered throughout the year and longer term – prep work for 2023 EDS2 collection underway for longer lead in and engagement to increase response and involvement for next report • Gender pay gap actions embedded in organisation (between 2023-25) – on going work. • 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

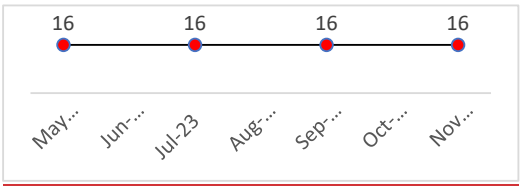
Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Updated 2022 staff survey results are being issued with local cascade and progression of actions and renewed focus • A suite of leadership and cultured development work is underway for use in the short and medium term • Time to resolve disciplinary cases has improved and is being sustained to improve employee relations • More work is underway to seek to resolve grievances informally and encourage early resolution.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
~~6092~~	~~There is a risk that the culture and context of the organisation leaves the workforce insufficiently empowered or enabled, impacting on the Trust's ability to deliver the required improvements and transformation, and impacting on the delivery of quality and compassionate care to the community.~~	~~12~~

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
Inherent	4	5	20
Current	4	4	16
Target	4	3	12

Risk Trend



Risk Lead	Lucy Davies, COO	Assurance committee	FPPC

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

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

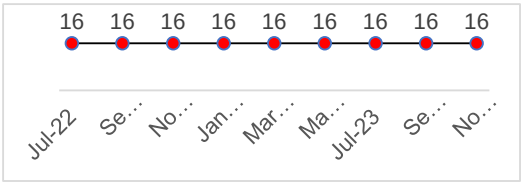
Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Speaking up • Complaints responded within agreed timeframe • Appraisal rate • CIPs achieved • Staff Survey results

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

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

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

Risk Trend



Risk Lead	Deputy Chief Executive	Assurance committee	FPPC

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

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

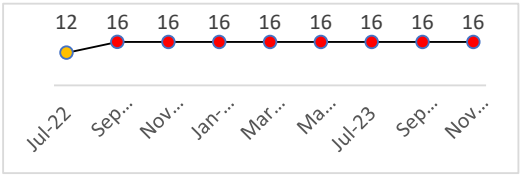
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • the IPR does not include any measures that specifically highlight the effectiveness or not of collaborative arrangements

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

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

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

Risk Trend



Risk Lead	Chief Operating Officer	Assurance committee	FPPC

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

• Divisional Board meetings • Regular tumour group meetings and improvement workstreams • System-wide Cancer Board chaired by Lead Divisional Director for Cancer • Specialty exception meetings	
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• New NHSE performance metrics (62 days cancer and 65 weeks waits)	• ARM meetings – a revised format is currently being developed. – Completed • complete • ICB system work to address Community Paeds demand/ capacity mismatch – ongoing • Assurance paper submitted to board and to ICB • Trust working with system on the next chapter of patient choice.
• Scope of validation of Patient Tracking Lists	• Increasing validation of Patient Tracking Lists – by Quarter 4 22/23 – completed • To commence contacting patients every week through use of Netcall
• Ambulance intelligent conveyancing lack of proactiveness	• System solution to intelligent conveyancing/ambulance intelligence will improve, but not fully address the challenge – ongoing • IC new SOP introduced May 23 • EEAST trialing call before convey and access to the stack to identify those patients who would be best cared for by alternative providers.
• Lack of social care and community capacity to support discharge • Utilisation of Hospital at Home not yet optimal – further work being undertaken to increase uptake.	• Extending scope of hospital at home – not matching what we need (taking patients who are awaiting packages of care). This will partially address the challenge of timely discharge for medically optimised patients. – ongoing [timeline to be confirmed once known] • E referral introduced for Hospital @ Home
• Capacity to increase referrals to cancer pathways	• Review of ARM meetings to ensure effectiveness – by Quarter 4 –Completed
• Diagnostic wait times – Access Board, Cancer Board	• Demand and capacity analysis – Quarter 3 22/23 – Completed – presented to Jan 23 FPPC • Additional capacity in plan: CT, echo, ultrasound, DEXA, MRI and plain film – Quarter 4 22/23 – completed • WLI in place in endoscopy • Network IRefer Quarter 2/3 23/24 • Recruitment into ultrasound / MRI / CT / echo and neurophysiology
• Consultant Vacancy rates in some services (Anaesthetics, Orthopaedics)	• Recruitment plans are part of Divisional operating plans
• Willingness of consultants to undertake extra contractual sessions	• New rates agreed Feb 23. Further limited incentive agreed March 23, with agreement of anaesthetists to recommence extra contractual sessions from April 2023 • All theatres being utilized by the end of May 23 • Review of workforce to reduce reliance on WLI

Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • % of 62 day PTL over 62 days

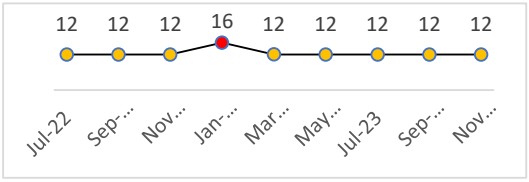
- 62-day/ 31-day cancer performance
- 78 weeks RTT
- 65 weeks RTT
- Ambulance handovers
- ED 4 and 12 hour performance
- Diagnostic waits
- 2 week waits
- Stroke performance
- Patient meeting the criteria to reside

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

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

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

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans • Agreed ERF targets for 23/24 with ICS. • Clinical Strategy and associated prioritisation and development framework. Linked to place priorities. **Financial Controls** • Monthly ERF & SLA activity reporting schedules **Governance & Performance Management Structures** • Identified Finance and Planning capacity to provide transformation evaluation support • Bi-weekly ICS System Leaders meeting • Bi-weekly ICS ~~DoFs~~CFOs and DDOFs meeting • Bi-weekly ICS CEO / CFOs meeting • Monthly E&N Herts Partnership Board & associated meetings • Elective Surgical Hub, Community Diagnostic Hub, Virtual Hospital and Heart Failure local and regional governance arrangements • PHM reporting mechanism to track changes in patient flows and associated costs and income • PHM steering and development group and link to place and system PHM development activity	**First and second line (internal) assurances** • System and Provider Collaboration reports to Trust Board advising on activity • Weekly D&C review sessions • Monthly project review sessions between Finance & Transformation Team. Transformation activity updates included in FPPC business cycle **Third line (external) assurances** • Consolidated ICS financial performance reports • Share further ICS performance reports as circulated by ICS.
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Risk of non-payment of ERF overperformance by ICB and NHSE	• Month ERF performance reports. Receipt of quarterly ERF reports from NHSE
• Establishment of transparent financial reporting environment across ICS partners	• ~~Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation~~ENHT has led the development of a transparent and accessible detailed financial reporting application for the ICS. Deployment in November 2023.
• Development of ICS financial risk management strategy	• ~~Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation~~The ICS has developed a system wide financial recovery plan, this incorporates assessment of financial risk and strategies to support their management

• Determination of place based financial responsibilities	• Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation
• Development of long-term financial plan for ICS	• ~~Ongoing – ICS DoFs to work together to develop ICS financial framework for implementation~~As per NHSE national guidance the ICS (and constituent organisations) have during Q2 developed a medium term financial plan – covering 24/25 and 25/26. This will be further refined in Q3 and will act as a platform for detailed financial planning for 24.25.
• Acute Provider Collaborative and associated business rules	• Approved by Trust CEOs – Move to implementation phase. Presentation to December Trust Board seminar to further discuss ENHT collaboration appetite.
• Further Board dialogue to be facilitated to help develop further metrics that can support assurance	• To be addressed through future board development sessions

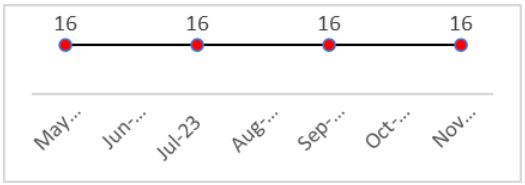
Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • Performance against ERF income and activity targets ~~Delivery of CDC activity levels~~

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

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

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

Risk Trend



Risk Lead	Chief Information Officer	Assurance committee	FPPC

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

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

Current Performance - Highlights
• -A successful recruitment campaign in Digital has secured a number of Substantive roles ahead of the EPR enhancement programme. • Successful Negotiation with EPR providers to establish licence models compliant with the Capital revenue mix available to the Trust.

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
0034	Risk of Cyber Attack due to 18 x Pathology servers unsupported on Windows server 2008 beyond Jan 2023.	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: **Enabling innovation**		
If we do not foster a learning culture where experimentation and questions are encouraged and staff are supported to innovate and do the right thing when mistakes happen	***Then*** there is the risk staff will become disempowered, will not identify solutions, not challenge without fear, not learn from mistakes and managers will hide issues and the culture will be psychologically unsafe.	***Resulting in*** avoidable harm to patients, missed opportunities for improvement and potential regulatory intervention and a culture of uncivil behaviour and lack of trust amongst staff

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

Risk Trend

Risk Lead	Director of Transformation	Assurance committee	People

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

• Freedom to Speak up Strategy not launched or imbedded	• • Launch new Freedom to Speak up Strategy in Q2 23/24 to formalise development and embedding of speaking up framework and processes implemented during 22/23.
• Variation in ward to Board quality governance structures and operational procedures	• Implement recommendations from Good Governance Institute review by Q2 23/24.Launch new Patient Safety Incident Response Framework following Board approval in July 23/24.
Assurance gaps • Efficacy of current learning systems from incidents, complaints, audit and wider performance issues where there are reoccurrences of similar themes and outcomes.	**Assurance treatments** • New Place and ICS Learning Networks established in Q1 23/24.Roll-out and embed ENHance across all domains by Q3 23/24. • Undertake a cultural readiness assessment with VMI , our improvement partner, in Q2 23/24.
• Level of staff absence, survey feedback themes and grievances reported by staff through FTSU Guardian.	• New 23/24 strategic objective for all staff to have a quality Grow Together conversation as part of the ENHT established leadership rhythm cycle. • Divisional highlight reports to continue through People Committee to highlight improvements made in response to key feedback themes.

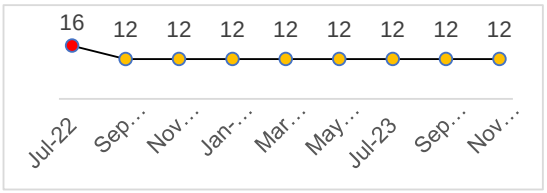
Current Performance - Highlights
• ~~HWE QI System Network launched in June to oversee system response to NHSE delivery and continuous improvement review, with ENHT CEO asked to act as ICS SRO for programme.~~ • ~~RCN/RCM Clinical Leadership Programme celebration event occurred in June to share best practice and case studies from the phase three cohort which has now ended.~~ • Freedom to Speak Up annual report and new policy detailing framework and processes approved at September Board. Additional recommendations for next steps agreed including leadership training development which will be taken forward as part of our VMI work, • PSIRF Framework update provided at September Board with next steps to involve the development of Standard Operating Procedures to cover processes and interventions for differing levels of reported incidents. • ICB Continuous Improvement Network launched in August, ICB SRO confirmed as ENHT CEO with Transformation team presenting work on the VMI partnership as part of the ICB QMS development programme. • Cultural readiness assessment scheduled for 21-26 Sept with comprehensive programme now confirmed. A formal internal and external launch event, led by Dr. Gary Kaplan, scheduled for 2 October. • VMI on-site days to plan the next Co-Design phase now confirmed as 2-3 November.

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

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

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

Risk Trend



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

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

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

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

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

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	10
Report title	Digital Update		**Meeting Date**	1 November 2023
Presenter	Mark Stanton CIO			
Author	Claire Orchard – Digital Director Solutions & Delivery			
Responsible Director	Mark Stanton CIO		**Approval Date**	20/10/23
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

1. **Digital Roadmap deliveries**

The Digital roadmap has been realigned with the Trusts guiding themes.

We have a significant number of projects in-flight currently, the Highlights are :-

Patient Engagement portal (PEP) – An app live in August that allows our patients to receive booking letters and cancel/rebook appointments. So far 4 specialties are live and we are seeing a good level of engagement. We will move all specialties on the app by the end of the year and start reporting KPI's.

Digital Radiology – Through the Radiology programme we have had funding for Imaging and deploying Clinical decision support (CDS) to improve the efficiencies of booking radiology. Chest X-ray AI is soon to go live with Chest MRI later in the year.

Maternity – Following a review we have agreed with Maternity stakeholders to restart the K2 EPR programme.

eFlow – We have an NHS E investment in order to deploy Real Time Location Services (RTLS) and bed Management, this is likely to include full tracking across the Lister site and help automate process. This project is still in the design phase and will roll out alongside the EPR upgrade (subject to approval).

Audiology – We have procured a new Audiology specialist EPR and are currently in the final go-live planning phase.

There are currently 58 Projects in our portfolio which are either at request stage or in delivery.

We have completed the roll out of eConsent and now withdrawing all the paper forms.

2. **EPR Strategy**

A full EPR upgrade Business case has been developed and is currently being reviewed.

Impact: where significant implication(s) need highlighting

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

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

Strategic Risk No.10: **Digital transformation**

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

Report previously considered by & date(s):

Recommendation	The Board/Committee is asked to note the Digital progress

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

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

Cover sheet: Jan 2022.v1

Digital Improvement Programme

Strategy and Roadmap – 2023-2025

NHS
East and North Hertfordshire
NHS Trust

Our Digital Landscape 2023

NHS East and North Hertfordshire NHS Trust

S

- VMI will support the Trust in adopting lean processes that complement agile improvement and delivery of new digital technology
- Strong organisational culture of collaboration and commitment to making patient care better
- Strong digital governance and team
- Limited commercial constraints putting the organisation in a competitive position to reshape the digital landscape using up to date technology

W

- Multiple digital systems in use across the trust that increase the technical complexity and cost of digital support
- Multiple digital systems and paper processes increase the administration, complexity and clinical risk around clinical pathways
- Digital landscape creates data silos and challenges for scaling technology. This lowers agility when making changes to models of care

O

- Technological Advances in AI, Machine Learning, Predictive Analytics and Cloud Computing now make it easier to adopt new technology than ever before
- NHSE Frontline Digitalisation funding provides an opportunity to adopt technology to support the improvement of care delivery

T

- Rising public expectations to have access to up-to-date information and after access to care
- Increased clinical activity likely to remain for many years creating a need to radically change the way our organisation delivers care
- Low staffing and high activity is adding to staff burnout and reduced productivity

Our Digital Vision 2025

NHS
East and North Hertfordshire
NHS Trust

“Revolutionising Healthcare Delivery through Seamless Digital Integration”

In our pursuit of excellence, we envision a digitally empowered future for ENHT, where digital technology serves as a catalyst for transformative healthcare experiences.

Strategic Priorities

NHS East and North Hertfordshire NHS Trust

Thriving People

- Digital will foster a collaborative work environment and ease administrative burdens for staff

Quality

- A paperless, digital, front door will empower patients and staff wherever they are with timely access to quality information
- Digital will support clinical services with direct access to electronic patient records, driving efficiencies around clinical workflows

Seamless Service

- When needed, customisable digital workflows supported by interoperable digital systems will ensure agile changes can be made to the delivery of care

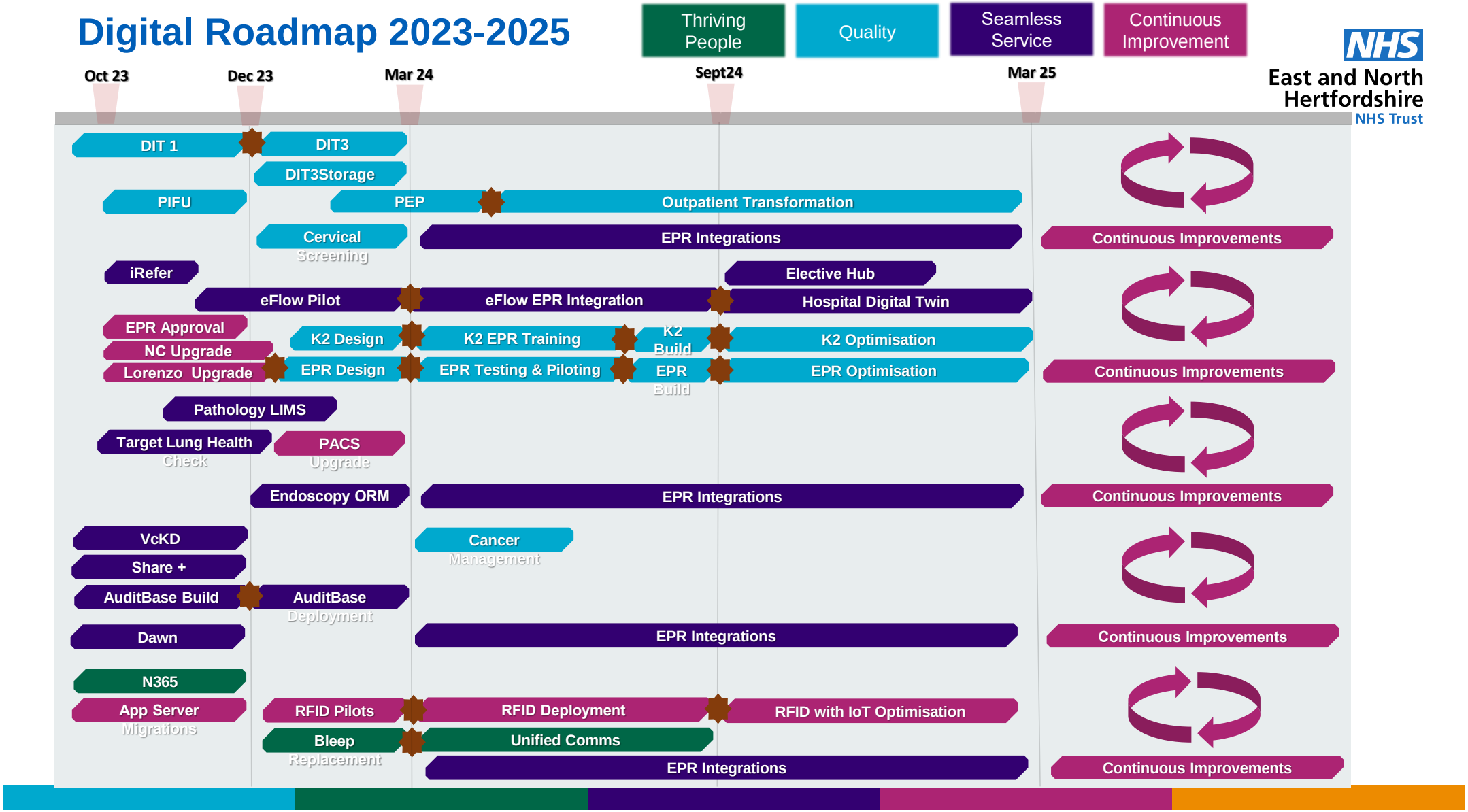
Continuous Improvement

- Continuous development of strong digital foundations and enabling technologies will support the transformation of care pathways both inside and beyond our hospital walls

Digital Vision

2024/25

"To be trusted to provide consistently outstanding care and exemplary service "


Digital Roadmap 2023-2025
Thriving People
Quality
Seamless Service
Continuous Improvement
NHS
East and North Hertfordshire
NHS Trust
Oct 23
Dec 23
Mar 24
Sept24
Mar 25
DIT 1
DIT3
DIT3Storage
PIFU
PEP
Outpatient Transformation
Cervical Screening
EPR Integrations
Continuous Improvements
iRefer
Elective Hub
eFlow Pilot
eFlow EPR Integration
Hospital Digital Twin
EPR Approval
NC Upgrade
Lorenzo Upgrade
K2 Design
K2 EPR Training
K2 Build
K2 Optimisation
EPR Design
EPR Testing & Piloting
EPR Build
EPR Optimisation
Continuous Improvements
Pathology LIMS
Target Lung Health Check
PACS Upgrade
Endoscopy ORM
EPR Integrations
Continuous Improvements
VcKD
Share +
Cancer Management
AuditBase Build
AuditBase Deployment
Dawn
EPR Integrations
Continuous Improvements
N365
App Server Migrations
RFID Pilots
RFID Deployment
RFID with IoT Optimisation
Bleep Replacement
Unified Comms
EPR Integrations
Continuous Improvements

EPR Programme Timeline

NHS
East and North Hertfordshire
NHS Trust

Jul - Sept
2023

System Selection and Business Case development

Jan - Mar
2024

Design workshops commence

Jul - Sept
2024

Full-Scale Deployment

Jan – Mar
2025

Healthcare Delivery through Seamless Digital Integration

Feedback

Feedback

Vision

Funding Approval and System Procurement

Oct - Dec
2023

Pilot Testing and Customisation

Apr - Jun
2024

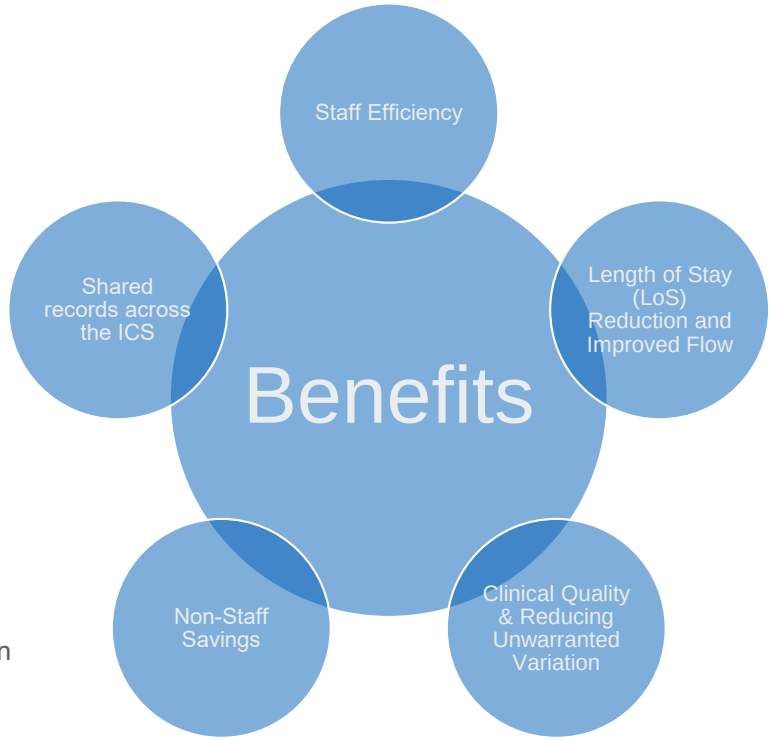
Optimisations and Continuous Improvement

Oct - Dec
2024

EPR Upgrade Expected Outcomes

East and North Hertfordshire NHS Trust

Direct cash releasing, productivity, and efficiency savings.



The availability of quality patient data will enable the Trust to share clinical information across the ICS via the HWE shared care record.

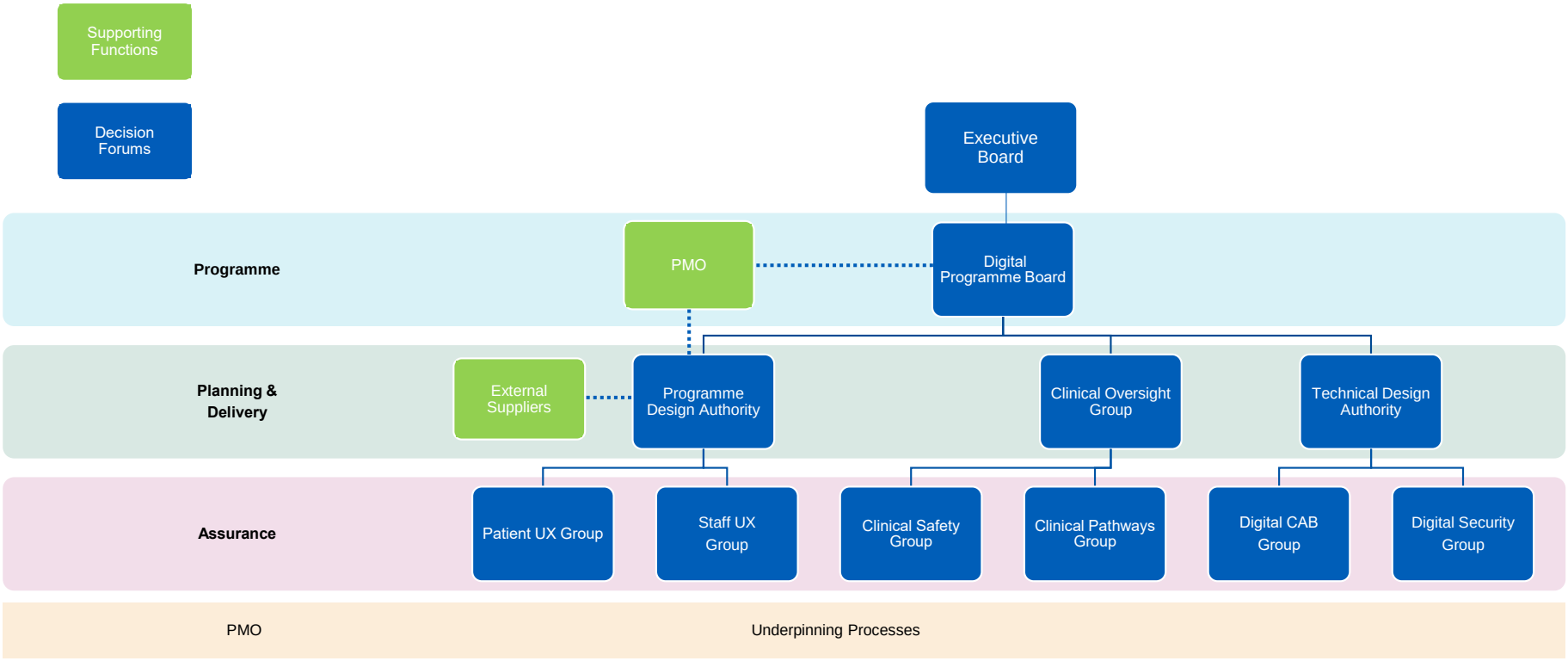
The ability to reduce LoS and re-admissions due to improved patient management, scheduling and discharge management.

Non-pay benefits that accrue from a paperless operation and better management of consumables. Reduction in storage costs and logistics involved in managing paper records

The benefits that accrue from better safety, reducing errors, clinical decision support and standardised care pathways to reduce variation.

Programme Governance

East and North Hertfordshire NHS Trust



Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board Meeting			**Agenda Item**	11
Report title	Green Plan report			**Meeting Date**	1 November 2023
Presenter	Kevin Howell, Director of Estates and Facilities				
Author	Helen O'Keefe, Head of Compliance and Sustainability				
Responsible Director	Kevin Howell, Director of Estates and Facilities			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

Purpose

The summary report provides an update on progress on the East and North Hertfordshire NHS Trust (ENHT) Green Plan since its publication in January 2022. The report is predominantly focussed on establishing the maturity of the Green Plan as a strategy and understanding the resources which are required to embed sustainable practices.

A more detailed review of each Green Plan work stream and the overall programme is given with recommendations.

Background/Context

In January 2022 East and North Hertfordshire NHS Trust formally adopted its Green Plan (2021- 2024), a live strategy outlining aims, objectives, and delivery plans for sustainable development. The Green Plan sets out the Trusts carbon emission reduction targets and resource use reduction targets in line with the Greener NHS 'Net Zero NHS' national ambitions and the UK Climate Change Act (2008).

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

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

Report previously considered by & date(s):

Previous update presented at Finance People and Performance (FPPC) Committee – February 2023.

Recommendation	The Board is asked to discuss the opportunities and challenges linked to embedding the Green Plan.

To be trusted to provide consistently outstanding care and exemplary service

1.0 Purpose

To inform the board on the Trust Green Plan and its supporting delivery programme comprised of 8 related but separate work streams.

2.0 Background

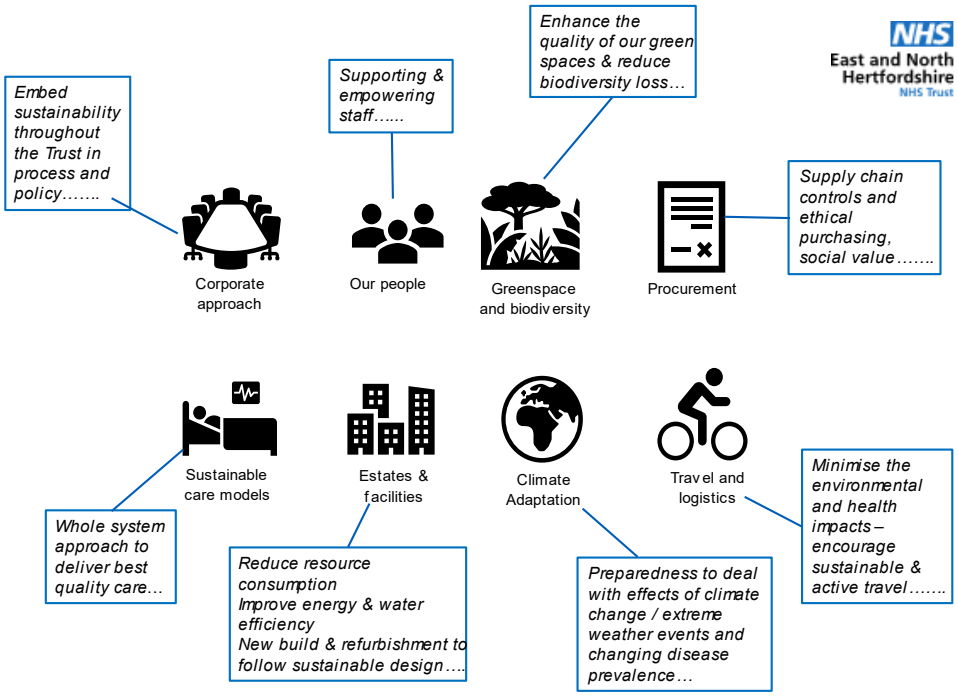
Programme outcomes – the Greener NHS has defined two net zero targets:

- **For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040,**
    - With an ambition to reach an 80% reduction by 2028 to 2032.
- **For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045.**
    - With ambition to reach an 80% reduction by 2036 to 2039

In January 2022 East and North Hertfordshire NHS Trust (ENHT) formally adopted its Green Plan (2021- 2024), a live strategy outlining aims, objectives, and delivery plans for sustainable development. The Green Plan sets out the Trusts carbon emission and resource use reduction targets in mandated policy and statute.

A key aim of the plan is to embed sustainability across all the Trust enabling strategies and operations to ensure effective delivery on these commitments.

The Green Plan is a strategy and is underpinned by a detailed delivery programme across 8 work streams, known as the Trust Green Plan Programme



3.0 Trust Green Plan position update

3.1 The Estate

The ENHT estate within direct control of the Trust is limited to the Lister Hospital at Stevenage. The Lister site is ageing and poorly maintained, and has amassed significant backlog maintenance of £26m, of which circa £15m is considered critical infrastructure risk. Replacement of the majority of the estate is unfeasible due to costs, and as such a ‘’fabric-first’’ approach is being developed to enable the existing estate to perform better and deliver against sustainability objectives.

Performing better refers to thermal performance but will also reduce heating costs and less heat will be lost. A ‘’fabric-first‘’ approach will require investment in cladding, and insulation which are parts of the developing decarbonisation strategy.

Investment in low-carbon technology and renewable generation is also required as ENHT’s largest emitters are related to the consumption of gas and electricity. A business case to support the roll-out of LED replacement across the site is now completed, significant carbon reduction gains will be made, in addition with a predicted Return on Investment (ROI) of 1.1 years.

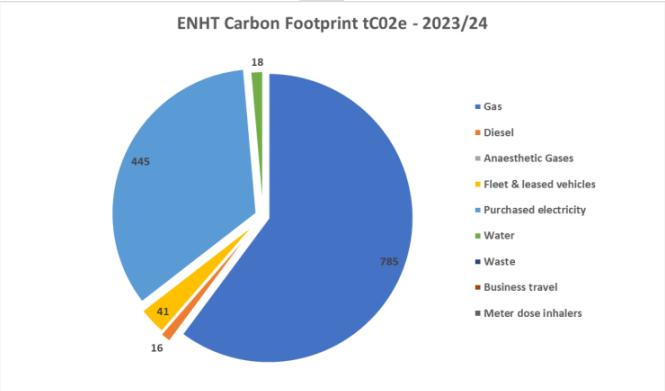
3.2.Decarbonisation

The Trust understands why decarbonisation is important. The key to the emerging decarbonisation strategy is to assist in discussions in how to move from ambition to action, and develop a clear roadmap to decarbonising the Lister site. The Trust-wide decarbonisation strategy was published in August 2023, work is underway with Veolia Energy to develop a supporting action plan, however, limited funding opportunities and competing financial priorities will impact delivery.

3.3. Carbon footprint data collection

ENHT are now collating emission data from a multitude of sources to produce its yearly carbon footprint. As part of ‘*The 2020 report ‘Delivering a ‘Net Zero’ National Health Service*’ all listed emission sources are now to be included within the ENHT yearly carbon footprint. However, ENHT do not include emission sources from anaesthetic gases, waste, business travel and meter dose inhalers. Work is now underway to develop and capture the emission data from these sources.

For the financial year of 23/24, ENHT total carbon emissions is calculated at 1,305 $tC0_2e$ – *diagram 1 for emission breakdown*.



D 1: ENH carbon foot- print 2023/24

To achieve Net Zero by 2040 (*diagram 2*), investment in low-carbon technology and renewable generation is required as ENHT's largest emitters are related to the consumption of gas and electricity.

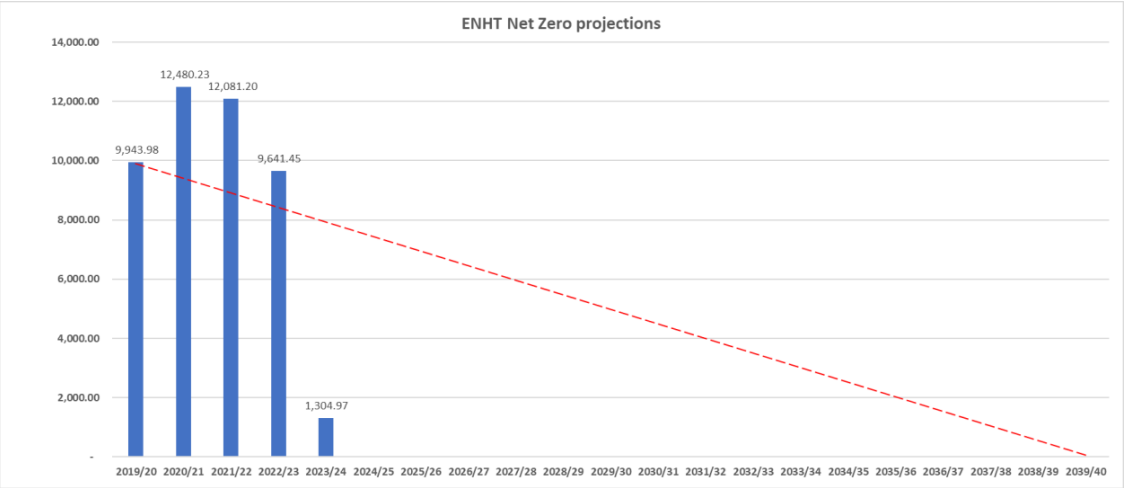


Diagram 2 Trajectory to achieving net zero by 2040.

As ENHT continues to collate emission data, this will be tracked monthly against our Net Zero target (using a FY 2019/20 baseline). This will enable the Trust to assess whether investment in low-carbon technology and renewable generation has been impactful on this trajectory.

Note: as new emission sources are included the likelihood is that the yearly $C0_2$ figure will increase, however this will be mitigated as carbon reduction projects are implemented across the ENHT estate.

3.4 Energy

The NHS estate uses approximately £500 million worth of energy a year in England alone. Energy used by the NHS throughout the UK is estimated to account for approximately 4 million tonnes of CO_2 - some 22% of the total carbon footprint for the NHS. The current costs of energy and the limited mechanism available to control use are of real concern to the Trust.

The current ENHT Energy Manager has in 12 months made inroads to delivering controls to the measurements and usage of energy at the Lister site, including project managing the installation of submetering, upgrading the current Building Management System (BMS) and consolidating utilities for single point oversight.

This focus has resulted in significant savings and greater controls for the Trust, vital at a time when energy prices are expected to increase by an average of 35% in 2023 across both electricity and gas tariffs resulting in a cost increase of approximately £1,300,000. The Trust has previously not had the ability to accurately forecast spend and assess cost impact.

3.5 NHS Standard Contract 2022/2023 sustainability requirements

ENHT current progress against NHS Standard Contract sustainability requirements.

Providers to have already met the target of 90% of their fleet being “low emission”. In line with the NHS Long Term Plan commitment, the Contract now requires transition to “ultra-low and zero emission” vehicles as quickly as reasonably practicable.	In progress new fleet tender
Providers must now develop plans to install electric vehicle charging infrastructure for fleet vehicles at their premises	Achieved
Any car leasing schemes for staff (including salary sacrifice schemes) do not allow use of high-emission vehicles	In progress
In line with Delivering a ‘Net Zero’ National Health Service, the Contract target reduction for desflurane use is 5% or less.	Achieved

3.6 Resources

The Green Plan Programme delivers activity through 8 separate work streams, in varying degrees of maturity. This is due to a myriad of reasons ranging from lack of senior sponsorship and leadership to complex policy environment. All of the work streams are wholly reliant on goodwill and free time of senior staff acting as work stream leads, as no dedicated resource is allocated to support the delivery of the function. There is currently only 0.5 WTE Project Manager allocated to delivering the Green Plan. The time demand, lack of resources and unfamiliarity with this dynamic policy area negatively impact delivery.

3.7 Governance

Good governance is key to the effective implementation of the actions and commitments made in the Green Plan. The governance structures for reporting and enabling remain undefined. Some self-supporting work streams, such as Estates and Facilities, Green Travel and Green Space & Biodiversity are able to enact and deliver with a degree of autonomy. Other more complex work streams, such as Sustainable Models of Care have far reaching impact and require changes to clinical models, and system wide partnership working.

3.8 Mandatory reporting

The Trust is responsible for mandatory collection of data, monitoring and reporting of progress against targets across the programme at national, regional and system level to The NHS Greener NHS, via the following frameworks:

- Sustainable Development Unit ‘Sustainability Reporting Framework Template’
- Greener NHS Data Collection
- NHS Estates NZC Delivery Plan

NHS England have indicated that from 2023 stricter reporting and greater scrutiny will be expected from Trusts. Rather than report flat data, there is now a need to evidence and triangulate actions taken and their associated impacts. There is

recognition that not all Trusts are able to accurately report on their carbon footprint and reductions at this time.

In support of this NHS England has published a prescriptive report ‘ Delivering a ‘Net Zero’ National Health Service’’ which provides a detailed account of the NHS’ modelling and analytics underpinning the latest NHS carbon footprint, trajectories to net zero and the interventions required to achieve that ambition. It establishes the direction, scale and pace of change required to reach targets and describes an iterative and adaptive approach. Several of the targets require investment either in staffing or infrastructure and these will need to be factored into future years financial planning.

4.0 Maturity matrix assessment of the Green Plan

Over one year since its publication an assessment has been undertaken to understand the emerging themes, depth and reach of the Green Plan as a strategy. The following summary ranks the progress levels of the key themes utilised to assess maturity of strategy and its associated implementation. Progress levels range from Baseline, Basic level, Early progress in development, Firm progress in development, to Maturity- Results being achieved. A sixth level ‘’ Exemplar’’ would not be appropriate as an assessment for a strategy in its infancy.

	Key dimensions	Progress Levels	Definition
1.	Leadership (Referring to senior and executive level leadership)	**Basic level**	Named board-level lead exists and senior leaders are familiar with the concepts of Sustainability and the Green Plan and seek to comply with relevant statutory obligation.
2.	Data and Measurement	**Early progress in development**	Data collection meets various legislative requirements. The Trusts uses tools to track, analyse and report on emissions within its control.
3.	Stakeholder identification (Inc. Staff, general public, patients, system partners, ICS, Regional and National Greener NHS)	**Early progress in development**	Organisation is aware of its key stakeholders and they are researched and way. They are occasionally considered when new projects emerge however the mapping and research of stakeholders is not a systemic ongoing or dynamic process development
4.	Investment structure	**Basic level**	Rudimentary investment to fund programme delivery staff. No revenue to fund support services (training, Communications support)
5.	Systems processes and procedures	**Early progress in development**	Annual retrospective report to matrix style reporting to Trusts boards and committees on Green Plan performance. Controls in place to ensure Estates and FM contracts and investment align with and compliment Green plan objectives- including capital

			developments. Systems and tools for monitoring and management of resources are in use.
6.	Perception and Reputation (Inc. Staff, general public, patients, system partners, ICS, Regional and National Greener NHS)	**Firm progress in development**	More developed understanding of the organisation's sustainability perceptions among stakeholders and some management of this with planned messaging and promotion to manage perception/reputation.
7.	Skills and capacity	**Early progress in development**	Some dedicated resource within Estates team (not necessarily a specific role). To support delivery of the Green Plan Programme

4.1 Green Plan Programme (work stream level) maturity matrix- summary

This summary below is based upon a detailed assessment (Appendix 2) of each of the 8 Green Plan work streams. The maturity rating was developed using other comparable NHS England National standards and adjusting the level criteria to reflect sustainability programme characteristics. The criteria provided is an indication of the level of maturity of a selection of factors considered including resourcing, funding and progress to date.

Level	Criteria guidance
Level 1 Self-assessment and setting aspiration	Less than 25% Green Plan commitments initiated No lead identified and no allocated resource No funding available
Level 2 Getting on taking action	25-50% of Green Plan commitments initiated Lead identified or future resource planned/identified Few funding opportunities
Level 3 Established	More than 50% of Green Plan commitments are initiated and achieved Workstream lead assigned with support available Funding opportunities available
Level 4 Above and beyond	More than 75% of Green Plan commitments are achieved Workstream lead assigned and dedicated resource in place Funding fully maximised

Workstream	Status	Workstream lead	Rating
Corporate approach	launched	Workstream merged – Green Ambassador. Debbie Cockcroft	Level 3
Our people	launched	Workstream merged – Green Ambassadors. Debbie Cockcroft	Level 3
Sustainable care models	launched	Dr Justin Daniels	Level 2
Travel and logistics	launched	Sam Woods	Level 2
Estates and facilities	launched	Helen O'Keefe / Ali Morris	Level 3
Greenspace	launched	Bridget Sanders	Level 2

and biodiversity			
Procurement	Not launched	TBC	**Level 1**
Climate adaptation	Not launched	TBC	**Level 1**

5.0 Sustainability Impact Assessments

The Green Plan has failed in its aim to embed sustainability across all the Trust enabling strategies and operations. This became apparent in an assessment of clinical strategies deployed in 2022.

The Hospital at Home (HAH) service provides care that traditionally takes place in a hospital in a patient's own home. There are a wide number of clinical benefits from adopting this care model including reduced bed days, reduced risk of infection and increased clinical efficiency.

There are also significant environmental benefits from this care model. These benefits include:

- Reduced air quality damage from reduced patient journeys to site
- Reduced carbon impact from reduced patient journeys to site
- Carbon savings for the Trust from reduced bed days
- Cost savings for the Trust from reduced bed days

Other societal benefits such as patients returning to work quicker as a result of improved recovery times are important considerations to include when assessing sustainable value.

When assessing the Hospital at Home service (chosen at random for demonstration purposes), no further assessment was made to capture impact and benefit linked to sustainability. There is currently no defined Trust process where business or policies are assessed through a sustainability impact assessment.

5.1 Sustainability impact analysis of Hospital at Home

As an **example,** the Hospital at Home strategy was assessed, using the Sustainability in Quality Improvement (SusQI) framework.

The SusQI framework follows the principles of sustainable clinical practice: prevention, patient empowerment and self-care, lean clinical pathways, low-carbon alternatives, and operational resource use.

The summary table below indicates the carbon and cost savings that could be calculated.

Reduced air quality damage. UK Government air quality damage costs for private vehicle (50% petrol and 50% diesel) are 19p/litre which equates to 0.98p per km. Average return journey for outpatients is 32km	**£384 annual benefit (Air quality)**
Reduced carbon impact. Data shows 1215 admissions have been avoided. The typical private car produces about 0.00018tCO_2/km. social cost of carbon is £248 per tCO_2e. Assume 75% of patients travel by private vehicle.	**£1323 annual benefit (Carbon)**
Carbon savings for the Trust from reduced bed days An equivalent of 54 occupied beds per year are saved via H@H. There is 0.193 kg of CO_2e per kWh of electricity and 0.183 kg per kWh of gas. This provides an average CO2 per bed tCO_2e at 12.42. Social cost of carbon is £248 per tCO_2e.	**£166,329 annual benefit (Carbon)**
Cost savings for the Trust from reduced bed days An equivalent of 54 occupied beds per year are saved via H@H. Using 2022 costs for electricity and gas, we show a cost saving of £2,335 in electricity and gas used per bed per year.	**£126,090 annual benefit (Revenue)**

6.0 Risk and mitigation

Risk	Mitigation
Lack of gaps in leadership, to drive forward Green Plan agenda, risk of programme fatigue	Non-executive director Karen McConnell and Director E&F Kevin Howell.
Delay launches of procurement / climate adaptation workstream	Monitoring direction / support from Integrated Care System Sustainability Working Group
Limited available funding / competing priorities (critical infrastructure) to invest to decarbonise the estate	Seek national / local funding opportunities, cross reference with critical infrastructure and backlog maintenance funding
Not achieving net zero targets due to lack of	Reliant on good will and free time of staff

funding to recruit staffing resource to drive and progress Green Plan programme.	to lead workstreams and progress green plan agenda.

7.0 Recommendations

- The Trust should prioritise a reoccurring budget to fund essential aspects of the Green Plan including the staffing requirements as defined within ‘’Delivering a ‘Net Zero’ National Health Service’’.
- The Trust should map its existing Green Plan Programme to ensure it matches the ambition of the Net Zero’ National Health Service report and can evidence ongoing delivery of required targets and understand any gaps in provision.
- Sustainability Impact Assessments, much like Equality Impact Assessments, should be captured as part of good governance when business cases and strategies are proposed and approved.
- New Clinical Strategies should be assessed for sustainability impact as part of the approvals process.
- Opportunities to maximise the impact of clinical practises on our carbon footprint should be promoted and transparently assessed.
- The Green Plan should report to the Finance Performance People Committee (FPPC) quarterly and Trust Board bi-annually on progress and compliance with policy.

8.0 Conclusion

The complexity of attempting to deliver a 16-year, multi-work-stream, unfunded programme underpinned by a 3-year Strategy (The Green Plan) should not be underestimated.

Achieving Net Carbon Zero is the most significant non-clinical policy agenda in the NHS, and the policy and protocols are developing and evolving alongside expected delivery. There are significant opportunities and challenges associated with delivering the Green Plan, despite it being a strategy in its infancy.

END OF REPORT

Helen O’Keefe (Head of Compliance & Sustainability)
22.10.2023

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	12
Report title	Strategic Transformation Update			**Meeting Date**	1 November 2023
Presenter	Kevin O'Hart, Director of Improvement				
Author	Kevin O'Hart, Director of Improvement				
Responsible Director	Kevin O'Hart, Director of Improvement			**Approval Date**	12 October 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

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

Impact: where significant implication(s) need highlighting

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

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

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

Risk 11 Innovation
Risk 10 Technology, systems and processes

Report previously considered by & date(s):

Executive Programme Board 12 October 2023

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

To be trusted to provide consistently outstanding care and exemplary service

2023/ 24 Strategic Transformation Report

Part 1: Strategic Objectives

Trust Board

Agenda Item 10

1 November 2023

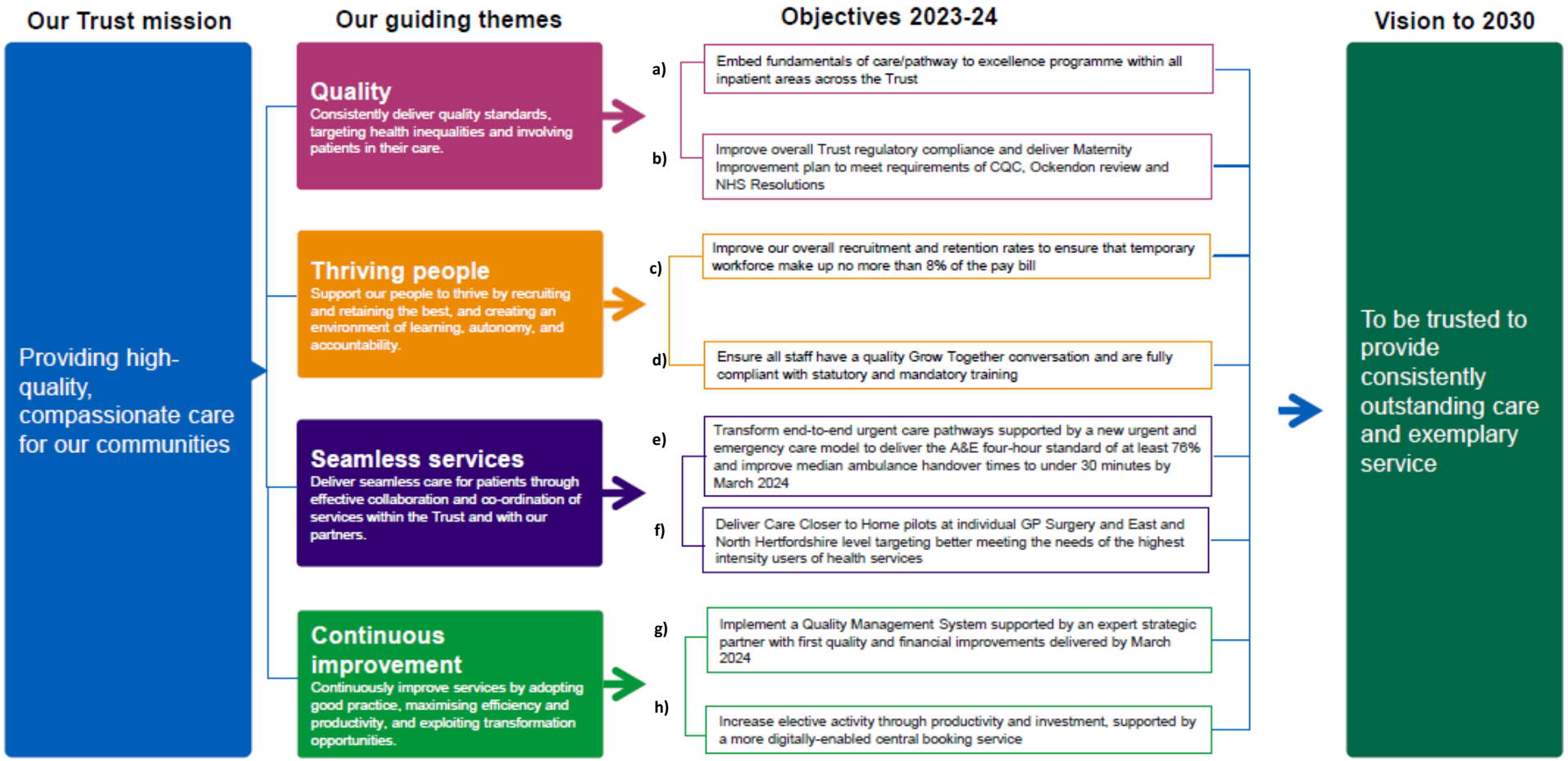
Kevin O'Hart, Director of Improvement

East and North Hertfordshire NHS Trust

ProudToBeENHT

Strategic Objectives 2023 - 24

East and North Hertfordshire NHS Trust



2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Quality / Objective A – Fundamentals of Care		
SRO – Theresa Murphy , Chief Nurse		

The Clinical Excellence Accreditation Framework (CEAF) was revised in April 2023. The new framework (CEAF) contains two parts. Part one is aligned to the CQC compliance standards and includes seventy-one fundamental standards of care. Part two of the CEAF include standards relating to 'clinical excellence'. Wards will only progress to part two of the framework when a minimum of 85% of all fundamental standards are achieved.

To relaunch the revised framework, there was a phased approach, separating all inpatient wards into two cohorts. The phased approach allows further support for all inpatient wards and aids monitoring progress throughout 2023/24. The first cohort of twelve inpatient wards commenced the CEAF in April and are now working through the independent assessment phase (a three-month period throughout August, September and October). The independent assessment team have been reviewing compliance against the fundamental standards by observing practice, talking to staff and patients, reviewing documentation and performance/compliance data and reviewing the CEAF staff survey responses. In addition to this we utilise 3 months of the nursing audit data and inpatient survey responses to ensure wards can sustain compliance against fundamental standards of care. The second cohort and all remaining inpatient wards (excluding maternity) commenced the CEAF in July and will commence the independent assessment period in November.

Currently cohort one wards are being supported to ensure compliance with all of the fundamental standards of care, before progressing to part two of the framework in 2024. Divisional progress meetings are held monthly with the chief nursing team to discuss progress, next steps and actions required. A panel meeting is provisionally scheduled in December to review assessments and agree outcomes for cohort one wards. All wards will be expected to work on their improvement plans to meet the required standards of care. All 71 fundamental standards must be achieved, and the excellence part of accreditation completed, before a ward can become accredited at either bronze, silver or gold level. Once accredited, wards will need to continue to demonstrate sustained improvement to maintain their status.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Thriving People / Objective C – Temporary Workforce
SRO – Thomas Pounds , Chief People Officer

The Trust has set a goal to reduce its expenditure on bank and agency workforce so that it makes up no more than 8% of the overall pay bill – the programme supporting the achievement of this goal has been called the Great for 8 programme. The Great for 8 programme is making progress, Bank and Agency % of pay bill currently equates to 11.6% of the Trust's payroll (8.5% for Bank and 3.1% for agency), down from 13.1% in June.

Agency utilisation has seen a significant reduction of 15 FTE since June 2023 with several key substantive posts landing within the medical directorate in recent months, this has allowed several agency locum posts to cease. A further three medical 'hard to recruit' positions will be filled in the coming months within Breast Surgery, Diabetes & Endocrinology, and Microbiology.
The medical recruitment action plan remains a priority for the triangulation work linked to bank and agency migration and remaining posts are scrutinised weekly.

A proposal is being worked up to establish a 'Resource Control Panel' providing additional challenge and governance to recruitment posts and to bank/agency requests. This panel would be jointly owned between the People Team and Finance Team and is likely to kick off in early November. This will provide additional check and challenge on all deployment requirements.
64 student nurses are currently undertaking pre-employment checks with the Trust with start dates planned for Q3/Q4 – this represents early over-achievement against an initial target of 50 appointments. 40 international nurses have arrived since April 23 with a further 6 to arrive before end of November.

Individual service led meetings are on-going for key hot-spot areas, and there is a separate theatres workforce group to work through demand requirements and support substantive pipelines. A review of spend on CSW roles (clinical support workers) is on-going, with daily review of rosters. Bank demand is based on professional judgement following review of acuity of patients on wards and patient safety. Non-Medical triangulation meetings are focusing on high-cost agency and any breaches against NHSE Price caps, and well as high utilisations areas such as ED, Childrens ED, and Assessment.

A deep dive review of the Allocate eRoster system has been held and report now received – recommendations are with operational stakeholders and there is an updated action plan in place which will address key controls, with governance benefits to be realised over the coming weeks.

Turnover rate is improving – 11.1% for September which is just above the 23/24 target of 11%.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Seamless Services / Objective E – Urgent & Emergency Care
SRO – Lucy Davies, Chief Operating Officer
In order to meet the March 2024 target of 76% performance against the 4-hour target in urgent and emergency care, and improve ambulance handover times, a comprehensive improvement programme has been developed and continues to work at pace across multiple key areas to transform end-to-end urgent care pathways. Pathways are being transformed in multiple areas across our "emergency village", which will ensure that patients receive the right care in the right place within the right timeframe, and by ensuring patients are treated in the right pathway, we will reduce pressure on the Emergency Department, reduce overcrowding, improve 4-hour performance, and reduce ambulance handover delays. Project 1: development of a co-located adults urgent treatment centre (UTC) on the Lister site, separate to the Emergency Department (ED) with its own leadership and staffing model. This will enable up to 80 patients per day (at full mobilisation) to be seen in an urgent care environment separate to ED, releasing true emergency capacity for patients who need it the most, and ensuring that those who have a same-day need for urgent care are treated more rapidly. Estates options have been reviewed and the current Graveley Annex will be used to establish the service – the change in use of the space requires works to be completed before a full opening, and during this time the team are focusing the finalisation of staffing to support the agreed clinical model. An innovative model utilising Advanced Care Practitioners, GPs, and nurses will ensure patients can be seen in a timely way, and reduce pressure on ED. Project 2: development of a children's UTC within the existing paediatric ED footprint – this will be considered as a pilot to test whether using a slightly different workforce model and integrating a UTC approach within ED will support improved flow through paediatric ED. Project 3: as patient pathways are changing across the ED, UTC, and SDEC, the staffing models and skill mix across each of these areas also need reviewing. This group are reviewing the whole UEC workforce as the UEC model changes, and ensuring that recruitment and retention plans are in place to support the transformed pathways. Project 4: the staffing model for an additional CT scanner located next to ED, dedicated to urgent and emergency diagnostics, has been approved and the team are now progressing to recruitment for this model. The new model will have later opening hours (11am-8pm) to align capacity with demand in this area, which peaks later in the afternoon meaning a traditional 9am-5pm model would not have provided the impact which this new model will. Project 5: SDEC and Assessment pathways are being reviewed for both medical and surgical patients, with new medical and surgical "front doors" being developed. This will enable more direct pathways for patients, avoiding the need to be booked in and triaged in ED, instead attending directly at the medical front door or surgical front door, depending on their need. They will be advised to do so by their GP, by 111 or 999 services, sent direct via ambulance, or by enhanced triage at the ED and UTC front doors. In addition, longer opening hours for SDEC will support improved patient flow at peak hours, reduce pressure on ED, and reduce emergency admissions.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Seamless Services / Objective E – Urgent & Emergency Care *(continued)*
SRO – Lucy Davies, Chief Operating Officer
Project 6: to ensure the right level of inpatient capacity in the right place, work is gathering pace on some inpatient bed moves. Once refurbishment has been completed on level 10A, this will be established as a more specialist Haemotology Oncology area. Moving patients out of Assessment to level 10 will free up space to establish a surgical assessment unit, and moving patients from Ashwell onto level 8 will create a frailty and elderly care hub. An operational group is focusing on the enabling factors for these moves, which aim to increase capacity for surgical review, and improve efficiency for the elderly care and frailty teams by co-locating their patients – this should in turn improve turnaround times within ED. These moves are expected to take place in January 2024. Project 7: an additional project has been added to the programme – “eFlow”. This project is being led by the Digital team and is looking at opportunities to create efficiency and reduce waste in relation to bed management, through taking up opportunities for increased digitalisation. It will also look at the use and function of patient and equipment tracking, and whether this could also support increased efficiency within ED. Additional areas of work which support improved flow and performance in urgent and emergency care are those that focus on discharge improvement. The roll out of criteria-led discharge (CLD) continues at pace, with Clinical Directors across all specialities supportive of the approach and willing to roll out in their areas. Early adopters within Cardiology and ENT are now beginning to test a new digital system which will support the roll out by embedding CLD into the existing NerveCentre system. It enables a range of registered healthcare practitioners (such as junior doctors, nurses, or therapists) to lead a patient’s discharge from hospital (rather than needing to wait for the consultant) and makes the discharge plan and progress of discharge planning transparent to the entire team caring for the patient, as well as the patient and family, and/or carers. Work is also commencing with partner organisations across our HCP area to look at ways of improving discharge performance for patients who require care and support on discharge. Through a series of workshops, colleagues from Hertfordshire County Council, Hertfordshire Community NHS Trust, and ENHT are working to design a new ‘trusted assessment’ model, meaning that a range of professionals (nurses and therapists) across different teams could complete care assessments for patients which will be trusted by all other partners. This will reduce the possibility of duplicate assessments, increase collaboration between organisations, and speed up the process of seeking care for patients on discharge. In turn, this should free up more specialist resource within the Integrated Discharge Team to assess and support patients with the most complex needs. As ENHT continues to act on the informal feedback about discharge received from the CQC, ward managers and their teams are working on increased knowledge, confidence, and empowerment to make discharge decisions and enact them in good time. This is also being supported by a new digitised version of the discharge passport for patients, which supports good decision making and communication, and is going live in November 2023.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Seamless Services / Objective F – Care Closer to Home
SRO – Kevin O'Hart, Director of Improvement
ENH HCP is working collaboratively to develop a 'care closer to home' model to provide services in our local area, where service provision is designed around people and tailored to their specific needs. This work will align with ICB proposals for a new primary care target operating model and an increasing ambition to drive change through local INTs: Integrated Neighbourhood Teams. A range of desired outcomes were agreed as part of the model's development that specifically focus on improving health and care access, reducing delays, increasing integration between services and expanding utilisation of community and primary services. The proposed model places people at the centre, with wrap-around services to focus on key 'touch points' including local authority, primary care, and the voluntary and community sector. This is likely to involve a core, integrated community and primary care team led by complex care coordinators, with specialist support from secondary care, public health, mental health, and voluntary sector co-opted in as required. There has been agreement that individual PCNs (Primary Care Networks) will need to move forward and design their own INTs at a locality level to respond to local needs (identified through population health management data), and outline timescales have been provisionally agreed for this – every PCN should be part of an operational INT by April 2024 and any required infrastructure will be developed at ENH Place level to enable the efficient and effective establishment and evaluation of INTs by April 2024. Two vanguard PCN areas have come forward (Hoddesdon & Broxbourne PCN and Welwyn Garden City PCN) and they will receive more intensive support from HCP and ICB project teams, as well as from Population Health Management teams. This will enable a more detailed granular approach to the population health needs in their area to agree a more focused cohort of patients. This will help ENHT to identify key speciality areas who will need to be involved most closely. Once these vanguard sites have begun to develop and test their models, the learning will be shared across the other areas to enable INTs to roll out more widely in a coherent way. Hoddesdon & Broxbourne and Welwyn Garden City PCNs have begun development of their INTs through a series of workshops which have focused on their local PHM data, local narrative and current service provision, gaps in what is available locally – which is supporting them to generate the key focus areas for their developing INT. As an example, Welwyn Garden City have agreed three key areas where there is an opportunity to focus locally on improvement via their INT: 1) Childhood obesity: is there more we could be doing locally to influence behaviours, and to link with education sector and local retailers; 2) Carers: how can we support carers before they reach crisis, which often results in ED attendance or other use of emergency services for what is not necessarily a health crisis; 3) Complex disease management (for high intensity users): developing an effective multi-disciplinary team approach to managing the most complex patients to ensure they receive the right care by the right profession and the right time (reducing inappropriate additional pressures on health and care services, providing better support to patients).

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective G – Quality Management System
SRO – Kevin O'Hart, Director of Improvement
Phase one of our improvement partnership with Virginia Mason Institute (VMI) consisted of a cultural readiness review that was planned during July – August and conducted in September. This process consisted of a documentation review, 15 one-to-one and group interviews with leadership teams, 28 staff focus groups covering over 200 staff from all disciplines and levels, an electronic staff survey involving 444 responses, observations of key organisational meetings as well as 13 Genba-style (go see, ask why, show respect) walkarounds. Sessions and visits to both front line and back-office areas covered all four main hospital sites at Lister, the New QE II Hospital, Hertford County Hospital, and Mount Vernon Cancer Centre. This review is pivotal in understanding our current state with key areas explored involving our current approach to continuous improvement and transformation, our strategic alignment of overall priorities from senior leaders to frontline staff, how behaviours, actions and policies demonstrate our culture and values, how expectations and behaviours of leaders either accelerate or impede adoption of continuous improvement as well as how data is deployed to drive decision-making in improvement initiatives. The output from this work was shared in October with findings correlated against themes from across a transformation continuum, this is a well-established and proven approach developed over 20 years and across 26 countries worldwide to support organisational change. The continuum encompasses both the technical infrastructure required and the cultural and leadership changes essential for fostering a successful learning and evolving organisation. The findings will serve as a baseline and will inform the subsequent phase of co-design which will begin in November. As part of next steps, the executive team and divisional leaders will visit part of the Virginia Mason Franciscan Health system in Seattle and over 3 days undertake an immersive experience in clinical and support areas to see and hear first-hand from staff and patients how a lean-based quality management system can be successfully deployed and embedded in a hospital, leading to high quality care and sustainable improvements in outcomes for patients and staff. The visit will also incorporate an in-depth analysis of the cultural readiness review and associated recommendations.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

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

The Trust's strategic objective to increase elective activity in line with the national recovery programme, incorporates improvement work within both outpatients (OPD) and theatres (Surgical Pathway Programme). Performance in Q1 places us 10th nationally with performance at 117% compared to pre-pandemic, and Q2 looking even more favourable.

The Outpatient Transformation programme started at the beginning of the year with a vision to consistently deliver exemplary outpatient services with high quality care to our patients and wider community. The programme focuses on three key areas: efficiencies within our pathways through redesign, improved patient experience through a new digital patient portal as well as improved contact centre processes and waiting lists digital infrastructure to streamline accuracy and real-time of patient pathways.

The Trust is being recognised for its improved outpatient performance nationally. Over the last year we have considerably reduced the number of missed appointments ensuring that more patients can be seen in our clinics. Some of the initiatives for proactive prevention of Did Not Attends included regular text reminders and phone calls offering options to cancel and rebook appointments. In August, a new patient portal was trialled with Orthotics patients to enable appointment letters to be viewed electronically - reducing the costs associated with paper letters and call waiting times to our call centre. The next phase of the project will enable patients to cancel or rebook appointments via portal making it much easier and quicker process, which will be rolled out to all specialties.

By delivering outpatient care remotely and reducing unnecessary steps in the pathways, the Trust has implemented innovative ways to see less follow up appointments, therefore releasing capacity for other patients to be seen. One of such initiatives is Patient-Initiated Follow Up (PIFU) which ensures that patients have access to a clinician at the time they need it. July's PIFU sprint week saw over 725 patient conversations take place, resulting in stronger patient awareness and empowerment directly leading to more patients being offered PIFU pathway as an option for their follow up care. Increasing Advice & Guidance available to GPs, streamlining referrals and early diagnostics in the beginning of the pathway will ensure that patients are seen quicker. Utilising all available clinic capacity and reducing wasted appointment slots is central part of the programme to support shorter waiting times.

The programme is based on a patient-centred approach ensuring that the patients' voice is represented through various engagement events. Using the power of patient stories, we have pledged to make changes to our outpatient booking processes making them more responsive to patient needs, easier to navigate and empowering patients to self-manage their condition where possible. As an example, 15-steps challenge is a tool the team has used to understand patients' first impressions of clinic environment and highlighted how we can improve patient experience as well as collaborate with system partners to drive health promotion in a more digitally-enhanced way.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective H – Elective Recovery *(continued)*
SRO(s) – Martin Armstrong, Director of Finance, Deputy Chief Executive & Mark Stanton, Chief Information Officer
The Surgical Pathway Programme (SPP) focuses on the key stages of the pathway that impact our overall performance within the Theatre environment. With a fixed capacity available it is essential that we use each session as effectively as possible, to ensure we can provide as many procedures as possible to help reduce the waiting times for our patients. Since the pandemic waiting lists have increased, and importantly the patients on the lists have become more complex requiring procedures that take longer to perform in theatres. Despite this we are performing well, consistently in the upper quartile of national performance for utilisation and leading our peers within the ICS. We are encouraged to share our approach with system partners to help them improve. Our performance, however, is variable, and there are areas for improvement that require continuous review and a collaborative approach. The SPP has been working closely with the Pre-Operative Assessment teams in conjunction with our system partners to ensure we understand the needs of the patients waiting for surgery, and that they are prepared appropriately and safely for their procedure. This work has been supported by a clear focus on how we book our theatre lists, ensuring that we make sure we are maximising the time available, and that we book the right cases onto each list, allowing for an anticipated level of cancellation. This work has been supported by attention to peer performance data to enable us to compare and challenge our approach. Each of our surgical specialities have agreed targets to improve the number of cases per theatre list which has resulted in upper quartile performance nationally for this metric in Q1 and a return to 2019/20 performance. In October, the Trust had a Theatre Focus Week that was supported by every Executive in the Trust coming to Theatres to meet staff and walk in their shoes. There were clear areas of focus in the week, looking at the journey our patients take, how long they spend in each part of the process, how we book and prioritise the theatre lists and how that impacts how we prepare our staff and equipment for each list. It was also an opportunity for us to celebrate the success of our Theatres teams and give them the opportunity to suggest ideas and changes not only to the management but also the Executives directly. In addition to this the SPP is working closely with Trauma and Orthopaedic Operational and Clinical Teams to understand the challenges faced by this speciality and agree some short rapid improvement ideas and solutions.

Board

East and North Hertfordshire NHS Trust

Meeting	Trust Board Meeting - Public			**Agenda Item**	13
Report title	External Audit – Value for Money Report			**Meeting Date**	1 November 2023
Presenter	Martin Armstrong – Chief Finance Officer				
Author	BDO External Audit				
Responsible Director	Martin Armstrong – Chief Finance Officer			**Approval Date**	26 October 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

As part of the annual audit of the trust financial accounts and governance arrangements, the Trusts appointed external auditors BDO are required to undertake an assessment of whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources. This is termed the Value for Money (VFM) report.

The VFM report was finalised and presented by BDO to the Audit and Risk Committee at its October meeting. The Audit Committee received and acknowledged the report and referred it to Trust Board for noting.

The VFM report identified significant weaknesses in respect of Financial Performance in respect of CIP savings delivery during 22/23, and also CQC inspection respects for Maternity. The report acknowledges steps that the Trust has made to address these weaknesses and makes a related recommendation.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal

Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability

CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

The delivery of value for money arrangements are an important element of the Trust's statutory obligations. Failure to achieve these duties compromises the organisation's ability to deliver sustainable services.

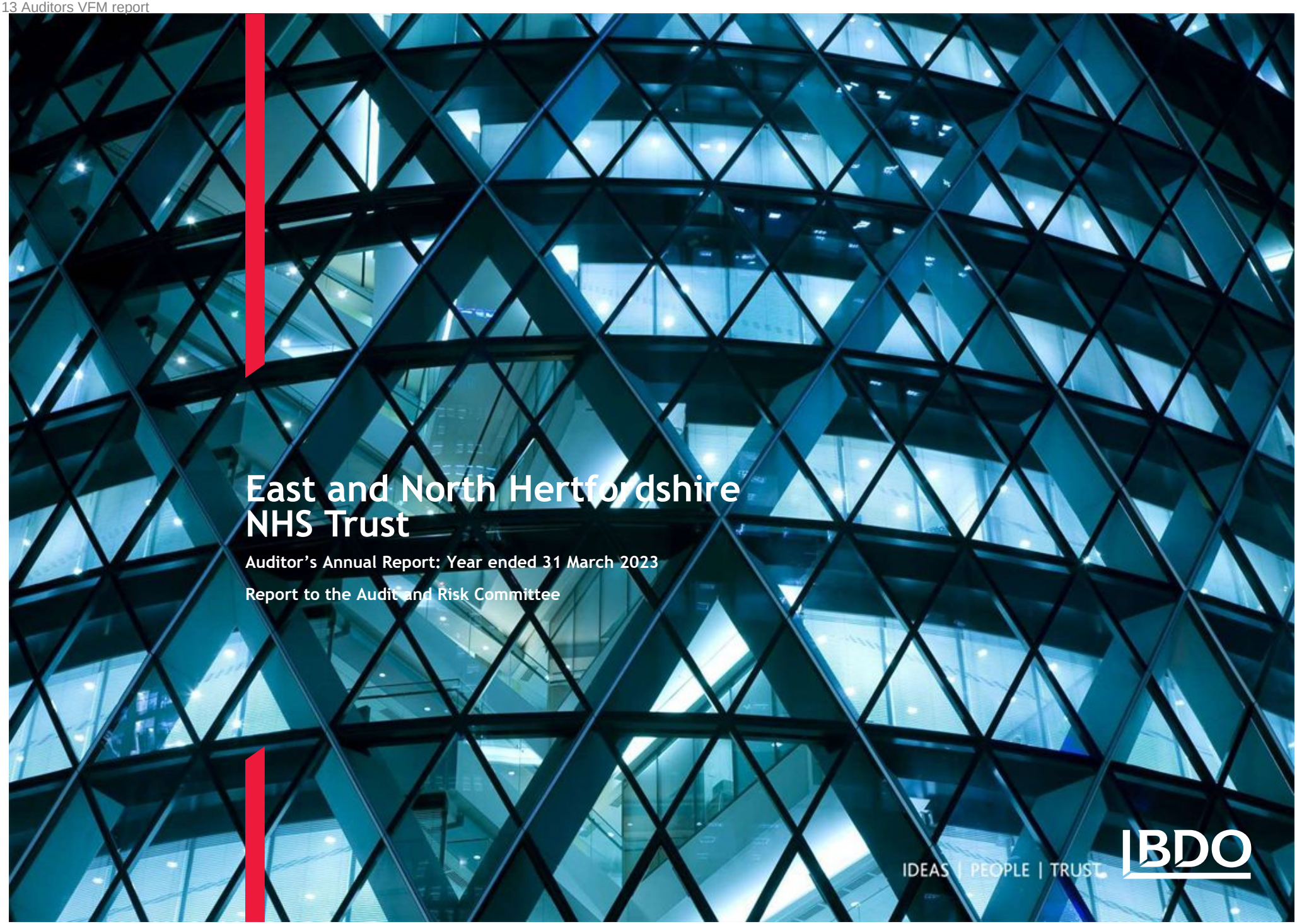
Risk: *Please specify any links to the BAF or Risk Register*

The report provides support to the Trusts ability to proactively deliver value for money arrangements in the provision of its services.

Report previously considered by & date(s):

Recommendation	The Board is asked to note the report and its recommendations.

To be trusted to provide consistently outstanding care and exemplary service



East and North Hertfordshire NHS Trust

Auditor's Annual Report: Year ended 31 March 2023

Report to the Audit and Risk Committee

IDEAS | PEOPLE | TRUST

BDO

Contents

Welcome

Executive Summary

This Auditor's Annual Report provides a summary of the key issues arising from our audit of East and North Hertfordshire NHS Trust (the Trust) for the year ended 31 March 2023.

Financial statements

We issued an unqualified opinion on the Trust's financial statements on 24 July 2023.

This means that we consider that the financial statements give a true and fair view of the financial position and its expenditure and income for the year.

Value for money

We have identified two significant weaknesses in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources having regard to the specified criteria in the Code of Audit Practice.

Other reporting

We did not consider it necessary to use our auditor powers or report on other matters.

On 27 May 2020 we reported to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 that the Trust has planned a cumulative deficit position and that as a result the Trust has begun to take a course of action that would be unlawful. The timespan covered by this referral is to 2023/24 and so no fresh referral was required this year. We note however that the Trust has failed in its break-even duty for 2022/23.

3rd October 2023

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Purpose and responsibilities

Executive summary

Purpose of the Auditor's Annual Report

This Auditor's Annual Report summarises the key issues arising from the work that we have carried out in respect of the Period ended 31 March 2023.

It is addressed to the Trust but is also intended to communicate the key findings we have identified to key external stakeholders and members of the public.

Responsibilities of the Trust

It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business and that public money is safeguarded and properly accounted for.

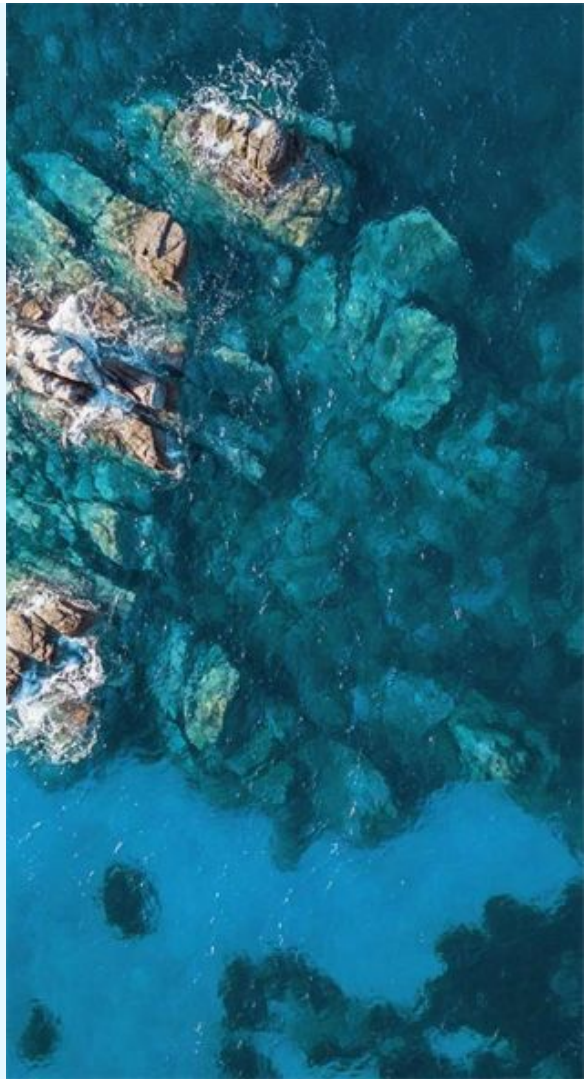
The Trust is also responsible for preparing and publishing its financial statements, annual report and governance statement.

Responsibilities of auditors

Our responsibility is to plan and carry out an audit that meets the requirements of the National Audit Office's (NAO's) Code of Audit Practice – April 2020 (the 'Code').

Under the Code, we are required to review and report on:

- Whether the financial statements give a true and fair view of the financial position of the Trust and of its income and expenditure for the year and have been properly prepared in accordance with the relevant legislation
- Whether the other information published together with the financial statements is consistent with the financial statements
- Whether the auditable parts of the remuneration and staff report are properly prepared
- Whether the governance statement complies with the guidance issued
- Whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources
- Where appropriate, make statutory recommendations, referral matters to the Secretary of State or issue a Public Interest Report.



Financial statements

Financial statements

Audit conclusion

We issued an unqualified audit opinion on the financial statements on 24 July 2023.

This means that we consider that the financial statements give a true and fair view of the financial position and its expenditure and income for the year.

We reported findings whilst the audit was in progress, but substantively complete, to the 11 July 2023 Audit and Risk Committee and circulated an update of our detailed findings on 24 July 2023.

Significant deficiencies in controls

We did not identify any significant control deficiencies during the audit of the financial statements.

Audit differences

The audit identified no material misstatements.

There were six unadjusted audit differences identified by our audit work, and a cumulative prior year uncorrected misstatement brought forward, which would decrease net operating expenditure for the year by £2.821 million. Management did not adjust the financial statements for these items as the impact was not material.

Value for Money

Summary

Scope

We are required to review and report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Where we identify significant weaknesses in these arrangements, we are required to report this in the auditor's report included in the financial statements and to make recommendations for improvement in the Auditor's Annual Report.

Specified criteria

The NAO has issued guidance for auditors to report against three specified reporting criteria:

- Financial sustainability - planning and managing resources to ensure the Trust can continue to deliver its services
- Governance - informed decisions and properly managing risks
- Improving economy, efficiency and effectiveness – using information about costs and performance to improve the way the Trust manages and delivers its services.

The NAO guidance also includes a number of further areas for review within each criteria to allow the auditor to assess those arrangements.

Risk Assessment

Our risk assessment identified three areas of potential significant weakness as follows:

- Financial Performance
- CQC inspection results – Maternity
- Internal Audit Recommendations

Audit conclusion

We have identified significant weaknesses in respect of Financial Performance and CQC inspection results for Maternity and have reported recommendations against these.

We had no matters to report by exception in the audit report on the financial statements. We also have no further matters to report in our closing audit certificate, regarding the completion of our work on the Trust's value for money arrangements.

Financial Sustainability

Planning and managing resources

Auditor's commentary on arrangements

Areas reviewed

- ***How significant financial pressures relevant to short and medium-term plans are identified and built into plans***
- ***Plans to bridge funding gaps and to identify achievable savings***
- ***Whether financial plans support the sustainable delivery of services in accordance with strategic priorities***
- ***The consistency of financial plans with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system***
- ***Identification and management of risks to financial resilience e.g. unplanned changes in demand, including challenge of assumptions underlying its plans.***

Risk Assessment

We identified a risk of significant weakness in relation to Financial Performance. As at month 10 (January 2023) the Trust had forecast a £8.0m deficit for the year ended 31 March 2023, and a year-to-date Cost Improvement Programme (CIP) underachievement of £4.9m. This subsequently crystallised to an actual year end deficit of £6.1m with full year CIP underachievement of £6.8m against a target of £18.8m. This presented a risk in respect of financial sustainability and a breach of the Trust's statutory duty to break even, and may be indicative of weaknesses in underlying arrangements with respect to achieving financial sustainability.

Work performed

In response to the risk identified we:

- Documented our understanding of the Trust's CIP arrangements for 2023/24
- Reviewed the Trust's financial plan and the assumptions used, as well as plans for longer term recovery
- Understood the extent to which the Trust is considering CIP delivery models such as mutli-year CIP and the extent of engagement with other bodies within the Integrated Care System (ICS)
- Considered the outcomes of any remedial work undertaken by the Trust to address known issues

Findings - Significant Weakness

As part of our auditor's annual report for the year ended 31 March 2022, we highlighted that there was a risk that the Trust would not achieve their CIP requirement for 2022/23, which if not appropriately mitigated may impair the Trust's ability to break even. The Trust's plan to break-even for the year was reliant on being able to achieve this target. 2022/23 was the first year in which Trusts were formally required to plan, monitor and report on CIP in a manner comparable to the 'pre-COVID' financial architecture of 2019/20. The target (initially £17.8m, subsequently £18.8m) was larger than that previously achieved by the Trust. While £15.0m had been achieved during 2019/20, this had largely been following the introduction of unplanned schemes, rather than representing achievement of plans as originally established.

Financial Sustainability

Planning and managing resources

From a review of Finance Performance and Planning Committee (FPPC) minutes during 2022/23, it is clear that risk around CIP performance began to crystalise relatively early in the year, with the M3 position (reported 26 July 2022) being £2m below plan from a 'year to date' position, a rate that continued across the year.

The Trust has undertaken steps to mitigate this, both within year and with a longer-term horizon in mind. A revised CIP delivery framework has been introduced, including a timeline of key actions required in support of this, generally timed from November 2022 to April 2023.

In addition, the Trust has taken remedial actions as part of the CIP planning for 2023/24 to address known areas of poorer performance (particularly unplanned care).

However, fundamentally the Trust was reliant on these arrangements being effective across the 2022/23 year in order to break even, and that arrangements in place did not support this.

The recurrency of the CIP achieved also differed from that planned; non-recurrent and recurrent CIP was planned as £8.453m and £10.327m respectively, with achievements of £6.533m (77%) and £5.417, (52%).

As noted in the April 2023 FPPC reports pack, the lower than planned level of recurrent savings is a direct contributor to the Trust's planned deficit for 2023/24.

The CIP target for 2023/24 is £33.1m;. As at month 4 this remains on track, although £2.4m remains unidentified in the Unplanned Care division, which was also flagged as being 'extremely weak' in the work up of CIP project initiation documentation.

In the context of the above and the significant weakness identified, we recommend that the Trust closely monitor CIP outturn over the course of 2023/24 , in particular the extent to which the revised CIP delivery framework is able to address areas of known weakness.

Other commentary

We also reviewed other elements of the Trust's arrangements in support of Financial Sustainability, as set out below. No significant weaknesses were identified from this assessment.

The Trust prepares a 'Finance Report' on a recurring basis. This monitors performance against budget for the month prepared as well as for the year to date. The reports consider activity levels, year on year comparisons, paybill analyses, divisional financial positions, capital programme position and balance sheet performance, with supporting detailed reporting.

This report is presented to the Finance, Performance and People Committee (FPPC) at each of its meetings; the Committee discuss and challenge the contents.

The discussion typically covers the risks and challenges faced to meet the budget requirements and observed unexpected performance/trends. While the finance reports do not routinely go to the Trust Board, the FPPC presents summaries of its activities to each Trust Board by way of executive summary reports, which includes the outcome of the review of the Finance Reports.

Financial Sustainability

Planning and managing resources

Alongside the monitoring reports above, reports are regularly presented to the FPPC and Board on matters that are relevant to the Trust's financial planning. For instance, in January 2023 a report was presented (Business Planning) setting out the Trust's approach to planning for 23/24 and the associated financial challenges, the approach having been previously approved by the FPPC.

The Business Planning Framework sets out basic principles and a clear process for holistic annual planning, detailing the time-frames and steps involved and roles and responsibilities of key stakeholders. It aims to integrate priorities identified in local business plans into a single annual plan as well as the longer-term strategic agenda while also focussing on meeting national and system requirements.

As highlighted in the Annual Report, The Trust has further invested in expanding its planned service capacity during 2022/23, completing the construction of two new surgical procedures rooms with a resulting expansion to capacity to perform elective operations at the Lister site. The Trust's capital programme and monitoring, which is integrated into the Finance Reports, helps the Trust in its delivery of sustainable services through capital investment.

The remit of the FPPC changed at the start of the financial year. Its remit includes routine financial reporting, business planning, procurement delivery and performance reporting. This broad remit (accommodated by a three hour Committee length) does support a direct link between financial planning and other plans.

The FPPC received the Business Planning Update 23/24 in March 2023, which provided an update on the 23/24 business planning process, specifically the basis of negotiations with the ICS and other system stakeholders in respect of the distribution of funding allocations, and the progress in relation to the development of the elective recovery programme and Urgent & Emergency Care capacity enhancements required in order to deliver national priorities.

The report also set out the interim deficit financial plan for the Trust and the scale of the CIP programme required for the new financial year and a view around its development, as well as the workforce establishment and capital plan for 23/24.

The Trust has a risk management strategy in place which states risks are identified, assessed and controlled and, where appropriate, escalated or de-escalated through the governance mechanisms of the Trust. The strategy was refreshed in early 2023. Management of financial risks and risks to the Trust's internal control environment are supported through the application of Standing Financial Instructions.

Trust management prepares a 'Finance Report' and 'Integrated Performance Report' for review of the Board and committees. These reports include analysis of under and overspend, revised forecasting to the year end and variances to date.

Financial Sustainability

Planning and managing resources

Sitting below the BAF, Corporate Services risk registers cover risks from corporate areas, such as Finance, and are maintained by Risk Leads with support from the Risk Manager. Corporate areas have Governance/Audit Leads who are responsible for consulting with teams to identify and assess risks. There are mechanisms in place to involve all staff in risk identification. The Risk Leads and Divisional Boards/Corporate Directorates approve escalation of risks from Corporate Services/Divisional risk registers to a Corporate Risk Register.

Risks to the Trust's strategic priorities are identified by directors and through Risk Manager analysis reported quarterly and managed through the BAF. Risks to financial resilience will make it from the Corporate Risk Register on to the BAF if they are a risk to the Trust's strategic priorities.

Conclusion

Except for significant weakness identified in relation to CIP, which is a significant weakness in respect of arrangements around Financial Sustainability, we do not consider there to be any further significant weaknesses from other arrangements reviewed.

The Trust had sufficient arrangements in place to enable it to plan and manage its resources to ensure it can continue to deliver its services.

Governance

Making informed decisions and properly managing risks

Auditor's commentary on arrangements

Areas reviewed

- ***Risks are assessed and monitored to gain assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud***
- ***The annual budget setting process is appropriate***
- ***Effective systems and processes are in place to ensure budgetary control, support statutory financial reporting requirements and ensure corrective action is taken where needed***
- ***The Trust makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency***
- ***The Trust monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of officer or member behaviour.***

Risk Assessment

We identified a risk of significant weakness in relation to the Trust's Care Quality Commission (CQC)inspection results (Maternity).

Following an inspection carried out by the CQC in October 2022 over maternity services at Lister Hospital, the service received a rating of 'Inadequate'. This represented a downgrading from the previous review.

Where services receive negative regulatory findings, this may be indicative of underlying weaknesses in arrangements with respect to governance.

Work performed

In response to the risk identified we followed up on the Trust's arrangements for responding to improvement areas identified.

Findings - Significant Weakness

CQC rated the service as inadequate primarily because:

The service did not have enough staff to keep women safe from avoidable harm and to provide the right care and treatment; the service provided mandatory training in key skills to all staff, however not all staff completed this; the service did not have effective systems to ensure staff received adequate safeguarding training; the service did not control infection risk well; the design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards.

Following this inspection the CQC issued a warning notice to the Trust under Section 29A of the Health and Social Care Act 2008. The CQC took this action as it believed a person would, or may be exposed to, the risk of harm if they had not done so.

The Trust has arrangements in place for addressing matters identified and it is clear that updates to the Board on maternity services (such as Maternity Assurance, CQC update) show that this remains a significant area of focus for the Trust. As such, we have not specifically identified a weakness in the Trust's response to the findings.

Governance

Making informed decisions and properly managing risks

However, in our view the significance of the findings represents a significant weakness in the Trust's governance arrangements for this service. We recommend that the Trust continue to monitor and address findings arising from this report. We recommend that the Trust also consider the extent to which the root causes of issues identified may have a bearing on arrangements elsewhere in the Trust, so that remedial action can be taken.

Other commentary

Internal audit is part of the Trust's governance and risk assessment structure and is outsourced to a third-party provider, TIAA, and is particularly crucial to providing assurance over the Trust's operation of internal controls. The Audit and Risk Committee has received reports, progress updates and action logs from Internal Audit covering a wide range of areas, including those we would consider to be particularly relevant to the Trust.

Risk management as a whole is supported by the Risk Management Strategy; see Financial Sustainability section above for more information. Arrangements include monthly meetings to identify and discuss risks and related controls for inclusion on local/divisional risk registers; Corporate Directorate meetings/Divisional Boards for monitoring risk management and approving escalation/de escalation of risks to a corporate risk register; identification of Risk Leads and Approving Managers to manage and approve risks operationally; identification of divisional Governance/Audit Leads and Quality Managers with responsibilities for facilitating risk management a divisional level. Risks are escalated to a Corporate Risk Register and BAF based on assessed risk scores and relevance to the Trust's strategic priorities. Reports have been observed to be included within the papers for Board meetings.

Through our attendance at the Audit and Risk Committee and review of Board and other committee minutes, we have observed formal consideration of the principal risks to strategic objectives and active monitoring of those risks through the BAF. Strategic risks included in the document are assessed with reference to controls and assurance to mitigate the risks, gaps in controls and assurance and actions to address gaps. The BAF is also considered at other Board Committees including Finance, Performance and People Committee.

The Trust has an anti-fraud and bribery policy in place approved by Board. It has an accredited Local Counter Fraud Specialist (LCFS), provided by TIAA in addition to internal audit services, with a programme of proactive counter fraud and corruption work which is risk based. The LCFS reports to the Audit and Risk Committee. From attending the committees, and a review of counter fraud reporting and through direct discussion with the LCFS, we can confirm that no major issues were identified during 2022/23 that would be significant VFM issues.

As reported in our audit completion report, we were made aware of an alleged fraud. The Trust engaged the LCFS to undertake an investigation into the allegations. We have reviewed the scope and outcome of this report, undertaken additional procedures and engaged our Forensic specialist to support our review. There has been no indication of fraud, however a small number of recommendations for improvement were identified by LCFS. The Trust has actioned all these recommendations and commissioned a review to further strengthen processes and governance in the area concerned.

Governance

Making informed decisions and properly managing risks

Internal audit recommendation progress is tracked on a quarterly basis at the Audit Committee. We identified the follow up of internal audit recommendations as a risk of significant weakness, as it is an area where issues have been noted in the recent past and as part of previous VFM reviews. These include high volumes of recommendations outstanding, high or urgent recommendations overdue, and evidence of repeated shifting of agreed dates which, while generally circumstance-specific, nevertheless contribute to a drift in underlying control issues being addressed. We have considered this risk on more detail under the "Improving economy, efficiency and effectiveness" section of our report.

The Head of Internal Audit's report for 2022/23 concluded that the Trust has reasonable and effective risk management, control and governance processes in place.

We noted as part of our external audit an increased number of control findings as compared with previous periods. While this is partly a reflection of an updated auditing standard (ISA (UK) 315 (Revised) July 2020)broadening the number of areas for external audit focus, there were also several instances of control recommendations from previous periods not having been implemented. We have already formally communicated these findings to the Audit and Risk Committee as part of our audit completion report.

Budgetary control is principally monitored through monthly Finance reporting and Integrated Performance reports (inclusive of performance data for financial plans in addition to non financial performance). As commented earlier in this report, we have obtained evidence of effective scrutiny of these reports by the Board and its committees, FPPC in particular.

The Trust has a statutory financial reporting requirement to break even and budgeted to do so in 2022/23. This has been monitored regularly at FPPC, although as noted in the Financial Sustainability section above this outcome was not achieved in 2022/23, and the Trust have set a deficit plan for 2023/24. The integrated planning report includes a quantification of the impact of inflation for the 23/24 year.

We have considered the role of FPPC in annual budget setting, including CIP planning, as part of our commentary on financial sustainability.

Budgetary control is principally monitored through monthly Finance reporting and Integrated Performance reports (inclusive of performance data for financial plans in addition to non-financial performance).

Internal Audit also has a role in the Trust's arrangements relevant to this reporting criteria both directly and indirectly, for example through review of Core Finance Systems which takes place annually and in 22/23 gave 'Reasonable Assurance'.

Primary oversight around informed decision making is the responsibility of the Trust's Board, with some delegated responsibilities to the Audit and Risk Committee. The Board is attended by all members of senior management when it meets (save apologies) and is presented with numerous papers covering a range of corporate and clinical matters of the Trust, with a good mixture of clinical and commercial expertise. We have reviewed papers and deemed them to cover key areas expected to inform effective decision making, for example operational and financial performance, summaries from the Board's committees, topical matters/risks relevant to the Trust's strategic priorities, governance and partnerships.

Governance

Making informed decisions and properly managing risks

A role of the Board is to ensure the Trust has appropriate arrangements for ensuring it exercises its functions effectively, efficiently and economically and complies with generally accepted principles of good governance as are relevant to it. Challenge and transparency are key to delivering robust governance and we have observed these behaviours during 2022/23 by the Board and its committees, including the Audit and Risk Committee which is responsible for maintaining an overview of the operation of internal control and governance.

We know from our review of Board and committee papers, minutes for these meetings and attendance at Audit and Risk Committee meetings, that the Board and its committees meet regularly and that key issues are addressed with effective challenge from members. We have also observed evidence of good arrangements in place regarding tracking and responding to the recommendations made by Internal Audit and that management has been held to account throughout the year regarding progress on recommended actions.

Responsibility for ensuring appropriate standards such as meeting legislative/regulatory requirements in terms of member behaviour sits primarily with the Audit and Risk Committee. Review of the effectiveness and compliance with key policies such as gifts and hospitality, declarations/conflicts of interest are confirmed to be covered by the Counter Fraud programme. This programme drew on the requirements of the Government Functional Standard's twelve components in 2022/23, in which policies and registers for gifts, hospitality and conflicts of interest are a component.

As referenced in the Trust's annual report, during the year the Trust introduced an online Declaration of Interests system for the first time

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

The 11 July 2023 Audit and Risk Committee received an update from Internal Audit highlighting that a draft audit report into the 22/23 Data Security & Protection Toolkit contained an 'Unsatisfactory' opinion, citing lack of engagement from the audit lead. We note from a review of the draft findings that a key factor in the rating is provision of evidence. We note that the equivalent review that took place for the 21/22 toolkit (submitted June 2022) gave an opinion of substantial assurance. A more recent update from internal audit has advised us that the 22/23 report remains in draft. We are therefore not able to assess whether the matters identified are final, or representative of a potential significant weakness. We are aware that the Committee has already been made aware of the delays in this report being completed. **Therefore, while no significant weakness has been reported, we recommend to the Audit and Risk Committee that addressing perceived gaps in the engagement with the internal audit process, both in terms of response to recommendations and responsiveness to individual assurance reviews, should remain an area of focus.**

Conclusion

Except for significant weakness identified in relation to Maternity Services, we do not consider there to be any significant weakness regarding the risk identified or the other arrangements we have reviewed. The Trust had sufficient arrangements in place to make informed decisions and properly manage its risks.

Improving economy, efficiency and effectiveness

Using information about costs and performance to improve its services

Auditor's commentary on arrangements

Areas reviewed

- ***Financial and performance information has been used to assess performance to identify areas for improvement***
- ***Services provided are evaluated to assess performance and identify areas for improvement***
- ***The Trust delivers its role within significant partnerships, engages with stakeholders it has identified, monitors performance against expectations, and ensures action is taken where necessary to improve***
- ***Where the Trust commissions or procures services, this is done in accordance with relevant legislation, professional standards and internal policies, and assesses whether it is realising the expected benefits of officer or member behaviour.***

Risk Assessment

We identified a risk of significant weakness in relation to internal audit recommendations.

At the Audit & Risk Committee's January 2023 meeting, it was noted in the Internal Audit Action Tracker that, as at 4 January, 18 actions were overdue including one urgent and six important recommendations, of which three were more than one year overdue. The pace of internal audit recommendation implementation has been flagged in our previous years' reports; we note that the most recently reported position is a slight deterioration on the position at 13th June 2022 (at the time of our last review).

Where internal audit recommendations are not implemented on a timely basis, this may undermine the Trust's arrangements for delivering continuous service improvement.

Work performed

We considered risks associated with audits that receive assurance ratings of either limited or no assurance, and the Trust's arrangements for following up on areas of identified weakness.

Findings

We have obtained the Trust's summary of recommendation status and observed the following:

We noted one significantly overdue high priority recommendation. The recommendation relates specifically to a historic recommendation around consultant job planning. This had been delayed on several occasions following the original planned implementation date (30 April 2020). The latest update reported in June 2023 confirmed that as at 19th April 2023 the medical workforce were on target to have all job plans on the L2P system by end of May 2023.

Two other high priority recommendations were outstanding, however, these were not considered significant in quantum from a VfM perspective.

We reviewed the overall rate of implementation and nature of other overdue recommendations. There are two other recommendations that, as at 20 June 2023, were more than 12 months overdue. Neither of these recommendations are high priority and responses received show that adequate regular follow up has taken place.

Improving economy, efficiency and effectiveness

Using information about costs and performance to improve its services

On this basis there are adequate arrangements in place for following up on outstanding internal audit recommendations. In the case of a long-standing overdue recommendation around consultant job planning, we have identified the reasons for the delay and have noted that appropriate escalation has taken place to enable the Trust to implement the recommendation. The delay is due to the specifics of the recommendation, not due to underlying governance weaknesses.

The rate of outstanding recommendations is comparable to previous years, with 21 being outstanding as at year end (24 at the equivalent point in time in the previous year). Having evaluated the background and follow up to higher priority or overdue recommendations we are satisfied that these do not represent fundamental weaknesses in arrangements, and that the rate of follow-up more generally, while an area that the Audit and Risk Committee should continue to monitor, is not reflective of a fundamental weakness in arrangements.

We noted in our audit plan that, as at January 2023, there were a limited number internal audit reports. This increases the risk that the Audit and Risk Committee is not going 'year round' assurance, or that insufficient work is performed to inform the Head of Internal Audit's conclusion.

However, as at the May 2023 Audit and Risk Committee Internal Audit were able to have completed sufficient work to inform their opinion, and a further update at 26 June 2023 confirmed that work completed since that date had not caused this opinion to change. Though indicative of work being 'backended' to the later part of the year, this is not uncommon in practice.

In addition, the Trust has been able to accommodate additional internal audit reports through the extraordinary Audit and Risk Committee of 26 June 2023.

The audit plan for 2023/24 is profiled in such a way that allows the work to be carried out over the course of the year. Discussions around better engagement with the internal audit process have been a recurring theme at the Audit and Risk Committee.

On the basis of the above, this is a known area of improvement for the Trust and not one which represents a significant weakness in arrangements.

There were no reports with 'no assurance'. Of those reports with limited assurance, none were considered sufficiently pervasive to be reflective of significant weaknesses in arrangements.

No significant weaknesses were identified against this risk.

Improving economy, efficiency and effectiveness

Using information about costs and performance to improve its services

Other commentary

Through review of Board papers, we have confirmed that the Board is provided with both financial and non financial performance information on a regular basis, principally through the Integrated Performance Report and highlight reporting from the FPPC. Board and committee members are able to challenge officers regarding departures from plans or expectations, as confirmed to meeting minutes. Within these reports, commentary is provided on the reasons for variances and executive responses, for the Board and relevant committees to identify and drive forward areas for improvement.

Through review of internal audit reporting during 2022/23 and the preceding year, we have confirmed a number of reviews focussed on financial and performance related information were completed. The 2021/22 internal audit programme specifically included a review into Performance Information: Business Planning (Demand and Capacity Plans) which provided reasonable assurance. Reviews in 2022/23 into Discharge Summaries and Emergency Department Standards similarly focus on performance information.

The Trust is required to report on the quality of its services against performance indicator targets throughout the year, culminating in an annual quality account report. The requirement for agreed upon procedures to be completed by an external auditor on the quality account was suspended during the coronavirus pandemic and has yet to return. However, the requirement remained for the Trust to publish a report in June 2023.

Quality indicators against which performance is measured for reporting are wide ranging and between them require numerous systems of processes and controls and IT applications to record and report accurate data. Performance against a wide range of indicators was monitored through the Board's Quality and Safety Committee (QSC) and reported to the Board through regular Integrated Performance Reports.

Integrated Performance reporting provided graphical dashboards for clear illustration of performance trends and also provided commentary on key issues identified and executive responses to aid Board scrutiny. Monitoring the Integrated Performance report at public Board level demonstrates clear accountability for improvement and arrangements in place to secure these improvements.

The Trust set four broad priorities for improvement linked to its "vision and values to 2030" and it has a programme of measures for progress across themes within its priorities for improvement. The four Strategic Themes are used to underpin other key frameworks in use at the Trust, for example, the Board Assurance Framework.

The annual clinical audit programme is reviewed and approved through the Clinical Effectiveness Committee and progress is monitored through the Divisions and QSC. The Audit and Risk Committee receives the annual self-assessment against the assurance framework.

Improving economy, efficiency and effectiveness

Using information about costs and performance to improve its services

The Trust is part of the Hertfordshire and West Essex Integrated Care System (ICS), with the ICS taking on statutory responsibilities for the strategic commissioning of healthcare in the area from July 2022. Through the Hertfordshire Health and Care Partnership the Trust is involved in projects such as the 'Hospital at Home' service and the creation of a 'vascular hub' at Lister Hospital.

The Trust has also continued to work with system partners through the East & North Hertfordshire Integrated Care Partnership (ICP). The ICS Monthly performance report produced by Hertfordshire and West Essex integrated care system and sets out performance against a range of access dimensions across the system and its constituent organisations.

There has been less focus on the procurement of services by commissioners / contract monitoring arrangements within the NHS in 2022/23 due to the extension of block contract arrangements. Our audit work had not identified any issues in respect of these arrangements.

We note also that procurement and commissioning are a recurring element of LCFS work, for both pro-active and investigatory work.

A report was taken to the January 2023 Audit and Risk Committee on the Trust's waiver volume and value during Q1-3. 74 waivers totalling £3.0m had been raised in Q1-3, of which 23 were retrospective and 10 were considered avoidable. The total value and level of waivers was comparable to the two previous years (total values being £4.9m and £2.9m for 2020/21 and 2021/22 respectively).

The ICS Procurement Service provides procurement services to the 5 Provider Trusts of the Hertfordshire and West Essex ICS. The FPPC receives periodic updates on Procurement Delivery. The March 2023 report, observed by the auditor, is an update from the HWE ICS Procurement Service and updates, amongst other things, on:

- Savings and Operational Performance Metrics
- Procurement projects
- Major Contracts Expiring in the next 24 months
- Key strategic and transformational activities
- ICS Procurement Milestones and Standards

Conclusion

We do not consider there to be any significant weaknesses in the arrangements on improving economy, efficiency, and effectiveness. The Trust had sufficient arrangements in place to use information about costs and performance to improve its services.

Recommendations

Significant weakness in arrangements	Recommendation
The Trust was reliant on achievement of £18.8m of savings from Cost Improvement Programmes (CIP) in order to meet its break-even obligations in 2022/23. This was not achieved, and underlying arrangements for CIP identification and monitoring were not sufficiently robust during the year to support this. In our view this is evidence of a significant weakness in the Trust's arrangements for financial sustainability.	We recommend that the Trust closely monitor CIP outturn over the course of 2023/24, in particular the extent to which the revised CIP delivery framework is able to address areas of known weakness. Where delivery risk is identified, the Trust should ensure appropriate intervention takes place.
In October 2022 the Care Quality Commission (CQC) inspected the maternity services at the Lister Hospital and rated it as 'inadequate'. CQC rated the service as inadequate primarily because: • The service did not have enough staff to keep women safe from avoidable harm and to provide the right care and treatment • The service provided mandatory training in key skills to all staff, however not all staff completed this • The service did not have effective systems to ensure staff received adequate safeguarding training • The service did not control infection risk well • The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards Following this inspection the CQC issued a warning notice to the Trust under Section 29A of the Health and Social Care Act 2008. The CQC took this action as it believed a person would, or may be exposed to, the risk of harm if they had not done so. In our view this is evidence of a significant weakness in the Trust's governance arrangements for this service.	We recommend that the Trust continue to monitor and address findings arising from this report. We recommend that the Trust also consider the extent to which the root causes of issues identified may have a bearing on arrangements elsewhere in the Trust, so that remedial action can be taken.

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	14
Report title	Summary Learning from Deaths Report			**Meeting Date**	1 November 2023
Presenter	Medical Director				
Author	Mortality Improvement Lead				
Responsible Director	Associate Medical Director for Reducing Unwarranted Variation			**Approval Date**	13 September 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

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

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

Impact: where significant implication(s) need highlighting

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

1. **Trust Strategic Objectives:**

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

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

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

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

2. **Compliance with Learning from Deaths NQB Guidance**
3. **Potential impact in all five CQC domains**

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

Please refer to page 3 of the report

Report previously considered by & date(s):

Mortality Surveillance Committee – 13 September 2023
Quality & Safety Committee – 27 September 2023

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 detailed 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, in the current 2022-24 Learning from Deaths Strategy.

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 Q1 2023-24. An in-depth Learning from Deaths Report covering the same period was provided to both the Quality & Safety Committee, and Mortality Surveillance Committee in September 2023.

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
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. Further internal and external specialist review of patient care is ongoing overseen by an external governance expert. Both NHSE and the ICB have been made aware of the findings and are involved with the ongoing investigation and assurance work. As a high probability has been identified that harm has been caused, the Trust has declared a Serious Incident. The SI Panel was satisfied that to date, there has been clear evidence of good assurance as demonstrated by the actions so far taken.	
Cardiology: recurrent HSMR and SHMI alerts (especially AMI) 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. Initial findings showed that approximately 50% of the deaths had been incorrectly coded for a variety of reasons resulting in the data not providing a true reflection of AMI clinical activity. A subsequent update confirmed that there was no clear indication of a systemic clinical problem or individual operator. It identified that coding errors or poor documentation leading to coding errors was having a significant impact on HSMR. When errors were removed from the data, the HSMR dropped to a level in line with similar PPCI centres.	
Medical Examiner Integration & Community expansion The Medical Examiner office is continuing to hold regular meetings with Community stakeholders regarding the roll-out of scrutiny of Community deaths. While the statutory deadline for implementation has been delayed to April 2024, progress is being made regarding the associated need to scrutinise GP records. Approximately, 50% of GP surgeries are currently sending in referrals and communication is ongoing with the remaining surgeries. Concerns raised by families regarding a community death are flagged to the relevant service provider. Each month these are also shared with the ICB. Of note is that we have been complimented by the Hertfordshire Coroner on how well the process has been set up and is working.	
Mortality review reform: Using the new review tool for reporting & learning The reporting tools associated with the NHS Apps structured judgement review tool were created by the NHSE Making Data Counts team. With the loss of funding for the Better Tomorrow team for the FutureNHS workspace, it is more difficult to get the support and traction we sometimes need. Following the recent move of the Better Tomorrow team to AQUA, it is not yet clear how robustly supported the framework will be.	
ENHance: Using the system for escalation, reporting and learning and sharing There have been delays and significant issues experienced regarding the transfer of other Trust systems onto ENHance. Until these have been fully resolved, it will not be possible for the ENHance programme team to focus on working with us to understand the reporting and learning/sharing potential of the system for our learning from deaths work.	

Table 1: Current risks

Risks	Red/amber rating
Implementation of the Patient Safety Incident Response Framework (PSIRF) While we are working closely with the PSIRF implementation programme, until the fine detail of that implementation has been developed, the precise details of changes required to our SJR process will not be known. As the implementation is rolled out it will be vital for close collaboration to remain ongoing.	

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 1.14% for the 12-month period to July 2023 compared to 1.25% for the latest 3 years.
HSMR: (data period Jun22 – May23)	HSMR for the 12-month period is **94.63, 'Mid-range'.**
SHMI: (data period Apr22 – Mar23)	Headline SHMI for the 12-month period is **92.95, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 3rd (of 11) within the Model Hospital list* of peers.

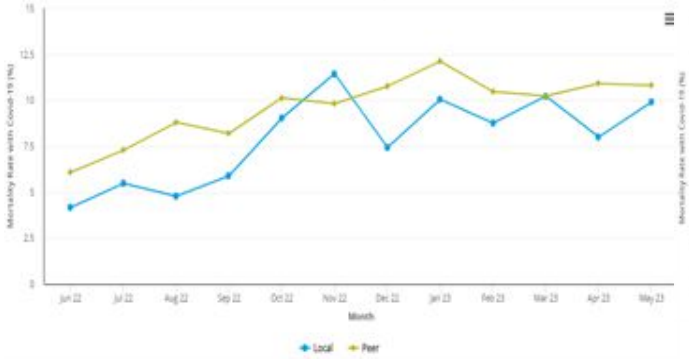
* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital (updated in 2022), rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

2.2 COVID-19

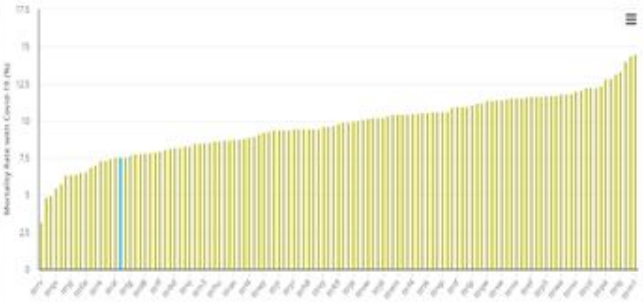
The following charts provided by CHKS show how the Trust's mortality rate for Covid compares with our national peers.

Fig 2: Covid-19 Peer Comparison: June 2022 to May 2023

Mortality Rate with Covid-19 (Peer: National)



Mortality Rate with Covid-19 National peer comparison



2.3 Mortality alerts

2.3.1 CQC CUSUM alerts
There have been no CQC alerts in Q1.

2.3.2 HSMR CUSUM alerts

The latest release from CHKS showed two HSMR CUSUM red alerts which constituted a rolling 12-month 3 standard deviation outlier, for the year to May 2023: Acute Myocardial infarction (AMI) and Urinary Tract Infections (UTI). Review of AMI had been included in the ongoing joint Coding/Cardiology initiative. A coding review of the UTI deaths has just been requested.

Table 3: HSMR CUSUM Alerts June 2022 to May 2023

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
159 - Urinary tract infections	153.39	55	36	19
100 - Acute myocardial infarction	152.23	51	34	18

Source: CHKS (CUSUM alerts coloured)

2.3.3 SHMI CUSUM alerts

The CHKS report also indicated four SHMI CUSUM red alerts for the period to February 2023 which constituted rolling 12-month 3 standard deviation outliers, as detailed in the table below.

Table 4: SHMI Outlier Alerts March 2022 to February 2023

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
101 - 159: Urinary tract infections	141.14	86	61	25
107 - 197: Skin and subcutaneous tissue infections	195.41	26	13	13
81 - 56, 133: Cystic fibrosis, Other lower respiratory disease	197.63	23	12	11
27 - 39: Leukemias	234.09	18	8	10

As the Leukaemia diagnosis group continued to alert, with a coding review showing no errors, a clinical review is to be requested to help understand the alert. The skin and subcutaneous tissues infections group has also been recently reviewed with information regarding patients admitted to hospital with pressure ulcers shared with the safeguarding team. A further review has been undertaken to check for any trend in where these patients are being admitted from. While there was no clear trend the detail has been shared with the Community. A preliminary coding review of UTI deaths has been requested. The Cystic fibrosis group was recently reviewed and will be monitored.

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

2.3.3 Key Learning from Deaths Data

2.3.3.1 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 Q1 2023-24.

Table 5: Q1 2023-23: Learning from deaths data

	Apr-23	May-23	Jun-23
Total in-patient deaths	103	109	85
Deaths with SJR completed to date (at 29.11.22)	23	25	14
Patient safety incident escalation from SJR (by month of death)	1	9	3
Concluded ACONs (2021-22 deaths): possibly avoidable (≥50%) due to problem in care	0	0	0
Learning disability deaths	0	1	1
Mental illness deaths	2	3	0
Stillbirths	1	1	1
Child deaths (including neonats/CED)	1	1	1
Maternity deaths	0	0	0
SIs declared regarding deceased patient	4	3	1
SIs approved regarding deceased patient	1	0	3
Complaints regarding deceased patient	4	3	3
Requests for a Report to the Coroner	18	15	25
Regulation 28 (Prevention of Future Deaths)	0	0	0

2.3.3.2 Learning from deaths dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This dashboard has previously been provided in this report. However, the recent transition from our old in-house mortality review tool to using the SJR*Plus* tool and approach, part way through the 2022-23 reporting year presents a reporting challenge, as the data aligns differently. In the short term, while the transition is completed, the dashboard will not be used. Once we have 12 months of data on the new system, a contextual dashboard will be reintroduced.

3.0 Scrutiny to SJR

3.1 Medical Examiner Scrutiny

Table 6: Medical Examiner scrutiny data: Q1 2023-24

Scrutiny detail	Apr	May	Jun	Q1 total
	103	109	85	297
Number of ENHT deaths scrutinised by ME	109	108	88	305
Number of MCCDs not completed within 3 calendar days of death	19	16	3	38
Number of ME referrals to Coroner	18	15	25	58
Number of deaths where significant concern re quality of care raised by bereaved families/carers	2	1	2	2
Number of patient safety incidents notified by ME office as a result of scrutiny	1	0	0	1
Number of ME referrals for SJR	15	28	29	70

Although the number of SJR referrals seems high, 61 of these relate to deaths that have occurred within 28 days of a recent discharge, which the National Medical Examiner directs should be put forward for further review.

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 on 1 July 2022, with supporting standard operating procedure, Qlik Sense mortality report and Mortality Support intranet page.

In addition to ensuring use of the new tool and processes become robustly embedded, the focus is now on developing supporting documentation and appropriate reporting tools for the new methodology.

3.2.2 SJR and deaths YTD headline data

Table 7: 2023-24 Deaths and SJR headline data to the end of Q1

Data count	Apr	May	Jun
Total in-patient deaths	103	109	85
Total ED deaths	7	5	7
SJRs completed on in-month deaths (at 03/08/2023)	23	25	14

The above table shows that to date, 20% of hospital deaths have received a formal structured judgement review. As our overall completion rate last year was in the region of 30%, this represents a slow start to the year against our expectations. A mortality reviewer forum is scheduled for September, with a key item for discussion being the reasons underpinning the downturn in reviews completed. At the same time, it should be noted that in discussions, the Better Tomorrow/FutureNHS team suggested that our review numbers were higher than needed for robust learning, many trusts reviewing between 15-20% of deaths.

3.2.3 Learning beyond SJR
3.2.3.1 SJR patient safety incident escalations

Table 8: Year to end of Q1 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 03/08/2023)	Apr	May	Jun	Total
Patient Safety Incident Escalations from SJRs	1	9	3	13

3.2.3.2 Mortality reviews undertaken prior to 1 July 2022
There are still a number of legacy ACONs being progressed that relate to deaths before 1 July 2022. Every effort is being made to close these cases identified via the Trust's previous mortality review tool, as quickly as possible. As these cases are concluded key outcomes will be reported for the sake of transparency and completeness.

For existing ACONs, it should be noted that the current lapse in time between the death and completion of the ACON means that the avoidability of death score may not be decided in the same review year. Therefore, for the sake of transparency and robust governance this report details ACONs relating to all deaths which have been concluded during the quarter in question where the Mortality Surveillance Committee agreed an avoidability of death score of 3 or less (irrespective of the year in which the death occurred).

Table 9: Q1 2022-23 Concluded ACONs: Avoidability Score ≤3

ID	Year of death	Serious Incident	Avoidability score	Avoidability definition
-	-	-	1	Definitely avoidable
-	-	-	2	Strong evidence of avoidability
534	20/21	No	3	Possibly avoidable: more than 50-50%

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 advent of the new approach to structured mortality review; the introduction of the new ENHance platform for patient safety incident monitoring; together with the imminent implementation of PSIRF, we are aware that further development is required regarding the

ways in which learning is shared and regarding the methods to be used for assessing its impact and effectiveness.

4.0 Improvement activity

4.1 Focus areas for improvement/monitoring

Table 10: Focus Areas for Improvement

Diagnosis group	Summary update
Ovarian Cancer	External peer review in response to findings from an ovarian 30 day post Systemic Anti-Cancer Therapy (SACT) dataset in March 2021. The peer review identified a lack of integrated care at MVCC. Following the review, a further internal and external specialist review of patient care is in progress. Harm has been identified in four cases. The next step will involve a review of further cases to determine whether further harm has occurred. An external governance expert is to oversee and support the Duty of Candour process. NHSE are aware and involved as are the ICB who are involved with pathway changes. The findings have resulted in the Trust declaring a Serious Incident.
Cardiology diagnoses	Following an initial six-month joint Cardiology-Coding initiative to review MI and update in July, the work to monitor the cardiology basket of diagnoses is continuing with further updates to the Mortality Surveillance Committee scheduled.
Sepsis	HSMR performance relative to national peer remains well placed. There has been some improvement regarding achievement of sepsis targets, but this has not been consistent or sustained.
Stroke	Latest SSNAP rating remains D. Following an upward trend in both HSMR and SHMI, reductions have been seen from January 2023. Following the national set up of Integrated Stroke Delivery Networks (ISDNs), collaborative work via the East of England South network has led to the set-up of local meetings to monitor performance and provide support.
Emergency Laparotomy	Focussed improvement work remains on-going. Positive news includes the fact that current mortality is at 8% in July 2023, and we closed the year to May 2023 with 9.4% mortality in line with national outcomes. Continuing delays to the re-establishment of the Surgical Assessment Unit/Surgical SDEC, the lack of a dedicated emergency theatre for general surgery and lack of timely access to CT for reporting of abdomen, continue to present challenges to improvement.

5.0 Avoidable 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 basis of 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 Q1 deaths/SJR/Preventability data (detailing SJRs conducted up to 03 August 2023). The outcome of investigations and actions relating to these deaths will be discussed by the Mortality Surveillance Committee.

Table 11: 2023-24 SJR preventable deaths data to the end of Q1

Data count (at 03/08/2023)	Apr-23	May-23	Jun-23	Total
Hospital deaths (ED & inpatient)	110	114	92	316
SJRs completed on in-month deaths	23	25	14	62
Deaths judged more likely than not to be due to a problem in healthcare	0	0	1	1
% SJRs assessed ≥50:50 preventable	0%	0%	7%	1.6%

6.0 Options/recommendations

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

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	15
Report title	Management of Complaints and Concerns Policy			**Meeting Date**	1 November 2023
Presenter					
Author	Sophie Williams, Complaints, PALS and Patient and Carer Experience Lead				
Responsible Director	Theresa Murphey, Chief Nurse			**Approval Date**	25/07/2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

As Complaints falls within the approval of management policies within the Trust, the Board are asked to approve this revised Trust wide policy.

Management of Complaints and Concerns policy has been revised to incorporate the new processes that we have developed over the last 18 months.

Clearer scope, definitions and purposes have been included so that staff are able to easily review the policy and understand the formal complaints processes and management of concerns (PALS). This is to ensure that expectations are managed of both patient, carers, families, and staff.

New parts to policy:

- Vexatious management plan template
- Learning from complaints and action plan guidance
- Complaints Training

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

Safe, Caring, Well-Lead, Responsive

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

N/A

Report previously considered by & date(s):

PACE Group – June 2023
Policy Review Group – July 2023

Recommendation	The Board/Committee is asked to review and approve

To be trusted to provide consistently outstanding care and exemplary service

DOC ID:
CP 306
0

East and North Hertfordshire NHS Trust

Management of complaints and concerns

About this document	
Document ID	CP 306 **Version:** 001
Full review due before	31 July 2026
Document type	Policy
Usage & applicability	For use Trust Wide by all staff at all sites

Summary

A fair, sensitive and accurate response to patient complaints is one of the ways of improving the quality of care in the NHS. It is important that if things go wrong, they are put right quickly and that lessons are learned. Learning from complaints can help staff achieve a higher standard of care and improve services. A complaint can arise from a perception of poor service rather than because of a genuine failure to provide a high-quality service. When this occurs, it is often due to poor communication.

All employees have a responsibility to abide by this policy and any decisions arising from the implementation of it. All members of staff have a duty to ensure that:

- They take immediate action and try their utmost to de-escalate a concern in real time where possible to prevent it from becoming a complaint and refer to PALS if they are unable to achieve this despite attempts
- They explain that this will not result in adverse treatment as a result of raising a concern or a complaint
- They take immediate action where failures have been identified to reduce the likelihood that further harm to other patients / carers will occur in the future
- They give assistance with any complaint investigation
- If requested they make a formal statement which reflects fact, not opinions

What you need to know about this version

VERSION TYPE: **Full review of document with amendments**

Revised Trust wide processes and appendices.

This has been issued as a new policy to replace a previously decommissioned policy on complaints (DOC ID CSEC 008).

Contents

Part 1 – Preliminary document information

1. Scope

A fair, sensitive and accurate response to patient complaints is one of the ways of improving the quality of care in the NHS. It is important that if things go wrong, they are put right quickly and that lessons are learned. Listening, and responding, to patient complaints and concerns provides an invaluable opportunity for improvements. Complaints should be handled in an open and transparent manner and used to promote organisational learning.

ENHT strives to create an environment and culture in which patients know it is acceptable to raise a complaint or concern, or offer feedback about our services. Staff should feel equipped, through training and managerial support, to act upon patient feedback promptly and in a manner which informs service delivery.

2. Purpose

The policy describes the process by which complaints are handled within the organisation according to the national regulations. The process described in this policy seeks to facilitate good local resolution and service development. Links between the Patient Advice & Liaison Service (PALS) and Complaints have been strengthened to ensure a consistent approach for anyone wishing to raise comments, concerns and complaints.

This policy sets out the framework for the management and resolution of complaints received about the service provided by East and North Hertfordshire Trust. This document provides information about how we manage, respond to and learn from complaints that are made about our services.

The Trust is committed to responding promptly to all concerns and complaints in an open, honest and sensitive way; ensuring that they are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner. Patients, carers and their representatives experience our services from a different perspective and can provide a valuable insight and enable the Trust to implement changes from lessons learnt as part of the organisation's commitment to continuous quality improvement.

The key issues taken into consideration when formulating this policy are that the complainant needs to:

- Know how to complain
- Feel confident that their complaint will be dealt with seriously
- Understand that their concerns will be investigated, and they will be informed of the findings of that investigation
- Trust that East and North Hertfordshire will offer an apology where required
- Trust that East and North Hertfordshire will learn from complaints, feedback and praise and apply those lessons whilst also learning from and sharing best practice

The Trust is committed to providing high quality care to all that use our services. We will ensure that patients, carers or other representatives can seek advice, raise concerns, or make a formal complaint.

When dealing with a complaint we aim to follow the Good Practice Standards for NHS complaints handling (2017) and our Trust values of: Include, Respect, Improve.

We will endeavour to ensure that:

- There is a culture of openness and transparency, that information and processes are accessible and understood by all those involved in a complaint
- Complaints are managed and investigated with a consistent approach
- Complaints are investigated and responded to sympathetically and in an appropriate negotiated timeframe
- Responses should provide a level of detail relative to the seriousness of the complaint
- Complainants are provided with support and guidance throughout the complaints process
- The care of a patient is not negatively impacted on as a result of a complaint
- Matters are put right wherever possible and an apology offered
- There is learning from complaints resulting in better practice

3. Definitions

Compliment: An expression of gratitude, thanks and positive comments directly at the Trust, services and staff by a patient, relative, carer, visitor or member of the public

Comment: A comment / suggestion made about any services the Trust provides. Positive comments may be treated as compliments

Concern: An expression of dissatisfaction that either takes less than 7 working days to resolve or where the individual raising the concern clearly says they are not making a complaint

Formal Complaint: A complaint requiring in-depth, formal investigation and response due to complexity or nature of content, by a person's independent to the immediate service.

4. Duties

Chief Executive

The Chief Executive has overall responsibility for the Trust's Complaints Procedure. This includes ensuring that there is appropriate policy and procedural guidance in place that is available to all staff. The Chief Executive or person acting on their behalf will sign all responses to formal complaints. The Chief Executive has overall accountability for the Trust Complaints procedure and will provide leadership and ensure that the Trust develops a positive culture towards investigating and learning from complaints and is committed to service improvement.

Chief Nurse and Deputy Chief Nurse

The Chief Nurse and Deputy Chief Nurse are responsible for monitoring the complaints performance for the Trust and reporting it to the Trust Board.

Clinical Directors/ Manging Directors/ Triumvirates

Clinical Directors, Managing Directors and Triumvirates are responsible for ensuring all complaints relating to their area are thoroughly investigated according to agreed policy and that resulting action plans are implemented. They must ensure that all their staff are fully aware of the requirements of the complaints process. They are responsible for the appropriate and timely response to formal complaints raised and for approving the content of the responses made. They must make sure that staff have all the information and support

they need to complete investigations. Following a complaint, they must then ensure that teams make the necessary improvements and any learning is shared.

Employees
All staff (including bank, agency and contractors) – will manage complaints within line of this policy.

5. Associated Documents

The following documents are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process. These items are different to the titles listed in Part 1 References, which contains external resources referenced in the development of this document.

Document title	Doc ID	Originator
Accident/Incident Reporting Policy (Safety and Security)	HSS 021	☒ENHT | ☐Affiliated network | ☐National/ regional
Adverse Incident Reporting and Investigation Policy	CSEC 049	☒ENHT | ☐Affiliated network | ☐National/ regional
Claims Handling Policy	CSEC 052	☒ENHT | ☐Affiliated network | ☐National/ regional
Being Open (Duty of Candour)	CSEC 010	☒ENHT | ☐Affiliated network | ☐National/ regional
Raising Concerns at Work Policy	HR 025	☒ENHT | ☐Affiliated network | ☐National/ regional
Safeguarding Children Policy	CSEC 046	☒ENHT | ☐Affiliated network | ☐National/ regional
Safeguarding Adults from Abuse Policy	CSEC 021	☒ENHT | ☐Affiliated network | ☐National/ regional
Information Security & Records Management Policy	IG 002	☒ENHT | ☐Affiliated network | ☐National/ regional
Formal Complaints SOP	N/A	☒ENHT | ☐Affiliated network | ☐National/ regional

6. Monitoring compliance

This document will be reviewed in **3 years** or earlier if any evidence or change in practice comes to light requiring an update to the document. Any further activity to monitor to the use and compliance of the document at the Trust is documented below.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
The complaint manager monitors that the complaints	Monthly	Complaints Manager	Complaints, PALS, Patient and Carer	This policy will be Reviewed earlier than 3 years or sooner in

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
team are adhering to processes and are compliant with guidelines			Experience Lead	light of new evidence

6.1. Equality Impact assessment

The Trust supports the practice of evidencing due regard to equality considerations. This means those involved have ensured the document and the function, outlined therein, applies to all, regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

This evidence is in the form of an equality impact assessment (only if initial screening form below prompts a full EIA) – a process which should be embedded within the early stages of planning or developments that relate to or impact on equality diversity and inclusion. This also applies to new proposals or changes on previous policy, procedure, strategy or processes that are coming up for review. More on this process for completing Equality Impact Assessments can be found on the Equality, Diversity & Inclusion section of the intranet.

Initial EIA screening form

The document author has ensured the policy/guideline avoids affecting one group less or more favourably than another on the basis of:		Impact Yes/No	Comments
1	Age (younger people & children & older people)	No	
2	Gender (men & women)	No	
3	Race (include gypsies and travellers)	No	
4	Disability (LD, hearing/visual impairment, physical disability, mental illness)	No	
5	Religion/Belief	No	
6	Sexual Orientation (Gay, Lesbian, Bisexual)	No	
7	Gender Re-assignment	No	
8	Marriage & Civil Partnership	No	
9	Pregnancy & Maternity	No	
10	Is there any evidence that some groups maybe affected differently?	No	

11	Could this document have an impact on other groups not covered by a protected characteristic? (e.g.: low wage earners or carers)	No	
If '**NO IMPACT'** is identified for any of the above protected characteristics, then no further action is required.			
If '**YES IMPACT**' is identified a full impact assessment should be carried out in compliance with HR028 Equality & Human Rights Policy and linked to this document			
Any other comments: [Default statement: There is no evidence that this policy will impact on any of the protected characteristics listed above, or other groups not covered by protected characteristics.]			
EIA screening form completed by: Vanessa Dawborn **Date completed**: 03/07/2023			

7. References

NHS Constitution (Department of Health, 2009, amended March 2013)
https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Francis Report (2013)
https://www.nmc.org.uk/about-us/policy/position-statements/francis-report/

Hard Truths: the journey to putting patients first: Government response to the Mid Staffordshire NHS Foundation Trust Public Inquiry (Department of Health, November 2013)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

Good governance institute, complaints handling within NHS organisations 2017
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/270368/34658_Cm_8777_Vol_1_accessible.pdf

Designing good together: transforming hospital complaints handling (Parliamentary and Health Service Ombudsman, August 2013)
https://www.ombudsman.org.uk/sites/default/files/LOW_RES_Designing_good_together_transforming_hospital_complaints_handling_0.pdf

Introducing the Statutory Duty of Candour (Dept. of Health 2014)
https://www.health-ni.gov.uk/publications/statutory-duty-candour-england

Part 2 – Complaints Process

Complaints Involving Partner Organisations

Where complaints involve one or more organisations, the Complaints Department will advise on co-operation required. The Complaints Department will negotiate with the partner agencies ensuring that an agreed plan to manage the complaint is in place. The Complaints Handler will ensure this is shared with the Division and complainant and all relevant contact details are available.

Each organisation will investigate in accordance with their own procedure keeping the 'lead' organisation informed of progress. Ideally all responses should be delivered together but where this is not possible the time frames will be agreed between all parties involved including the complainant.

In the event of a complaint being sent to only one organisation but raising concerns across a number of organisations the receiving organisation will seek consent from the complainant and copy the complaint to the other organisations involved.

Where a complaint is shared across organisations the lead organisation will confirm to the complainant the name of each organisation, the investigating officer details and any relevant contact details. The lead organisation will receive responses from all other organisations and collate these to produce one final response unless the complainant directs otherwise. The final response must indicate which issue relates to which organisation and all escalation processes should be clearly identified for each of the organisations involved.

If a delay is likely to occur in getting a response to the lead organisation they must be informed immediately. The lead organisation will provide a response with the information provided indicting that the outstanding responses will

Complaints from third party agencies

Any complaints from MP's and Officers of the Crown, CQC enquiries, complaints that may result in litigation, involve accidents and injury or that may involve a gesture of goodwill payment being made must be emailed to the Complaints Department immediately to log on Enhance and process with the Chief Executive or Legal Claims Team as appropriate. If the MP or CQC enquiry is deemed a formal complaint this will follow the 35 or 60 day process. If the concern does not require an in depth investigation then a turnaround of 10 working days is given.

Fraud and Bribery

There may be occasions when fraud or bribery is identified as part of a concern or a complaint. East and North Hertfordshire Trust is committed to reducing the level of fraud, bribery and corruption within the organisation and the wider NHS to an absolute minimum and keeping it at that level, thus helping to ensure that public resources are focused on providing better patient care rather than being diverted elsewhere. East and North Hertfordshire Trust adopts a zero-tolerance attitude to fraud, bribery and corruption within the NHS. The aim is to eliminate as far as possible all fraud, bribery and corruption within the Trust.

Fraud

Any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.

Bribery and corruption
Bribery and corruption involve offering, promising or giving a payment of benefit-in kind to influence others to use their position in an improper way to gain an advantage. Bribery does not have to involve cash, or an actual payment exchanging hands and can take many forms such as a gift, lavish treatment during a business trip or tickets to an event. Bribery does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another. The Bribery Act 2010[2] set out the relevant offences.

Time limits for raising a complaint

A complaint must be made within twelve months of the date of the incident. Should a complaint be made after the expiry of the period specified, the Complaints, Pals and Patient and Carer Experience lead may decide to investigate if it is accepted that the complainant had good reasons for not making the complaint within that period. The complainant must be advised that the passage of time may affect the investigation.

Raising a complaint

Complaints can be made to any member of the Trust's staff either verbally, or in writing, by email, or letter. The Complaints Department has a designated Trust web page with a generic email address **patcomplaints.enh-tr@nhs.net**.

Complaints may also be raised by patients, carers or their representatives verbally by telephone on: 01438 284387. It should be noted that the method of raising a complaint, either orally or in writing, does not necessitate the investigation route or determine degree of seriousness.

Complaints Type

PALS – Concern

Minor issues occurring in the day-to-day running of a service which can be resolved relatively quickly (within 48hours), including ideas and suggestions, comments and feedback, and general criticisms. Front line administration staff, nurses, doctors, allied health professionals and departmental managers are best able to deal with these issues or concerns, and these should be considered as part of our ongoing commitment to improvement of services.

Formal Complaint – 35 or 60 working days

A complaint requiring in-depth, formal investigation and response due to complexity or nature of content, by a person independent to the immediate service. Initial contact or phone call to discuss the complaint to completed where the complaint may be resolved and closed without investigation.

Note: All complaints which require notification to Adult or Child local safeguarding authorities must be considered under the formal complaints policy. Where the complainant is not

satisfied with the PALS outcome, or where the matter immediately necessitates independent, formal investigation, then the staff member should immediately forward the complaint for logging with the complaints department. This can be done verbally on **01438 284387** or via email to **patcomplaints.enh-tr@nhs.net**.

Formal Complaint grading matrix

All formal complaints will be triaged within the formal complaint grading matrix, this will ensure that the correct time allocation is required to fully investigate the concerns raised. (**See appendix 1, page 16)**

Formal complaint – Process flowcharts

To ensure that all timescales are adhered too, formal complaint process charts have been created to aid all parties involved within the formal complaint process. (**See appendix 2, page 16)**

Formal Complaints Standard Operational Procedure (SOP)

To ensure that staff are aware of the full procedure and expectations**.** (**See appendix 3, page 16)**

Consent

Consent to access personal information for the purpose of investigating a complaint is implied when the complaint is raised by the patient. Where a complaint is received from someone acting on behalf of a patient, the Trust will only instigate a full investigation once written consent is received from the patient. If consent is not received within 10 days, it will be presumed that consent has been refused.

Capacity

Where a patient lacks capacity and someone with Lasting Power of Attorney (LPoA) has been appointed to act on their behalf, then the LPoA should be consulted – as long as the LPoA specifically states that they have the authority to consent on behalf of the patient. The Complaints department must ask for evidence of this.

Appeals

If the complainant requires help in understanding the response given, the Patient Experience Team will support them to understand this and tentatively refer the individual to an advocacy service. If the individual is unhappy with the response given by the Trust following a formal complaint investigation, the complainant will be advised of their right to appeal to the Parliamentary and Health Service Ombudsman.

Dealing with Habitual and Vexatious Complainants

From time to time the Trust may come into contact with a small number of complainants who require a disproportionate amount of time and resource in managing their complaints. It is important to identify those situations in which a complainant's behaviour might be considered to be unacceptable and to suggest ways of responding to those situations which are fair to both colleagues and complainant. The Trust is committed to dealing with all concerns, complaints and requests for information fairly and impartially, providing a high-quality service. As part of this approach, the Trust would rarely limit people from making contact. The below template must be completed during any proposed Habitual and Vexatious Complainant meeting.

Complainants (and/or anyone acting on their behalf) may be deemed to be vexatious where contact with them shows that they meet two or more of the following criteria, (or are in serious breach of one):

- Have **harassed**, **threatened**, or used actual physical violence, been personally **abusive** or **verbally aggressive**, racist or homophobic towards staff dealing with their complaint or their families or associates. (This will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, there after only be pursued through written communication. Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They must document all incidents of harassment using the Trust's incident reporting system)

- Have in the course of addressing or raising a complaint had an **excessive number of contacts** with the Trust placing unreasonable demands on staff. A contact may be in person or by telephone, letter or fax. Discretion must be used in determining the precise number of "excessive contacts" applicable under this section, using judgement based on the specific circumstances of each individual case.

- **Persist in pursuing a complaint** when the Trust's complaints procedure has been fully and properly implemented and exhausted, or is not within the Trust's remit to investigate

- **Change the substance** of a complaint or **continually raise new issues** or seek to prolong contact by **continually raising further concerns or questions** upon receipt of a response whilst the complaint is being addressed (Care must be taken not to discard new issues which are significantly different from the original complaint. These should to be addressed as separate complaints)

- Are **unwilling to accept documented evidence** of treatment given as being factual. e.g. drug records, manual or computer records, nursing records

- **Deny receipt** of an adequate response in spite of correspondence specifically answering their questions

- **Do not clearly identify the precise issues** which they wish to be investigated, despite reasonable efforts of Trust staff and, where appropriate, the aid of advocacy services to help them specify their concerns. Or the concerns identified are not within the remit of the Trust to investigate but they continue to be raised.

- **Focus on a trivial matter** to an extent that is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what is a "trivial" matter can be subjective and careful judgement must be used in applying this criteria)

Whilst staff must endeavour to respond to all complainants with patience and sympathy there are times when unreasonable behaviour is extreme or persistent and there is nothing further which can be reasonably done to assist the complainant or to rectify a real or perceived problem. When considering management of complainants considered vexatious, staff must ensure;

- That the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint overlooked (even habitual or vexatious

complaints may have aspects which contain some genuine substance, ensure that an equitable approach has been followed);

- That the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint overlooked (even habitual or vexatious complaints may have aspects which contain some genuine substance, ensure that an equitable approach has been followed);

- That the response has been communicated in a manner which is understood by the complainant, and all reasonable and practicable steps have been taken to ensure understanding.

- Ensure a fair and reasonable response.

- There is a clear documented evidence of behaviour which is considered unacceptable and staff are able to identify the stage in which the complainant became vexatious
- That the complainant has been afforded opportunity to discuss the matter in an agreed and pre-arranged forum with a colleague best suited to address their concerns.

- Where appropriate, the complainant has been encouraged to contact an independent Advocate for support and advice, or a referral has been made.

Where complainants meet the criteria as stipulated above, the service must refer the case to the Complaints, PALS and Patient and Carer Experience Lead or Deputy Chief Nurse, who will review the case and determine whether there is enough evidence to implement a vexatious complainant management plan.

The Complaints, PALS and Patient and Carer Experience Lead or Deputy Chief Nurse have discretion on how they may decide to manage vexatious complaints. Consideration of this may include, but is not limited to, directing the following;

1) Try to resolve matters by drawing up a signed “agreement” with the complainant (and if appropriate involving the relevant clinician in a two-way agreement) which sets out a code of behaviour for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened, consideration would then be given to implementing other action

2) Decline contact with the complainant/s either in person, by telephone, by letter or any combination of these, provided that one form of contact is maintained. (If staff are to withdraw from a telephone conversation with a complainant the following statement or other alternative may be used for example “I’m sorry I am unable to deal with your complaint. I understand your complaint is being dealt with by XXX, please contact telephone number”

3) Restrict communication through a third party (e.g. advocate) by negotiation

4) Notify the complainant in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainants should also be notified that the correspondence is at an end and that further letters

received will be acknowledged but not answered (other than a request for Independent Review, if applicable (NB: before this action is taken, the Complaints Handler must ensure that the complainant has been informed of their right to request an Independent Review by the Ombudsman)

5) Inform the complainants that in extreme circumstances the Trust reserves the right to pass unreasonable or vexatious complaints to the Trust's solicitors

6) Temporarily suspend all contact with the complainants or investigation of a complaint whilst seeking legal advice or guidance from the Strategic Health Authority or other relevant agencies

7) Time limit the declaration or make it subject to its review or reconsideration

An agreed Management Plan will be devised by the Complaints Manager or Complaints, PALS and Patient and Carer Experience Lead and signed off by the Deputy Chief Nurse and Chief Nurse. The Management Plan will be circulated to all relevant staff to ensure consistent delivery and loaded onto the Enhance file.

Withdrawing vexatious status
Once complainants have been determined as vexatious, the Deputy Chief Nurse and Complaints, PALS and Patient and Carer Experience Lead, in liaison with the Triumvirate, will determine at a later stage that the complainant is no longer vexatious.

Patient and Advice Liaison Service (PALS)

The PALS in East and North Hertfordshire NHS Trust, aims to provide a fast and appropriate access to help, advice and information to those users of our services who require assistance or support.

- The service is available to patients, their relatives and carers or friends (referred to as patients throughout this document) using health services provided or commissioned by the East and North Hertfordshire NHS Trust. It will also offer information and advice to anyone contacting it.

- The service will operate on a "one stop shop" approach to avoid the need for users to explain their problem more than once.

- The service is managed by the Complaints, PALS and Patient and Carer Experience Lead.

Key Objectives:

- To provide assistance in the quick and efficient resolution of questions and concerns raised by patients through negotiation and liaison with Trust staff, other local NHS staff, health and health related organisations and where appropriate, other PALS.

- Give accurate and appropriate information in line with the Trust's Concerns and Complaints Policies to individuals wishing to access the NHS complaints procedure.

- The service will steer patients towards the complaints process when necessary and provide guidance and information.

- Provide feedback arising from the patients and publics' perspective about the services the Trust provides.

- The PALS officers have the power to negotiate immediate solutions with the relevant ward/department manager.

Operational Guidance for staff:

- The PALS team will operate a drop-in service in the main corridor at the Lister Hospital.

- QEII Hospital, Mount Vernon Cancer Centre (MVCC) and Hertford County Hospital (HCH) may access the PALS by phone or email.

- The PALS staff will sit in the PALS office where they have the facility to conduct confidential interviews, when necessary.

- The service is available Monday to Friday between the hours of 8 am to 4 pm. An answer phone service is available out of hours. Patients are advised through the answer phone message how the Duty Matron can be contacted out of hours.

- The PALS officers or their volunteers will visit the ward areas on a regular basis to raise awareness of the PALS and establish communication links.

- The PALS officers will visit patients on the wards when requested.

- All contacts will have a concern sheet completed and be logged on the Enhance database.

Learning from Complaints and PALS

The Trust is strongly committed to organisational learning, and recognises that whatever the circumstances, and however regrettable these may be, each complaint provides opportunities for organisational learning to occur. Sometimes, the complaint has Trust wide, or cross service implications. The learning for such complaints will be ensured by Quality and Safety Committee and Patient and Carer Experience Group.

Action plans

Action plans form part of the formal complaints process and investigators should ensure that they share the recommendations from their investigation findings with the service managers

of the relevant areas to allow for the development of an action plan which is SMART. A SMART approach to when planning actions arising from complaints is essential. Actions should be Specific, Measurable, Achievable, Relevant and Time-bound.

- Each recommendation must have a clearly defined action
- A responsible person designated as the lead for each action
- Dates for proposed completion of actions
- Evidence to confirm completion of each action

It is the responsibility of the service manager or delegated team leader/ward manager to work with the staff member to complete and evidence this. All action plans will be logged and tracked via Enhance.

Training

The Complaints Department will provide training on national guidance and ensure that they are supporting staff in investigating and handling complaints. The Complaints Team will deliver training on the Trust induction to all new staff outlining the complaints process and provide further in depth training on investigations to band 6 and above during monthly training sessions.

Part 3 – Appendices

Appendix 1 – Formal Complaint Grading Matrix

Formal Complaints Grading Matrix

35 days Working Days

Amber

Customer service/ few issues/ straightforward complaint.

Clinical care/ more than one service.

- Perceived neglect or failings of care/treatment.
- Possible clinical harm
- More than one service involved.
- A mixture of customer service and clinical issues/concerns.
- Medication error
- Minor injuries
- Failing in care/planning arrangements
- No apparent clinical harm
- Attitude of staff/poor customer service
- Appointment issues
- Access to service
- Environment/facilities
- Inappropriate discharge

60 Working Days

Red

Clinical care/clinical harm caused to patient/other provider involved.

Over 10 points to be investigated

- Possible Serious clinical harm
- Involved other providers external to the Trust.
- Possible serious neglect or abuse by staff.
- Ongoing serious incident investigation.
- Unexpected/unexplained death
- Major injury

Appendix 2 – Vexatious Management Plan Meeting Log

Habitual and Vexatious Complainant – Management Plan Template	
Name	
NHS Number	
Service	
Division	
Meeting Details	
Date	
Attendees	
Proposed Criteria **(page 10, Complaints and PALS Management policy)**	
Action Taken	
Final Letter to be linked or saved with plan	

Part 4 - Document record

As per policy **CP 116 Trust policies and procedural documents**, this document is using the latest format of **Template for Trust-approved documents TMP 001 (Version 2)**.

Document info	Doc ID: CP 306, Version – 001 Management of complaints and concerns This version is using TMP 001 – 01 April 2023
Document type	Select one option: ☐ Guideline, ☐ Pathway, ☒ Policy,☐ Procedure, ☐ Protocol, ☐ Standard Operating Procedure **Policy**
Document applicability across the organisation	SELECT ONE for each of the 3 items 1. **For use** ☒Trust wide (at corporate level for both clinical and non-clinical roles); ☐ clinical cross specialty; ☐ in multiple areas (non-clinical); ☐ locally 2. **For use by** (ROLES): ☒All roles, ☐clinical roles only, ☐non-clinical roles only 3. **For use at** (SITES): ☒All sites,☐ Lister Hospital, ☐New QEII, ☐Hertford County Hospital, ☐Renal Satellite sites, ☐Mount Vernon Cancer Centre, ☐Other: **Input your selection here:** **For use Trust Wide by all staff at all sites**
Review cycle	☒ Every 3 years (standard) ☐Annual review ☐ Other: **31 July 2026**
Version type	SELECT ONE ☐New document – full consultation and endorsements ☐Full review of document - various amendments/ complete re-write ☒Full review of document - minor amendments ☐Full review of document - no changes to content, still fit for use ☐Interim update - document not fully reviewed, amendments only **Full review of document with amendments** Select the appropriate sign-off category ☒TYPE A (full review requires both endorsement and approval) ☐TYPE B (interim update – only approval required) ☐TYPE C (local use): Both endorsement and approver required **TYPE A – endorsements and approval required**
Keywords	
Version author/owner	Sophie Williams – Complaints, PALS and Patient and Carer Experience Lead ☐Cancer ☐Planned ☐Unplanned ☐Women & Children ☒Corporate/Directorate
Document classifications	Please select all that apply to this document ☐ **Sensitive information**: This document contains sensitive information that should not be shared outside the organisation ☒ **Public website**: this document has been selected for publication

	on the Trust website, maintained by the Communications Dept. ☐ **Patient Consent**: This document contains content about patient consent ☐ **Forms** - This document contains forms in use at the Trust ☐ None of the above

Consultation & review

In the checklist below, the document author has considered the following **resource implications** and **impact to Trust-wide functions/services**, which also require **oversight** of local processes. Any of these listed stakeholders may also be an endorser of the final version of this document in the Record of agreement section.

If a new document, or newly amended content to this version contains processes that will have an impact on Trust functions and their users, the following actions are required.

Trust stakeholder	Action required by author
1. **Equality, Diversity & inclusion**	Trust **policies** require an Equality Impact Assessment (EIA) as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document. If the initial EIA screening in Part 1, section 6.1 determines a full EIA is required, visit the Equality, Diversity & Inclusion intranet section for next steps, which could take **3 to 4 weeks to receive approval.** EIA approval (supplied via email): Click or tap to enter a date.
2. Clinical Ethics Committee	This document may contain content that is contentious or raises moral debate. ☒No – proceed to next item ☐Yes – please see following actions **Step 1**: Seek advice from Clinical Ethics committee: ethics.enh-tr@nhs.net **Step 2**: Please provide the following info: Date of recommendations received: Were recommendations implemented and/or incorporated into document? ☐yes ☐no What was recommendation:
3. Medicines Management (Pharmacy)	This document contains processes about the use of medicines at the Trust. ☒No – proceed to next item ☐Yes – please follow these steps

Trust stakeholder	Action required by author
	Step 1: Contact local pharmacy lead to coordinate presentation to Therapeutics Policy Committee to request their **endorsement (formal agreement the document is fit for use at the Trust)** **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: TPC requires sign off on the final file and will be the final approver in the Record of agreement.
4. Nursing, Midwifery & AHP	This document contains processes that will have an impact on staff and care or that would affect work routines. ☒No – proceed to next item ☐Yes – please see following steps **Step 1:** For documents that are for Trust-wide use, **contact Nursing & Midwifery Excellence team** to discuss who would need to be involved in reviewing and agreeing the document is fit for use at the Trust. ☐Clinical skills group and/or ☐Nursing, Midwifery, AHP Quality Committee and/or ☐The appropriate training team eg Nursing/Maternity Training Team (For documents for local use, contact in the first instance). ☐Other: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
5. Safeguarding	This document (either for local or Trust-wide use) contains processes or information that may have an impact on children or vulnerable adults using our services. ☒No – proceed to next item ☐Yes **Step 1**: Contact **Safeguarding** team for initial discussion. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**
6. People (Human resources)	This document (either for local or Trust-wide use) contains processes or information about the recruitment or management of staff or other processes applicable to staff. ☒No – proceed to next item ☐Yes **Step 1**: Contact Trust Partnership committee, staff side and/or staff network groups for initial discussions.

Trust stakeholder	Action required by author
	Step 2: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: In most cases, for these Trust-wide documents owned by the People team, the **Trust Partnership** requires sign off on the final file and should be the **approver** in the Record of agreement.
7. Finance	This document contains processes or information that affects the acquisition of resources (recurring or one-off) or payments of salaries or anything that has financial implications either Trust wide or locally within the Trust. ☒No – proceed to next item ☐Yes – please follow steps **Step 1**: Involve/request input from: ☐payroll, ☐local budget holders, ☐anti-fraud team Name of contact: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
8. Estates & Facilities	This document contains processes or information about the use of Trust property or affects facilities and security on Trust premises. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from ☐Estates ☐Facilities **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
9. Digital (IT)	This document contains processes or information about the use of Trust computer hardware, software or systems. This includes systems either managed by our local Digital team or an external supplier. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from the appropriate team in Digital services

Trust stakeholder	Action required by author
	Step 2: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
10. Senior division/ directorate staff	Document owner must apprise senior staff in their relevant area of this new or fully reviewed document. **Step 1** **Divisions (clinical areas)**: Apprise **divisional clinical governance group** of document development or send final draft for the formal meeting record and so respective the clinical director is apprised at that meeting. **Directorate (corporate/ non-clinical areas)**: Advise respective senior level group meeting of updated document so this activity is on the formal record. **Step 2** In item 11 below, record date and name of clinical governance meeting/ senior level group meeting as a stakeholder (select external). Select the activity type as "other" and indicate "for information only".
11. Document stakeholders	In the table below, please record evidence (ie date of meetings or email) of activity with departments, groups, stakeholders involved in the update/development of this document. A minimum of one stakeholder must be listed. Please delete unused rows.

11.1 List of document stakeholders

Document stakeholder	Date	Activity type
Patient and Carer Experience Group ☒**Internal*** ☐**External****	26-06-2023 ☒Meeting date ☐Email date	☐Content contribution ☒ Read and agree fit for use ☐Other:
Policy Review Group ☒**Internal*** ☐**External****	13-07-2023 ☒Meeting date ☐Email date	☐Content contribution ☒ ☐Read and agree fit for use ☐Other:
☒**Internal*** ☐**External****	DD-MM-YYYY ☐Meeting date ☐Email date	☐Content contribution ☐Read and agree fit for use ☐Other:

***Internal** – a stakeholder within document author's dept/service/area – a service manager, team meeting, etc.
****External** - a stakeholder outside of dept/service/area or outside the organisation

☐At least one of the above in the consultation list is a formal endorser in the Record of agreement.
☒I understand an endorser and/or approver may request evidence of consultation (with any of the above or others not mentioned) before their sign off is granted.

Record of agreement

Full details of the **endorsement and approval process** can be found in policy **CP 116 - Trust policies and procedural documents**.

DOC ID & title	Complaints and Concerns Trust wide management
Due date of next full review	31 July 2026
Document type	Policy
Version type	Full review of document with amendments
Applicability	For use Trust Wide by all staff at all sites
Version author	Sophie Williams – Complaints, PALS and Patient and Carer Experience Lead
Sign-off type	TYPE A – endorsements and approval required

Endorsement	Record of formal agreement this version is fit for use at the Trust by **Patient Experience department** PENDING meeting to be held on **2023-07-18**.
Trust endorsement for all policies	Record of formal agreement this version is fit for use at the Trust by **Policy Compliance Group** at meeting held on **2023-07-13**.
Approval	Upon considering the above endorsements, the approver* **Patient and Carer Experience Group (PACE)** agrees this document is fit for use at the Trust. Confirmation of this agreement is PENDING and awaiting meeting on **2023-07-24**.
Ratification	PENDING: Scheduled for Board Sept 2023
Governance checks	Marie Orara, Documents Manager, 2023-07-14

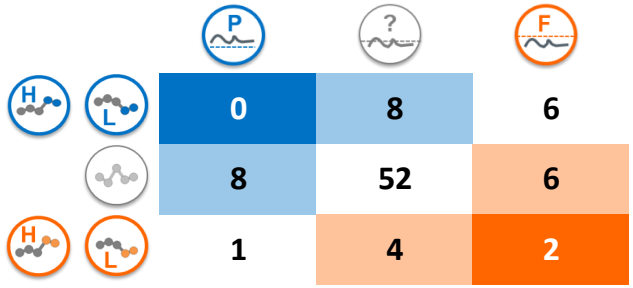
*Types of **approvers** (as per policy CP 116):

- A committee/group or Trust function stakeholder's name, role, dept can approve a **fully reviewed** document
- A head of service, or stakeholder or committee chairperson (usually endorser 1 listed at the last full review) can approve an **interim update** of a document
- A head of service or department can approve documents for **local use only** (for all version types)
- All policies require "additional endorsement" from the Policy Compliance Group.

NHS
East and North Hertfordshire
NHS Trust

Integrated Performance Report

Month 06 | 2023-24

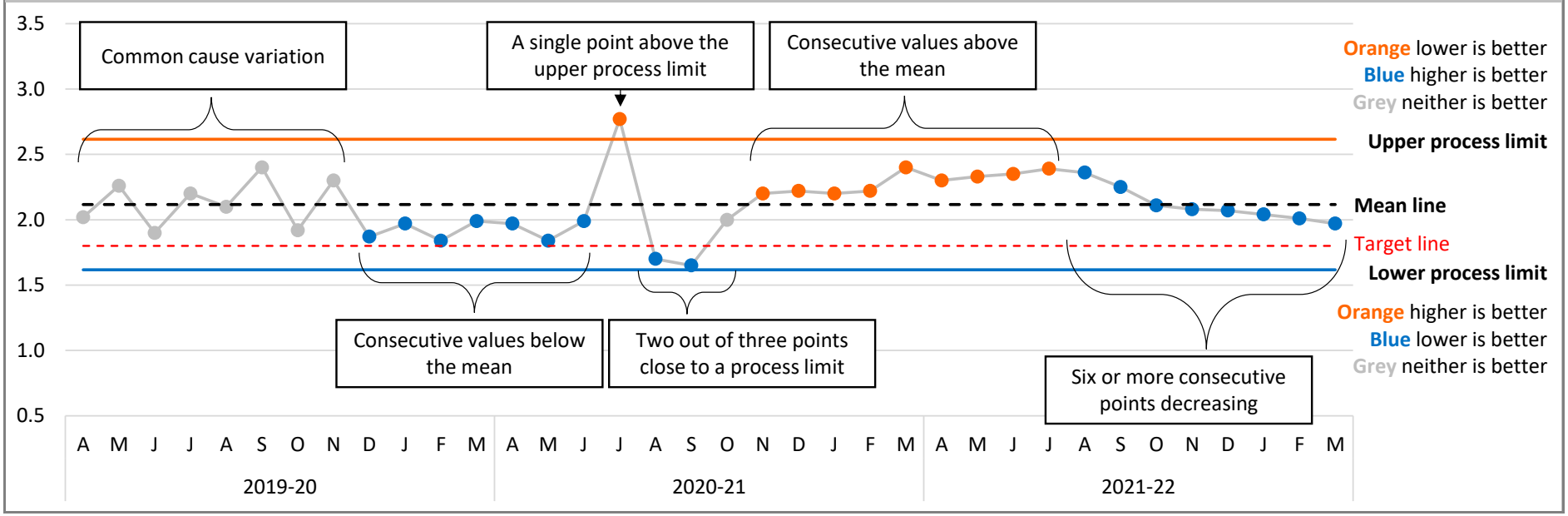


Data correct as at 20/10/2023

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

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

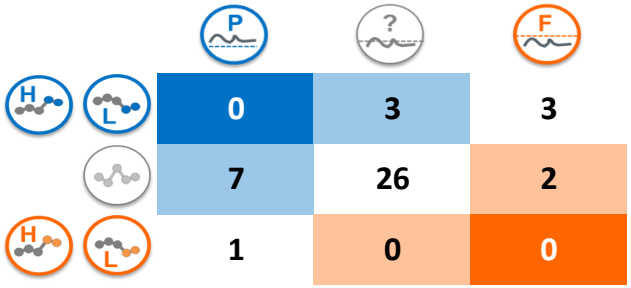
Assurance

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

East and North Hertfordshire NHS Trust

Quality

Month 06 | 2023-24



Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Sep-23	n/a	1,182	L		8 Consecutive points below the mean No target
	Serious incidents in-month	Sep-23	0	6		?	Common cause variation Metric will inconsistently pass and fail the target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Sep-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Sep-23	0	5		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Sep-23	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Sep-23	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Sep-23	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Sep-23	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Sep-23	0	0	L	?	13 consecutive points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Sep-23	80%	93.1%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Sep-23	n/a	80.2%	H		8 consecutive points above the mean No target
	Staff shortage incidents	Sep-23	n/a	18	L		7 consecutive points below the mean No target

Month 06 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Sep-23	n/a	0.50			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Sep-23	n/a	0.80			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Sep-23	95%	81.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Sep-23	95%	43.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Sep-23	95%	85.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Sep-23	95%	56.0%		F	Common cause variation Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Sep-23	85%	79.2%	H	?	8 consecutive points above the mean Metric will inconsistently pass and fail the target
HATs	Number of HAT RCAs in progress	Sep-23	n/a	68			Common cause variation No target
	Number of HAT RCAs completed	Sep-23	n/a	25			Common cause variation No target
	HATs confirmed potentially preventable	Sep-23	n/a	0			Common cause variation No target
PU	Pressure ulcers All category ≥2	Sep-23	0	6		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Sep-23	n/a	4.0			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Sep-23	n/a	0.0%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Jan-23	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Feb-23	6.0%	5.8%			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	Sep-23	95%	94.8%	L	P	1 people below the lower process limit Metric will consistently pass the target
	A&E positive feedback	Sep-23	90%	87.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Sep-23	93%	88.0%	H	F	9 points above the upper process limit Metric will consistently fail the target
	Maternity Birth positive feedback	Sep-23	93%	94.4%	H	F	7 points above the upper process limit Metric will consistently fail the target
	Maternity Postnatal positive feedback	Sep-23	93%	100.0%	H	?	2 points above the upper process limit Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Sep-23	93%	100.0%	H	F	1 point above the upper process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	Sep-23	95.0%	96.1%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Sep-23	n/a	398		-	Common cause variation No target

Month 06 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Sep-23	n/a	71		-	Common cause variation No target
	Number of complaints closed in-month	Sep-23	n/a	58		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Sep-23	75%	97.4%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Sep-23	80%	41.5%		?	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	Sep-23	60 - 70%	71.4%		?	One point above the upper process limit Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Sep-23	3.3%	1.8%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear vaginal	Sep-23	2.5%	2.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Sep-23	4.5%	0.3%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear instrumental	Sep-23	6.3%	4.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Sep-23	6.0%	6.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Sep-23	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Sep-23	12.5%	5.0%		P	Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Sep-23	2.3%	4.0%		F	Common cause variation Metric will consistently fail the target
	Bookings completed by 9+6 weeks gestation	Sep-23	50.5%	76.0%		P	Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Sep-23	72.7%	77.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	Number of serious incidents	Sep-23	0.5	0		?	Common cause variation Metric will inconsistently pass and fail the target
	SLA income against plan (£m)	Sep-23	2.7	2.6		?	Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Sep-23	12.8	7.8		?	Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Sep-23	12.8	11.0			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Jul-23	100	95.5		?	Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Jul-23	100	89.9			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Apr-23	100	84.5		?	Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Apr-23	100	90.9			Rolling 12-months - unsuitable for SPC

Month 06 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Jun-23	n/a	654			Common cause variation No target
	Rate of emergency re-admissions within 30 days of discharge	Jun-23	9.0%	6.2%		P	Common cause variation Metric will consistently pass the target
Length of Stay	Average elective length of stay	Sep-23	2.8	2.2		?	Common cause variation Metric will inconsistently pass and fail the target
	Average non-elective length of stay	Sep-23	4.6	5.2		?	Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Sep-23	n/a	98.9%	H		2 consecutive points above the upper process limit No target
	Individualised care pathways	Sep-23	n/a	32			Common cause variation No target

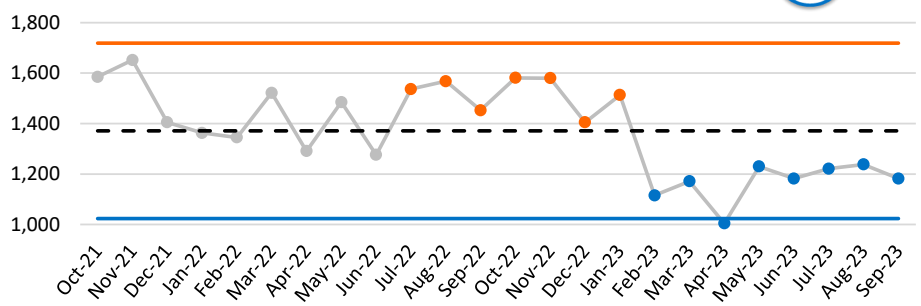
Month 06 | 2023-24

Quality

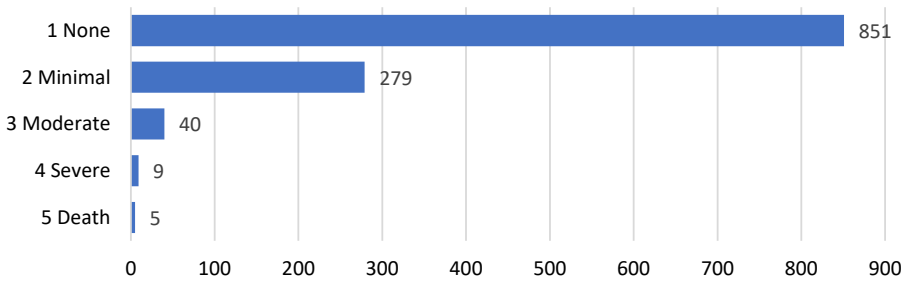
Patient Safety Incidents

East and North Hertfordshire NHS Trust

Total incidents reported



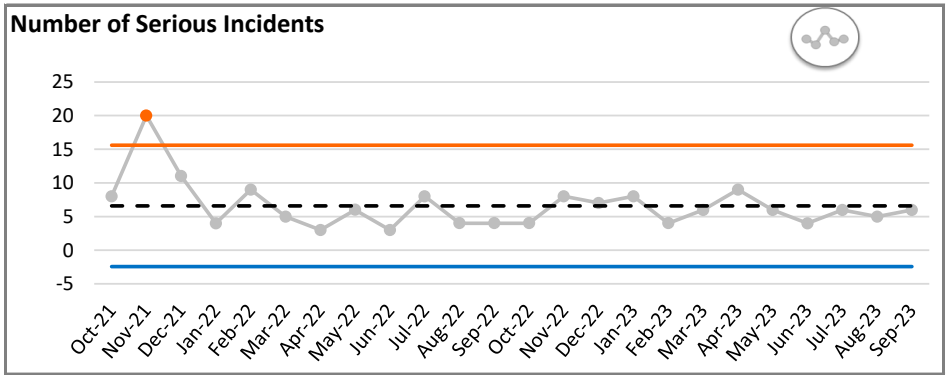
Number of patient safety incidents by level of harm - Sep-23



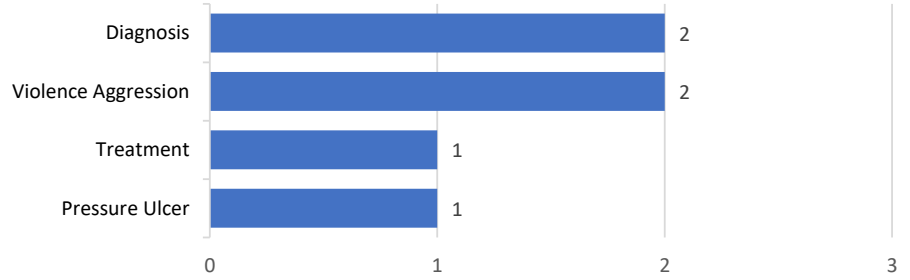
Key Issues and Executive Response

- Reduction in incident reporting levels
- Of the incidents reported in month, 111 have been closed, 375 are awaiting Divisional lead sign off and 711 are open being investigated.
- ED continues to be the highest reporting specialty of incidents followed by Acute Medicine and then Obstetrics, in line with previous months.
- The top 3 themes of incidents reported are pressure ulcers, medication incidents and violence and aggression.
- Normal variation in the number of new SIs declared in month (6).
- Currently 33 open SI ongoing, 17 of which are overdue.
- Ongoing thematic review of incidents involving violence and aggression with patients with mental health needs. Second roundtable meeting (multi-agency) scheduled.
- Ongoing thematic review of paediatric audiology incidents, draft report in progress.
- New Serious Incidents will no longer be declared as we have started transition to PSIRF. SI revew panel meeting transitioning to become a central oversight meeting with Divisions establishing their own incident review meetings.

Number of Serious Incidents



Serious Incidents Themes - Sep-23



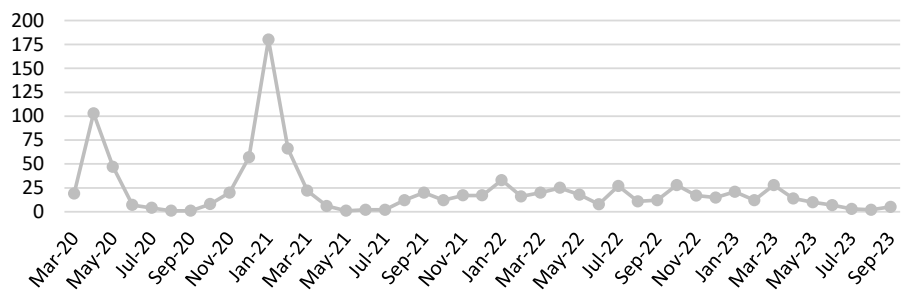
Month 06 | 2023-24

Quality

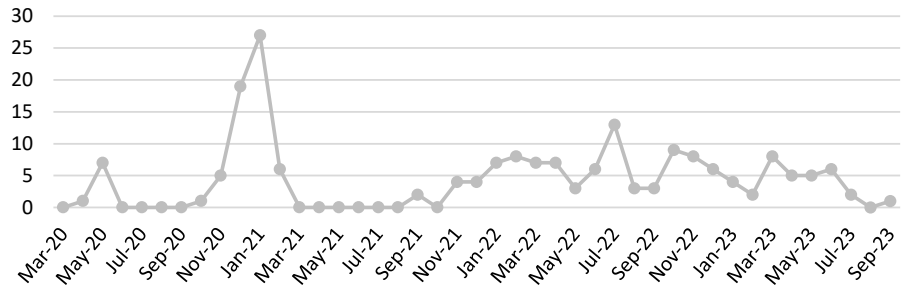
COVID-19

East and North Hertfordshire NHS Trust

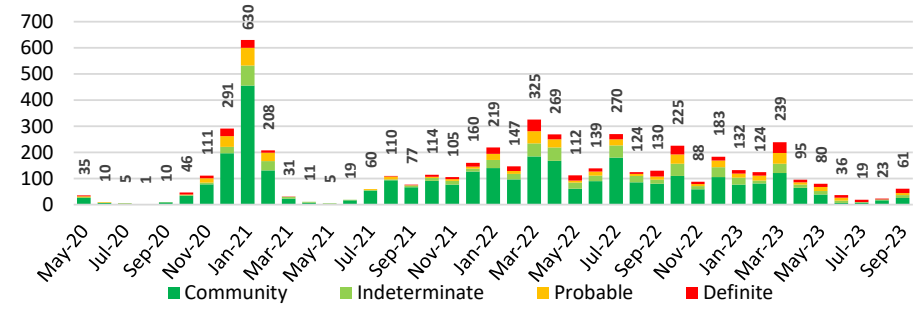
Number of deaths from COVID-19



Number of deaths from hospital-acquired COVID-19



COVID-19 cases by category



Key Issues and Executive Response

- The total number of inpatients with COVID-19 in September rose to 61. Of these cases, 25 were contributed to community onset and one indeterminate case where by the sample was taken between day 3 to 7 of admission. There was no healthcare - associated harms cases were reported.
- Screening for COVID-19 continues to be undertaken for clinically indicated patients using PCR. Lateral Flow Device (LFD) testing is carried out for all patients going to assisted living care facility.
- There was 1 COVID-19 death reported in the month of September, where appropriate palliative care treatment plans were in place.
- The Trust continues to utilise Redirooms to support appropriate and timely isolation of patients when availability of a side room becomes a challenge.

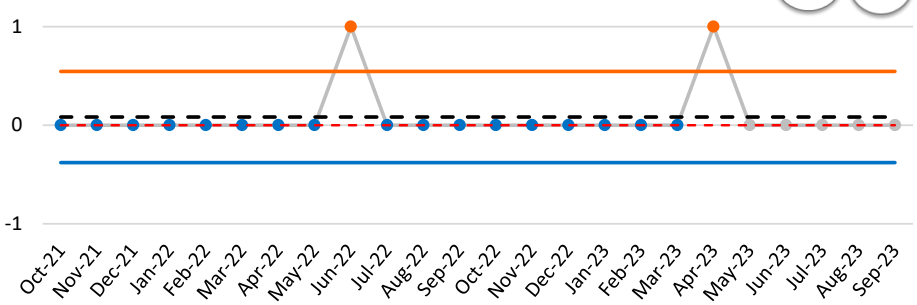
Month 06 | 2023-24

Quality

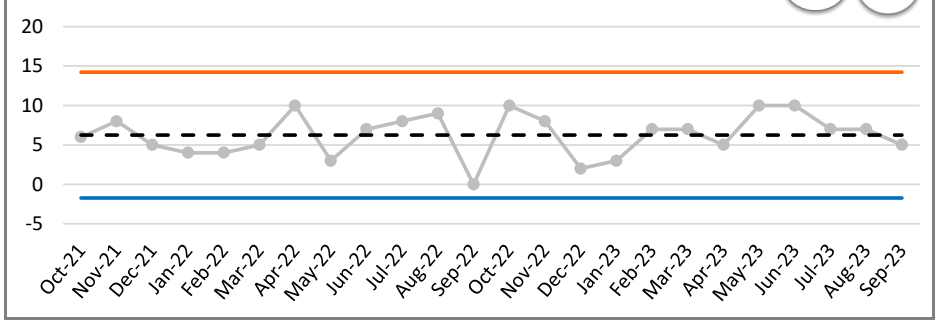
Infection Prevention and Control

East and North Hertfordshire NHS Trust

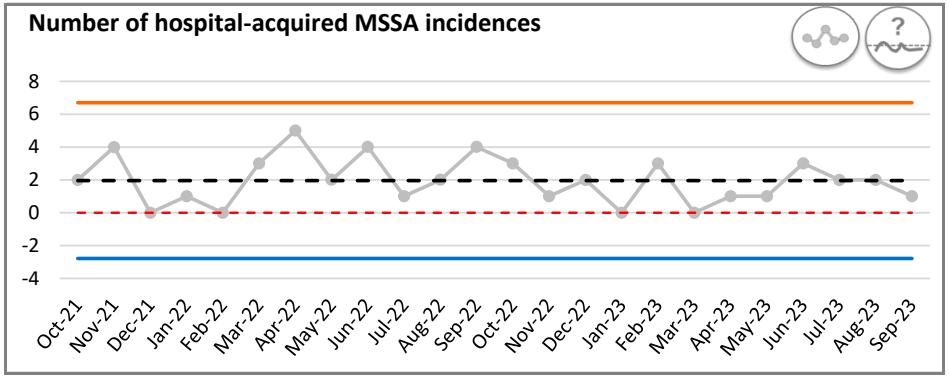
Number of hospital-acquired MRSA BSI incidences



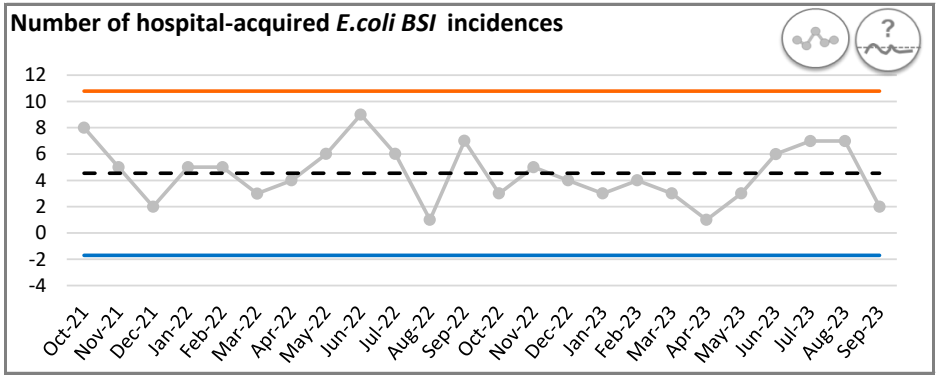
Number of hospital-acquired *C.difficile* incidences



Number of hospital-acquired MSSA incidences



Number of hospital-acquired *E.coli BSI* incidences



- *C difficile (C diff.)* - Year to date (YTD) cases remain above trajectory against the threshold of 58. There has been a reduction in the number of *C diff.* cases in the month of Sept. against the previous month. The timely sending of sample and prompt isolation of cases has also improved. The IPCT continues to provide support the divisions of their infection rate, and share any learning identified from reviews to improve practice. The *C diff.* focus group reconvened along with pharmacy, microbiology and the genitourinary consultant representative to review the medicine guidelines related to the body system to support antimicrobial stewardship.

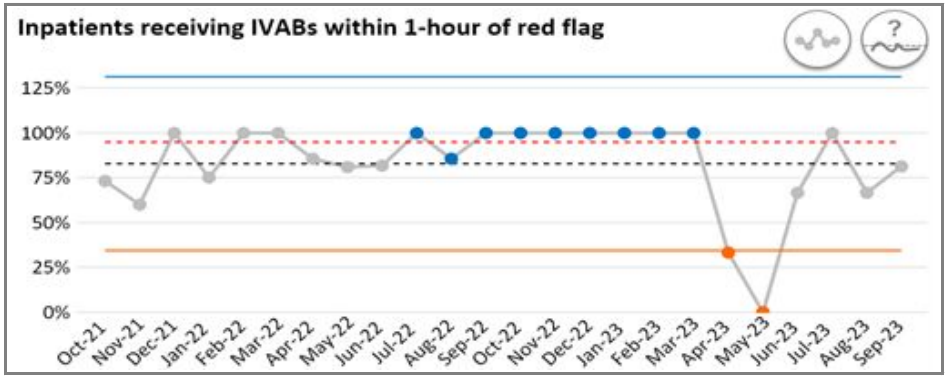
Continuation of *C diff* - To date, two body systems antimicrobial guide have been reviewed, and further reviews will be scheduled by the pharmacy colleagues

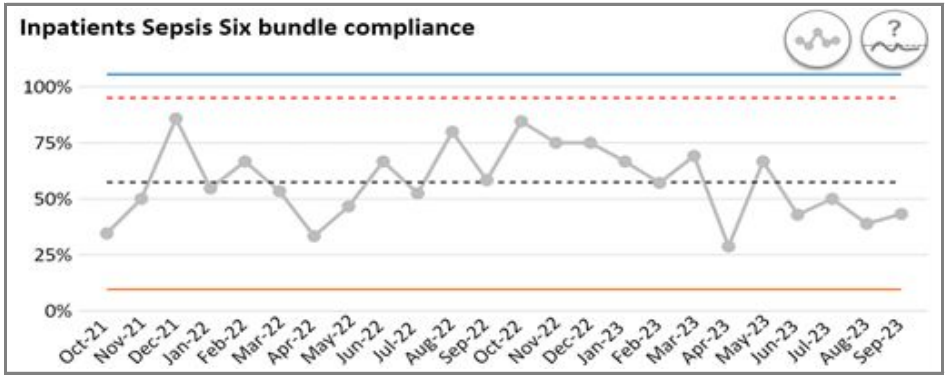
- MRSA BSI - there are no MRSA BSI in the month of Sept. 2023
- MSSA BSI - the rate remains below that of the same period in financial year 2022-2023. There is no threshold
- *E.coli BSI*- the Trust is currently below monthly threshold. There has been a significant reduction on the number of cases from the previous three months. IPCT is continuing to work with the divisions to ensure learning outcome is recognised and implemented.

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust





Themes

Sepsis IP	2022-23						2023-24					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%
Blood cultures	82%	83%	86%	88%	100%	100%	29%	100%	69%	67%	80%	64%
IV antibiotics	100%	100%	100%	100%	100%	100%	0%	0%	83%	100%	67%	60%
IV fluids	86%	100%	100%	100%	100%	67%	33%	100%	50%	56%	55%	57%
Lactate	83%	88%	80%	63%	62%	80%	43%	67%	54%	58%	65%	64%
Urine measure	100%	88%	88%	75%	86%	86%	71%	100%	64%	75%	59%	42%

Key Issues and Executive Response

Themes

- IV antibiotic compliance sits at 60% in September, with one bigger delay in antibiotics due to a prescription error that was picked up and addressed.
- The overall Sepsis six compliance has dipped in September however this can be contributed to industrial action and staffing pressures across the trust and within the team itself.
- O2 administration remains at 100% for September whilst urine measurement remains poor at 42%. Urine balance monitoring appears to be a trust wide challenge and not one only seen in the case of septic patients.
- Lactate has remained steady at 64% for September.
- The Sepsis Team was not informed of any serious harm or patient incidents related to sepsis throughout September.

Response

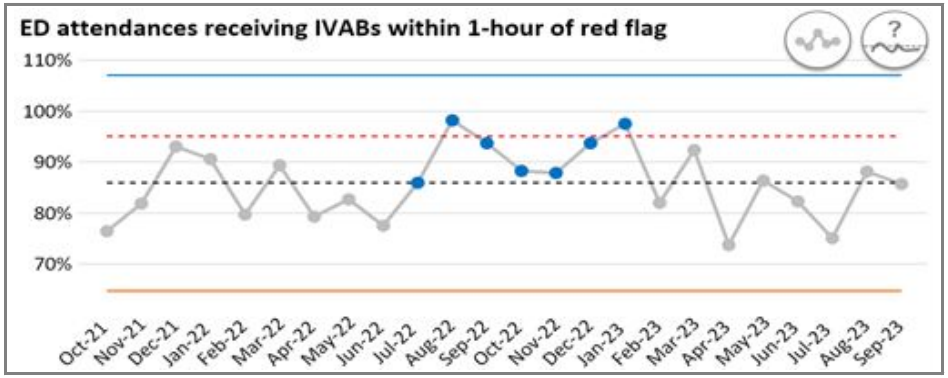
- Following well-received sepsis teaching sessions in the planned care division, the Sepsis Team have organised further sessions for planned care to continue throughout October and the coming months.
- Following on from a successful NTL forum the Sepsis Team are still working with the unplanned care practice development team and will be attending the band 5 forum in October.
- The Sepsis Team has delivered doctor's teaching with Foundation doctors in September. Following this we are currently in the process of arranging teaching for the surgical foundation doctors to take place.
- The team are liaising with Dr Franks to arrange teaching sessions to the frailty teams which will take place in November.
- The team are working with the renal practice development team to work on a QI project providing multiple bitesize Sepsis sessions on the ward over a number of weeks with the aim to see an improvement in compliance.

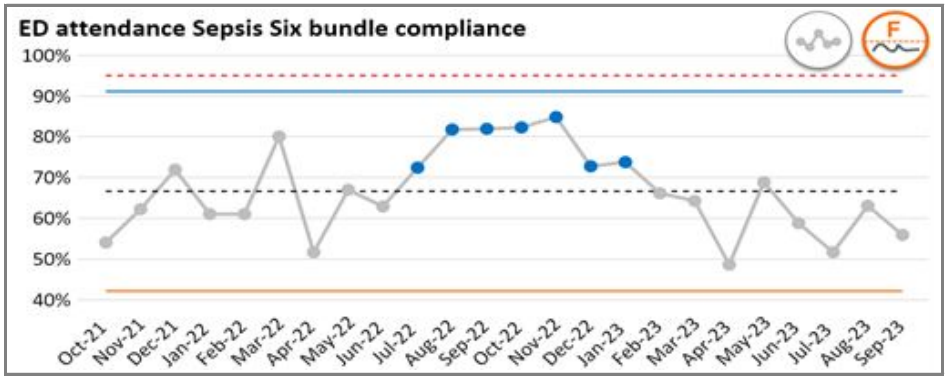
Month 06 | 2023-24

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust





Themes

Sepsis ED	2022-23						2023-24					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	100%	100%	100%	100%	98%	100%	100%	95%	100%	98%	94%	100%
Blood cultures	88%	94%	93%	90%	90%	93%	87%	93%	90%	87%	89%	88%
IV antibiotics	88%	88%	94%	98%	82%	93%	74%	86%	82%	75%	88%	86%
IV fluids	93%	90%	92%	97%	85%	100%	84%	81%	79%	81%	83%	89%
Lactate	100%	97%	100%	100%	95%	100%	92%	96%	96%	95%	96%	100%
Urine measure	88%	94%	78%	81%	74%	79%	67%	80%	74%	68%	72%	64%

Key Issues and Executive Response

Themes

- IV antibiotic compliance within ED shows normal variation sitting at 86% for September (88% in August)
- Average time to IV antibiotics was 42 minutes which is within trust timeframe of 1 hour. The minimal delays seen were often due to patients are being treated in areas with high patient to nurse ratio such as waiting areas as opposed to resus or delays in ambulance offloads.
- The overall sepsis six compliance within ED sits at 56% however this can be largely be contributed to poor urine output compliance which falls to 64% in September.
- IV fluid compliance increased to 89% in September whilst lactate measurement achieved 100% compliance within an hour in September.
- The Sepsis Team was not informed of any serious harm to any patients in relation to sepsis in September.

Response

- The Sepsis Team continue to clinically provide bedside education to newer/junior staff, often attending to sepsis patients in ED and going through the tool with ED nurses and doctors in real time.
- The Sepsis Team has also continued to encourage sepsis screening on patients when the team isn't around.
- The numbers of patients being screened for sepsis using the NerveCentre tool have dropped since weekly teaching sessions within ED have stopped, this is something the team are in liaison with the practice development team about.
- Encouragement and education surrounding the importance of fluid balance monitoring and using the digital fluid chart is continuing to be pushed and promoted with the aim of improving compliance.

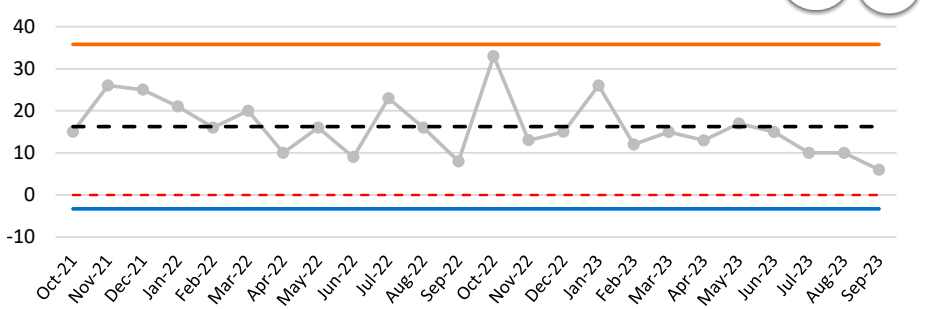
Month 06 | 2023-24

Quality

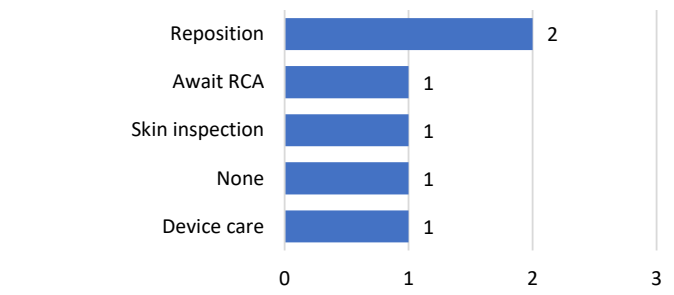
Pressure Ulcers | VTE

East and North Hertfordshire NHS Trust

Number of hospital-acquired pressure ulcers



Themes - Sep-23

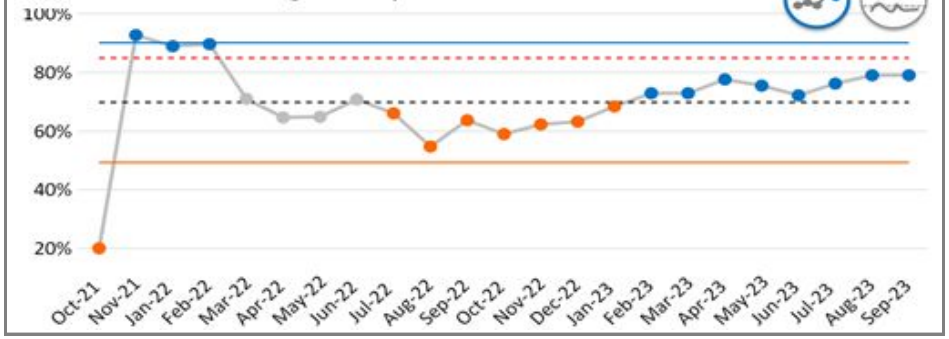


104

days since last category 4

as at 20/10/2023

VTE risk assessment stage 1 completed



Key Issues and Executive Response

- QiP work is ongoing in CRCU with the trial of a new Urinary catheter fixation device. Recent communication has reported that they are struggling with the supplier they were using for the device. They have discontinued the current trial and are looking for a new supplier.
- PU Risk assessment CQUIN is ongoing Q1 data is at 57% compliance with 6hr time frame and care planning. TVT engaging with wards to prioritise Risk assessment.
- TVT Actions FOR 2023/24
    - Continuation of face to face teaching to fulfil action plans from 22/23 SI reports. Dates for 2024 set and await publication.
    - Implementation of new National Wound Care Strategy Programme (NWCSP) PU recommendations.
    - Convert PU risk assessment tool to PURPOSE-T to align with the new NWCSP recommendations.

VTE

- In the beginning of June the Trust implemented a 'combined' assessment and single measure in line with VTE exemplar sites. Compliance is being closely monitored and shows early improvement with positive feedback
- Several clinical areas have QI projects in progress and show local improvements. Data is continuously shared with specialities through RHDs, ward feedback and QI projects. Next RHD in October.
- Ward and speciality level data have allowed for tailored QI projects and continue to provide good oversight. Local QI project learning and success to be rolled out to lower compliance areas over upcoming months.

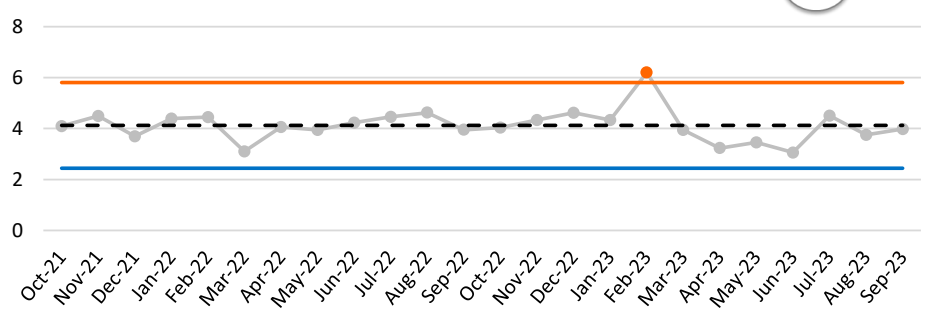
Month 06 | 2023-24

Quality

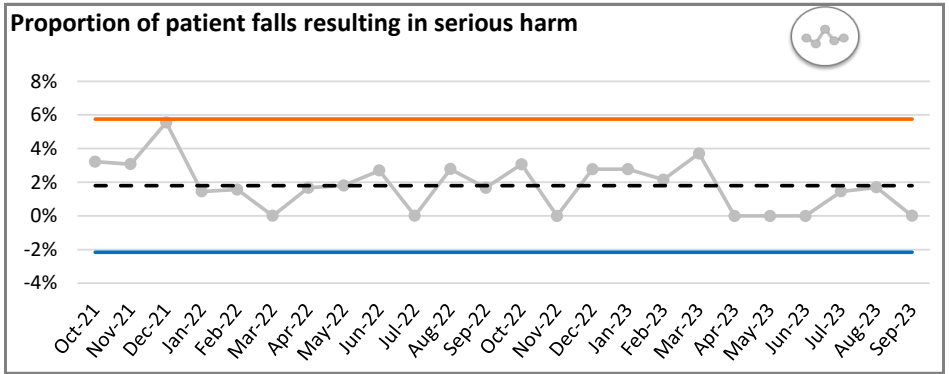
Patient Falls

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.
- No falls with moderate or severe harm recorded for the month of September.
- Falls prevention steering group are being set up as part of falls prevention policy and to support PSIRF investigations
- Falls lead providing falls prevention training to OSCE staff at least once a month.
- We are currently reviewing post fall assessment and will make necessary changes to adapt to PSIRF.

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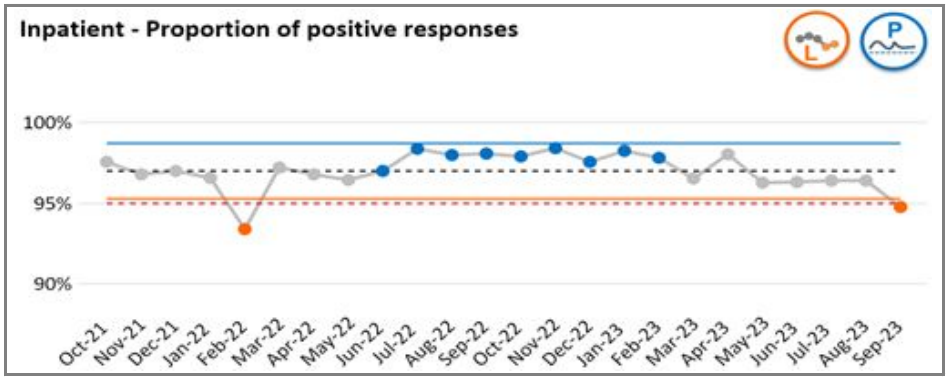
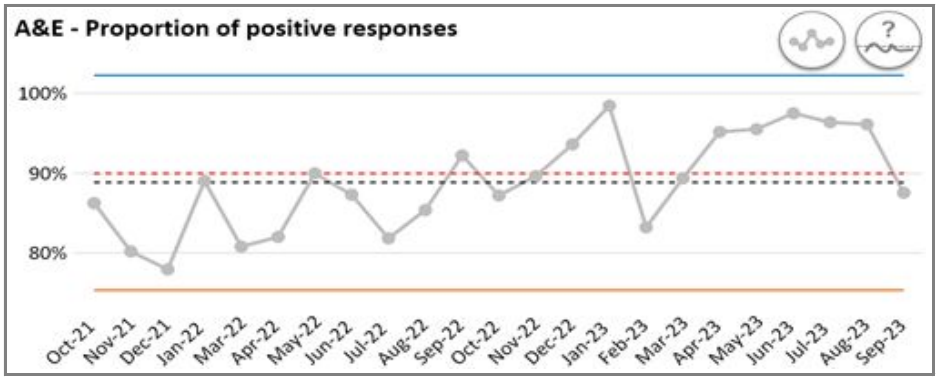
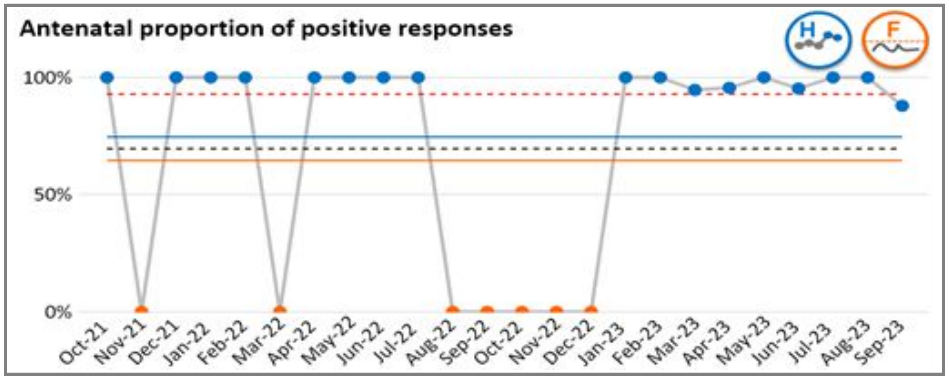
Quality

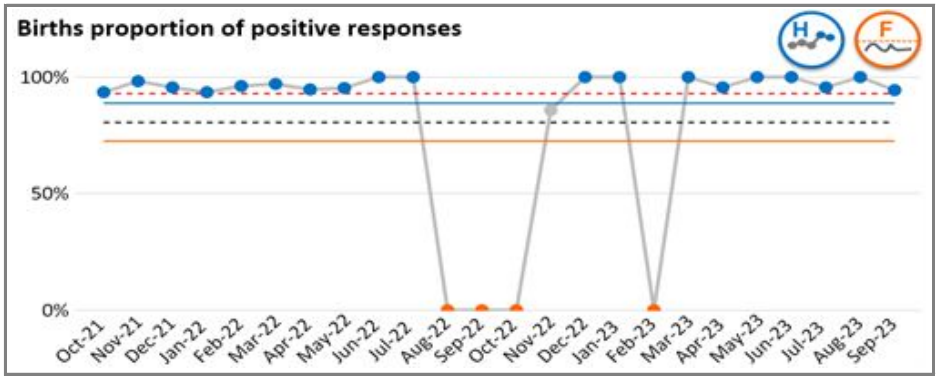
Friends and Family Test

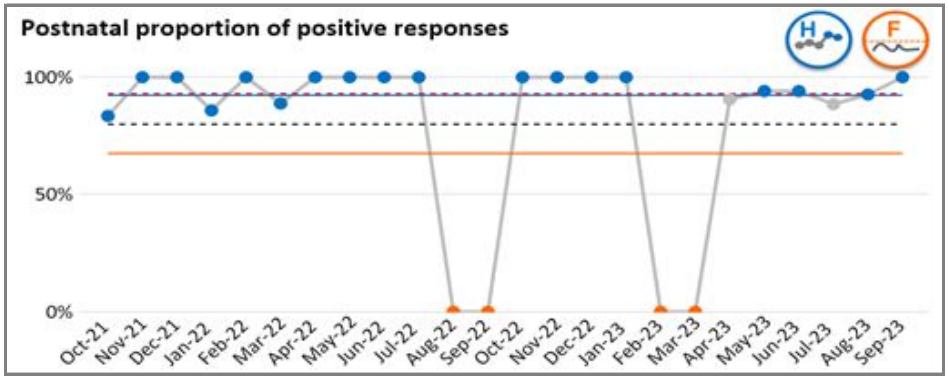
East and North Hertfordshire NHS Trust

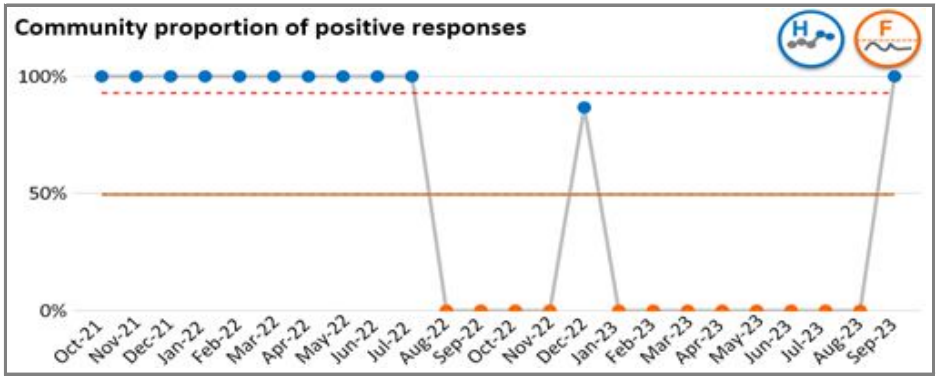












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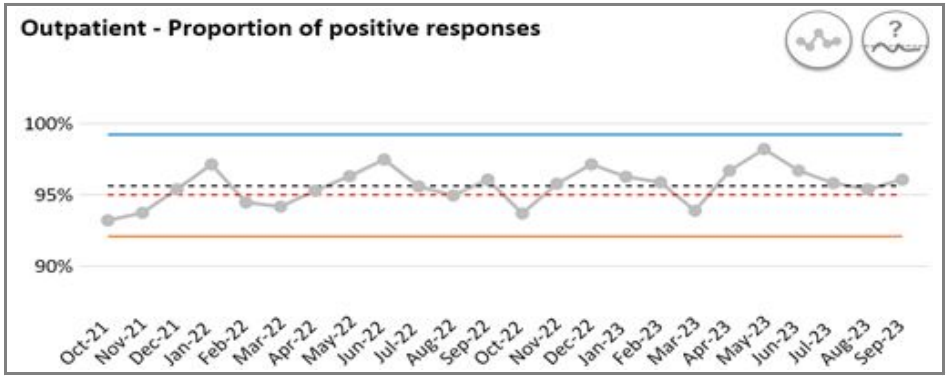
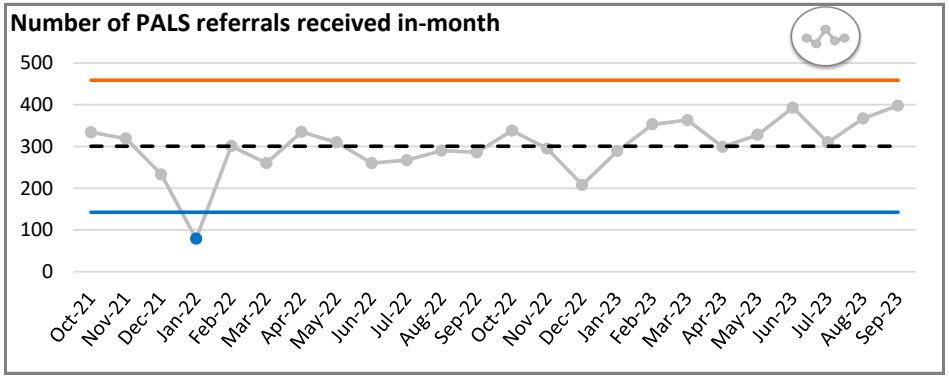
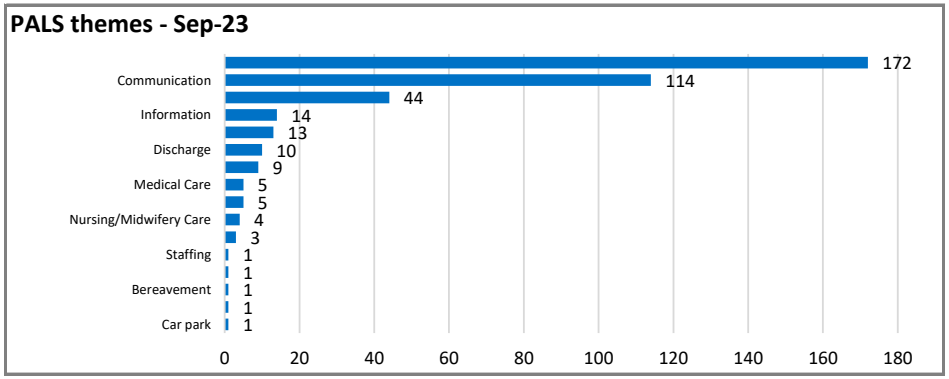
Quality

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

- New leaflets with QR codes have been provided and distributed to the Community Midwives. These went live from the 15th September.
- There has been a rise in Community Midwife feedback, which is a very positive outcome of the new QR code leaflets that have been created.

Patient Advice Liaison Service

Excellence

- PALS continue to drive the response timeframe down - currently sitting on 2 week turn around.

Challenges

- Emails have started to mount up within the department. This is due to the amount of emails and phone calls, when team members on leave etc, the risk / reality is that it does increase etc, despite the massive efforts to reduce. Additional support is needed.

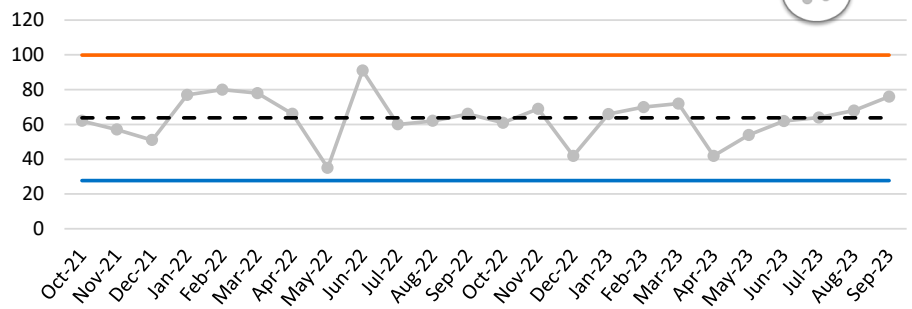
Month 06 | 2023-24

Quality

Complaints

East and North Hertfordshire NHS Trust

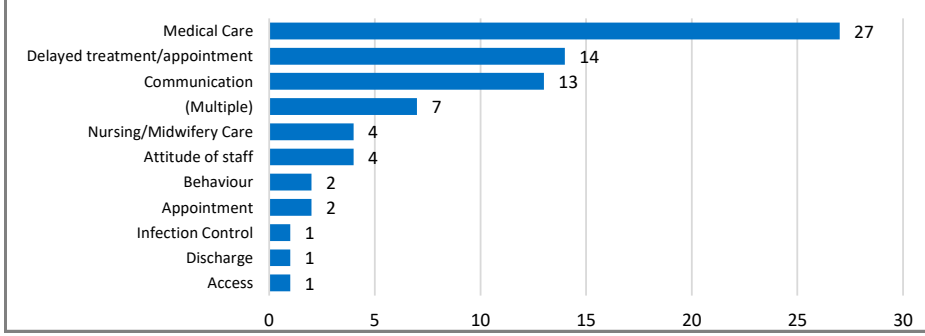
Number of written complaints received



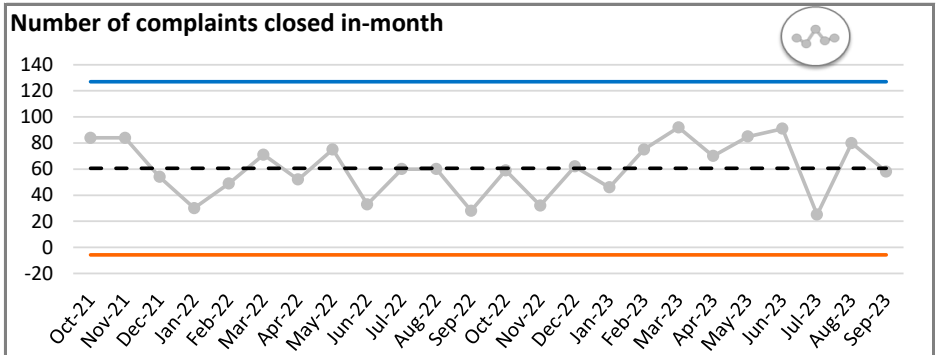
Key Issues and Executive Response

- Large amount of drafting still remains in the Complaints team - no divisional support available.
- Slight dip in complaint acknowledgment and complaints closed due to annual leave within the team.
- It is apparent that when there is annual leave or sickness in the team that the department suffers due to an already small team where more staffing is needed.
- Actions from divisions following the outcome of upheld or partially upheld complaints remains difficult. This is currently being addressed in Trust wide formal complaints training and escalations to senior management.

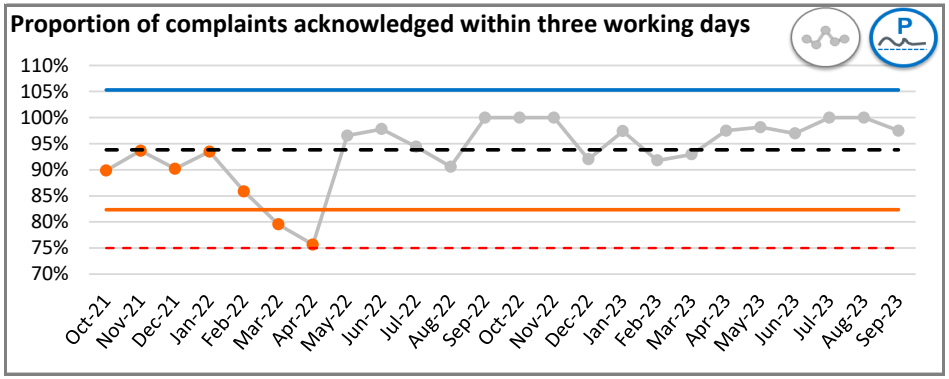
Complaints themes - Sep-23



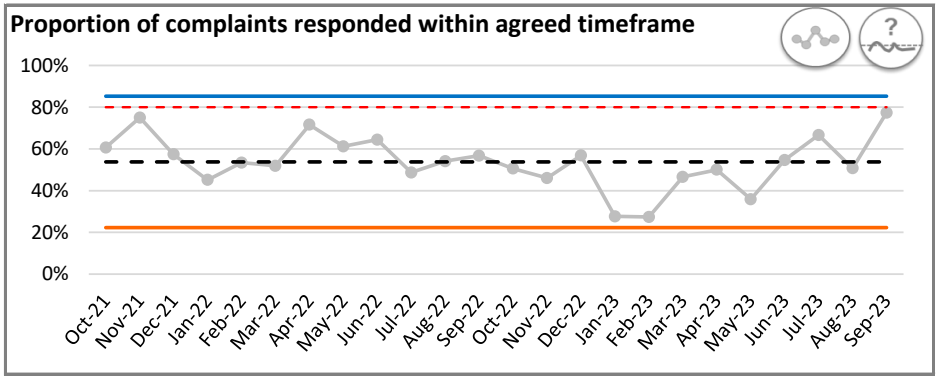
Number of complaints closed in-month



Proportion of complaints acknowledged within three working days



Proportion of complaints responded within agreed timeframe



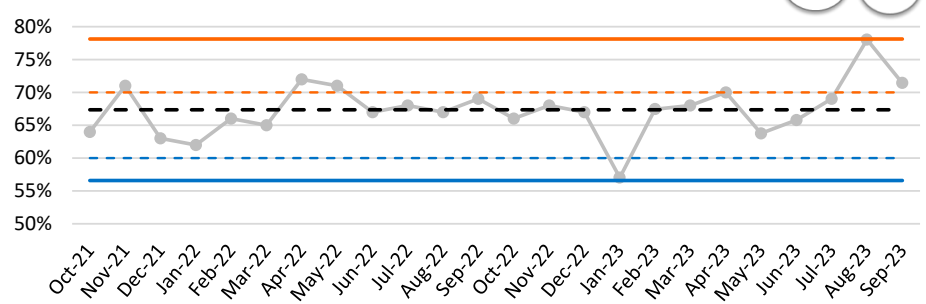
Month 06 | 2023-24

Quality

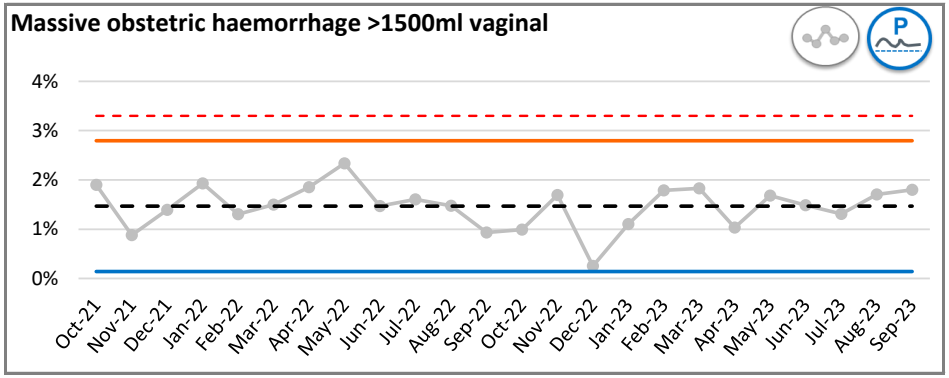
Maternity | Safety Metrics

East and North Hertfordshire NHS Trust

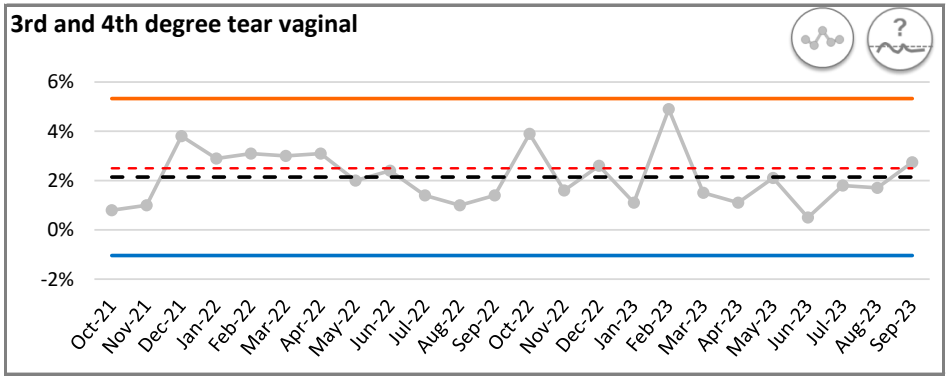
Total caesarean section rate from RG1, 2 and 5 combined



Massive obstetric haemorrhage >1500ml vaginal



3rd and 4th degree tear vaginal



Key issues and executive response

- No SIs declared in month.
- No HSIB referrable cases this month
- Smoking at booking remains below 6%. While concerning special cause variation is noted in relation to smoking rates at time of delivery, there are < 4 points below the mean of a decreasing trend. Comparison data between booking and delivery is not directly comparable (these are different cohorts of women.
- 3rd / 4th degree tears - Normal variation noted. 2023 Cases remain significantly below 2022 numbers currently. Monthly audit continues and a working party is now in place to implement the Obstetric anal sphincter injury (OASI) 2 care bundle as a quality improvement initiative.
- Massive Obstetric Haemorrhage (MOH) - Normal variation continues. Cases continue to be reviewed by the risk management MDT on a monthly basis.
- Breastfeeding Initiation rate has increased to above target

Robson Group Criteria

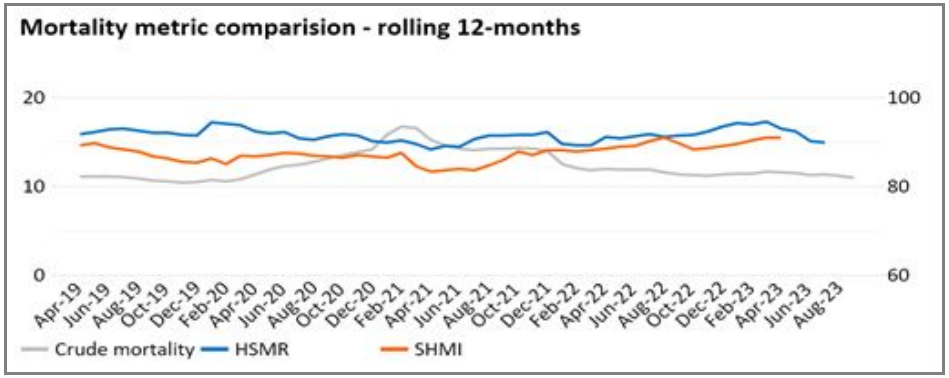
- This considers the obstetric variables to enable classification into one of 10 groups. This categorisation assists in understanding the reasons for the increasing trend in caesarean section rates.
    - **Robson group 1**: Nulliparous singleton pregnancy > 37 weeks with spontaneous labour onset.
    - **Robson group 2**: Nulliparous singleton pregnancy > 37 weeks delivered before labour onset or where labour induced.
    - **Robson group 5**: Multiparous women, singleton pregnancy >37 weeks with at least one previous uterine scar.
- These 3 groups combined normally contribute to 2/3rds of all CS performed in most hospitals. For month 5 the combined rate is 70% This may indicate fewer LSCS performed in other Robson Groups for example multiparous women in spontaneous or induced labour, We will continue to monitor this trend.

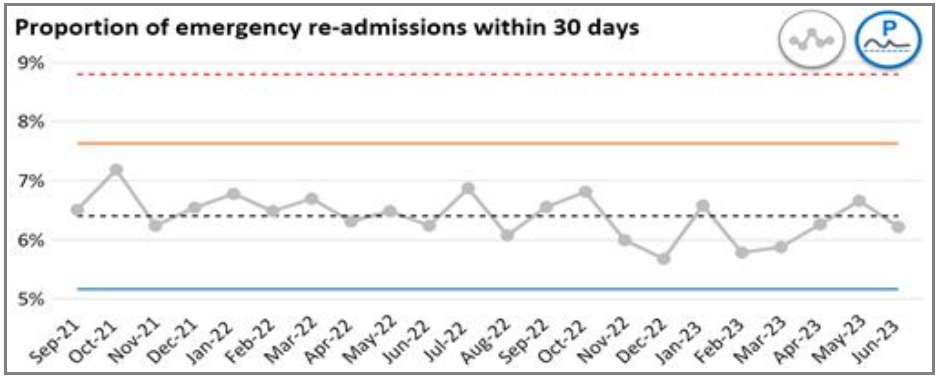
Month 06 | 2023-24

Quality

Mortality Summary | Emergency Re-admissions

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

Mortality Metrics

- Following the rise in crude mortality seen during the pandemic, levels are now stable and slightly above those seen prior the pandemic.
- Despite recent increases to both HSMR and SHMI we continue to be well placed vs national peers. After a prolonged upward trend, rolling 12-month HSMR has seen a four month reduction.

Learning from Deaths

- Reforms continue regarding the Trust's learning from deaths framework, including the adoption of an SJRPlus Review format, developed by NHSE which commenced on 1 July 2022. Reforms include the reduction in the number of reviews undertaken, with the focus being on gaining richer learning from the process.
- From December 2022 the on-line SJRPlus tool migrated from the NHSE ORIS platform to NHS Apps.
- The SJRPlus review format, adopted by the Trust in July 2022 has provided an opportunity to revisit our broader learning from deaths processes, to take into account recent and imminent changes in the fields of scrutiny, quality, and governance, including the introduction of the Medical Examiner function and the forthcoming introduction of the new PSIRF approach to patient safety.
- To provide additional clarity and focus, a Learning from Deaths Strategy (2022-24) was developed which aligns with the Trust's overarching strategy and the Quality strategy. The strategy was approved by the Mortality Surveillance Committee in November 2022. An update on progress at year-end was included in September Learning from Deaths report to Q&SC.

Re-admissions

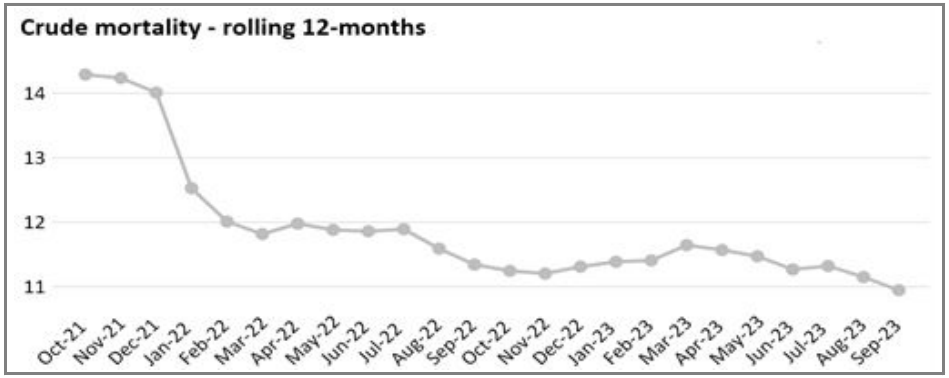
- The Trust's re-admissions performance for both readmissions within 30 days and for the rate of readmissions within 30 days remains relatively stable but with an upward trend for both over recent months.
- The Trust's performance is well positioned in comparison to national and our Model Hospital peer group.

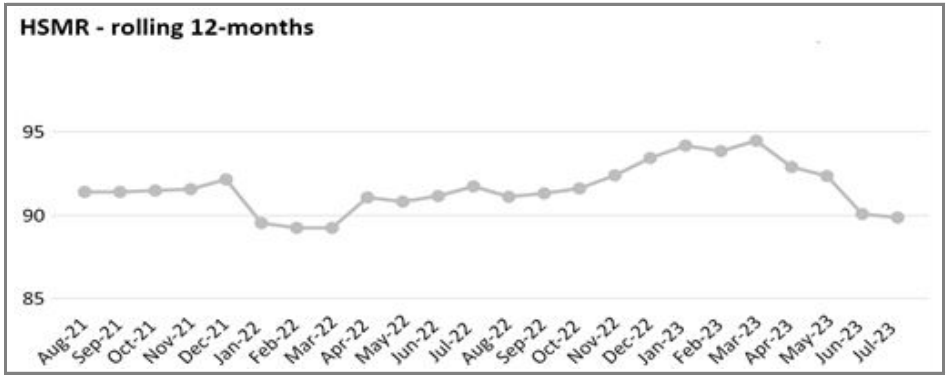
Month 06 | 2023-24

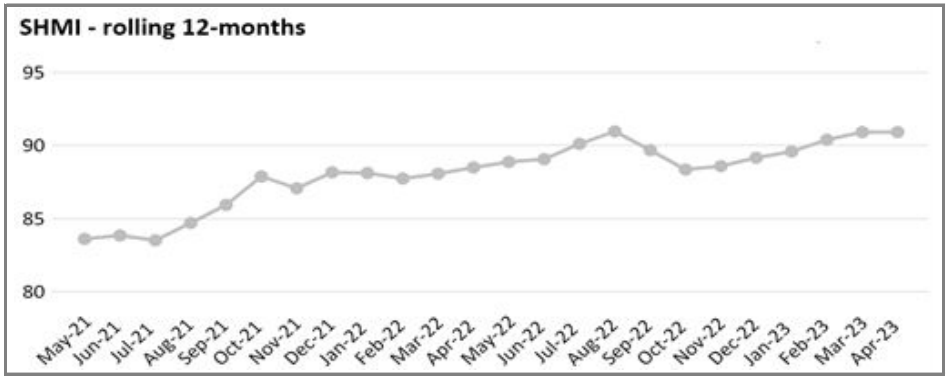
Quality

Mortality

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

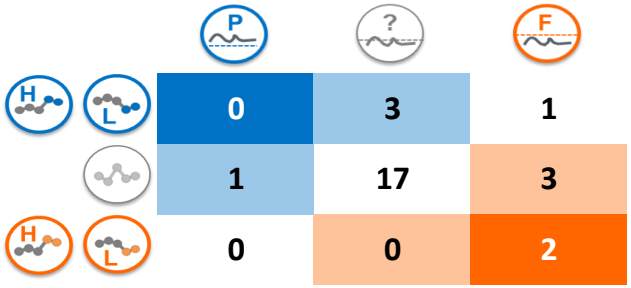
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception has been during the COVID pandemic, when the usual correlation has been weakened by the partial exclusion of COVID-19 patients from the HSMR metric.
- The general improvements in mortality prior to the COVID-19 resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work. Of particular importance has been the continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average.
- Up to March 2023, there had been a gradual upward trend in rolling 12-month HSMR since December 2021. This contrasted with a downward trend in crude mortality for the same period, which is unusual as HSMR tends to follow the crude metric. HSMR has since seen 4 consecutive reductions. The situation has been discussed with CHKS, who advised that the there appeared to be some correlation between the divergence between crude and HSMR and a reduction in depth of coding. This is being reviewed by the Head of Coding.
- Our rolling 12-month HSMR data to July 2023 (91.9) shows the Trust has remained well positioned compared to our Model Hospital Peer group and has returned to the top quartile of trusts nationally.
- The latest in-month position for April 2023 reported by CHKS shows common cause variation.
- Latest NHSD published rolling 12-month SHMI to May 2023 showed a decrease from 92.95 to 91.96.
- The Trust remains well placed in the 'as expected band 2, in the top quartile of trusts nationally.

Month 06 | 2023-24

East and North Hertfordshire NHS Trust

Operations

Month 06 | 2023-24



Operations

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Sep-23	95%	65.8%		F	Common cause variation Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Sep-23	2%	7.8%		F	Common cause variation Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	Sep-23	65%	12.6%	H	F	9 consecutive points above the mean Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Sep-23	80%	40.9%	L	F	1 Point below the lower process limit Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Sep-23	240	216.6		?	Common cause variation Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Sep-23	tbc	627.4			Common cause variation No target
	Average minutes from clinically ready to proceed to departure	Sep-23	tbc	241	L		3 points below the lower process limit No target
	Critical time standards	Sep-23	tbc				Pending data
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Sep-23	92%	49.8%	L	F	7 consecutive points below the lower process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Sep-23	0%	42.8%		F	Common cause variation Metric will consistently fail the target

Operations

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	Two week waits for suspected cancer	Aug-23	93%	91.5%			Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Aug-23	93%	89.0%			Common cause variation Metric will inconsistently pass and fail the target
	28-day faster diagnosis	Aug-23	75%	73.0%			Common cause variation Metric will inconsistently pass and fail the target
	31-days from diagnosis to first definitive treatment	Aug-23	96%	96.6%			Common cause variation Metric will inconsistently pass and fail the target
	31-days for subsequent treatment - anti-cancer drugs	Aug-23	98%	100.0%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - radiotherapy	Aug-23	94%	95.9%			Common cause variation Metric will inconsistently pass and fail the target
	31-days for subsequent treatment - surgery	Aug-23	94%	89.4%			Common cause variation Metric will inconsistently pass and fail the target
	62-days from urgent GP referral to first definitive treatment	Aug-23	85%	83.3%			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	Aug-23	0	4.5			Common cause variation Metric will inconsistently pass and fail the target
	62-days from referral from an NHS screening service to first definitive treatment	Aug-23	90%	90.0%			Common cause variation Metric will inconsistently pass and fail the target
	62-days from consultant upgrade to first definitive treatment	Aug-23	n/a	71.9%			Common cause variation No target

Month 06 | 2023-24

Operations

Summary

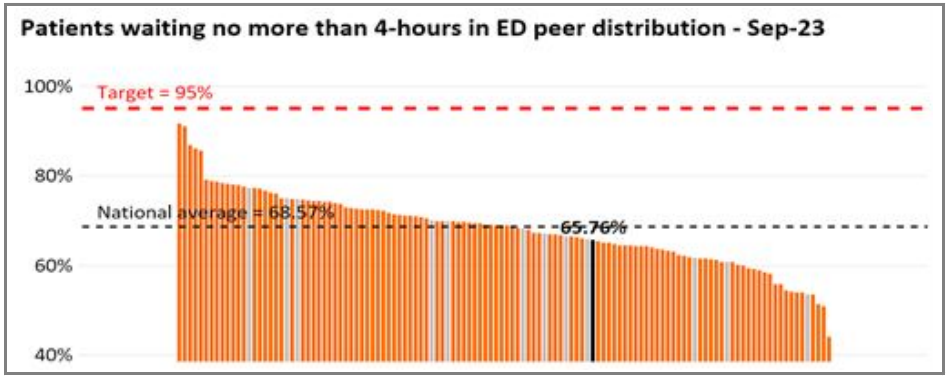
East and North Hertfordshire NHS Trust

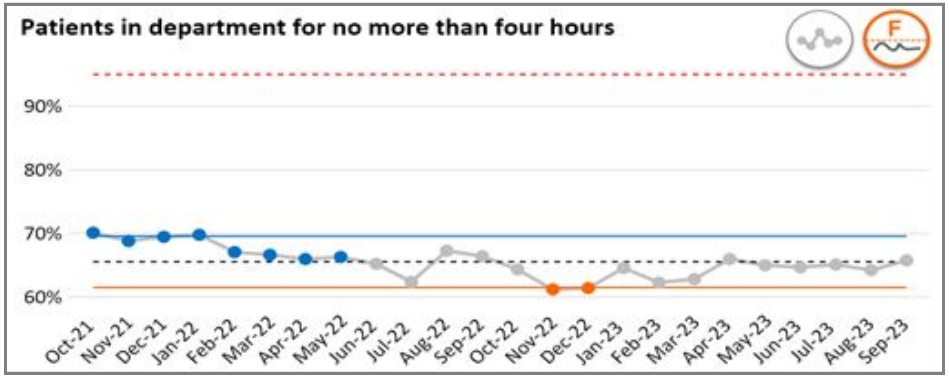
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q1 2023-24	A	C			
	4-hours direct to Stroke unit from ED	Sep-23	80%	32.1%		?	Common cause variation Metric will inconsistently hit and miss the target
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Sep-23	63%	100.0%	H	?	7 Consecutive points above the mean Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Sep-23	63%	32.7%		?	Common cause variation Metric will inconsistently hit and miss the target
	Number of confirmed Strokes in-month on SSNAP	Sep-23	n/a	61			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Sep-23	80%	94.8%		?	Common cause variation Metric will inconsistently hit and miss the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Sep-23	50%	62.7%		?	Common cause variation Metric will inconsistently hit and miss the target
	Scanned within 12-hours - all Strokes	Sep-23	100%	102.8%	H	?	1 point above the upper process limit Metric will inconsistently hit and miss the target
	% of all stroke patients who receive thrombolysis	Sep-23	11%	6.8%		?	Common cause variation Metric will inconsistently hit and miss the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	Sep-23	70%	25.0%		?	Common cause variation Metric will inconsistently hit and miss the target
	Discharged with JCP	Sep-23	80%	90.9%	H	?	7 consecutive points above the mean Metric will inconsistently hit and miss the target
	Discharged with ESD	Sep-23	40%	58.7%		?	Common cause variation Metric will inconsistently hit and miss the target

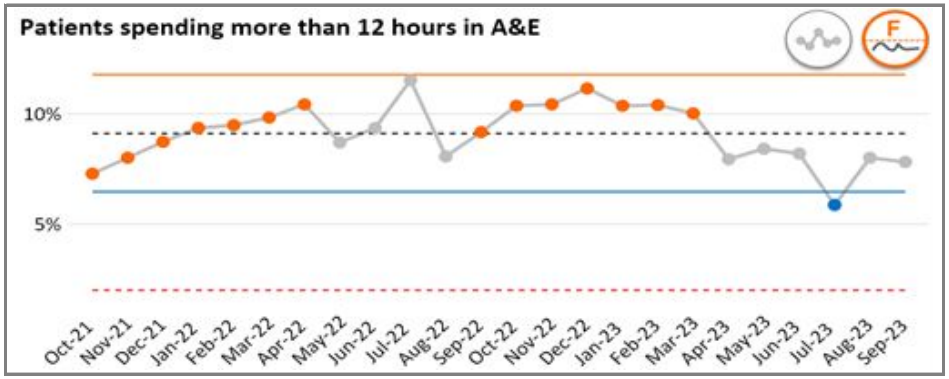
Operations

Emergency Department

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

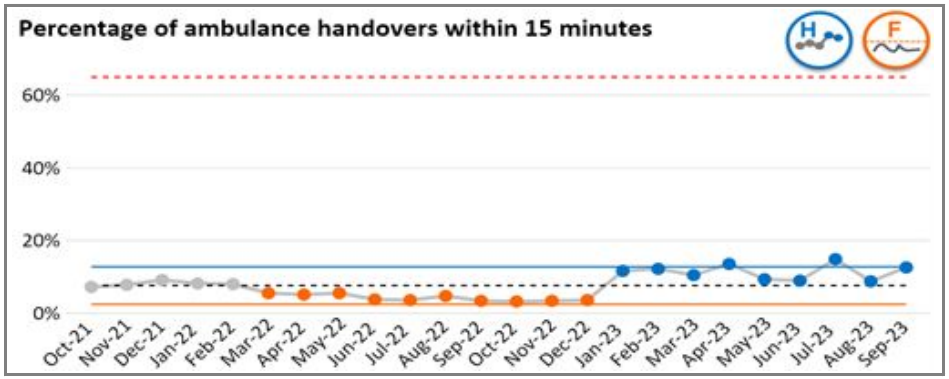
- Monthly attendances increased compared to last month. ENHT continues to progress delivery of the UEC Improvement Programme at pace, including confirmation of investment into several associated workforce structures together with recruitment mobilisation plans.
- Performance against the 4-hour standard demonstrated improvement compared to previous 4 months. Patients spending 12 hours in department also reduced compared to previous month. The introduction of the new surgical assessment unit is making significant progress with key appointments already made including the Senior Sister role. In addition, the review of the ED Consultant and junior doctor's rotas have been completed with proposals for change being presented at the October UEC Board. The rotas have been redesigned to reflect demand on the emergency department and support improved compliance with emergency standards. The new rotas, if approved, will be commence immediately, in a phased approach, with full implementation expected by month 12 (23/24) following appropriate consultations with the affected workforce.
- Ambulance arrivals decreased in month with notable improvement in the percentage of ambulances handed over within 15minutes. Ambulance handover continues to be of high priority and a series of new patient pathways to UTC, SDEC, SAU and MAU have been designed and approved to create effective flow through ED. The unplanned division have also taken strides to involve ward managers and other speciality based colleagues in identifying 'quick wins' to improve patient flow with early impact reflected in the improved weekend discharges and discharges before midday.
- Bed days for patients 'not meeting the criteria to reside' remained high and continued to impact on UEC flow, however, it was at its lowest level since May 2023. Although in its infancy, progress on implementing a trusted assessment process is gathering momentum.

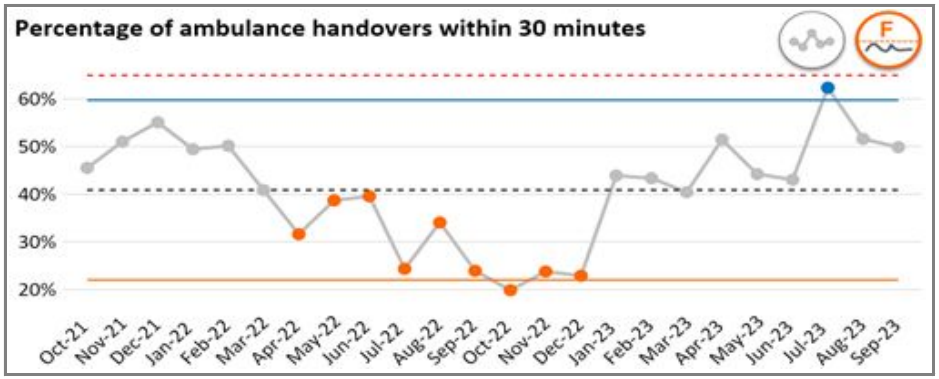
Month 06 | 2023-24

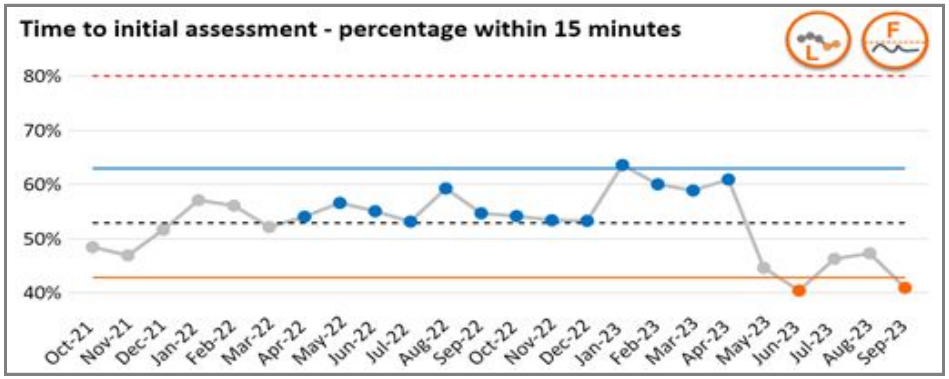
Operations

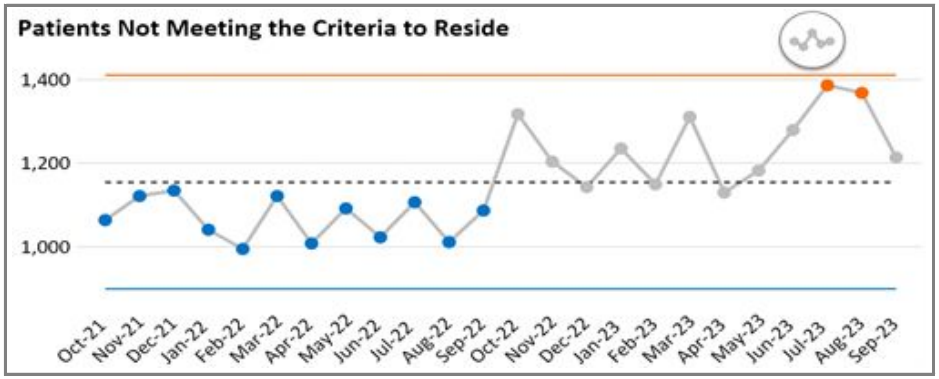
Emergency Department New Standards

East and North Hertfordshire NHS Trust







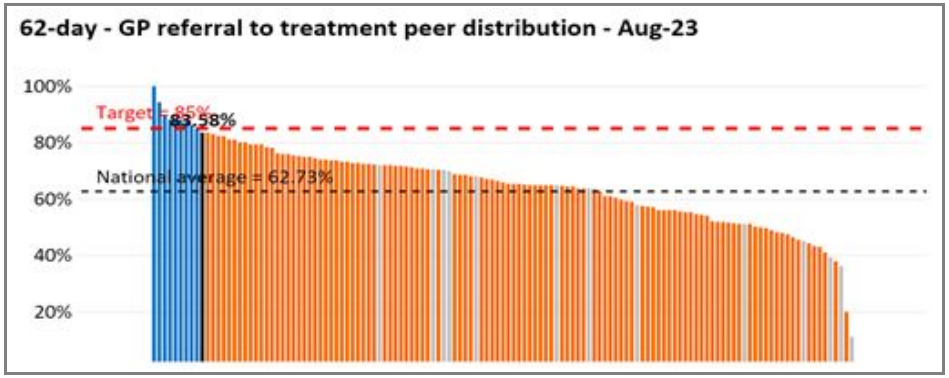


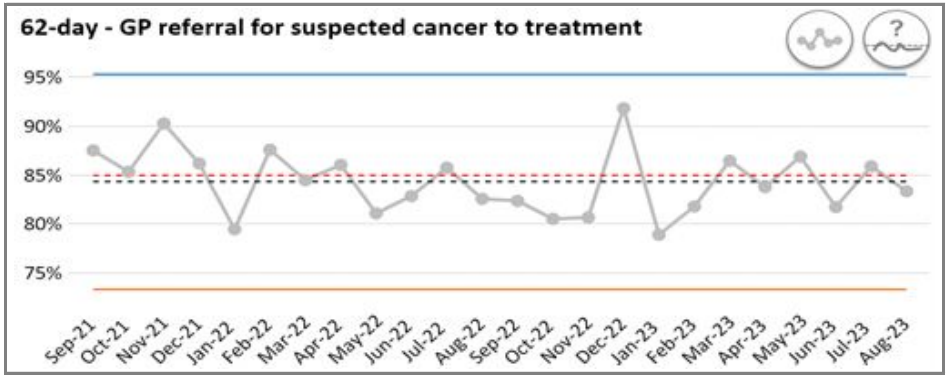
Month 06 | 2023-24

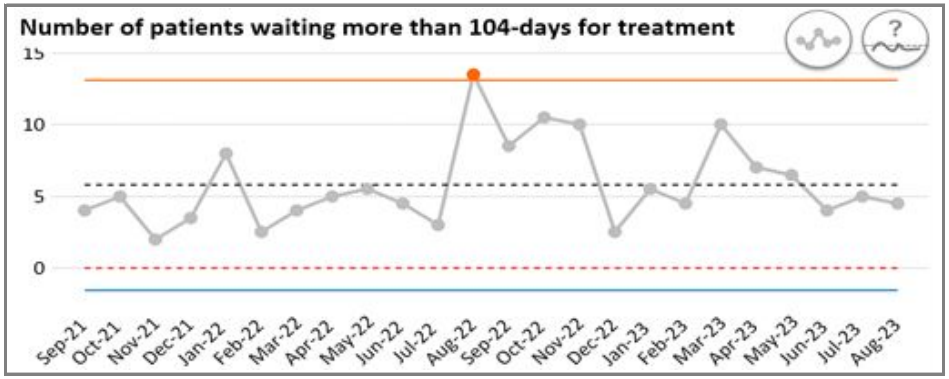
Operations

Cancer Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- The Trust has been removed from Tier 2 for cancer as a result of progress with reducing the 62-day pathway backlog. Weekly monitoring has moved to monthly oversight.
- We achieved 4 of the 9 national targets in August with compliance in 31-day first treatment, 31-day second or subsequent treatment for chemotherapy and radiotherapy, and 62-day referral to treatment from screening.
- The Trust has not achieved the 2ww GP referrals due to patient choice and high number of referrals and 2ww Breast symptoms due to Patient choice and a small denominator
- 31-day subsequent treatments for surgery is non compliant due to theatre capacity for Skin and breast. Additional WLI agreed to cover backlog.
- 62-day referral to treatment performance is non compliant due to colonoscopy capacity which is being sought from independent sector, patient choice delaying the diagnostic pathway, TP biopsy capacity for Urology pathway which has now been increased by adding an extra case per list, Breast radiology delays this has been now addressed with a Locum radiologist and also complex pathways which patient needed additional tests outside the Trust and strikes.
- 28 FDS is non compliant but delivering against agreed recovery trajectory. Main drives include delayed additional Colonoscopy capacity, breast radiology delays due to high number of referrals, TP biopsy capacity and consultant TAT due to strikes.
- Work continues with IMAS around pathway analysis, to identify constraints in tumour level pathways and whole Trust cancer training.
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning.

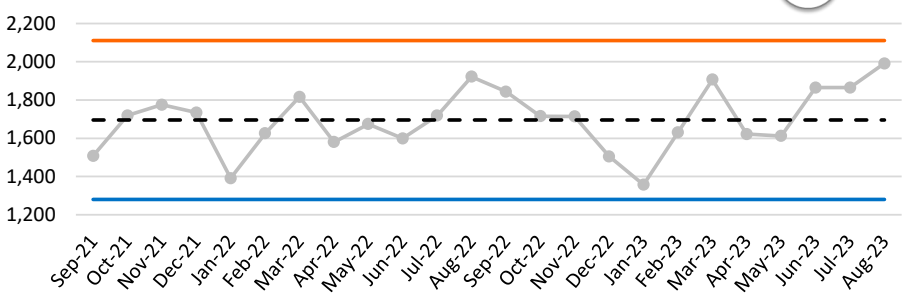
Month 06 | 2023-24

Operations

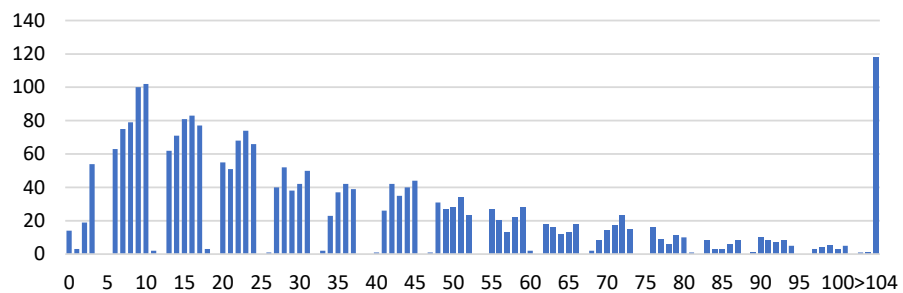
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

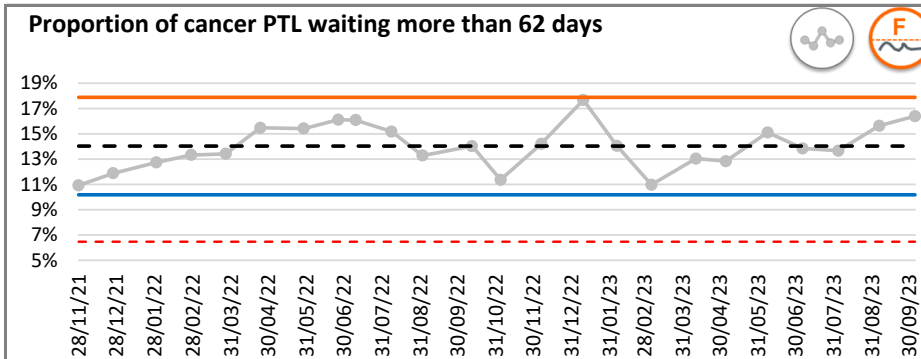
Suspected cancer referrals



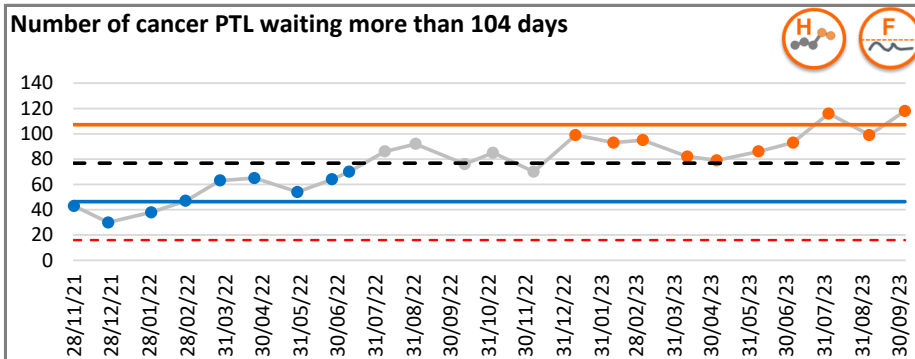
62-day PTL as at 05/10/2023



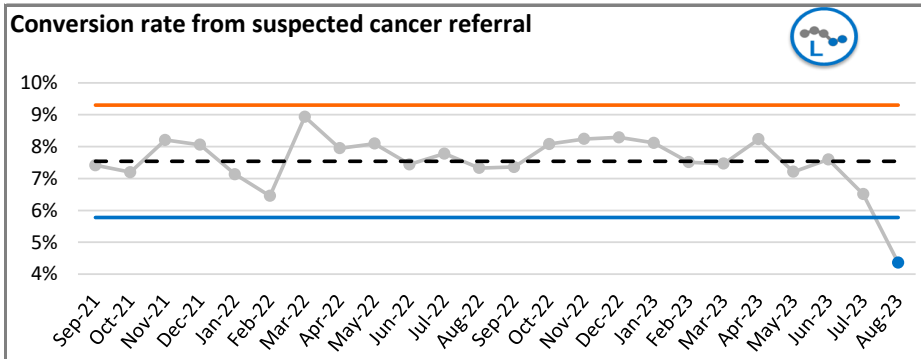
Proportion of cancer PTL waiting more than 62 days



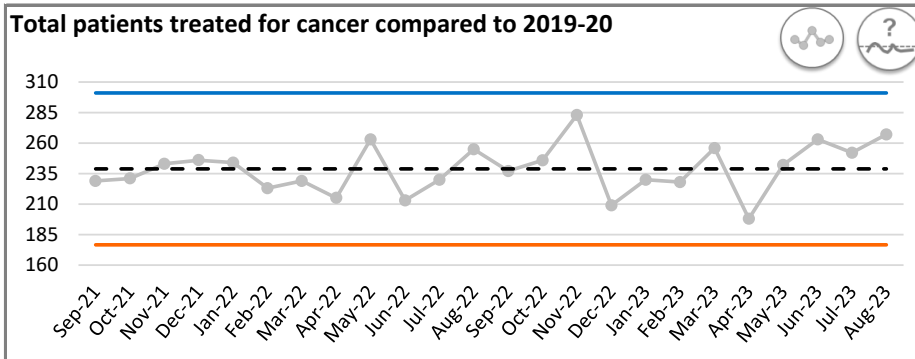
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



Total patients treated for cancer compared to 2019-20

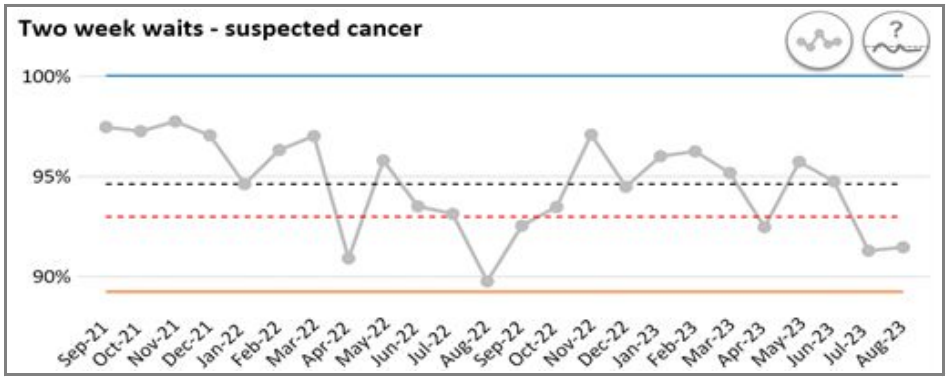


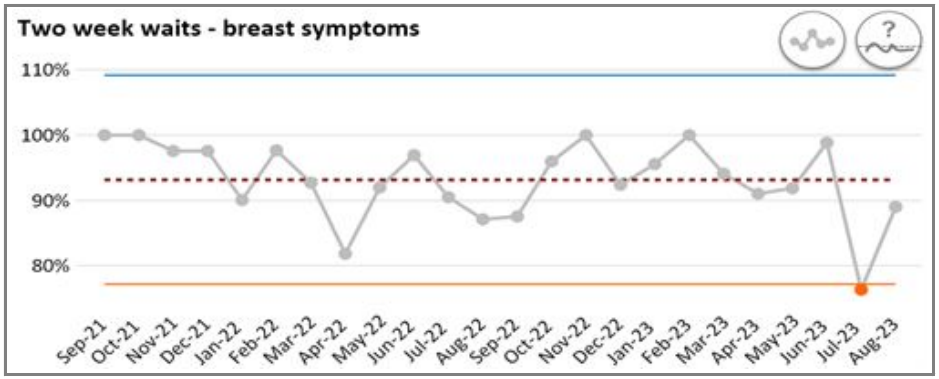
Month 06 | 2023-24

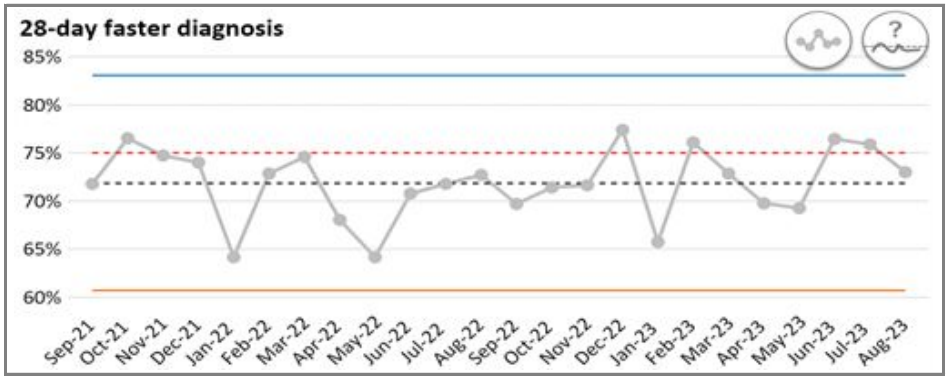
Operations

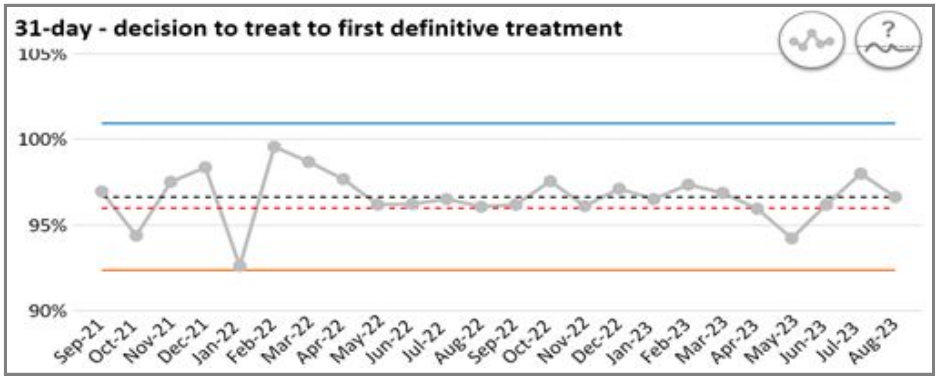
Cancer Waiting Times

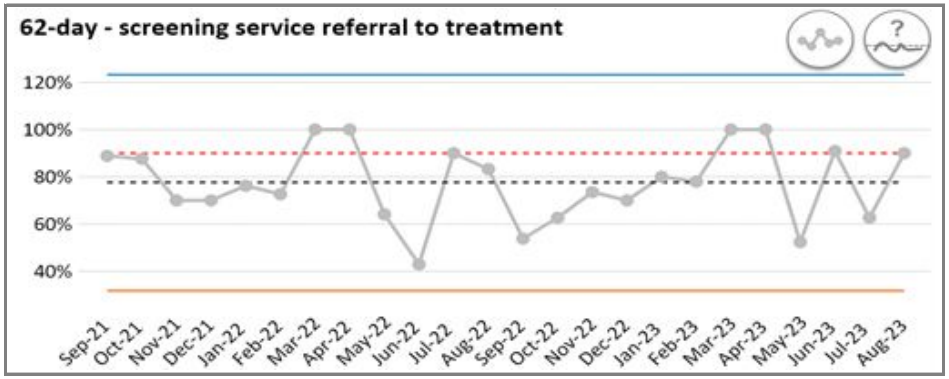
East and North Hertfordshire NHS Trust









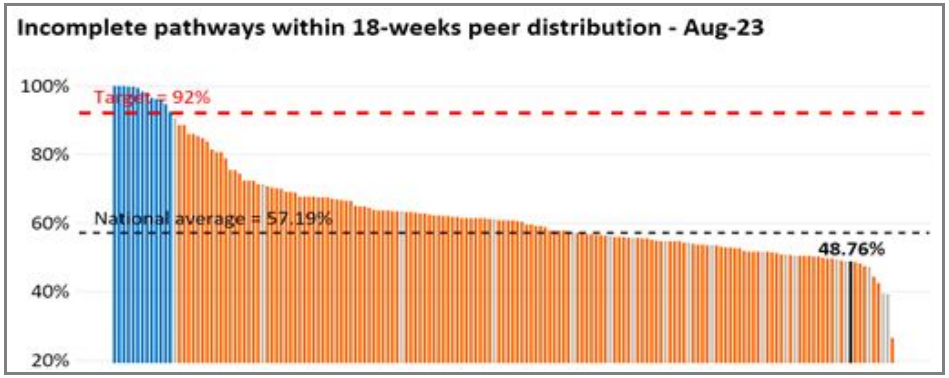


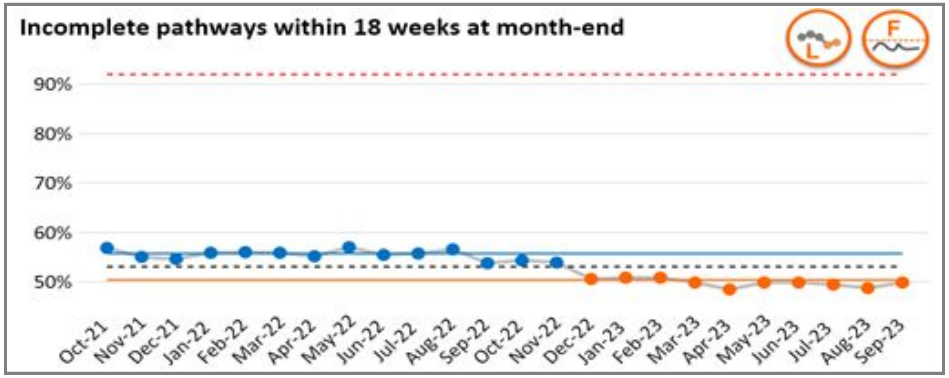
Month 06 | 2023-24

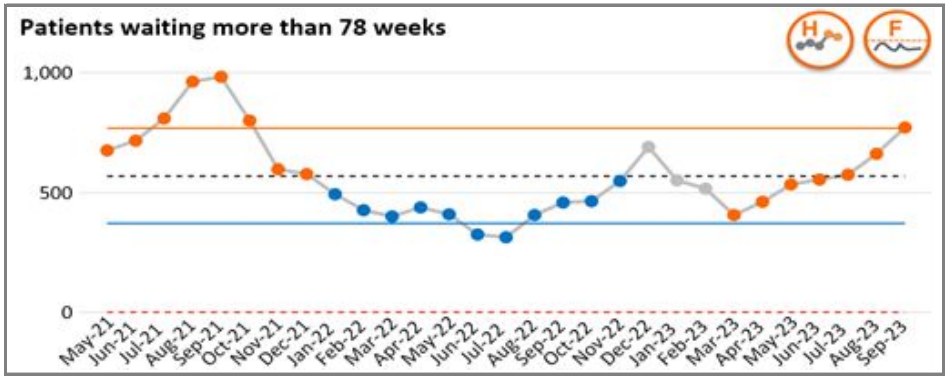
Operations

RTT 18 Weeks

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

RTT Performance

- 104+ week waiters: There were 2 patients waiting over 104 weeks at the end of September. Both were late pop on, one was treated on 12/10, the other on 16/10.
- 78+ week waiters: There were 768 patients waiting over 78 weeks at the end of September, compared to 662 the previous month. This was due to an increase of 112 patients in Community Paediatrics (742), Trauma and Orthopaedics (9), or patient choice, complexity delays and IA impact (17).
- The number of patients waiting 78+ weeks was 1.2% of total PTL.
- 65+ weeks: There were 2,068 patients waiting over 65 weeks for first definitive treatment at the end of September (1,547 were for Community Paediatrics).
- 65 week first appointment: excluding Community Paediatrics (2,551), there were 2,809 patients without a first appointment booked before the end of October 2023 and 903 booked beyond October 2023. Challenged specialties are Ophthalmology (1,152), ENT (992) and Gastroenterology (462). Services are addressing this with additional ad hoc capacity.

Validation

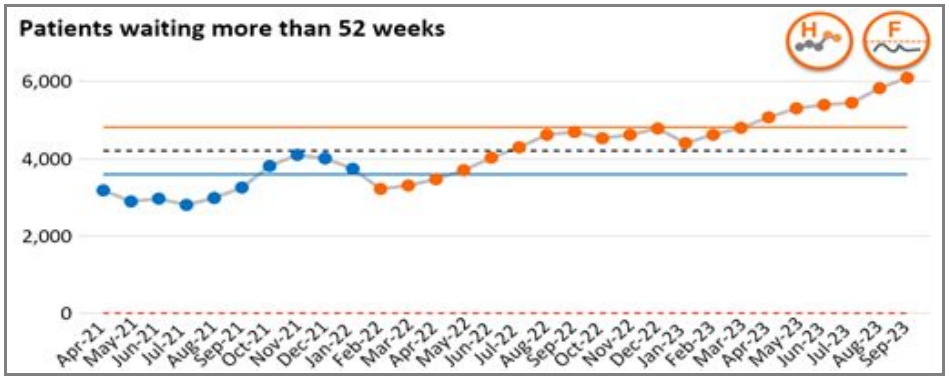
- In line with the new NHS target, 26% of patients 'in scope' (waiting more than 12 weeks without an appointment in the last 12 weeks or in the next 4 weeks) have been validated within the last 12 weeks.
- This does not include patients contacted and we will be messaging 29,500 'in scope' patients by the end of October 2023 to confirm that they are still awaiting an appointment to meet the 90% target.
- 65% of patients with identified potential data quality issues waiting more than 12 weeks, were validated in the last 12 weeks.

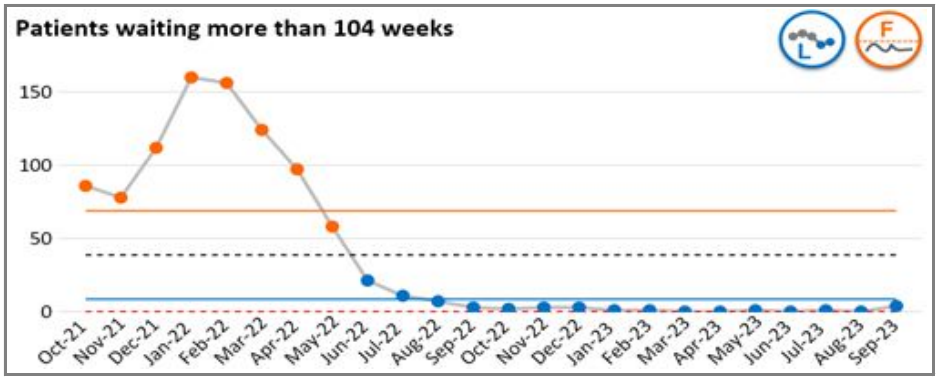
Month 06 | 2023-24

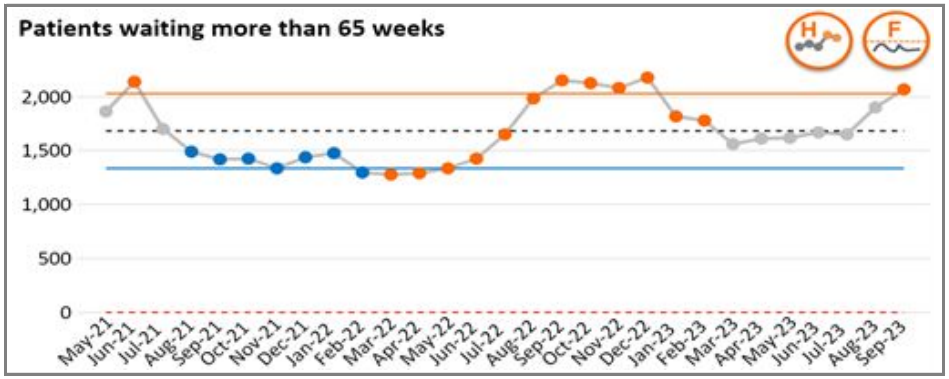
Operations

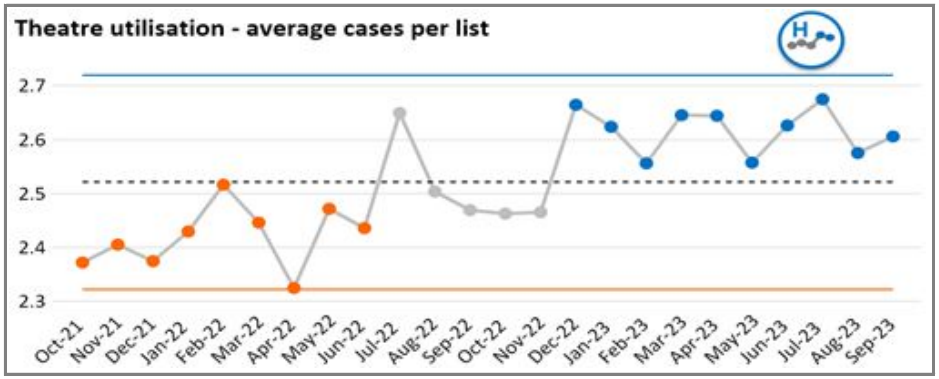
RTT 18 Weeks Supporting Metrics

East and North Hertfordshire NHS Trust







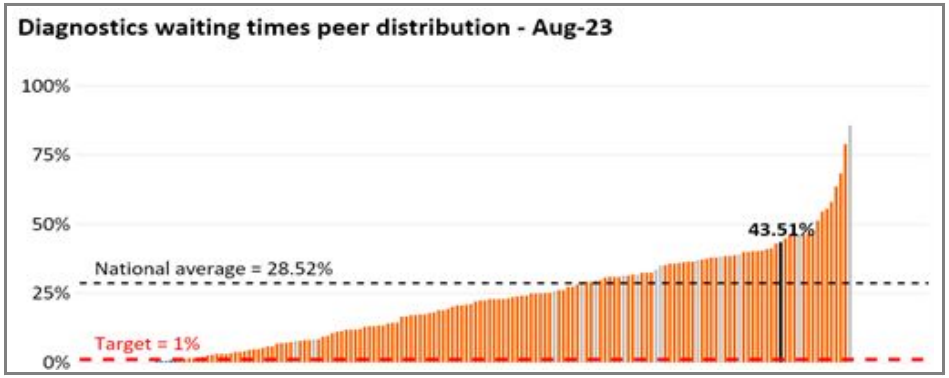


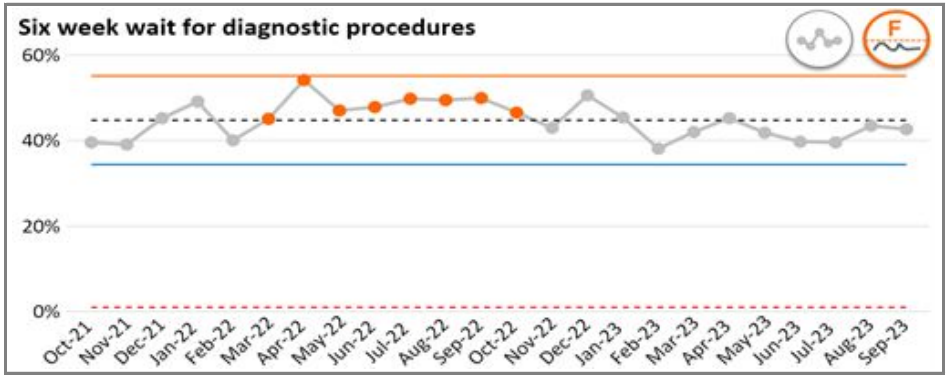
Month 06 | 2023-24

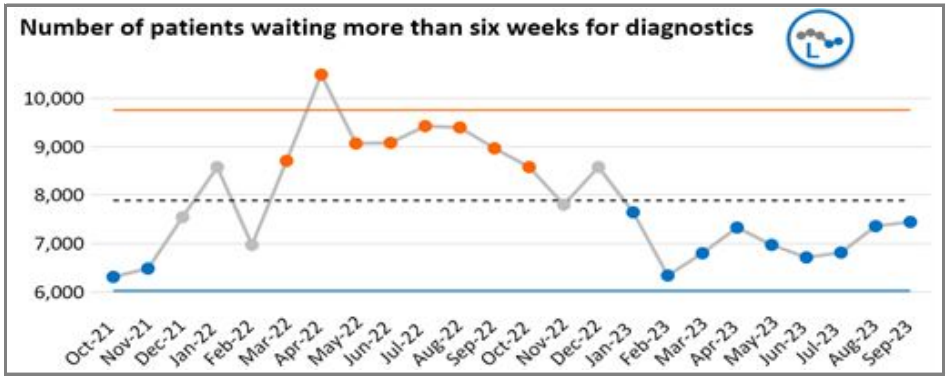
Operations

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Improvements

- Overall demand in Sep (12,672) is similar compared with Aug (12,517) demand (events).
- 79.4% of the demand (10,057) were completed in month, 1% lower than previous month. This is likely due to 5 day-doctor strike.
- Community Diagnostic Centre (CDC) activity did not meet planned activity in M6 except Ultrasound, but YTD still over delivering except for DEXA and MRI contrast
- Urgent Endoscopy now meeting DMO1 standards and booked within 2 weeks.
- Continuous reduction in Endoscopy for patients > 13 weeks
- Cardiology CDC is live and referrals are increasing, additional communications provide to GP's. Planned PTL patients booked within clinical requirements.

Challenges

- Continued increased in cancer demand remains a challenge for prioritising long waiting routine RTT patients (20% cancer wait)
- Lost activity due to doctor strike, US 75 events; CT 23 events
- Pay/band rate for MRI in dispute - being reviewed by the division
- Endoscopy managing balance + risk. Significant increase in 2ww demand
- Endoscopy paper referral process increasing inefficiencies and risks.
- 2 x WTE Vacancies newly recruited, impact for training period.
- Dr's strikes reduced capacity for Endoscopy
- Waiting time for new ECHO referrals is approx. 11wks. Increase in urgent referral demand, which is taking up routine capacity.

Actions

- Team having regular meetings and forward look to identify gaps and mitigate
- East network recruiting DEXA Practitioner hosted by ENHT
- ECHO: Demand and Capacity review to be undertaken, to highlight risk to service provision with shortfall in capacity.
- Ongoing management of Endoscopy waiting times to meet DMO1 trajectory by end of March 2024.
- Further Gastro Consultant input with GP practices with high volume of referrals.

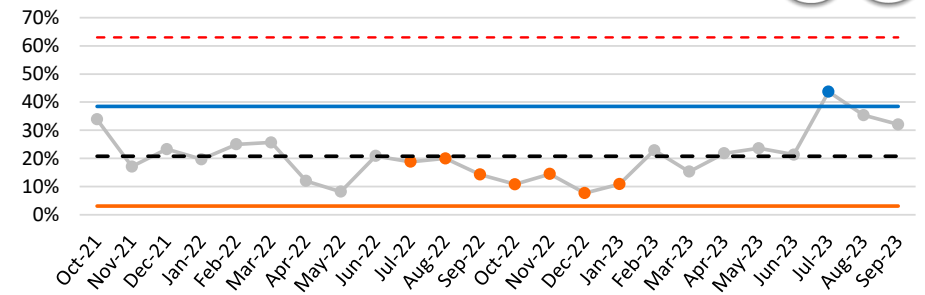
Month 06 | 2023-24

Operations

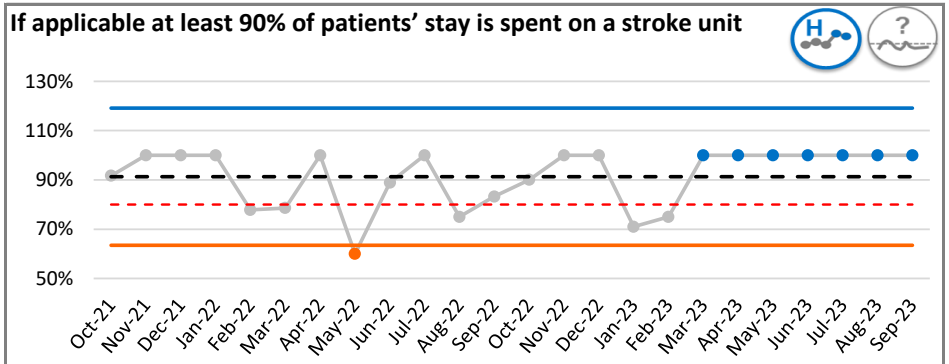
Stroke Services Supporting Metrics

East and North Hertfordshire NHS Trust

4-hours direct to Stroke unit from ED



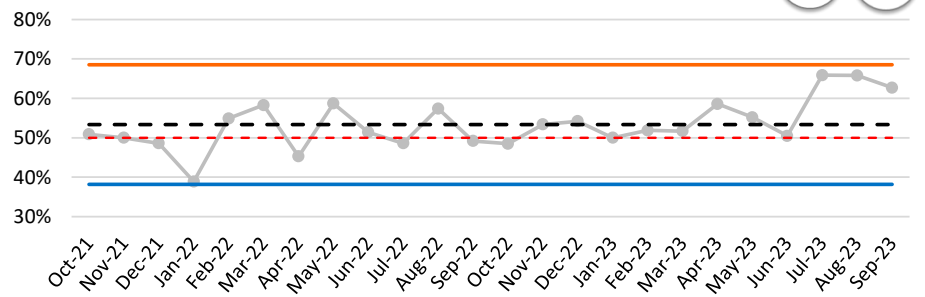
If applicable at least 90% of patients' stay is spent on a stroke unit



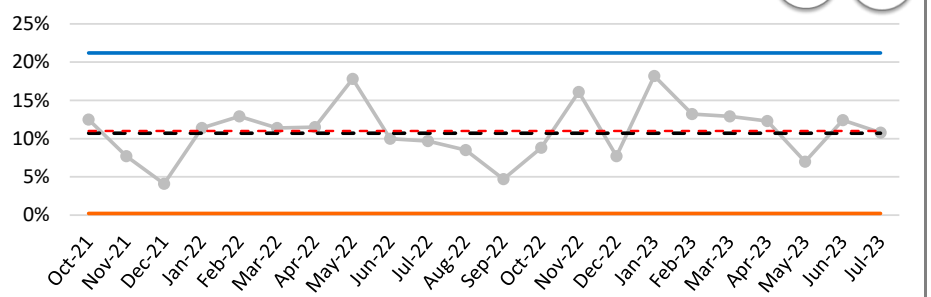
Key Issues and Executive Response

- Stroke Video Triage Pilot bid has been successful and will support improvements in 4-hour direct to stroke and direct to CT pathways. Currently in mobilisation phase with aims to go live in November, subject to recruitment at UCLH to support triaging of patients.
- ED to stroke unit in-hours and out-of-hours transfer pathway trial ongoing to support '4hr direct to stroke unit' standard and ED flow. Patients fast tracked to stroke unit in hours without bed manager allocation. This relies on bed capacity and continued ring-fencing of stroke beds. Ongoing audit to measure impact of trial.
- All 20 stroke monitors have been upgraded to detect AF. This will support early diagnosis and management of patient pathway, appropriate ILR requests, and therefore improve LOS. SOP to be signed off jointly by Stroke and Cardiology.
- Benchmarking piece taking place to review external Stroke Unit which has improved from a D to A rating. Aim to establish key learning outcomes and actions in order to mirror improvement trajectory at ENHT.
- Ongoing challenge with OT/PT service as unable to provide 7-day service and workforce vacancies. Locum starting in October and recruitment campaign being launched.

Urgent brain imaging within 60-mins for suspected acute stroke



% of all stroke patients who receive thrombolysis

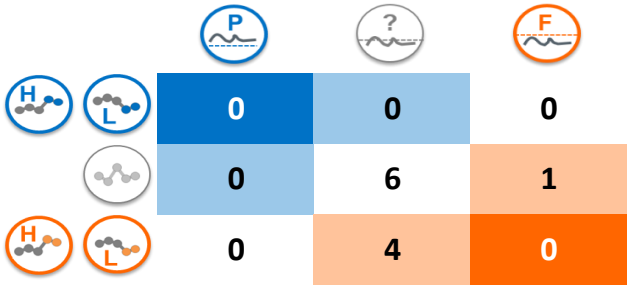


Month 06 | 2023-24

East and North Hertfordshire NHS Trust

Finance

Month 06 | 2023-24



Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Sep-23	-2.4	-1.05			Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Sep-23	1,245	3,515	H		1 point above the upper process limit No target
	Cash balance	Sep-23	77.9	51.4	L		1 point below the lower process limit Metric will inconsistently pass and fail the target
Key Financial Drivers	Income earned	Sep-23	45.3	50.9			Common cause variation Metric will inconsistently pass and fail the target
	Pay costs	Sep-23	29.5	32.5	H		8 points above the mean Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	Sep-23	15.5	19.5			Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2023-24

Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Sep-23	24.9	28.7	H	?	8 points above the mean Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	Sep-23	0.9	4.9		F	Common cause variation Metric will consistently fail the target
	Agency costs	Sep-23		0.9			Common cause variation No target
	Unit cost of agency staff	Sep-23		11.5			Common cause variation No target
	Bank costs	Sep-23	3.7	2.9		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Sep-23	0.5	0.8	H	?	4 points above the upper process limit Metric will inconsistently pass and fail the target
Other Financial Metrics	Drugs and consumable spend	Sep-23	2.8	2.9		?	Common cause variation Metric will inconsistently pass and fail the target
	Private patients income earned	Sep-23	0.4	0.5		?	Common cause variation Metric will inconsistently pass and fail the target

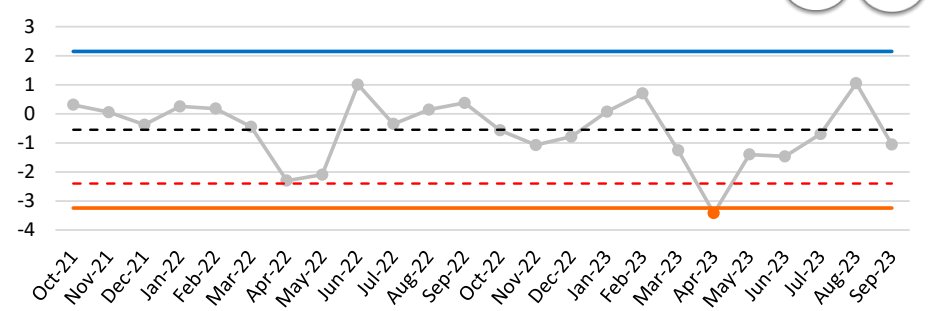
Month 06 | 2023-24

Finance

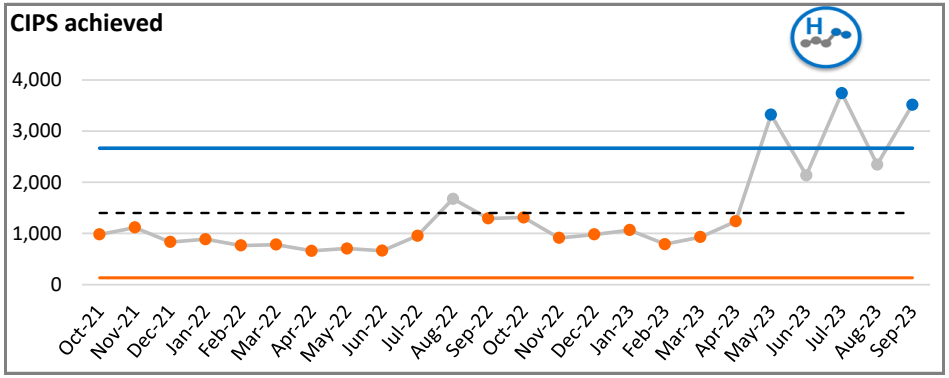
Summary Financial Position

East and North Hertfordshire NHS Trust

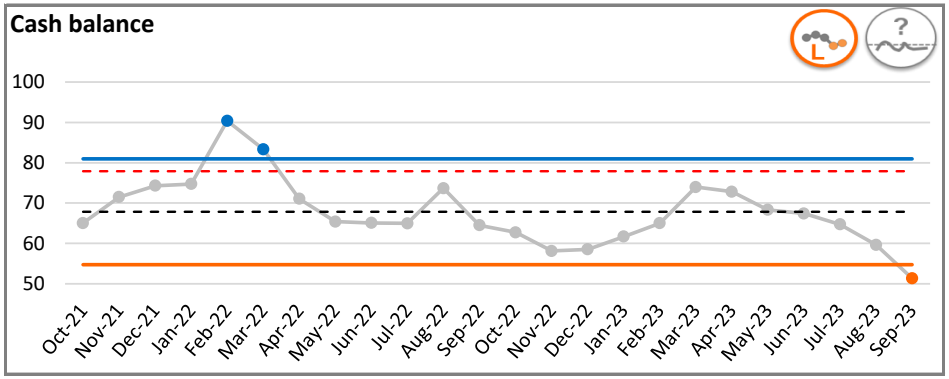
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust submitted a final 23/24 plan in May of £2.5m deficit. This plan assumes that a £33.1m cost improvement programme will be delivered.
- At Month 6, the Trust had planned for a YTD deficit of £7.6m and reported an actual YTD deficit of £7.0m.
- The financial impact of industrial action (IA) of the Trust during the YTD has been significant, resulting in net extra pay costs of £986k and lost activity valued at £4,963k. This has been partly mitigated by the reset of ERF targets for April, but the net IA impact in the YTD is a pressure of £4.8m.
- Pay budgets report a YTD overspend of £2.5.m. A number of hotspots of concern have emerged in respect of management of CSW budgets and elements of medical staffing spend.
- The CIP target for the YTD is £14.2m, against which savings of £16.3m have been recorded. Concern remains in respect of the level of unidentified savings plans within the Unplanned Division, and the achievement of planned medical locum and agency savings.

	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	613.5	302.8	306.3	3.4
Pay	-382.1	-193.0	-195.5	-2.5
Non Pay	-199.8	-100.4	-102.4	-2.0
EBITDA	**31.7**	**9.5**	**8.4**	**-1.1**
Financing Costs	-34.2	-17.1	-15.4	1.7
Surplus / Deficit (excl Fin Adj's)	**-2.5**	**-7.6**	**-7.0**	**0.6**
Adj Financial Performance	-0.3	-0.1	-0.1	-0.0
Deficit (Incl Fin Adj's)	**-2.8**	**-7.7**	**-7.1**	**0.6**

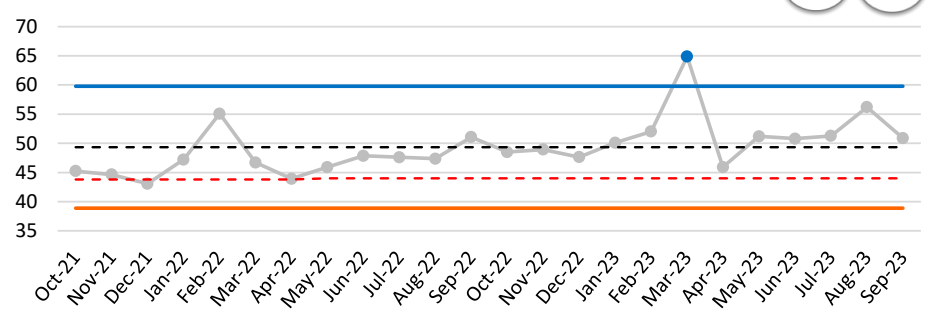
Month 06 | 2023-24

Finance

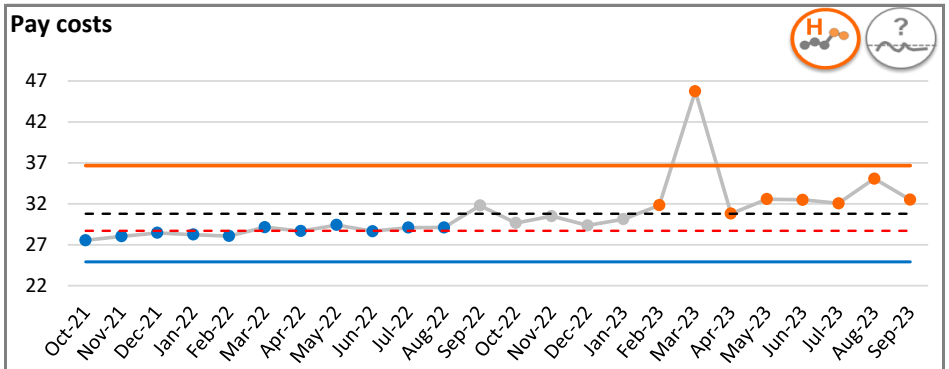
Key Financial Drivers

East and North Hertfordshire NHS Trust

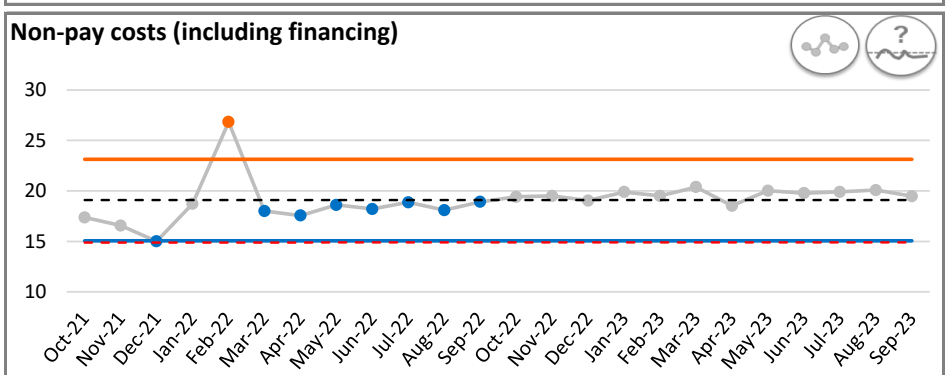
Income earned



Pay costs



Non-pay costs (including financing)



Key Issues and Executive Response

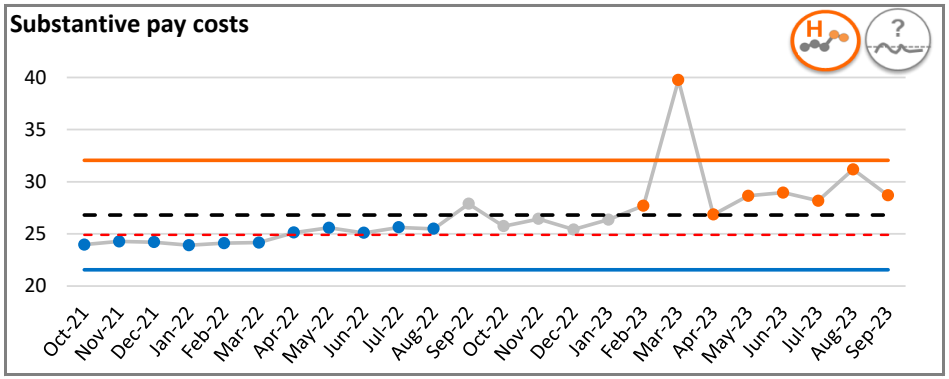
- At Month 6 YTD, the Trust planned for a deficit of £7.6m and the actual deficit was £7.0m.There was a £0.2m adverse variance in month against an in month deficit plan of £0.8m.
- The reported position includes the early phasing of income (£0.3m in month and £1.7m YTD) received for a MOU from the H&WE ICB.
- Month 6 continues to report the position for ERF based on actual activity delivery. This is in line with national guidance. The impact of this will be included in more detail in the ERF and Productivity report.
- The reported position includes the impact of the September industrial action. The net impact of the industrial action costs, lost ERF income and increase in the fixed baseline is £4.8m adverse year to date.
- The month 6 position also includes a £0.5m adverse variance due to the YTD impact of the Medical Pay award, which has not been fully funded. Confirmation has now been received of the funding uplift for the training and education tariffs, which have been reflected in the month 6 position. However, this still leaves a £1m full year unfunded pressure.
- Medical staff was £0.4m adverse in month excluding the impact of industrial action. There continues to be some significant 'hotspots' within Womens services, Childrens services, Microbiology and Orthopaedics. The impact of some mitigations, particularly within Women's and Childrens Division have resulted in a reduction in run rate this month. Work is ongoing to develop mitigations to further reduce this overspend in the latter months of the year.
- The overspend against Clinical Support Worker budgets continues with a £0.1m in month overspend (£1.2m YTD). The Trust has successfully recruited additional permanent CSW's over recent months but has been unable to manage down bank spend to within budget.
- The Trust has a challenging CIP target of £33.1m this year. The year to date CIP performance is favourable against plan, however the plan significantly increases in the second half of the year.

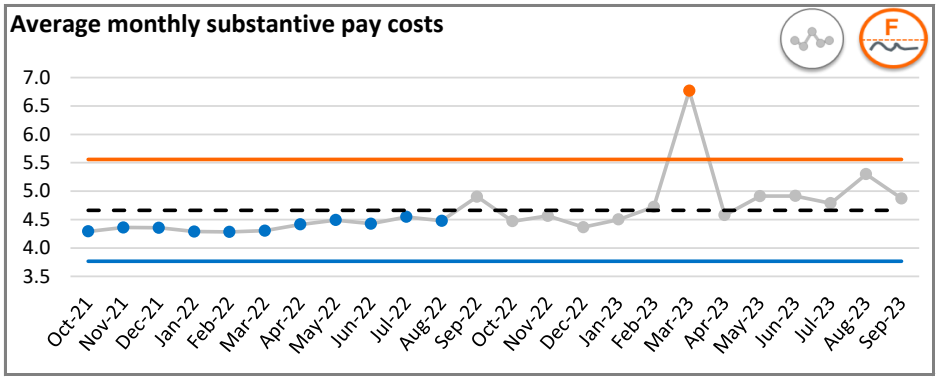
Month 06 | 2023-24

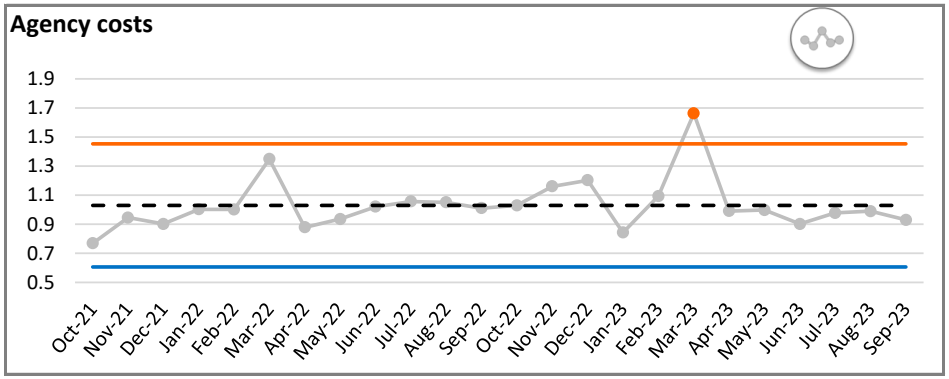
Finance

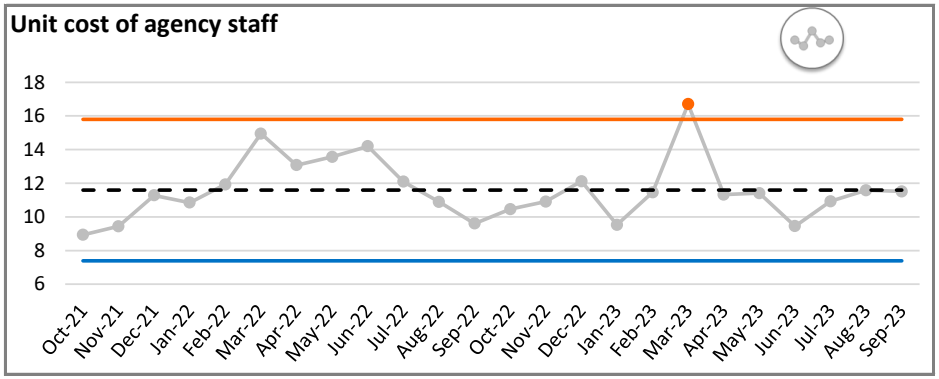
Other Financial Indicators

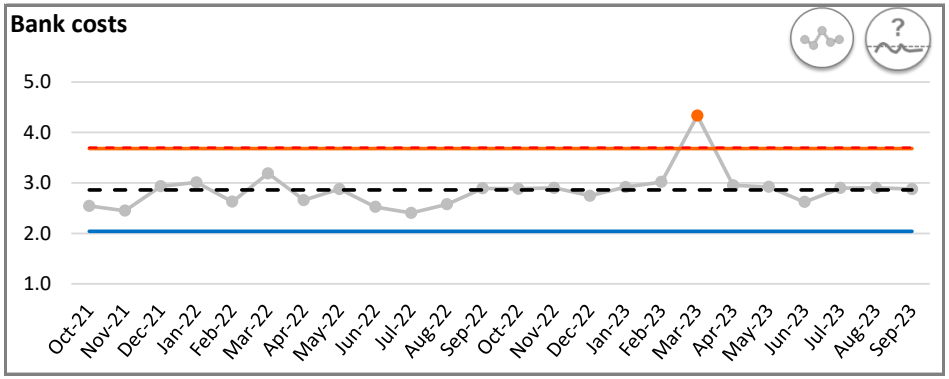
East and North Hertfordshire NHS Trust

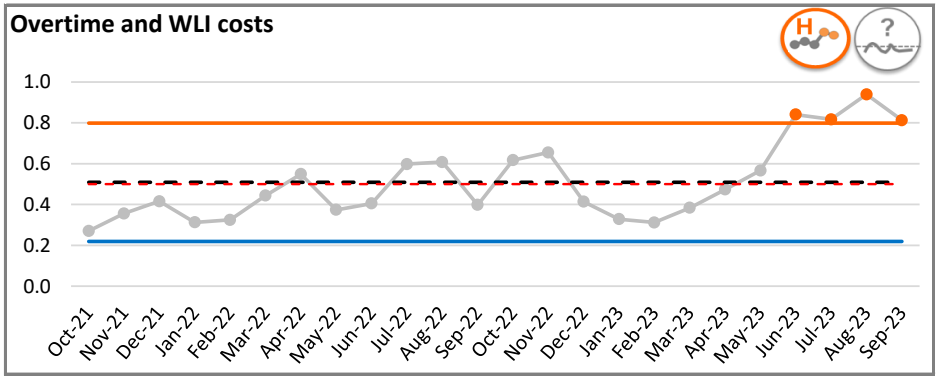










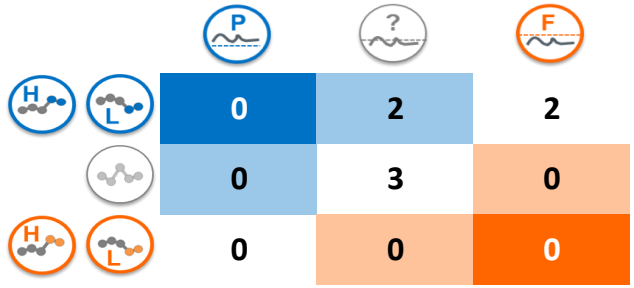


Month 06 | 2023-24

East and North Hertfordshire NHS Trust

People

Month 06 | 2023-24



Data correct as at 20/10/2023

People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Sep-23	5%	8.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Sep-23	5%	8.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	Sep-23	3%	2.9%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Sep-23	90%	90.1%	H	F	3 points above the upper process limit Metric will consistently fail the target
	Appraisal rate	Sep-23	90%	77.7%	H	F	4 points above the upper process limit Metric will consistently fail the target
Thrive	Turnover rate	Sep-23	11%	11.1%	L	?	2 points below the lower process limit Metric will inconsistently pass and fail the target
Care	Sickness rate	Sep-23	3.8%	4.7%	L	?	8 consecutive points below the mean Metric will inconsistently pass and fail the target

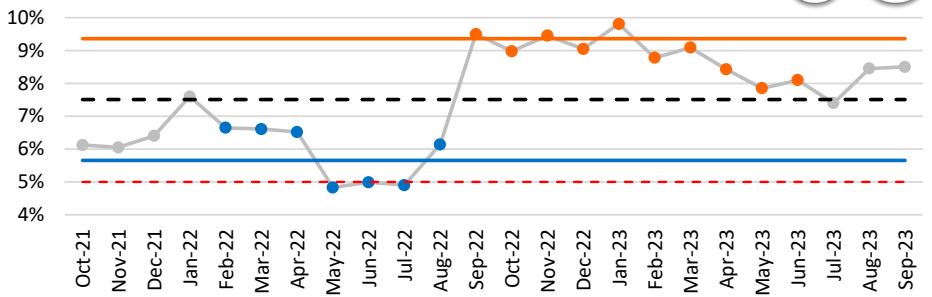
Month 06 | 2023-24

People

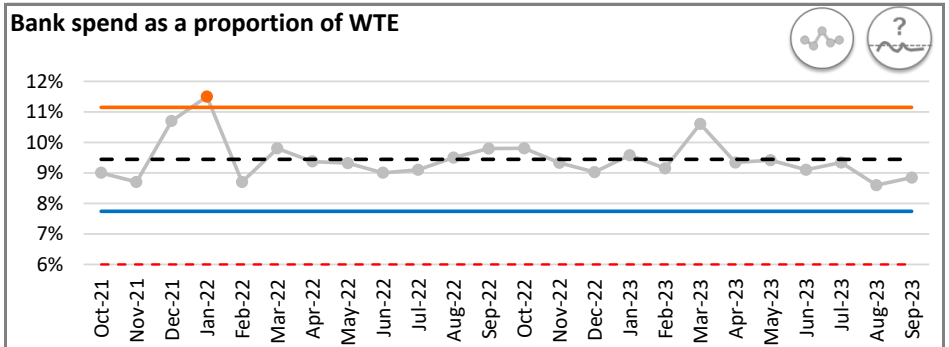
Work Together

East and North Hertfordshire NHS Trust

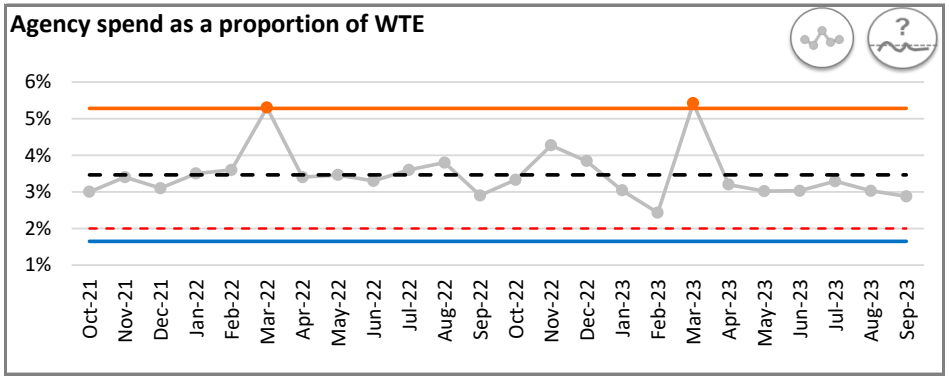
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- Recruitable establishment increased by 5 WTE resulting in the vacancy rate increasing to 8.5% (563 vacancies) in M6, there are 177 more staff in post than September 2022. Overall, the trust remains 3.5% above vacancy target.
- Nursing & Midwifery vacancy rate increased to 8.5% (173 vacancies) primarily due to 13 WTE fewer staff in post vs M5. A targeted approach towards UK based nurses is underway to balance skill-mix. Audiology and Occupational Therapy are currently hot spot areas with social media campaigns planned and the creation of UEC at Lister plus other reconfigurations means that there are likely to be more staffing requirements across the board.
- 65 student nurses are undergoing pre employment checks roles to commence in post between October 23 and January 24 (against a target of 50)
- International nurse recruitment continues at a slower pace following a look ahead review, with 40 arrived since April 23 and a further 6 to arrive by end of November
- Overall, there are 311 applicants in the pipeline including 36 doctors, 146 nurses/midwives, 28 clinical support workers and 20 allied health professionals.
- Agency spend was 104k under M6 NHSI agency ceiling target. Improvement in 'Great for 8%' temporary staffing playbill reducing to 11.8% (from 13.3% in M1), proactive actions remain underway between Resourcing, Temporary Staffing and Finance triangulation to improve metrics and local challenge on usage and deployment.
- 89% of clinical staff are on eRoster – implementations in progress; Cardiology Physiologists & Radiographers (target Go Live Nov 23), Radiology Pay Lister and QEII (Sonography target Go Live Nov 23), MV R&D Staffing and Quality Control in progress.

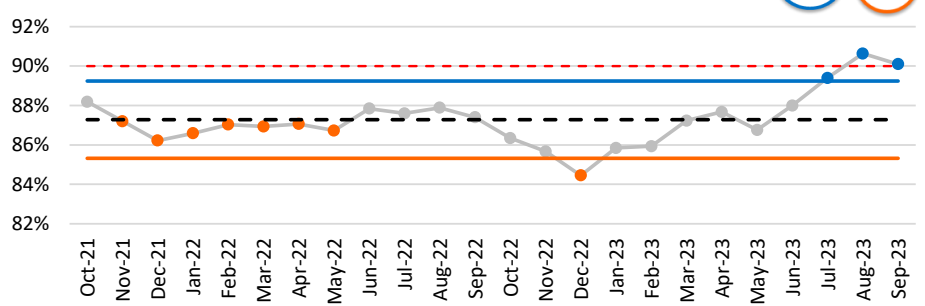
Month 06 | 2023-24

People

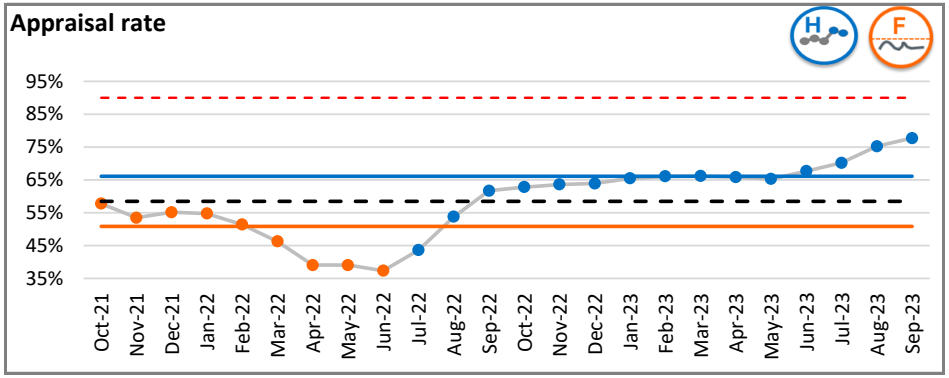
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- Grow Together review compliance has increased once again this month by 2.7% to 77.7%, however with the Grow Together Review window closing in August, this is still below the 90% target , though an improvement on previous month,
- Regular Trust wide reminders will continue over the coming months, to increase compliance rates. An action plan has been developed to address some of the issues that were identified following feedback surveys , with improvements to training and specific responses to frequently asked questions being made available, in readiness for the new window opening in April 2024.
- Mandatory training remains on target, at just above 90%. A review of all Role Essential training courses, is taking place to ensure that no new courses are added which impact adversely on core mandatory training, as well as to make sure that decisions made to include some courses as role essential during and post the pandemic are reviewed and remain valid.
- Compliance with Moving and Handling and Resus training still remain a concern. Additional training space to support delivery of moving and handling training has been identified with additional equipment (hoists and mannequin) currently on order. This will increase capacity for training and support with achieving targets. We expect to commence additional Delivery within the next 2 months.
- Similar space is being sourced for Resus training, but this has yet to be identified. Therefore, our ability to achieve Resus training target levels still remains at risk.

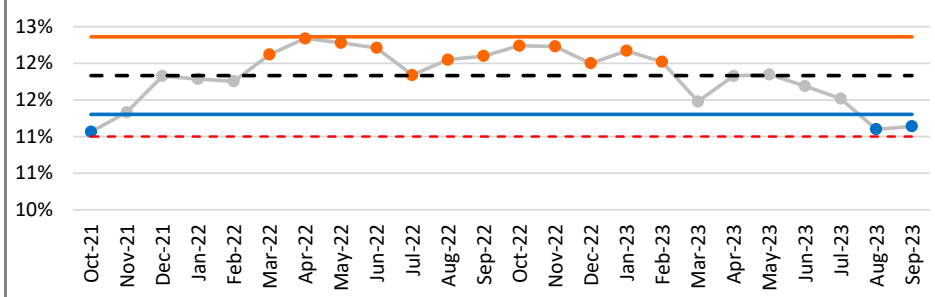
Month 06 | 2023-24

People

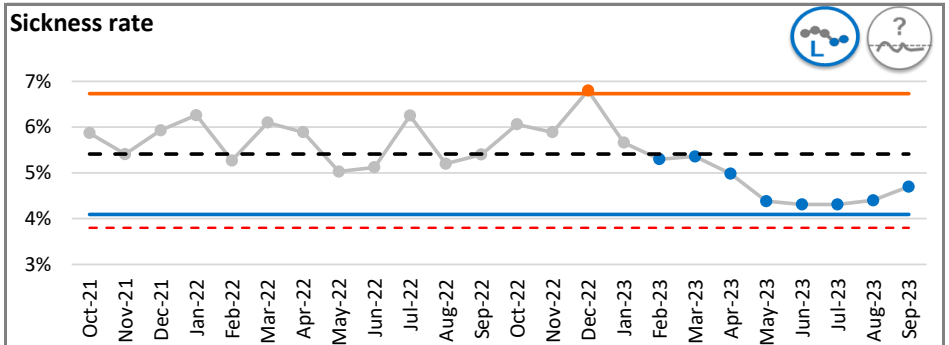
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

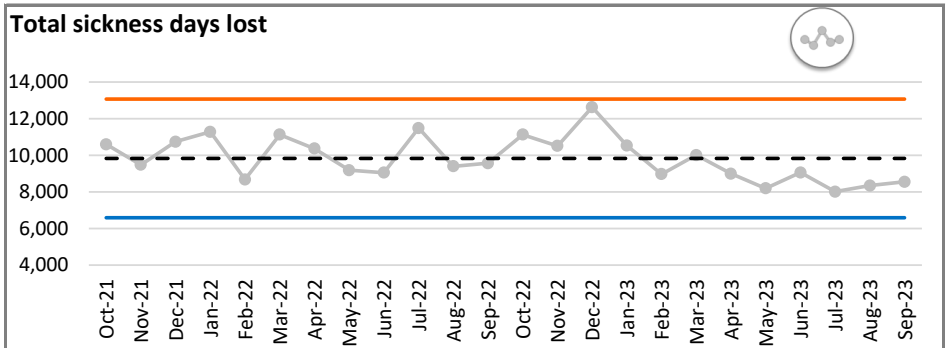
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- The average length of grievance case work continues to reduce and is at 35.7 days for disciplinary from notification to ERAS to formal hearing and 62.2 days for grievance cases
- Average length of suspension in this period stands at 89 days due to a case concluding and we are expecting this to remain here or lower as we continue to improve our approaches to case management
- National Staff Survey has reached week 4 and we have 27% response rate, an increase of 3% compared to 2022 and National Bank Staff Survey has a lower return rate by 1% for the same period
- Promotional work continues to encourage staff to raise their voices and be heard by completing the staff survey
- Work progresses on EDI strategy and plans of work to deliver continuous improvement to create real inclusion in the trust, update due to People Committee in November

Care Together

- At 5th October 519 Flu and 451 Covid vaccinations had been administered by the Health and Wellbeing team
- Charity advised of funds raised (£900) for the staff shop, and donation is being used to provide an all staff prize draw of free lunch vouchers for Lister, in partnership with catering and for other sites there will be Sainsbury's vouchers drawn during November 23
- Initial meeting held in relation to establishing a Men's network within the Trust with a number of topics and themes including men's mental health and men's health, will use November to promote and commence conversations and explore further and launch network from December 2023.

Month 06 | 2023-24

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	16.1
Report title	Maternity Assurance			**Meeting Date**	1 November 2023
Presenter	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Lesley Overy, Head of Midwifery				
Author	Amanda Rowley, Director of Midwifery				
Responsible Director	Amanda Rowley - Director of Midwifery			**Approval Date**	
Purpose *(tick one box only)*	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

Maternity Services are required to provide assurance to the Board based on a number of core data sets in response to national reviews, the ambition of maternity transformation and long-term plan, provided as one assurance report.

Areas for Trust Board's attention:

- Maternity Incentive Scheme (MIS) assurance:
  - Safety Action 1 – quarter 2 Perinatal Mortality Review report
  - Safety Action 2 – Materntiy Services data set compliance
  - Safety Action 4 – Anaesthetic Workforce
  - Safety Action 9 - update on Perinatal leadership and culture programme
  -

Impact: where significant implication(s) need highlighting

NHS Resolution is operating year five of the CNST Maternity Incentive Scheme to deliver a safer maternity service. The scheme incentivises ten maternity safety actions. If trusts achieve all of the ten safety actions, they will recover their contribution relating to the CNST maternity incentive fund as well as a share of any unallocated funds.
ENHT was compliant with 8/10 Safety Actions from Year 4.

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

Risk of non-compliance with Y5 MIS

Report previously considered by & date(s):

N/A.

Recommendation	• **The Trust Board are asked to review and approve the evidence of CNST to comply with Year 5 CNST requirements.**

To be trusted to provide consistently outstanding care and exemplary service

Maternity Update for Trust Board
1 November 2023

Amanda Rowley, Director of Midwifery
Lesley Overy, Head of Midwifery
Douglas Salvesen, Divisional Medical Director for Women's and Childrens

NHS
East and North Hertfordshire
NHS Trust

ProudToBeENHT

Purpose of the Report

East and North Hertfordshire NHS Trust

Recognising the requirement for Maternity services to give assurance to board based on a number of core data sets in response to national reviews, the ambition of maternity transformation and long-term plan, this will be presented in one assurance report.

For discussion this month:

- Materntiy IPR report.
- MIS progress towards full compliance

Actions required by the Committee:

- Note the content of the report
- Ensure that compliance with safety actions 1, 2, 4 and 9 of the maternity incentive scheme are approved and noted in the formal minutes of Trust Board.
- Note any key risks identified

Executive Summary

Safety & Quality :

Perinatal Quality Surveillance Framework: Incidents graded as moderate harm or above in obstetrics September 2023

- No serious incident investigations were declared within this reporting period.
- No moderate harm incidents were reported in September 2023.

Service Closures:

- There was one occasion where the materntiy unit was placed on divert in September 2023.
- There were 4 reported occasions where the MLU was closed and women who were suitable for care in that location received their care on CLU. This was due to high activity and reduced staffing. This has impacted on the birth rate in MLU for September. All missed opportunities for MLU birth are reviewed, While women's choice of place have birth has been affected, no harm has been identified related to MLU closure.

Materntiy Incentive Scheme (MIS) year 5 progress and assurance:

Safety Action 1: Assurance that the National Perinatal Mortality Review Tool (PMRT) is being used to review perinatal deaths to the required standard.

- The quarter 2 PMRT report was received and approved by QSC on 25th October. The 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) A summary of the outcomes and actions for the second quarter of 2023/2024 (Jul-Sept) was provided to the committee.

Safety Action 2: This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.

- ENHT can evidence compliance with 10 of the 11 clinical quality Improvement metrics (CQIM's) in the July scorecard which meets the minimum required standard for this safety action for year 5 and can evidence sustained engagement with the data quality submission summary tool.
- Assurance was provided to the quality and safety committee on 25th October 2023 of compliance with all aspects of this safety standard.

Safety Action 4: Clinical workforce planning to the required standard.

- The service gave assurance to QSC on 6th September 2023 of compliance with ACSA standard 1.7.2.1.
- Anaesthetic rotas evidencing compliance with the standard have been reviewed and confirmed by the divisional triumvirate and are available in the MIS year 5 evidence log.

Perinatal Quadrumvirate Culture and Leadership Development programme

East and North Hertfordshire NHS Trust

Update:

- The Trust have supported quadrumvirate attendance on the above programme from the Director of Midwifery, the Clinical Director for Obstetrics, the General manager for women's and children's and the Matron for neonatal unit) who have now completed module 1 of the programme.

- Module 1 has given the opportunity for Individual and team leadership development, collaborative learning and growth and facilitated discussion of 360-degree feedback from Trust colleagues.

- Module 2 includes the SCORE staff culture survey which has been undertaken across all disciplines within the service with a 50% uptake overall. The findings are currently being collated and the leadership team will be supported with sharing the output with teams and developing actions moving forwards.

- The Chief Nurse and the Board level materntiy safety champion were updated on the ongoing work to support culture utilising learning and a collaborative approach supported by the programme and the Healthy Teams framework at the board seminar on September 6th, 2023.

- As the Quadumvirate move into phase 3 of the programme individual stakeholder meetings have been undertaken and the first quadrumvirate session focusing on team purpose has been delivered by Korn Ferry, an organisational consulting firm who have been commissioned by NHSE.

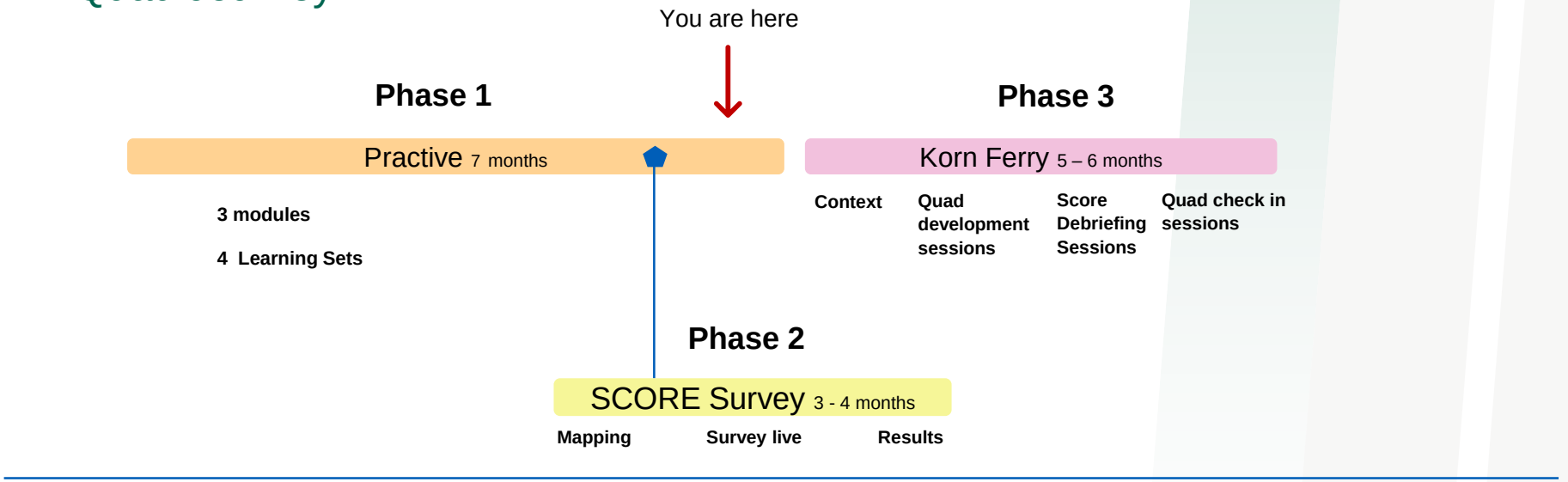
- We have developed a quadrumvirate team charter to demonstrate our aligned values, commitment and priorities as a leadership team.

- There is a significant time investment required as we move into the next stage of the programme which will run over the next 6 month.

- The Trust board are asked to support the time commitment required from the quadrumvirate as they move through the programme.

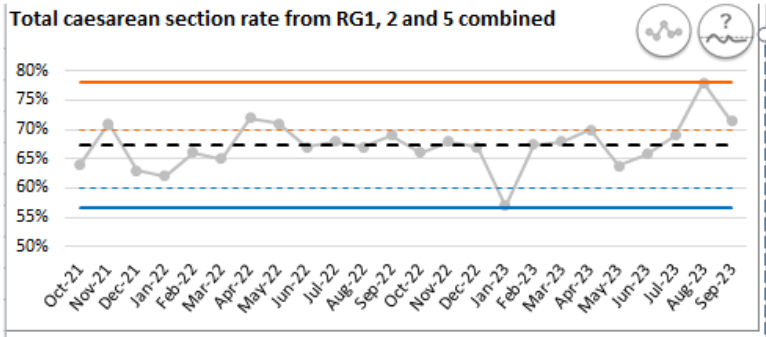
Perinatal Quadrumvirate Culture and Leadership Development programme

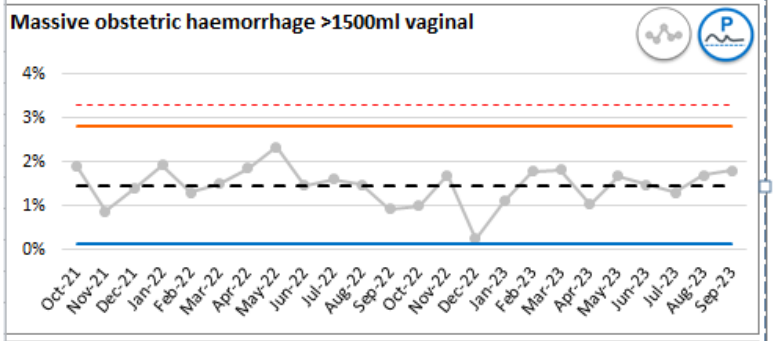
Quad Journey

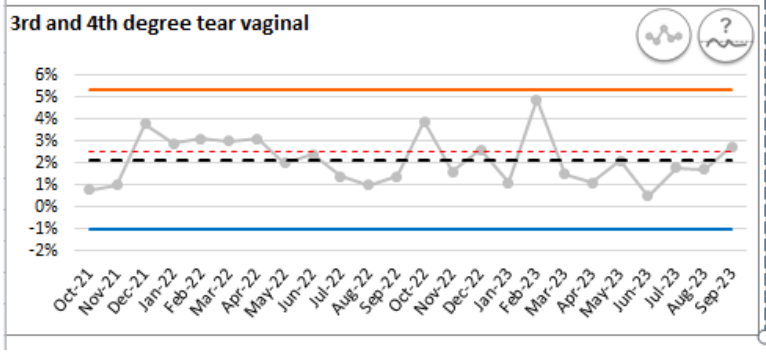


Maternity Integrated Performance Report 1

East and North Hertfordshire NHS Trust







Key issues and executive response

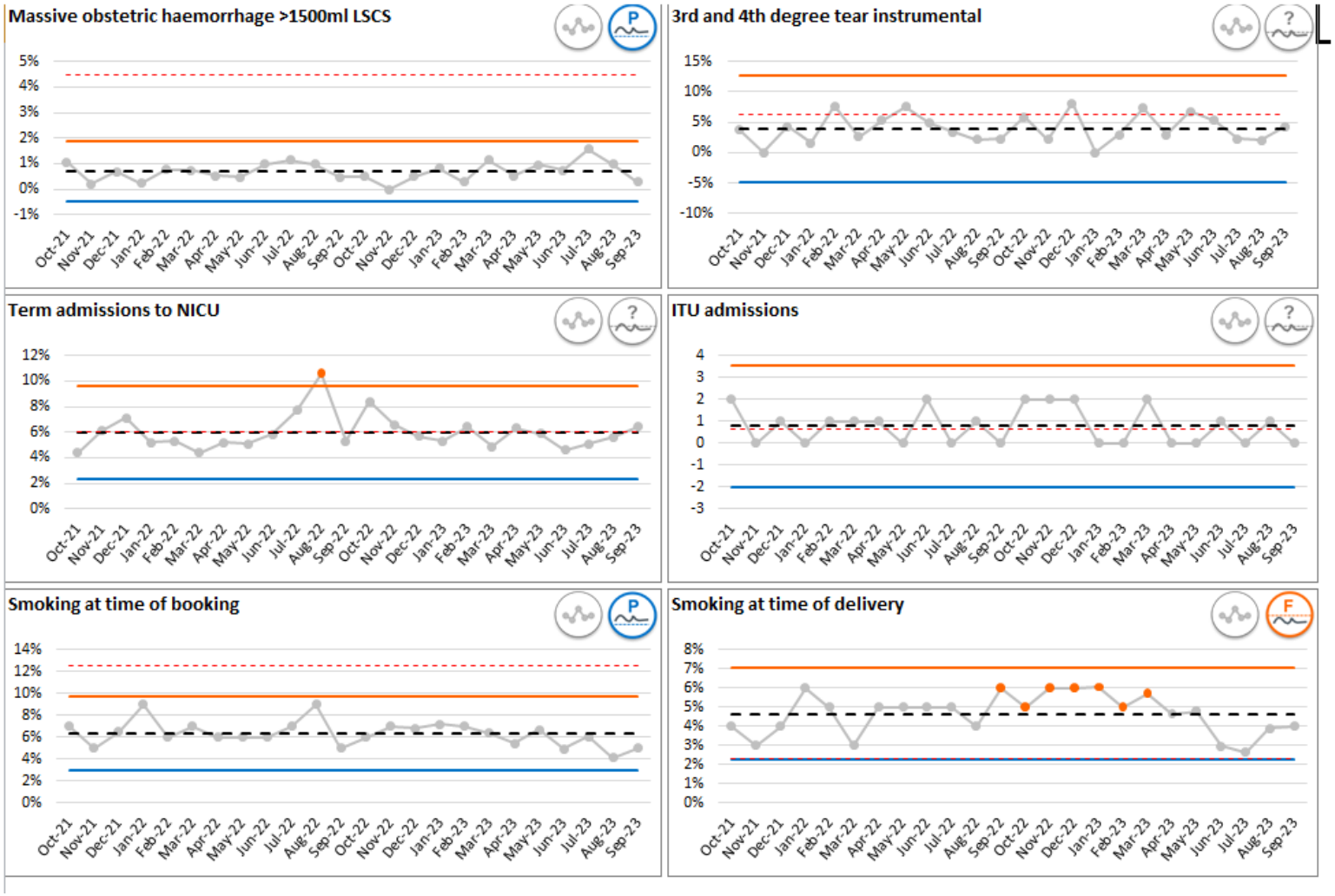
- No SIs declared in month.
- No HSIB referrable cases this month
- Smoking at booking remains below 6%. While concerning special cause variation is noted in relation to smoking rates at time of delivery, there are < 4 points below the mean of a decreasing trend. Comparison data between booking and delivery is not directly comparable (these are different cohorts of women.
- 3rd / 4th degree tears - Normal variation noted. 2023 Cases remain significantly below 2022 numbers currently. Monthly audit continues and a working party is now in place to implement the Obstetric anal sphincter injury (OASI) 2 care bundle as a quality improvement initiative.
- Massive Obstetric Haemorrhage (MOH) - Normal variation continues. Cases continue to be reviewed by the risk management MDT on a monthly basis.
- Breastfeeding Initiation rate has increased to above target

Robson Group Criteria

- This considers the obstetric variables to enable classification into one of 10 groups. This categorisation assists in understanding the reasons for the increasing trend in caesarean section rates.
  - **Robson group 1**: Nulliparous singleton pregnancy > 37 weeks with spontaneous labour onset.
  - **Robson group 2**: Nulliparous singleton pregnancy > 37 weeks delivered before labour onset or where labour induced.
  - **Robson group 5**: Multiparous women, singleton pregnancy >37 weeks with at least one previous uterine scar.
- These 3 groups combined normally contribute to 2/3rds of all CS performed in most hospitals. For month 5 the combined rate is 70% This may indicate fewer LSCS performed in other Robson Groups for example multiparous women in spontaneous or induced labour, We will continue to monitor this trend.

Maternity Integrated Performance Report 2

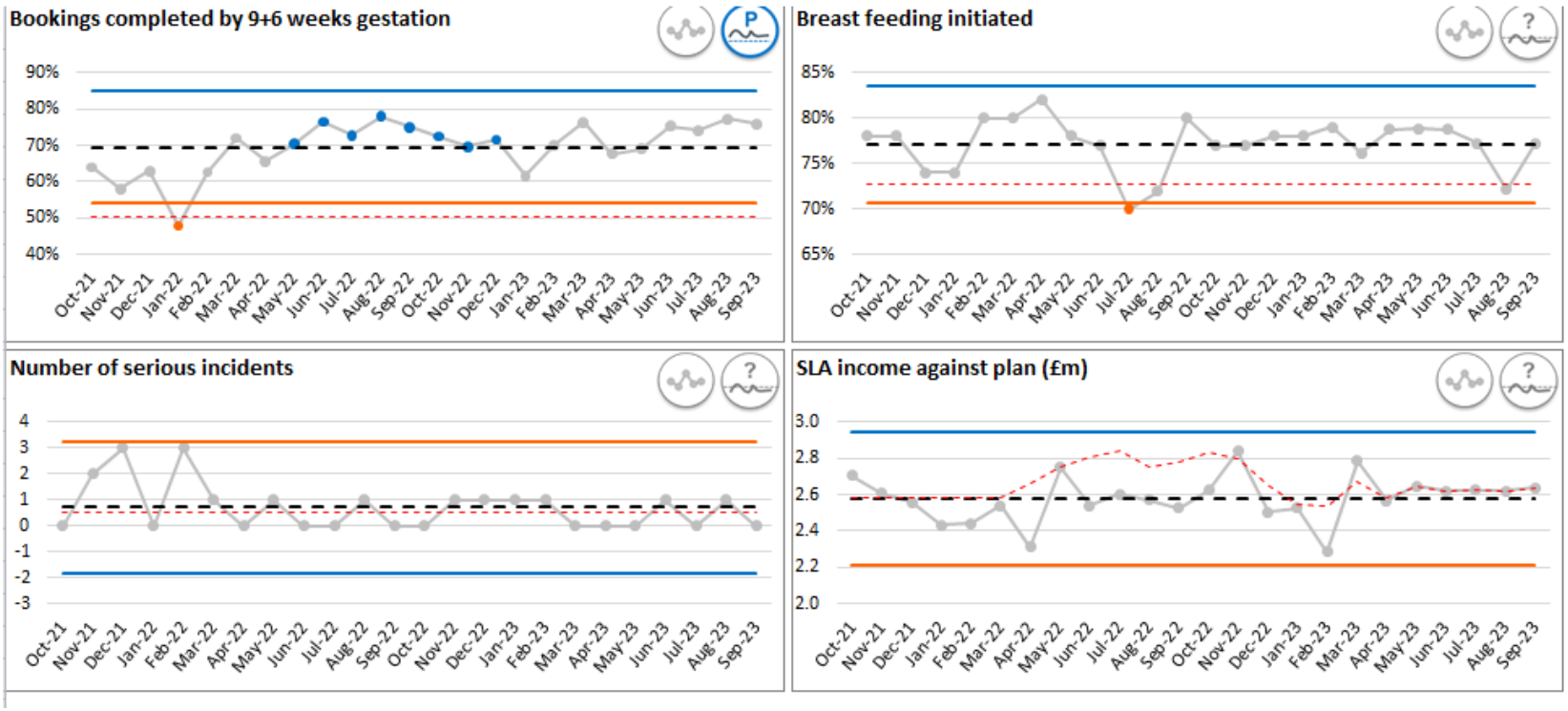
East and North Hertfordshire NHS Trust



7 | Presentation title

Maternity Integrated Performance Report 3

East and North Hertfordshire NHS Trust



8 | Presentation title

Hertfordshire and West Essex Integrated Care System

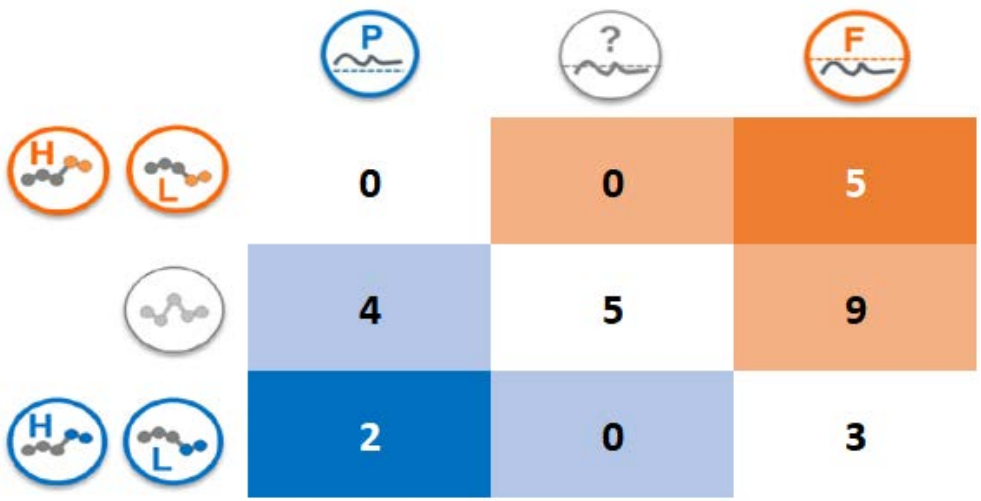
Presentation to: HWE ICB Board

HWE ICS Performance Report

September 2023

Working together
for a healthier future

Executive Summary – KPI Risk Summary



Highest Risk	Programme
ED 4 Hour Standard	UEC
62 Day Standard	Cancer
RTT 78 Week Waits	Elective
RTT 52 Week Waits	Elective
Community Waits (Children)	Community

Lowest Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
CHC Assessments in Acute	Community

Low Risk	Programme
2 Hour UCR	UEC
Adult Crisis 4 Hour	Mental Health
Mental Health EIP	Mental Health
Community Waits (Adults)	Community

Variable Risk	Programme
GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
NHS 111 Calls Abandoned	UEC
Ambulance Handovers	UEC
90% Stroke Unit	Stroke
28 Day Faster Diagnosis	Cancer
HPFT Early Memory Diagnosis (EMDASS)	Mental Health
CHC Assessments < 28 Days	Community

High Risk	Programme
Ambulance Response Times	UEC
% in ED > 12 Hours	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
62 Day Backlog	Cancer
Out of Area Bed Days	Mental Health
Adult 28 Day Standard	Mental Health
RTT 65 Week Waits	Elective
6 Week Waits	Diagnostics

Moved to lower risk category **Moved to higher risk category** **No change to risk category**

Executive Summary

URGENT CARE, Slides 7-12: Calls abandoned performance = better than regional and national position; ED 4 hour performance = worse than regional and national position

- 111 percentage of calls abandoned continues to improve overall but remains outside the 3% standard. Recovery trajectory agreed for 23/24;
- Cat 2 mean ambulance response times remain similar to previous months at 41 minutes for the ICS; whilst this is outside the 18 minute standard, performance is ahead of the 23/24 recovery trajectory;
- Ambulance hours lost to handover has continued to improve over the last three months and whilst not meeting target, is currently ahead of the 23/24 recovery trajectory;
- ED 4 hour performance remains at similar levels to previous months and below the agreed 23/24 recovery trajectory, with the variance to plan increasing;
- Whilst data suggests that plans are starting to deliver improvements in some areas, performance against improvement trajectories for UEC remain off track in some areas.

CANCER, Slides 28-29: 62 day first and 28 day FDS performance = better than regional and national positions, but 62 day backlogs behind recovery trajectory

- 28 day Faster Diagnosis performance returned to meet the 75% standard in June and continues ahead of the national average;
- Patients waiting >62 days has improved however remains behind recovery trajectory. Referrals remain high, increasing further in last two months and on-going industrial action continues to impact recovery;
- Performance against 62 day standard remains below target as providers continue to treat the longest waiting patients, however performance remains above both regional and national positions.

PLANNED CARE, Slides 24-27: 18 week performance = better than regional but worse than national position

- The number of patients waiting >78 weeks has been increasing since March and all HWE acute trusts had breaches at the end of June. The remaining 78 week backlog is predominantly in Community Paediatrics. The 65 weeks recovery trajectory was achieved in June but will fall behind plan in July with numbers also increasing since March. On-going industrial action continues to impact;
- ENHT remain in Tier 1 management for elective recovery;
- The total PTL and the number of patients waiting over 52 weeks continues to increase and remains of concern.

DIAGNOSTICS, Slide 26: 6 week performance = worse than regional and national position

- Improvements have been seen in diagnostic performance, with June performance the highest in over 12 months. Performance remains below regional and national positions, with PTL remaining static;
- System-wide diagnostic improvement plan in place, with 23/24 operational plan building on existing work to increase activity levels and decrease waiting times.

COMMUNITY, Slides 12-23

- The percentage of adults waiting less than 18 weeks has continued to improve and is now at 93.5% against a national average of 85.2%. Children's waiting lists remain extremely high (however June was the first month not to see an increase) and 18 week performance of concern; inequality in access to services between adult and children continues to widen;
- Longest wait for children was at 101 weeks in June (60 for adults) with pressures predominantly in community paediatrics, as well as therapies and audiology services;
- Waits for Autism Spectrum Disorder (ASD) assessments and diagnosis are challenged in all three Places, with waits of up to 175 weeks. System wide plan being developed to address the current backlog.

MENTAL HEALTH, Slides 32-39

- Demand remains high in Adult, Older Adult and CAMHS services with some KPIs remaining below standard. Vacancies and recruitment remain the key challenges;
- Pressure for Mental Health Assessments and acute beds continues. An increase in the number Out of Area Bed Days in May and June halted a 5 month improving trend;
- Dementia diagnosis in Primary Care remains challenged in Hertfordshire, but is an improving position. 63.2% was achieved in June against the 66.7% national standard.

PRIMARY CARE AND CONTINUING HEALTHCARE, Slides 40-41

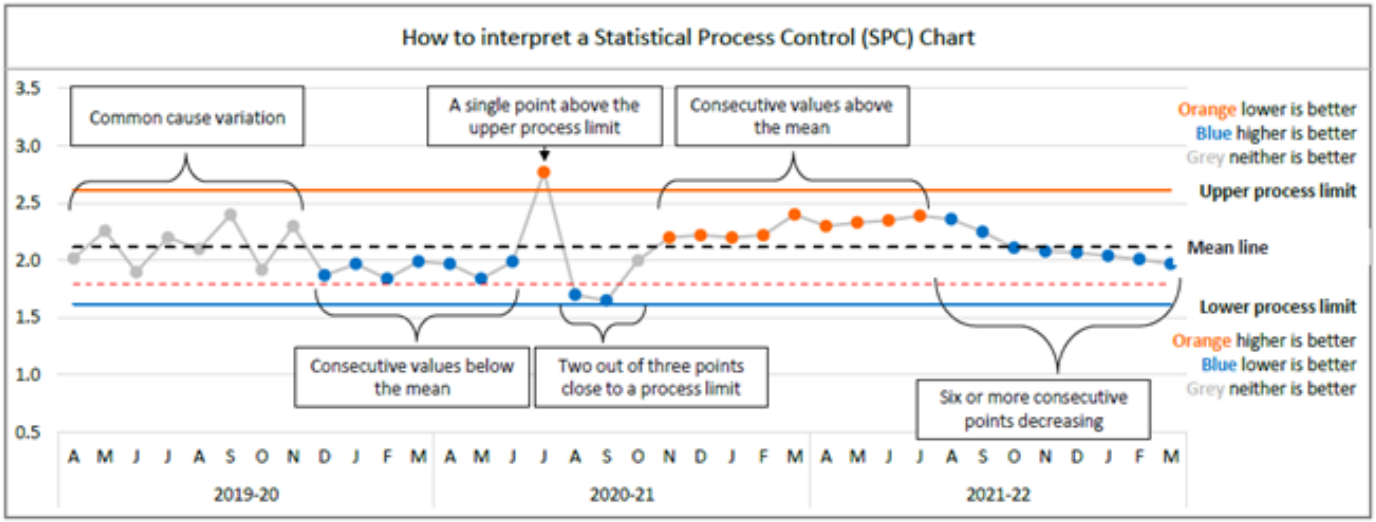
- Total number of GP appointments are variable but remain higher than pre-pandemic levels with the proportion of face to face appointments continuing around 70%. Further Primary Care reporting is being developed for inclusion in the next report;
- The percentage of CHC assessments completed within 28 days remains challenged in SWH but continues to improve (74%) with an action plan in place; ICS returned to meet the 80% standard in June.

Executive Summary – Performance Overview

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Jul 23	65.1%	76.0%			66.6%	61.7%	71.6%
A&E - % spending more than 12 Hours in Dept	Jul 23	9.3%	-			9.8%	7.3%	12.3%
A&E - ED Attendances	Jul 23	41422	-			40292	33959	46626
Trolley Waits	Jul 23	95	-			168	-58	395
2 Hour Community Response	Jul 23	79.1%	-			83.3%	70.1%	96.5%
14 day LOS	Jul 23	25.0%	-			25.0%	21.2%	28.8%
Ambulance - Handover >60 Mins	Jul 23	680	-			979	613	1345
EEAST: Cat 1 - Mean (<7min)	Jul 23	00:08:41	00:07:00			00:09:33	00:07:52	00:11:14
EEAST: Cat 2 - Mean (<18 Mins)	Jul 23	00:41:14	00:15:00			00:52:51	00:15:37	01:30:06
RTT - 18 Weeks	Jun 23	52.8%	92.0%			56.7%	53.7%	59.8%
RTT - 52 Week Waits	Jun 23	10184	-			7628	6202	9055
RTT - PTL Size	Jun 23	151008	-			125683	118370	132996
RTT - 78 Week Waits	Jun 23	597	-			922	592	1253
Diagnostics - 6 Week Wait	Jun 23	66.4%	99.0%			64.6%	57.1%	72.2%
Diagnostics - PTL Size	Jun 23	27813	-			24958	19846	30071
Cancer - 2 Week Wait Standard	Jun 23	85.7%	93.0%			81.1%	68.4%	93.8%
Cancer - 2 Week Wait Referrals	Jun 23	6085	-			5126	3644	6607
Cancer - 62 Day Standard	Jun 23	64.6%	85.0%			72.4%	61.7%	83.1%
Cancer - 62 Day Total Waiting	Jul 23	527	-			587	378	796
Cancer - 104 Day Total Waiting	Jul 23	181	-			157	103	210
Cancer - 28 Day Faster Diagnosis Standard	Jun 23	75.2%	75.0%			70.3%	59.6%	81.1%
Mental Health - Out of Area Bed Days	Jun 23	1171	-			960	604	1316
Mental Health - Recorded >65s Dementia Diagnosis	Jun 23	63.2%	66.6%			61.8%	61.1%	62.5%
Mental Health - IAPT Entering Treatment	Jun 23	2672	-			2410	1420	3399
Early Intervention in Psychosis	Jun 23	85.7%	60.0%			82.2%	61.9%	102.5%

A Dashboard including Place and Trust based performance is included within Appendix A of this report

Statistical Process Control (SPC)

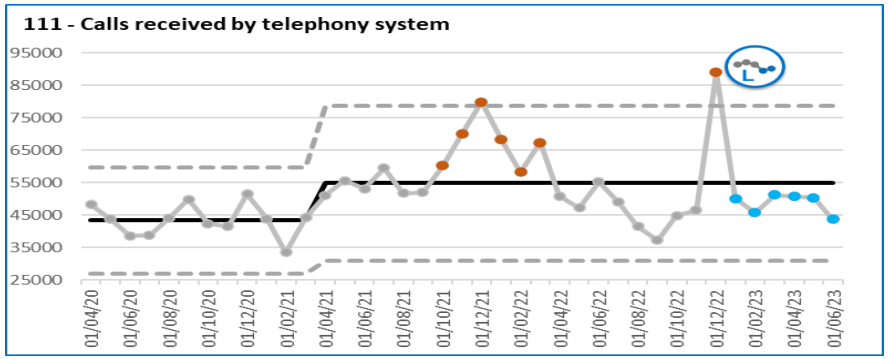


Variation	
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

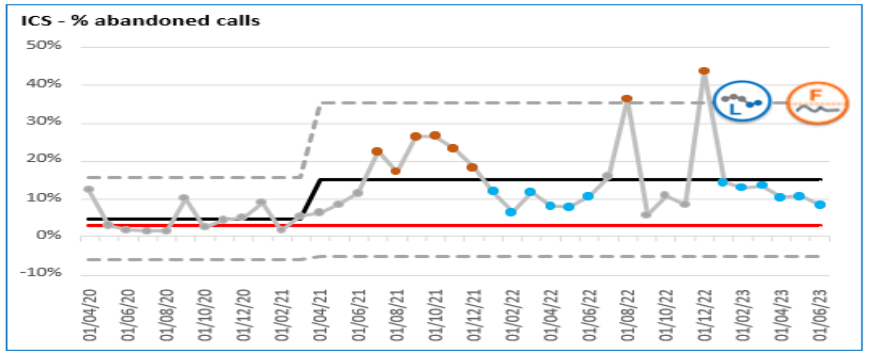
Assurance	
F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

Performance by Work Programme

NHS 111



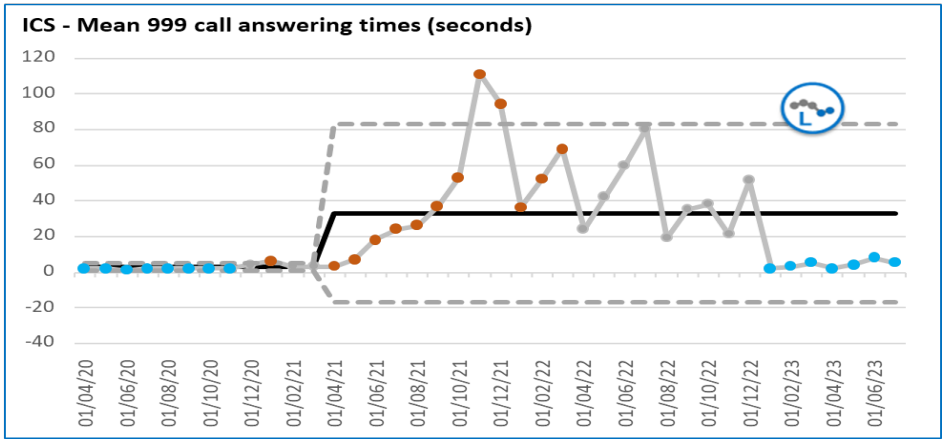
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Hertfordshire	38,47	35,15	31,51	31,16	35,55	40,33	34,00	33,32	41,20	35,15	26,87	35417	40,96	44,29	42,71	47,28	41,15	41,25	48,10	59,03	67,42	58,72	50,28	58011	40,99	38,10	44,67	39,74	33,48	30,01	35,97	37,40	72,59	40,95	37,02	41370	40,90	40,64	35,30
West Essex	9,752	8,593	7,090	7,572	8,586	9,523	8,378	8,229	10,30	8,718	6,717	8877	10,19	11,29	10,45	12,19	10,59	10,78	12,17	10,98	12,41	9,549	8,013	9377	9,904	9,165	10,64	9,452	8,020	7,255	8,861	9,121	16,41	9,145	8,739	9878	9,924	9,715	8,465
ICS	48,22	43,74	38,60	38,74	44,14	49,85	42,38	41,55	51,51	43,86	33,58	44,29	51,16	55,58	53,17	59,47	51,74	52,04	60,27	70,01	79,84	68,27	58,29	67,38	50,89	47,26	55,32	49,19	41,50	37,26	44,84	46,52	89,01	50,09	45,76	51,24	50,83	50,35	43,77

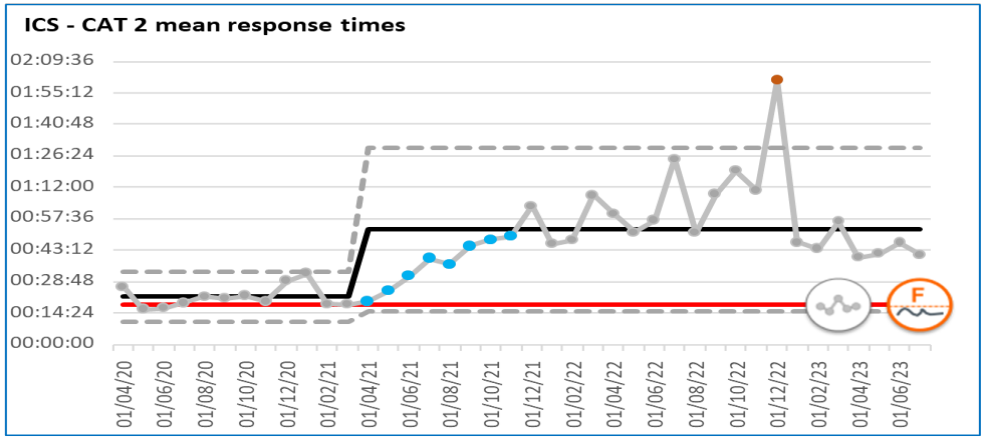


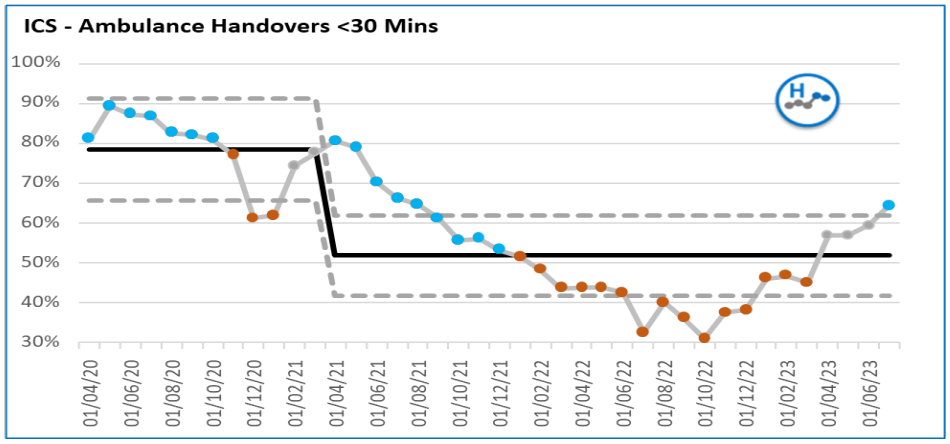
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Hertfordshire	12.0%	3.0%	1.8%	1.5%	1.5%	9.7%	2.3%	4.3%	4.9%	8.7%	1.6%	5.2%	6.1%	8.3%	11.2%	21.7%	16.4%	25.6%	25.7%	22.5%	18.0%	11.7%	6.5%	11.6%	7.8%	7.4%	10.3%	15.0%	35.5%	5.6%	10.5%	8.1%	42.7%	13.8%	12.7%	13.0%	10.2%	10.3%	8.2%
West Essex	13.6%	2.3%	1.1%	1.6%	1.4%	10.6%	2.3%	4.8%	5.6%	10.2%	1.4%	6.0%	7.1%	9.4%	12.4%	25.1%	19.2%	29.1%	29.0%	25.1%	19.0%	11.8%	6.3%	11.9%	8.5%	9.4%	11.8%	18.5%	38.5%	6.2%	11.8%	9.6%	46.2%	16.2%	13.7%	14.7%	10.9%	12.1%	8.7%
ICS	12.3%	2.8%	1.7%	1.5%	1.4%	9.9%	2.3%	4.4%	5.0%	9.0%	1.6%	5.3%	6.3%	8.5%	11.5%	22.4%	17.0%	26.3%	26.4%	23.0%	18.2%	11.7%	6.4%	11.6%	7.9%	7.8%	10.6%	15.7%	36.1%	5.7%	10.7%	8.4%	43.4%	14.3%	12.9%	13.4%	10.3%	10.6%	8.3%
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%

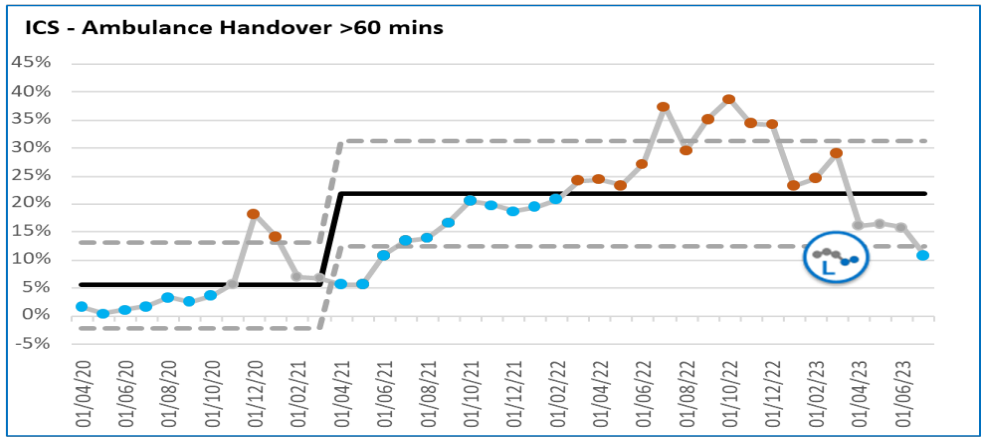
ICB Area	What the charts tell us	Issues	Actions	Expected Outcomes
HUC	• Call volumes have been trending below the historic mean for the last 6 months • Hertfordshire abandoned calls in June improved to 8.2% • West Essex abandoned calls improved to 8.7% • The level of variation between Hertfordshire and West Essex reduced from 1.8% to 0.5%	• Increased pressures resulting from Industrial Action • Recruitment challenged for weekend and part time posts • High attrition rates and short notice sickness • Call volumes remain high at weekends • Increasing 111 online activity • Variation in performance between West Essex and Hertfordshire, but improving	• Review of West Essex call routes to understand the variance with Hertfordshire • Regular rota fill meetings to assign staff to peak call times • Continue to promote Health Advisor home working • Non-clinical "floorwalker" to support Health Advisors in call turnaround times. E.g. DOS query resolution • Review of recruitment processes • Range of staff support and welfare measures in place • HUC Footprint group fortnightly meetings in place to oversee 23/24 contracts as well as identify and implement efficiencies improving the service	• Sharing CAS resource to strengthen clinical support where required across HUC Footprint (HWE, BLMK, C&P) • Efficiency findings planned to strengthen the services • Minimising gaps within the clinical rota fill

UEC - Ambulance Response and Handover

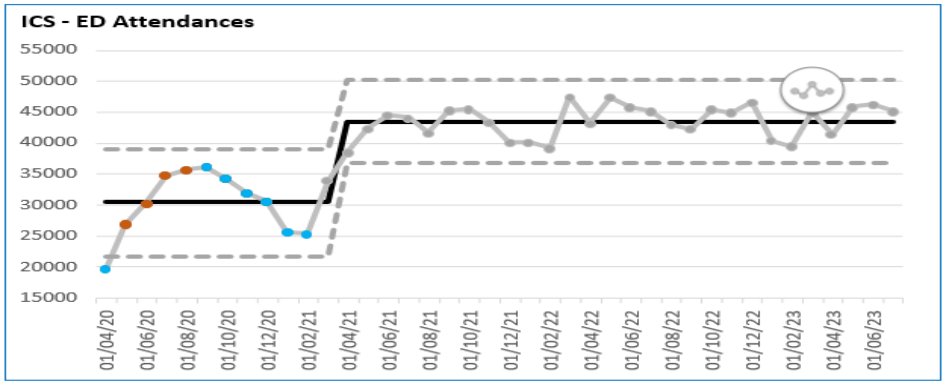


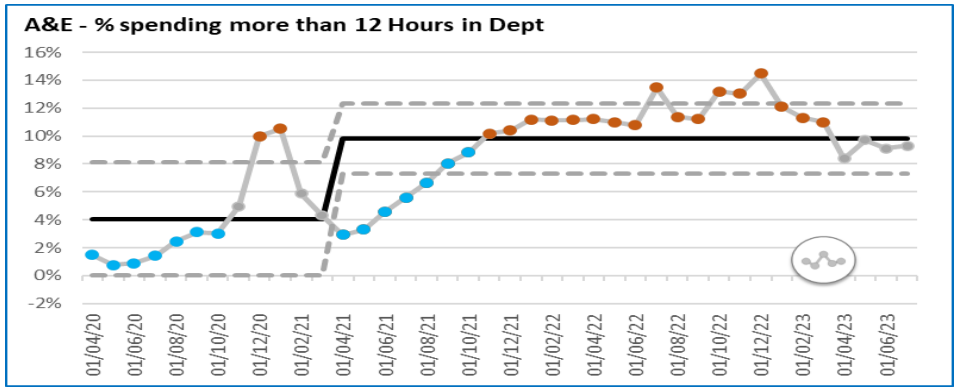


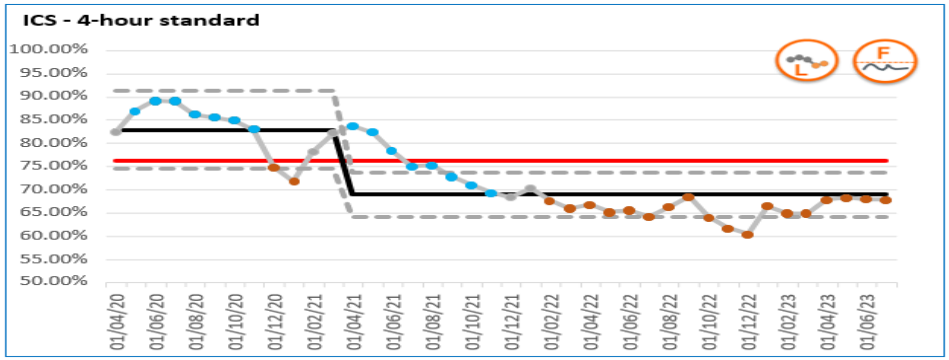




Urgent & Emergency Care (UEC)





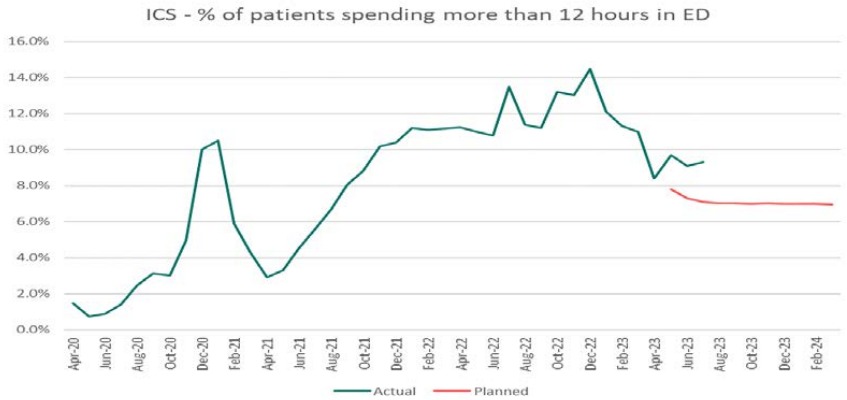


- Attendance and 4 Hour performance data from the ICS's Minor Injuries Units (MIUs) is now included in our monthly UEC reporting. Overall 4 Hour performance has improved by 2.6% as a result
- No Criteria to Reside (NCTR) data has not been included in this report due to data quality issues. Expected to be reinstated from next month

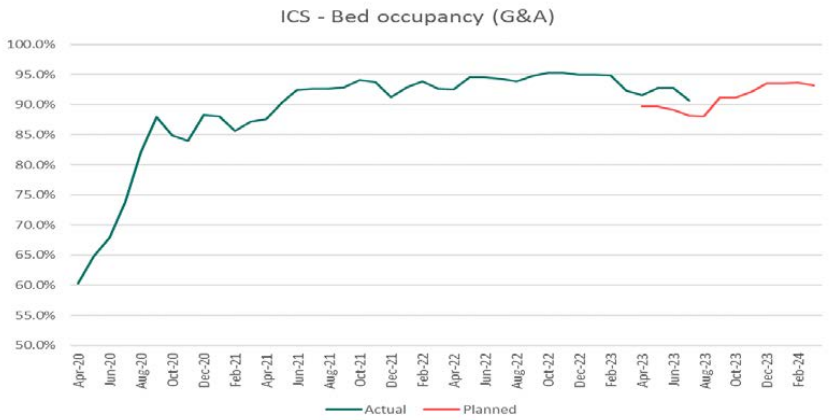
Urgent & Emergency Care (UEC) Improvement Trajectories

4 Hour Standard

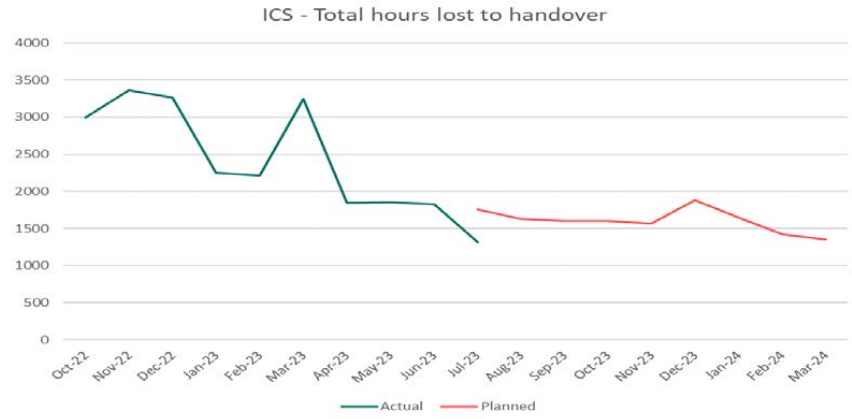
% of Patients Spending > 12 Hours in ED



Bed Occupancy



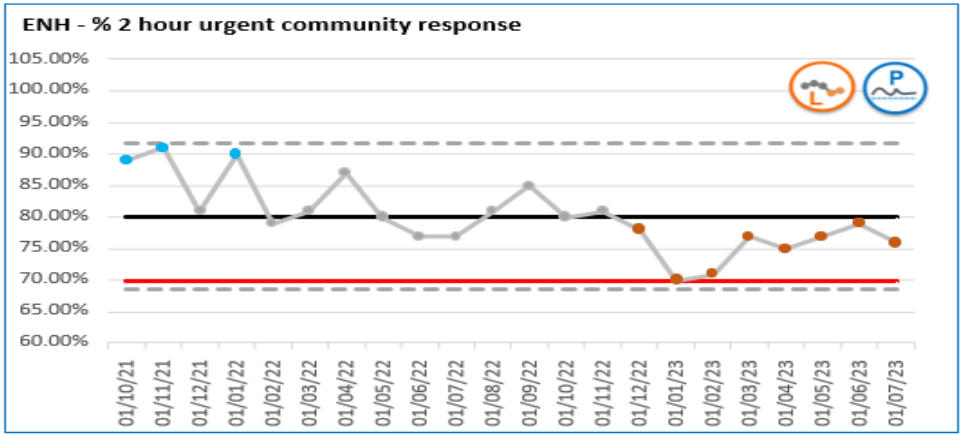
Hours Lost to Handover

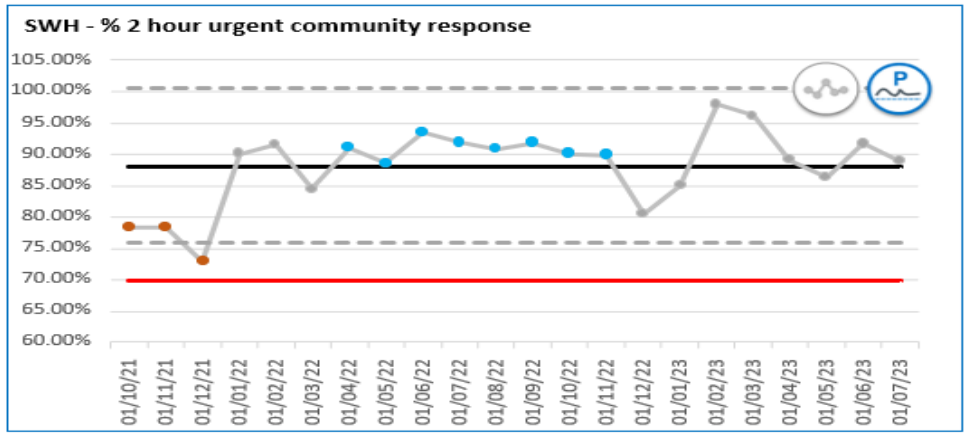


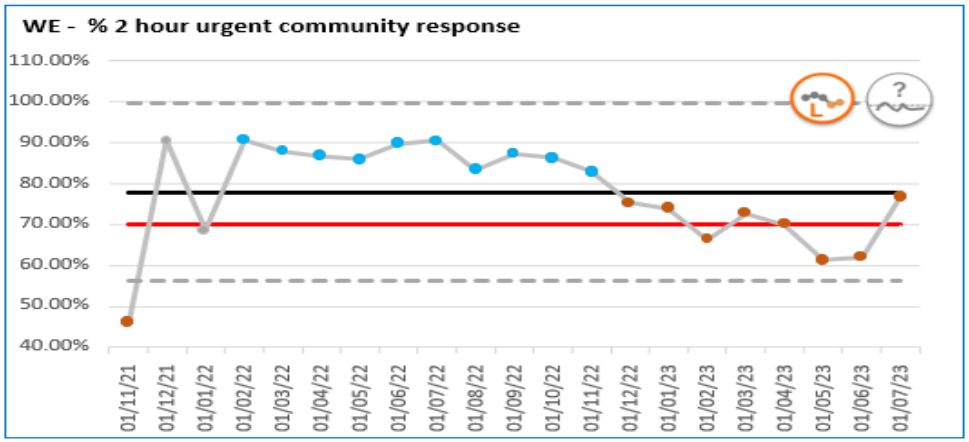
Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• 999 call answering times have remained low with an average of 5 seconds in July. This is the 7th consecutive month with performance between 2 and 8 seconds • Average category 2 ambulance response times were 41 minutes in July. This is a similar performance to previous seven months and remains above the performance standard of 18 minutes. However, this performance is ahead of the recovery target for Jul-23 of 44 minutes. Category 2 response times at a place level have not been available since Mar-23 • At an ICS level, ambulance handover performance has continued to improve during recent months. In July there were 1316 hours lost to handover across the ICS which is ahead of the recovery trajectory of 1757 hours for Jul-23 • Performance against the 4 hour ED standard reached 67.7% in May. This is behind the recovery trajectory of 74.8%. The reported 4 hour ED performance for the ICS now includes the two minor injuries units in Cheshunt and Bishops Stortford • There remains considerable variation at a Trust level for performance against the 4 hour standard in May: – WHHT = 71.3% – ENHT = 65.2% – PAH = 55.5% • The percentage of patients spending longer than 12 hours in ED has been largely static at an ICS level over the last four months and is currently at 9.3% in July. This is above the recovery trajectory of 7.1% for July	• Continued high demand and high acuity of patients for UEC services. However, ED attendances across the health system are lower in Jan-Jul 2023 than they were in Jan-Jul 2022 • Across the ICS, the average daily ambulance arrivals in Jul-23 was 24% higher than during the Jan-23 to Mar-23 period • Ongoing industrial action across various staffing groups has impacted recent performance • Staffing vacancies – e.g. c.80 vacancies at EEAST; 18 medical vacancies in PAH ED; 40% of staffing at St Albans Integrated Urgent Care Hub are agency • Staffing rotas in ED not always aligned to daily peaks in demand • Mental Health presentations remain high, coupled with a shortage of beds / assessment space • Low utilisation of virtual wards in West Essex • ED departments have a view that batches of ambulances are arriving at the same time and that intelligent conveyancing is not working as well as it should be • Hospital flow remains challenging with high occupancy rates, especially at PAH • Non-emergency patient transport delays	**ICB** • Handover@home / Access-to-stack - since June EEAST paramedics have physical presence in Robertson House to pass patients over to EPUT / CLCH / HCT and reduce conveyances. In July there was an average of 12.5 patients per day accepted from the stack. This compares to 6 patients per day in May-23, but is lower than during the trail in Oct-22. However, the overall number of conveyances are still increasing increasing • HUC commencing a 3 month test phase for a single call queue across a number of providers. Anticipated that this should further reduce call waiting times and call abandonment % • ICB People Board focus on reducing vacancy rates across all providers **East and North Herts** • The number of discharges per day has been increasing over recent months as a result of increased focused on ward rounds and also increased resources in the integrated discharge team • ENHT recently appointed a new paediatric ED locum to support with paediatric ED performance and the Trust has recently agreed a new medical rota for adult ED on the Lister site **West Essex** • PAH have refreshed medical roster to improve flexibility within the dept and to increase the WTE during the 24hrs • Working with SDEC to create capacity and increase numbers of patients seen on the day **South West Herts** • St Albans Integrated Urgent Care Hub (IUCH) now well established and utilisation has increased month-on-month • WHHT corridor nursing in place including a joint Trust and EEAST corridor SOP. Has had a significant impact on hours lost to handover

UEC - Urgent 2 Hour Community Response





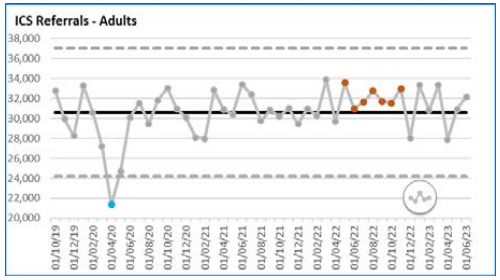


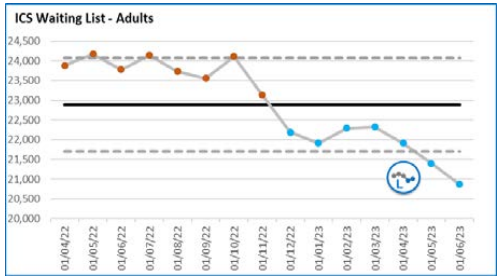
Activity	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
West Essex	428	337	451	519	395	403	442	466	376	348	472	429
East & North Herts	312	327	336	305	396	512	459	471	454	545	545	439
South & West Herts	165	124	163	139	165	154	103	136	203	222	196	232

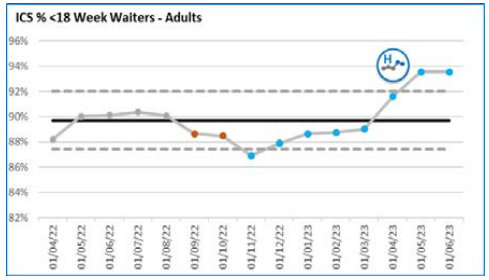
ICB Issues, escalation and next steps

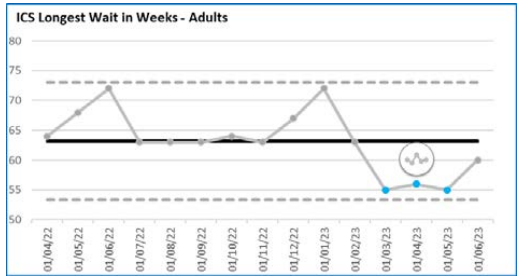
- West Essex performance returned to compliance with all three Places achieving the national 70% standard
- The SWH EIV activity is now being captured and activity levels have increased as a result
- SWH activity is still comparatively low however, indicating that the service is managing less patients than the other two places. Further investigative work is required to understand the data and ensure it is correct

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	30908	32166	↑	21402	20873	↓	93.56%	93.56%	→	55	60	↑	June

Place	Provider	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
ENH	HCT	8697	8312	↓	8546	8258	↓	91.19%	91.03%	↓	55	60	↑	June
ENH	AJM/Millbrook	83	114	↑	323	331	↑	78.95%	76.74%	↓	39	43	↑	June
ENH	**All**	**8780**	**8426**	↓	**8869**	**8589**	↓	**90.74%**	**90.48%**	↓	**55**	**60**	↑	**June**

Place	Provider	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
SWH	CLCH	5884	6536	↑	3112	2363	↓	93.09%	92.51%	↓	54	57	↑	June
SWH	Connect	3835	4111	↑	5289	5900	↑	96.54%	96.95%	↑	52	52	→	June
SWH	HCT	984	1133	↑	1114	1138	↑	94.61%	93.67%	↓	53	57	↑	June
SWH	AJM/Millbrook	106	143	↑	407	416	↑	76.17%	76.68%	↑	40	40	→	June
SWH	**All**	**10809**	**11923**	↑	**9922**	**9817**	↓	**94.41%**	**94.64%**	↑	**54**	**57**	↑	**June**

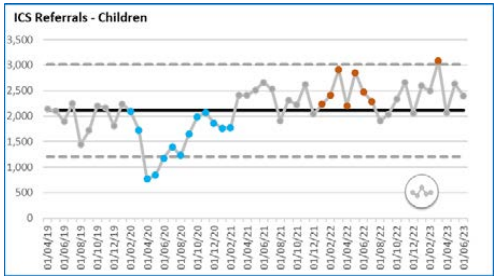
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	11208	11697	↑	2482	2329	↓	100.00%	100.00%	→	17	17	→	June
WE	EPUT - Wheelchairs	111	120	↑	129	138	↑	98.45%	99.28%	↑	20	19	↓	June
WE	**All**	**11319**	**11817**	↑	**2611**	**2467**	↓	**99.92%**	**99.96%**	↑	**20**	**19**	↓	**June**

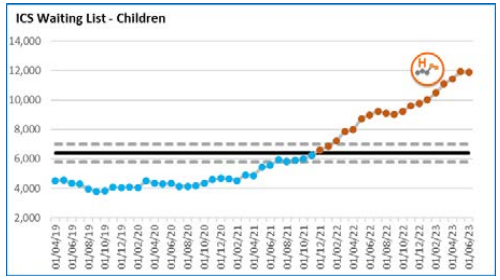
Community Waiting Times (Adults)

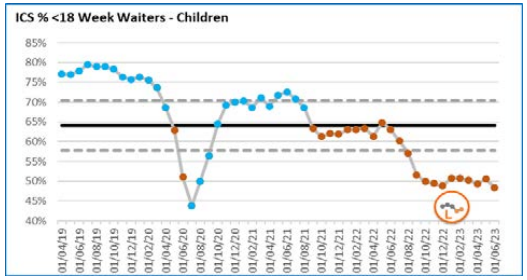
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full detail of commissioned services in HWE is contained within Appendix B.

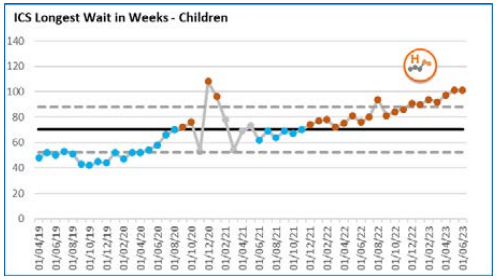
ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals are variable but within expected common cause variation • The % of patients waiting less than 18 weeks continues to improve. Current performance is 93.5%, compared to the national average of 85.2% • The total number of adults waiting on waiting lists continues to show special cause variation of an improving nature • Longest waits within HCT services in East & North Hertfordshire increased from 55-60 weeks • Consultant led 18 week RTT performance: ENH Skin Health – 89.3% SWH Respiratory – 92.8% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Overall waiting within target performance is more favourable compared to the pre-pandemic baseline • Waiting times for the MSK Physio Service continue to show clear improvement, and against the 12 week contracted target are better than 2019/20 **South & West Hertfordshire (SWH)** • Referrals have increased across most service lines which is reflected in the increase in referrals from previous month • Overall number of patients on waiting list have reduced. This is reflected in particular within Bladder & Bowel and Respiratory service where there were high number of patients waiting • Slight increase in RTT position. This is due to long sleep waits within respiratory service • Longest waiter currently within the Neuro service. This is a patient on PD nursing caseload • Staff sickness and vacancies are improving and processes are in place to monitor progress **West Essex (WE)** • Pulmonary Rehab - increased demand, return to face to face classes and long term sick impacting capacity • Bladder & Bowel issues previously reported are now resolved - zero breaches remain within the service • Small numbers of wheelchair breaches due to supplier delays	**East & North Hertfordshire (ENH)** • Increasing MSK Physio capacity though estates and recruitment. Also continuing to review pathways. Initiatives are working well • All waits are closely monitored and are subject to robust internal governance **South & West Hertfordshire (SWH)** • Continue to review Respiratory long waits daily (in particular sleep studies and clinics). Additional sleep clinics have been put in place and it is expected that this will much improve position going forward • WHTH are unable to provide required consultant provision for respiratory and therefore, temporary respiratory consultant capacity remain in place. This is via bank, agency and external provider. This has helped the position and current wait for a 1st appointment is at 3-4 weeks, which is well withing the 18 week target • External provider in place to support Neuro Rehab long waits. Initially 100 appropriate patients have been referred and seen. Further 175 patients identified. External provider seeing approximately 5 patients per week • In addition, external provider now sourced to provide PD nursing support. Service has also recruited to substantive post. Both to be in place by end of September • Division specific recruitment plan developed which includes developing videos to compliment adverts and targeting social media channels • On going discussions with internal Divisions and system partners to look how resilience can be built for Neuro • Trajectories now in place for all services where there are waiting times concerns. These are reviewed and monitored weekly **West Essex (WE)** • Pulmonary Rehab deep dive completed and 23/24 funding agreed. Recruitment for additional capacity has commenced and longest waiting patients being prioritised • Wheelchair temporary equipment supplied where impact from supplier delays

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	2630	2395	↓	11925	11891	↓	50.52%	48.47%	↓	101	101	→	June

Place	Provider	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
ENH	HCT	416	356	↓	979	1038	↑	80.80%	83.53%	↑	46	45	↓	June
ENH	AJM/Millbrook	20	29	↑	107	111	↑	72.90%	68.47%	↓	38	40	↑	June
ENH	ENHT Community Paeds.	280	286	↑	4297	4461	↑	25.67%	25.53%	↓	101	101	→	June
ENH	**All**	**716**	**671**	↓	**5383**	**5610**	↑	**36.63%**	**37.11%**	↑	**101**	**101**	→	**June**

Place	Provider	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
SWH	HCT	1420	1276	↓	5462	5454	↓	55.00%	52.82%	↓	72	70	↓	June
SWH	AJM/Millbrook	18	28	↑	91	97	↑	72.53%	72.16%	↓	39	39	→	June
SWH	**All**	**1438**	**1304**	↓	**5553**	**5551**	↓	**55.29%**	**53.16%**	↓	**72**	**70**	↓	**June**

Place	Provider	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
WE	EPUT - Wheelchairs	19	16	↓	29	27	↓	96.55%	100.00%	↑	20	14	↓	June
WE	HCRG / Virgin	457	404	↓	960	703	↓	99.48%	100.00%	↑	26	17	↓	June
WE	**All**	**476**	**420**	↓	**989**	**730**	↓	**99.39%**	**100.00%**	↑	**26**	**17**	↓	**June**

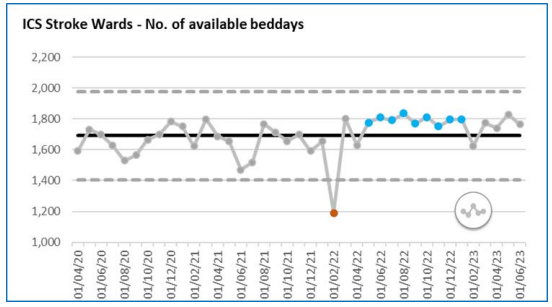
NOTE: ENHT Community Paediatrics data is included above to give a full picture for Children's Services, but is also included in the Planned Care position described in Slides 24 & 25

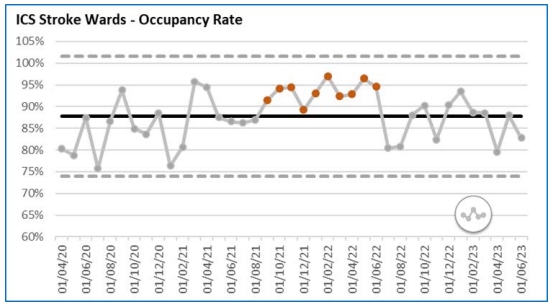
Community Waiting Times (Children)

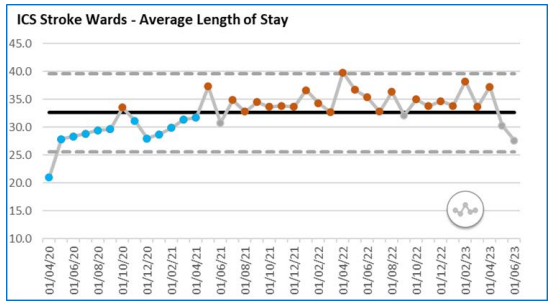
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services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

ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals are variable but within expected common cause variation • The total number of children on waiting lists remains extremely high, however overall, there was no increase in June • Waiting lists continue to grow in East & North Hertfordshire, but the increase in June was offset by reductions elsewhere, predominantly in West Essex • The % of children waiting less than 18 weeks remains of concern. Performance in June was 48.5%, compared to the national average of 61.6% • The longest waits are within the ENHT Community Paediatrics Service at 101 weeks. There are also long waits of up to 70 weeks within HCT services in South & West Hertfordshire • Consultant led 18 week RTT performance: SWH Community Paediatrics – 44.0% SWH Children's Audiology – 41.0% ENH Community Paediatrics – 25.5% WE Community Paediatrics – 100%	**Hertfordshire** • Referrals to children's specialist service have increased by more than 30% compared to 2019/20, with the majority of services seeing a marked increase in demand • Waiting times in the SWH HCT Community Paediatrics service remains challenged. Service productivity shows clear improvement since 2019/20, but referrals have increased by c.30% • There is a rise in longer waits for Paediatric Audiology in SWH. The service is also currently supporting ENHT new born hearing pathways • Waiting times across Hertfordshire for Children's Therapies (OT, Speech & Language and Physiotherapy) remain under pressure, including in particular the Education, Health & Care Plan (EHCP) element • The ENHT Community Paediatrics position is described within the Planned Care and ASD slides of this report **West Essex (WE)** • The volume of children on the Community Paediatrics waiting list has stabilised in recent months following a trend of steady increase • There are no longer any patients exceeding 18 weeks across all services, excluding ASD	**Hertfordshire** • HCT has established BI forecasting which will be further developed in coming months to integrate with demand and capacity measures • Community Paediatrics is working with NHSE Elect to optimise waiting list management • Key focus on avoiding 78 and 65 week waits • Community Paediatrics in SWH is receiving non-recurrent additional investment, increasing workforce capacity and introducing new specialist nursing posts. Risk remains on recruitment to these roles. Transformation Programme Group established to take forward service redesign • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow up appointments. Signposting to interim advice whilst awaiting assessment. Analysis for workforce business case has resulted in Increasing capacity with recruitment of two posts, as capacity is not currently sufficient to meet demand • Children's Therapies – increasing capacity through recruitment, waiting list initiatives and outsourcing • Working closely with commissioners on wider improvements across Special Education Needs (SEN) / Education, Health & Care Plan (EHCP) processes focusing on initial assessments **West Essex (WE)** • WE Community Paediatrics Business Case discussions are ongoing. The ask for additional investment into the overall continues to be negotiated • Speech & Language Therapy (SLT) waiting list has significantly reduced in month. Pre-school children who would not be seen prior to September have been removed from the waiting list. Schools (supported by SLT) will assess children's needs and refer into the school age SLT service as appropriate

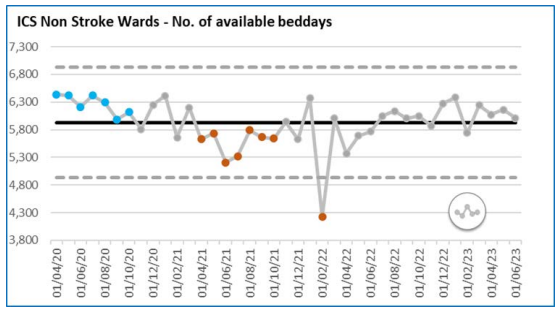
Community Beds (Stroke & Non-Stroke)

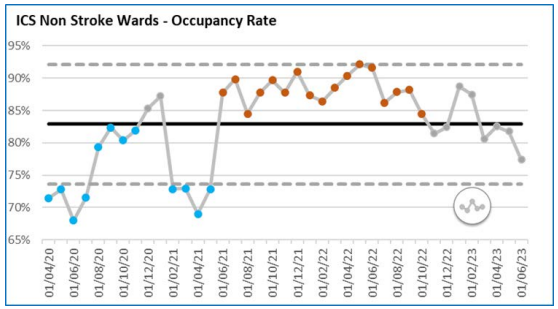


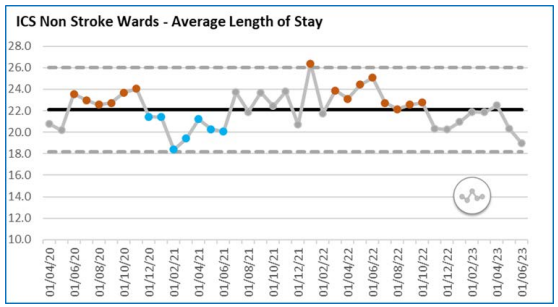




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	744	720	↓	94.09%	92.36%	↓	28.2	15.7	↓	June
SWH	CLCH	620	594	↓	73.55%	62.63%	↓	29.0	26.4	↓	June
WE	EPUT	465	450	↓	97.42%	94.22%	↓	35.0	47.4	↑	June
ICS	**All**	**1829**	**1764**	↓	**87.97%**	**82.82%**	↓	**30.3**	**27.6**	↓	**June**





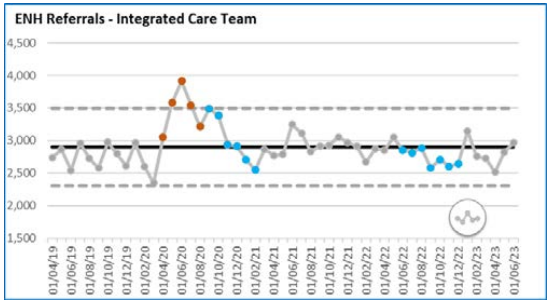


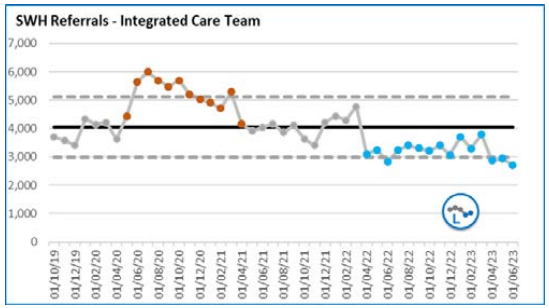
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1643	1636	↓	87.52%	88.14%	↑	20.4	16.5	↓	June
SWH	CLCH	2315	2244	↓	76.20%	61.45%	↓	25.4	23.1	↓	June
WE	EPUT	2201	2130	↓	83.28%	85.92%	↑	15.4	17.8	↑	June
ICS	**All**	**6159**	**6010**	↓	**81.75%**	**77.39%**	↓	**20.3**	**19.0**	↓	**June**

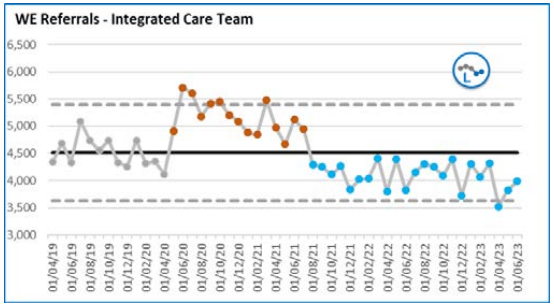
Community Beds (Stroke & Non-Stroke)

ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds Days** • Available stroke bed days reduced across the system but remain within expected common cause variation limits • Overall occupancy rates reduced across the system but are within common cause variation limits. There remains notable variation across the 3 Places. CLCH occupancy in June was 62.6%, with EPUT at 94.2% occupancy • Overall length of stay reduced in May and June, but again there is variation across the 3 Places. HCT was 15.7 days in June, with EPUT at 47.7 days **Non-Stroke Beds Days** • Available bed days reduced across the system but within expected common cause variation limits • Overall occupancy rates across the system are within common cause variation limits but there remains notable variation across the 3 Places. CLCH occupancy in June was 61.5%, with HCT at 88.1% occupancy • Overall length of stay reduced in May and June, but again there is variation across the 3 Places. HCT was 16.5 days in June, with CLCH at 23.1 days	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 93% over the past two years. Herts & Essex and QVM have an average occupancy of 84% and 82% respectively • Average length of stay for Herts & Essex shows normal variation with an average of 24 days. For QVM and Danesbury, there has been a recent increase in average length of stay since April 2023 (following a period of a lower trend since July 2022); with QVM currently at 26 days and Danesbury 35 days • Admissions rates are stable **South & West Hertfordshire (SWH)** • Small reduction in number of stroke and non-stroke bed days available due to on going building works across some sites **West Essex (WE)** • High levels of referrals and admissions resulting in high occupancy rates • Two long stay stroke patients > 6 weeks • High volume of Discharge to Assess (D2A) patients awaiting Care Homes; 1 long stay patient > 3 months	**East & North Hertfordshire (ENH)** • Introduction of Discharge Medicines Service (DMS) is being taken forward • Note: NHSE has published data showing that patients who receive the DMS are less likely to be readmitted (5.8% vs 16% at 30 days), and spend fewer days in hospital (7.2 days on average compared to 13.1 for patients who did not receive the service) in instances where they are readmitted **South & West Hertfordshire (SWH)** • Delay assurance calls remain in place with HCC with clear escalation process in place • Currently reviewing all processes to manage patients in and out of wards • In collaboration with system partners, action plan agreed to support flow and winter plan also drafted **West Essex (WE)** • All patients awaiting Care Homes reviewed on daily social care escalation call

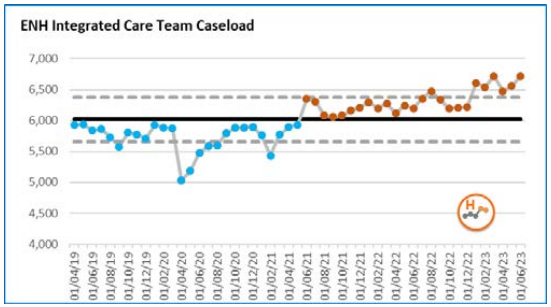
Integrated Care Teams

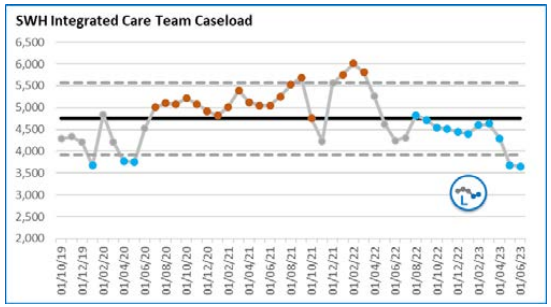


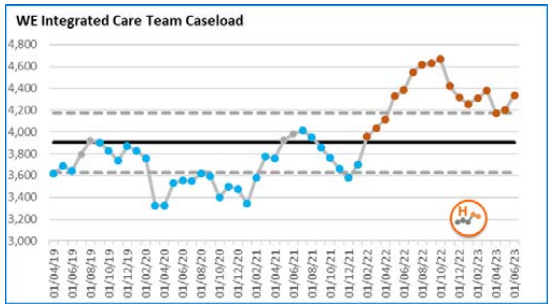




			Referrals			Referral Rate per 1,000 Population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	2824	2967	↑	4.8	5.0	↑	June
SWH	CLCH	All	2936	2716	↓	4.3	3.9	↓	June
WE	EPUT	All	3828	3986	↑	12.0	12.5	↑	June
ICS	**All**	**All**	**9588**	**9669**	↑	**6.0**	**6.0**	↑	**June**







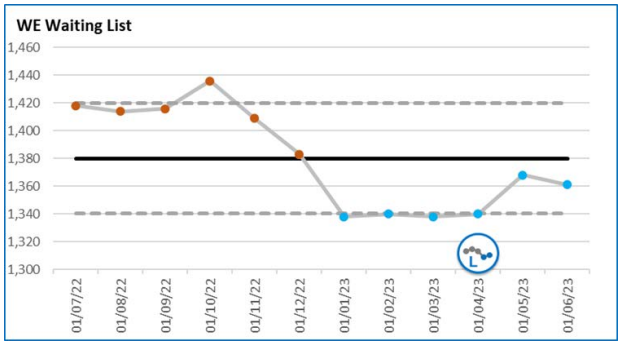
			Caseload			Caseload per 1000 population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	6557	6722	↑	11.1	11.4	↑	June
SWH	CLCH	All	3679	3650	↓	5.3	5.3	↓	June
WE	EPUT	All	4203	4337	↑	13.1	13.6	↑	June
ICS	**All**	**All**	**14439**	**14709**	↑	**9.0**	**9.2**	↑	**June**

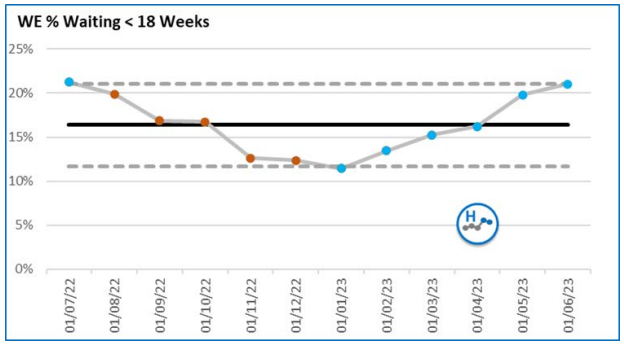
Integrated Care Teams

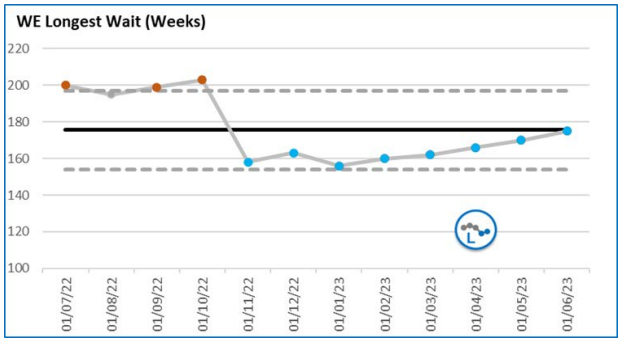
ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall referral volumes to Integrated Care Teams have been consistently reducing since the restoration of services post-Covid • West Essex referral volumes appear disproportionately high given the relative population size • Integrated Care Team caseloads in East & North Hertfordshire and West Essex are consistently high, and notably above the pre-Covid baseline • South & West Hertfordshire caseload appears disproportionately low given the relative population size – under investigation	• The 3 Providers BI teams have investigated the high referral numbers in West Essex compared to Herts. Initial investigations have not identified any specific recording issues suggesting that teams are reporting consistently, however this may require further analysis **East & North Hertfordshire (ENH)** • Overall, referrals show a small increase compared to pre-pandemic although this differs significantly at Locality level • Increasing patient complexity has driven an increasing caseload and an increasing first to follow up ratio **South & West Hertfordshire (SWH)** • SWH – slight reduction in number of referrals from previous month • Further work required to understand why referrals and caseload numbers are so different to ENH and ensure correct numbers are captured and services are being measured like for like. For example in SWH service is called planned care and unplanned care is separate. Where as in ENH, planned care is integrated with unplanned care.	• Community services review underway across HWE to reduce variation and shift to reporting outcomes and impact to compliment the activity driven data that exists **East & North Hertfordshire (ENH)** • A comprehensive support programme in place focused on workforce, wound care and diabetes management with the ICT **South & West Hertfordshire (SWH)** • Review of workforce and criteria with ENH to understand differences. Ensure like for like comparisons between providers

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	1368	1361	↓	19.81%	21.01%	↑	170	175	↑	June



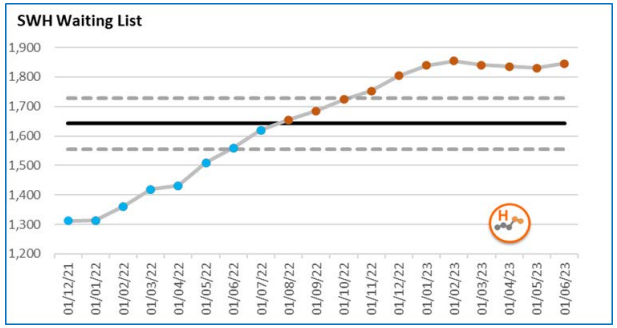


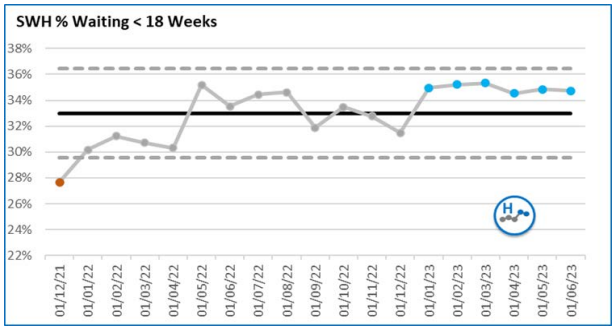


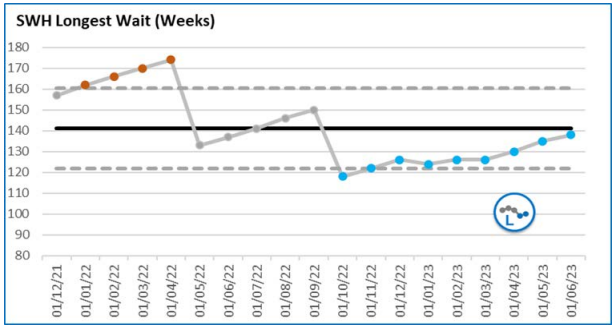
ICB Area	What the charts tell us	Issues	Actions
West Essex	• The ASD waiting list showed good improvement following agreement of a recovery plan in late 2022 • There has been no further reduction to the waiting list since January and the recovery plan is behind trajectory • The % of ASD waiters < 18 weeks has improved for five consecutive months, but remains comparatively low at c.21% • Longest waits in the service have improved from a high of 200 weeks, but have been steadily increasing over recent months, and are also behind trajectory. However there are just 3 patients > 155 weeks	• Reconciliation of backlog funds against activity to date is estimating current funding to be exhausted by mid-Sep 23, after which waiting lists will return to a growth position • Referral rate remains above core commissioned capacity • Further 31% projected demand increase by 2026 • Prescribing costs have increased by 188% since the start of the contract (17/18), mainly driven by ASD/ADHD medications, creating a £60k cost pressure • Outstanding Exec. decision with regard to business case to increase core capacity for sustainable delivery and address prescribing gap	• Business case submitted to Exec to increase core capacity for sustainable delivery and address prescribing gap – decision remains outstanding • Community Paediatric capacity fully staffed and recruited to at-risk, with additional Associate Specialist doctors focusing on ASD • Potential project management support identified for driving forward 'waiting well' workstream, working closely with HCRG • Patient level review of 3 patients > 155 weeks requested from HCRG

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	1831	1845	↑	34.84%	34.74%	↓	135	138	↑	June

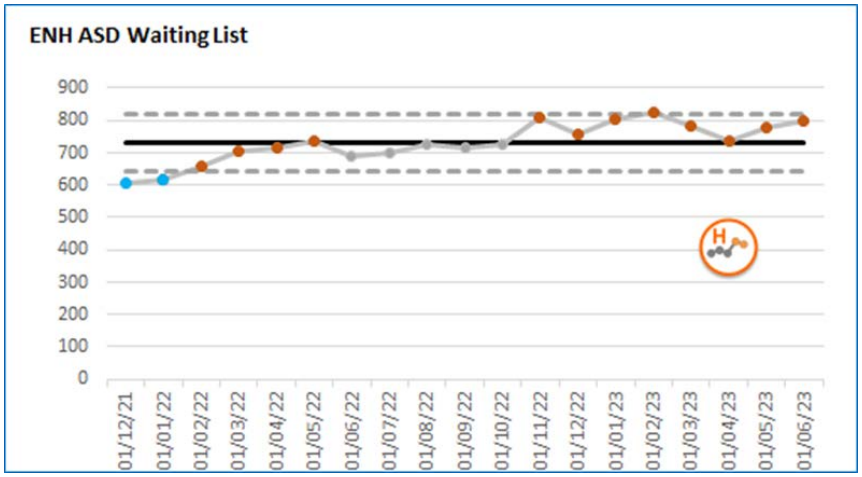






ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The overall waiting list is relatively stable following the sharp increase seen during 22/23, but remains notably above the historic mean • The % of ASD waiters < 18 weeks fluctuates around a historic mean of c.33% • The longest waits have been slowly increasing in recent months, with the longest now at 138 weeks • Impact of the increased internal and outsourced capacity for autism assessments seen in the latest local data	• Neurodiversity Support Centre (Single Point of Access for parents, carers and professionals) is a pilot with funding ending in Sept 2024. Longer term investment decision required by October 2023 to allow for procurement. • Capacity in existing services does not meet demand • Further increases in demand predicted	• Significant additional diagnostic assessments have been delivered through joint outsourcing to Avenue Therapies Ltd and The Owl Centre Ltd and outsourcing is continuing at pace through The Owl Centre with increased face to face assessments for CYP aged 5 and 6 • Additional internal capacity and improved processes • In 2023/24 HCT will continue with outsourcing using the remaining funding from the initial business case at £437k • Learning Disabilities, Mental Health and Autism Collaborative are continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with autism and / or ADHD. Currently pilot funding and decisions with regards to long term funding will need to be made • EPs allocated to clinics with SLTs for quality check assessments • Clinicians have agreed future best practice clinical pathway and model for Hertfordshire and this is due to be reviewed by operational teams to plan staff model and capacity required

Autism Spectrum Disorder (ASD) – East & North Hertfordshire



- In East and North Hertfordshire 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 Jul-23):

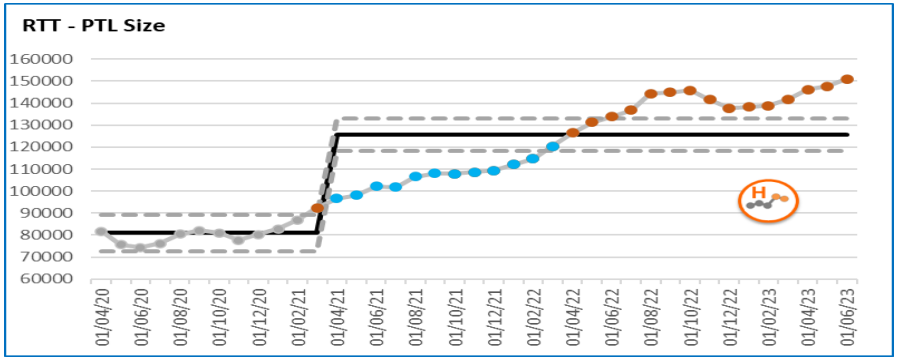
Summary of ENHT ASD assessment waiting list

Waiting list bucket	Number of patients (Jun-23)	Number of patients (Jul-23)
<18 weeks	139	153
18 – 65 weeks	444	344
66 – 78 weeks	64	75
>78 weeks	152	126

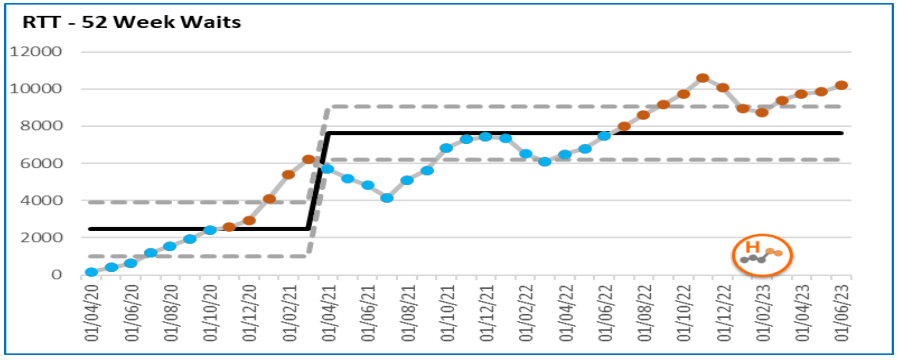
ICB Area	What the charts tell us	Issues	Actions

East & North Herts	• The ASD waiting list continues to fluctuate between 700 and 800 patients – slightly above the historic mean
	• Indicative data for July suggests there has been good improvement in the 18-65 week cohort
	• The waiting list shown above does not include patients who are 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
		• ENHT is currently subject to fortnightly Tier 1 Oversight and Scrutiny meetings for Community Paediatrics with NHSE/I as a result of increasing >78 week waiters
		• Backlog funding will end December 2023. Without additional investment, waiting lists will return to a position of growth
		• Further increases in demand predicted
		• Neurodiversity Support Centre (Single Point of Access for parents, carers and professionals) is a pilot with funding ending in Sept 2024. Longer term investment decision required by October 2023 to allow for procurement
			• ENHT and HWE ICS are currently putting in place a recovery plan for the community paediatrics service in ENH. Actions from this plan relating to ASD include:
			  • Exploring whether there is an opportunity to outsource additional ASD diagnostic assessments
			  • For those with suspected ASD over age of 7yrs, exploring new pathway direct from primary care to OWL to undertake the assessment from initial appointment to discharge
			• Learning Disabilities, Mental Health and Autism Collaborative continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with autism and / or ADHD. Currently pilot funding and decisions with regards to long term funding need to be made
			• Clinicians have agreed future best practice clinical pathway and model for Hertfordshire. To be reviewed by operational teams to plan staff model and capacity

Planned Care – PTL Size and Long Waits



	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
EAST AND NORTH HERTFORDSHIRE NHS TRUST	51722	48493	46875	45845	46963	46178	43775	40219	42298	43796	45899	48160	50812	50103	52368	51326	54504	54794	54200	53331	49521	48264	47103	49182	51259	52241	53993	55737	59979	58006	59917	60711	60999	60488	61406	61782	62296	62295	63245
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	15490	13037	13455	15352	17537	18663	19192	19531	20409	21525	22503	24415	25025	25842	27090	27923	28401	28438	28380	29017	32809	36110	40241	45085	49522	53146	54626	55530	57611	60326	59727	53831	49537	50043	50169	52995	55574	57935	60626
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	14584	14057	13944	15012	16318	17274	18029	17927	17473	17493	18642	19863	21297	22126	22654	22706	23706	24827	25359	26196	27081	27688	27444	26157	25780	25862	25287	25573	26759	26628	26287	27099	27172	27408	27247	27022	27872	27923	27137
ICS	81799	75587	74274	76209	80415	82115	80996	77677	80180	82814	86844	92438	96634	98071	102119	101859	106611	108269	107991	108544	109411	112062	114768	120424	126561	131249	133908	136840	144349	144959	145883	141613	137708	138239	138822	141789	146242	147755	151008



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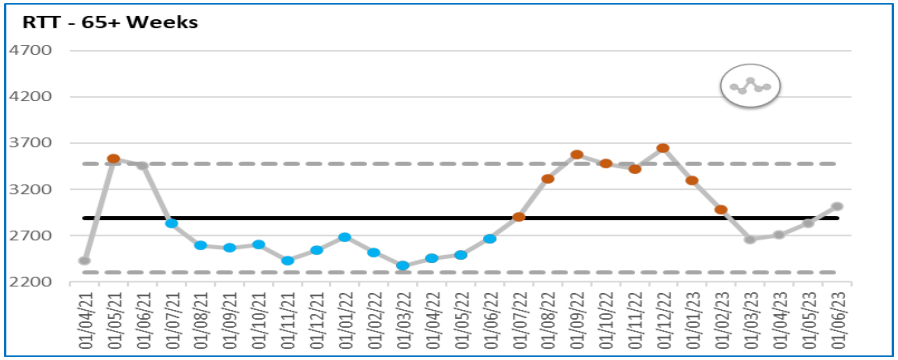
	202021												202122												202223												202324		
Other	101	179	391	594	741	917	1021	1088	1197	1577	2004	4082	3740	3162	2782	2578	2447	2441	2394	2296	2321	3348	2853	2868	3033	2496	2412	2648	2532	2437	2583	2570	2728	2691	2641	2782	3133	3318	3109
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	27	60	140	213	272	363	420	467	657	914	1177	1286	1302	1249	1143	1269	1394	1536	2141	2321	2486	2613	2221	1737	1818	1674	1785	1911	1909	1898	1804	1721	1773	1850	1814	1870	1973	2098	2280
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	53	135	302	484	669	855	1075	1112	1151	1463	1735	1702	1462	1162	898	789	800	858	878	862	927	1006	1105	1059	1193	1431	1660	1783	2078	2587	3413	4272	3544	2681	2315	2729	2694	2439	2504
EAST AND NORTH HERTFORDSHIRE NHS TRUST	90	209	190	483	604	735	931	987	1158	1724	2499	3221	2936	2791	2785	2095	2910	3259	3818	4102	4016	3739	3184	3313	3473	3699	4027	4294	4628	4688	4527	4618	4778	4404	4618	4797	5064	5308	5400



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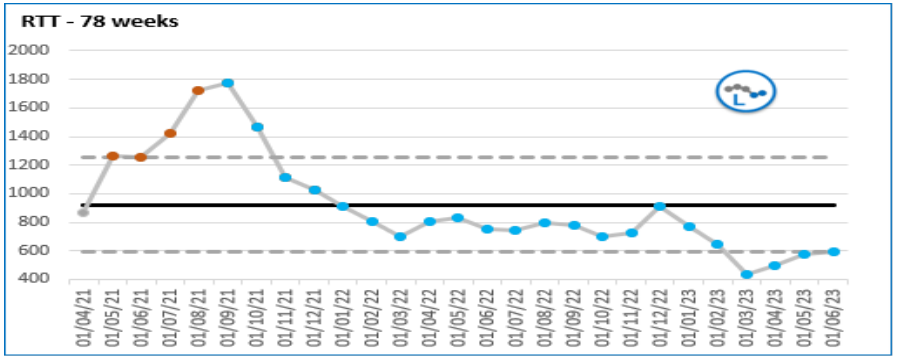
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	722	673	650	665	719	776	744	715	772	780	685	701	679	739	768	765	745	636	572	636	658	592	549	604	707	816
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1026	1007	783	578	477	431	399	351	390	437	461	413	459	480	499	480	566	680	719	767	831	819	607	548	495	504	524
EAST AND NORTH HERTFORDSHIRE NHS TRUST	1405	1799	1998	1601	1452	1417	1428	1338	1438	1475	1279	1278	1293	1334	1428	1653	1983	2150	2124	2081	2178	1816	1778	1562	1610	1621	1673



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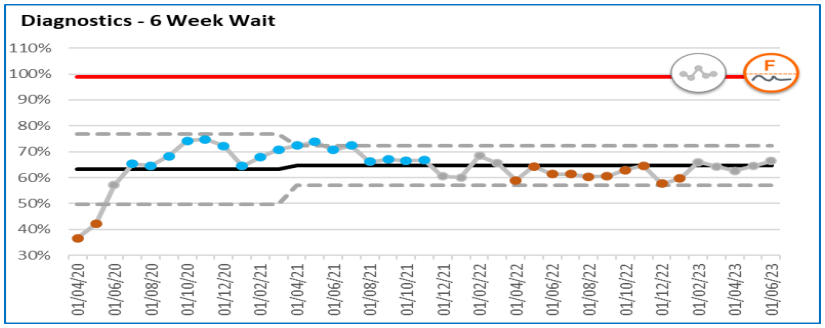
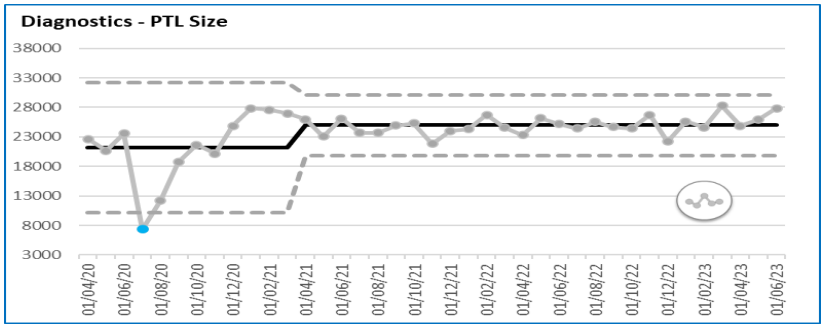
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	0	231	218	288	378	434	399	325	283	260	243	190	223	266	281	296	248	208	141	108	157	147	95	14	23	37	37
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	353	389	364	388	407	362	271	189	169	162	140	111	144	155	143	133	137	116	92	69	69	69	38	15	11	9	7
EAST AND NORTH HERTFORDSHIRE NHS TRUST	516	646	674	748	940	983	800	598	577	492	420	401	439	408	324	312	407	458	464	548	689	551	516	405	461	532	553

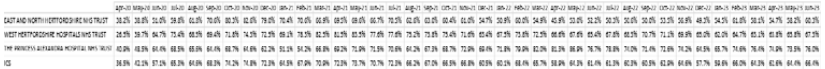
Planned Care – PTL Size and Long Waits

ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWE	• The overall PTL size has been steadily increasing over the last six months, mainly at WHTH and ENHT, whilst PAH has remained steady. The driver for the growth in the PTL is outpatients. • May & June have seen an increased number of patients >78 weeks with ENHT increasing whilst WHTH & Pah have remained steady. • The number of patients waiting >65 weeks saw a significant drop between Dec '22 – March '23 however, there has been a steady increase since April, with July reaching similar numbers to February. • The number of patients waiting over 52 weeks has seen an increase over the last five months and therefore remains an area of high concern.	• Not enough activity is being delivered to manage the backlog effectively • Staffing remains a challenge, particularly Anaesthetics & Community Paediatrics at ENHT • ENHT 78 week waits is primarily in Community Paediatrics • Trauma and Orthopaedics and Community Paediatrics remain the main areas of pressure • The impact of on-going industrial action is seen in the increasing waiting lists although Trusts are managing the IA well • The continued industrial action has impacted the 78ww trajectory; the forecast for the end of August (as of 23/8) is 718 for the system (ENHT 655 / WHTH 7 / PAH 54 / HCT 1 / ISP 1)	**Management of waiting lists:** • System focus on reducing number of patients waiting >78 weeks and >65 weeks, with regional and national oversight • Demand, capacity & recovery plans are in place to monitor 78 & 65 weeks • Weekly KLOEs in place with NHSE to track 104/78/65 week position • Fortnightly performance meetings with each of the three acute Trusts are in place with NHSE support (ENHT remains Tier 1 for elective recovery) • Validation and robust PTL management in place **Increasing Capacity and Improving productivity:** • Pro-active identification of pressured specialties with mutual aid sought vial local, regional & national processes • Outpatients has a full programme of work to increase productivity including PIFU (patient initiated follow up), reducing follow ups including discharging where appropriate, and increasing take up of advice & guidance • Maximising use of ISP capacity and WLIs where possible • Theatre Utilisation Programmes in place including an ICB wide programme • Anaesthetist recruitment • Three accelerated pilot schemes identified to reduce community paediatrics waits in ENHT: 1) ENHT ADHD diagnosis and ongoing management combined with HPFT to form a single Hertfordshire service, 2) Implement primary care-led ADHD follow-up service for ENH patients and 3) explore if the Owl Centre (non consultant led ASD diagnostic service) can provide 200 additional ASD diagnostic assessments under the current procurement up until March 2024	• Actions delivering overall reductions to long waiting patients • National emphasis on prioritising patients in order of clinical need resulting in longer waits for routine patients • Clinical harm reviews and regular patient contact to manage patient safety and experience • System wide Community Paediatrics plan in development

Planned Care – Diagnostics







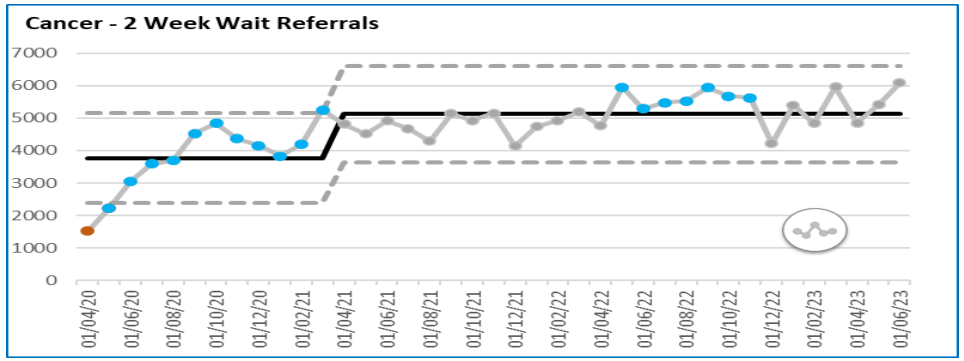
ICB Area	What the charts tell us	Issues (DM01 figures given are % of patients waiting over 6 weeks, June data)	Actions	Mitigation
HWEICB	• 6 week wait performance across the system improved by 3.8% between April and June • Performance improved at all three acute trusts • Demand continues to increase, but the overall PTL remains within common cause variation limits	• Workforce remains the key area of concern • DEXA continues to be a key risk area at ENHT and WHTH; this is mainly a staffing issue, but also WHTH has a scanner down awaiting a part. DM01 is 74.2% across both • MRI (51.2%) & CT (44.1%) performance at ENHT remains challenged • Audiology (82%) and Endoscopy (37.9%) (esp. Cystoscopy) are the key challenges at PAH • PAH have had issues covering a staffing gap for Echos which has impacted waiting times • WHTH is challenged around Echos (62.4%) and Audiology (63%)	• DEXA has been escalated to the Imaging Network (IN) and NHSE for additional support Funding has been approved for an imaging network DEXA practice educator to support training of staff • WHTH are looking to outsource to a 2nd provider, but they are awaiting CQC registration. Also looking at mutual aid to support WHTH during repair to scanner. ENHT CDC DEXA performance has improved • PAH Audiology – have had funding approved from NHSE for additional CDC activity that they will use for an insourcing provider • Revised WHTH Endoscopy bid approved. Need to resolve an issue with the capital profile • New QEII CDC is live for all modalities and they are expecting to recover activity for any under performing modalities. A number of imaging modalities are also over performing, although this may not be sustained as no guarantee of funding from NHSE for overperformance • WHTH have had funding approved for a Care Navigator role to support Endoscopy, but also working closely with other modalities such as Radiology • CDC Pathway funding approved for breathlessness funding (PAH), Urology (WHTH) and Telederm (System)	• Continued use of insourcing / outsourcing where funding permits • Use of mutual aid • Use of telephone assessments being trialled • Validation of lists • Workforce paper presented to Workforce Supply Committee • Continue to apply for NHSE funding opportunities

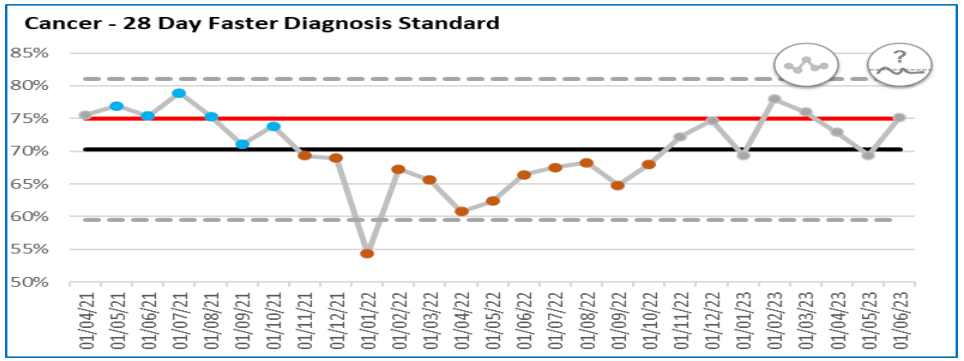
Planned Care – Theatre Utilisation

Theatres	ENH	PAH	W Herts
Number of cases*	315	78	273
Average cases per 4 hour session*	2.4	1.8	2.0
Utilisation - Capped	87.5%	76.9%	72.5%
Average late starts (Minutes)†	22	37	35
Average inter case downtime (Minutes)	15	12	14
Average early finish (Minutes)†	58	55	95
Average unplanned extensions (Minutes)†	51	30	129
% Emergency cases on elective lists *	2.5%	0.0%	1.5%
BADS Day Case	85.1%	75.2%	74.2%
Conversion from day case to inpatient	7.0%	17.0%	12.0%
* no national target † where list started late / finished early /extended time	Worst quartile		Best Quartile

ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Comparison of Model Health System theatre utilisation data presentation supplied by NHSE (July 23) • Theatre data w/e 2.7.23 for ENHT and WHTH, and w/e18.6.23 for PAH • Day case metrics Jan-March 23	Potential areas for review of action identified in NHSE slides: • ENH – high emergency surgery rate in general surgery (10.4%) and Gynaecology (6.3%) • PAH – consistently high conversion from day case to inpatient rate (44%), alongside a low day case rate (38%) • WH – lower efficiency and increased emergency surgery rate on Watford site	**GIRFT High Value Low Complexity Targets (HVLC):** 1. Theatres Capped Touch time Utilisation = 85% 2. BADS Day Case Rates = 85% • A series of reviews of DQ issues and solutions have taken place with Trusts through the GIRFT theatre programme team • Learning session to be planned for the Autumn to allow Trusts to share areas of good practice and look at challenges

Cancer





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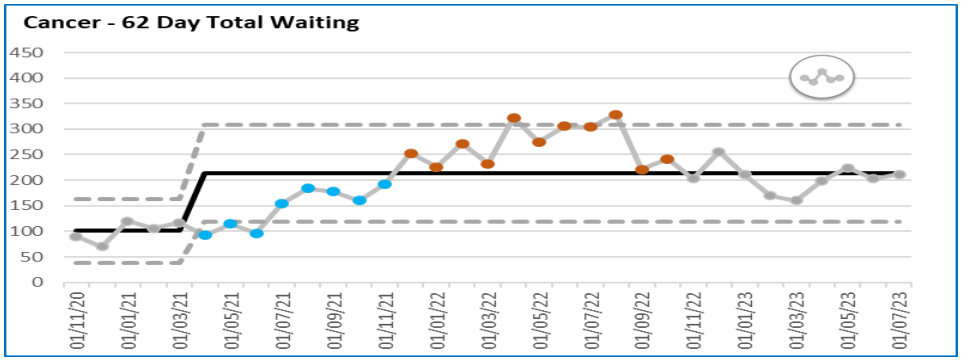
EAST AND NORTH HERTFORDSHIRE NHS TRUST	72.1%	75.6%	76.2%	76.7%	72.0%	71.8%	76.5%	74.8%	74.1%	64.2%	72.9%	74.6%	68.0%	64.2%	70.6%	71.7%	72.6%	69.7%	71.5%	71.7%	77.4%	65.8%	76.3%	72.9%	69.8%	69.3%	76.4%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	81.3%	79.8%	81.4%	82.1%	77.8%	77.2%	77.7%	71.9%	64.7%	47.0%	59.2%	54.6%	51.3%	57.7%	55.6%	60.3%	60.2%	57.8%	63.2%	71.5%	72.7%	70.1%	79.9%	78.6%	76.0%	68.0%	74.8%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	72.3%	74.6%	66.8%	77.1%	75.9%	62.9%	65.1%	60.6%	66.8%	50.9%	69.4%	69.3%	64.1%	65.9%	74.3%	72.3%	72.8%	68.3%	70.4%	73.7%	74.5%	72.2%	77.4%	76.5%	72.4%	71.2%	74.7%
ICS	75.6%	76.9%	75.4%	78.9%	75.3%	71.1%	73.8%	69.3%	68.9%	54.4%	67.3%	65.6%	60.8%	62.4%	66.4%	67.5%	68.3%	64.8%	68.0%	72.2%	74.7%	69.4%	78.0%	76.0%	72.9%	69.4%	75.2%



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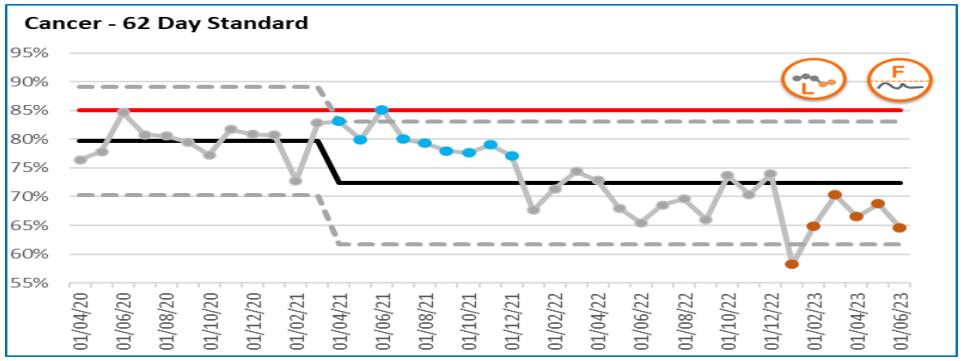
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	73	76	96	105	79	83	109	88	132	179	130	128	129	331	347	374	307	261	297	297	277	270	257	233	195	191	184	129	125	148	127	158	149
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	129	118	200	187	127	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125	162	152	163	149	193	182	153	120	148	213	203	166
EAST AND NORTH HERTFORDSHIRE NHS TRUST	90	70	120	106	117	92	114	96	155	184	178	160	193	253	226	272	232	322	275	306	304	329	221	242	203	256	211	170	160	199	224	203	212

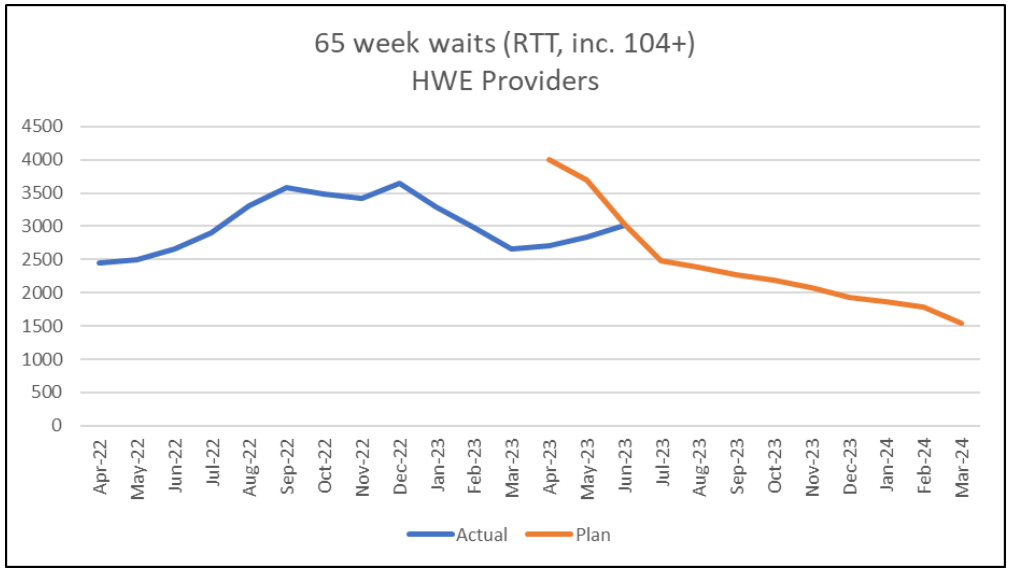


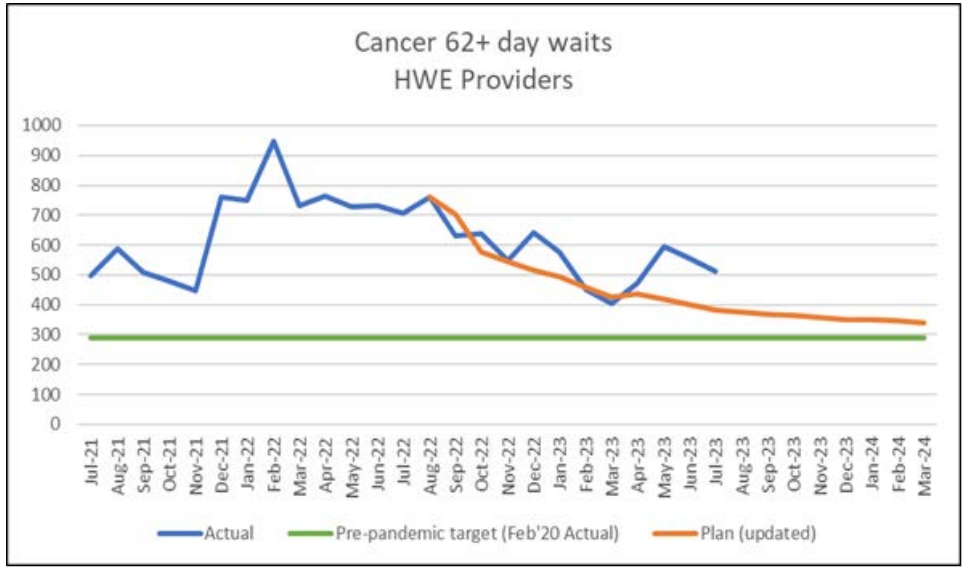
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
EAST AND NORTH HERTFORDSHIRE NHS TRUST	87.3%	85.9%	87.3%	89.2%	85.3%	80.1%	86.9%	86.6%	87.0%	86.9%	83.4%	87.4%	91.1%	88.2%	85.0%	90.3%	86.1%	87.5%	86.1%	89.9%	86.2%	79.5%	87.6%	84.1%	86.0%	81.1%	82.4%	86.0%	82.6%	81.8%	80.7%	74.9%	91.0%	78.6%	81.8%	87.1%	83.8%	86.8%	81.7%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	68.8%	73.9%	86.4%	74.7%	85.7%	83.7%	80.0%	83.1%	81.1%	83.1%	73.4%	84.5%	84.9%	75.0%	86.8%	80.1%	79.8%	70.9%	75.0%	77.2%	75.1%	57.3%	62.5%	72.6%	60.2%	61.4%	56.1%	58.8%	59.6%	60.2%	68.7%	64.4%	69.5%	51.2%	58.6%	57.0%	64.7%	58.8%	60.0%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	58.1%	63.1%	75.6%	75.0%	59.3%	66.3%	54.9%	67.3%	68.4%	65.4%	40.6%	68.3%	63.1%	68.9%	78.4%	56.1%	58.4%	69.8%	64.1%	52.5%	53.8%	47.7%	41.4%	58.1%	61.7%	49.2%	45.0%	46.8%	61.2%	31.9%	65.3%	55.7%	47.4%	32.1%	44.9%	51.8%	38.9%	43.8%	40.3%
ICS	76.5%	77.9%	84.6%	80.8%	80.6%	79.5%	77.3%	81.7%	80.8%	80.7%	72.7%	82.8%	83.1%	80.0%	85.1%	80.0%	79.3%	78.0%	77.7%	79.0%	77.2%	67.6%	71.4%	74.4%	72.8%	68.0%	65.5%	68.6%	69.6%	66.0%	73.7%	70.4%	74.0%	58.2%	64.9%	70.3%	66.5%	68.8%	64.6%

Cancer

ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• 2week wait referrals increased sharply in both May and June • 28 day Faster Diagnosis Standard performance declined in May but improved in June, in line with target • Performance stabilised for the number of patients waiting >62 days, in June and July • Performance against the 62 day standard remains below standard with the treatment of the longest waiting patients, which although improved slightly in June, declined again July, showing an overall declining pattern	**ENHT** • Theatre capacity for skin and breast has been challenging and has impacted the performance for the 31 day subsequent treatments for surgery • Radiographer staffing vacancies and delayed replacement of linac machines have impacted the 31 day subsequent radiotherapy performance • 62 day treatment performance is being impacted by colonoscopy capacity, TP biopsy capacity and breast radiology delays • High, and variable, weekly volumes of 2WW referrals **WHTH** • Increase in demand and insufficient capacity for diagnostics, across both services and clinical support (histopathology particularly) • Dermatology particularly challenged • Although cancer patients were prioritised during the recent industrial action, overall capacity was compromised **PAH** • Urology and Lower GI capacity and workforce. These two services hold 75% of the total backlog	**ENHT** • Additional WLI agreed to cover backlog in skin and breast surgeries • Additional radiographers have been recruited and it is expected that the 31 day subsequent radiotherapy performance will recover by September. Doing additional Saturday lists in the meantime • Locum radiologist appointed which has enabled breast one stop service to be offered again • ICB and ENHT have conducted a review of 2WW referral trends but no significant findings **WHTH** • Breast Pain pathway set to 'go live' September 2023 • Work to improve the gynae urgent cancer referral form has begun, aimed at improving the quality of referrals and ensuring pre referral investigations are completed. Plans to re-review the Urology and Dermatology forms • Patients tracked bi-weekly, escalation process in place and weekly huddle meetings for each tumour type to ensure early sight of issues and improve communication • Performance reviewed in weekly Access meetings. All services are working on improvements • Patient-level scrutiny for all long waiters during the weekly Cancer Long Waiters' meeting has resulted in a reduction in long waiters. Long Waiters Reviews now beginning at 40 days across all specialties • Plans in place for every patient >100 – service and clinical lead for each service to own these plans and will be monitored against these separately to reduce this number **PAH** • PAH 62 day backlog has significantly improved during June, July and August. As of 20/8/23 the gap to year end plan is 44 patients • Majority of theatre lists, outpatients and MDTs maintained during industrial action Prioritisation and rebooking of the small number cancelled • Urology and Lower GI recruitment underway following receipt of Cancer Alliance funding • MDT tracker / coordinator recruitment - full establishment once final recruit starts 2/10/23 • Super PTL days is in place to target booking and validation on a service by service basis • Ongoing demand / capacity / planning analysis across all tumour sites and diagnostics	**ENHT** • Additional case per list being added to TP biopsy lists • Additional colonoscopy capacity is being sought from the independent sector • Seeking funding to replace obsolete LINAC machines which are less reliable than newer models **WHTH** • All patients who are treated after Day 62 will be subject to a Clinical Harm Review • Clinical review is requested by MDT trackers as they track patients and escalated as necessary using new escalation process. Any patient found to have cancer will be subject to a clinical harm review after treatment • The Dermatology service are putting on additional clinics where possible and seeking to increase the workforce to address the issues. Referrals are being reviewed as they come in to ensure that those clinically urgent are prioritised and not delayed **PAH** • System support and oversight in place, with Cancer Alliance & NHSE attendance • Cancer "Real-time" Harm Review process • Safety netting in place to review any patient cohorts remaining on PTL inappropriately

Performance v. 23/24 Operational Plans

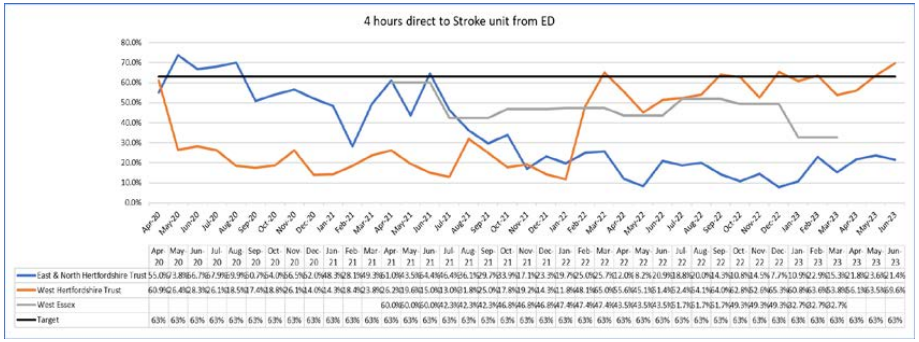


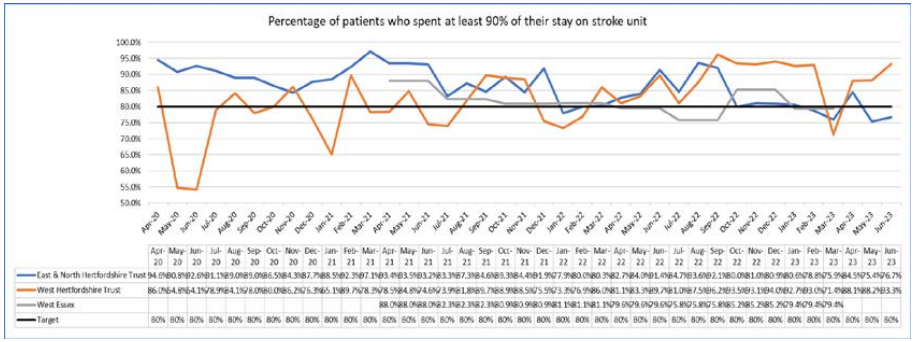


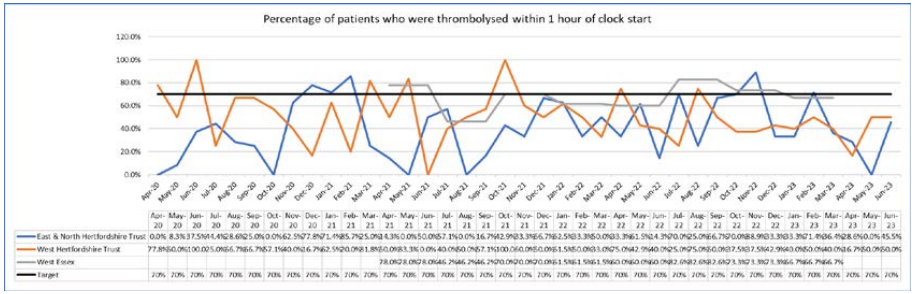
ICB Issues and escalations

- 65 week and 62 day cancer recovery continues to be impacted by the ongoing Junior Doctor and Consultant Industrial Action
- 65 week backlog recovery was just on plan in June, but will be off trajectory from July. As of 13th August the latest unvalidated position is 3278
- Cancer 62 day backlogs improved in June and July but are not meeting trajectory. As of 13th August, the latest unvalidated 62 day backlog is 496

Stroke







ICB Issues, escalation and next steps

West Essex: Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for WE patients, reported quarterly via SSNAP. BHRT overall 22/23 Q4 SSNAP rating is C. At the time of writing 23/24 Q1 is yet to be published

- Pre-hospital Stroke Video Assessment pilot: Ambulance crews suspecting a stroke can call a consultant directly via ipad to support the most appropriate / timely next steps. Project evaluation due August 23
- Stroke Association contract extended to March 25 to allow for broader review across HWE and alignment of contracts
- ICB Squire bid £13K, 0.2wte successful for CLCH and HCT nominated staff to complete a gap analysis of community across the ICB. Work being progressed through NHSE led Task & Finish groups
- Catalyst funding bid £183K successful to pilot the implementation of vocational rehab. EPUT are the lead provider across the ICB. Final specification of the service to be worked through with the staff recruited

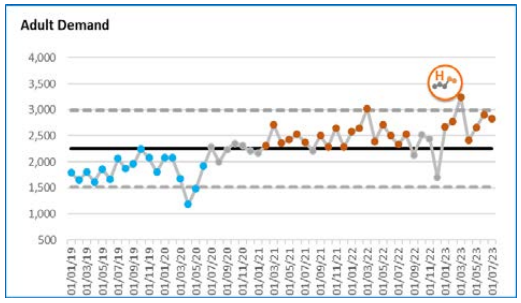
ENH

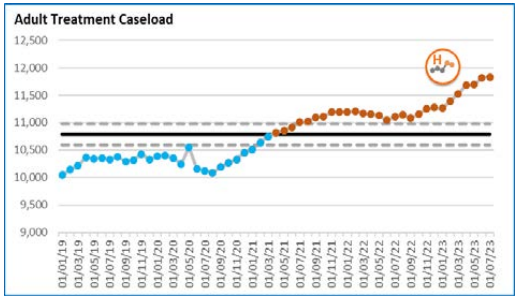
- The ENHT SSNAP performance for Q4 FY2223 remained as a D rating
- In Jun-23, 76.7% of stroke patients at ENHT spent 90% of their stay on a stroke unit. This is below the national standard of 80%. Four ring-fenced stroke beds remain in place
- In Jun-23, only 21.4% of patients met the 4 hours direct to stroke unit from ED target. To address this, out-of-hours medical clerking has been strengthened with allocated support from the medical on call team. In hours, subject to bed capacity, patients are taken direct from ED to the stroke unit and clerking takes place on the ward by Stroke on-call team.
- In Jun-23, 45.5% of eligible patients were thrombolysed within 1 hour of arrival in ED. EEAST and the stroke team are working to improve communication to support crews on site and awareness of patients attending ED. Specific roles have been implemented to improve the thrombolysis pathway across ED and Stroke
- There are ongoing challenges with the percentage of patients seen by a dietician. Escalation process are being followed and an action plan has been developed to improve performance

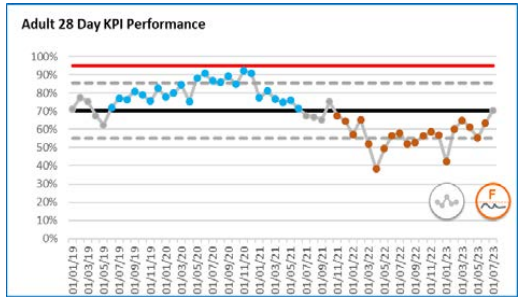
S&W Herts

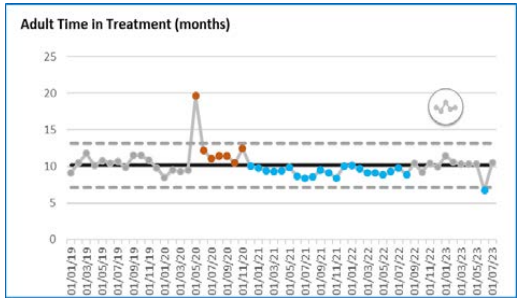
- SSNAP performance is at WHTHT is at a B rating (22/23 Q4) which is attributed to continued pressures on the system as a whole, ongoing the therapy workforce
- The % thrombolysed within 1 hour of clock start not meeting the one-hour target is most often due to delays in telemedicine/out of hours consultation or the need for CT perfusion
- Performance remains below standard (90%) at for 4 hours direct to stroke unit from ED. Although above the local WHTHT standard of 60% and reflects a sustained return to pre covid performance. Patients receive stroke consultant input for their care while waiting for admission to the stroke unit
- ESD performance continues to be impacted by increased referrals and workforce issues, current wait times for ESD is around 14 days. Patients are contacted on referral, assessed, prioritised, and informed about how to access alternative support and self-manage while they are waiting to be seen
- Rehabilitation Gym in WHTHT continues to be used as a bed occupancy surge area, which impacts gym usage which impacts on patient dependency along the whole pathway
- New Nurse Consultant post to be introduced as Medical Consultant vacancies remain. (1.5WTE vacant)
- Trust NOSIP (National Optimal Stroke Imaging Pathway) action plan in place overseen by the ISDN NOSIP Team, aimed at improving access to scanning and efficiency in reporting

Mental Health – Adult Services



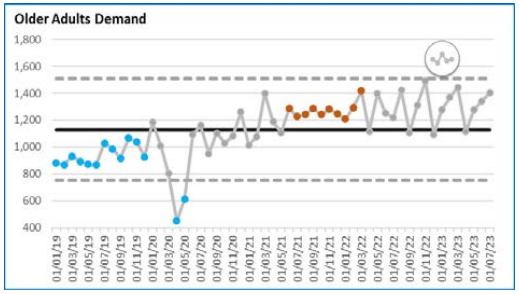


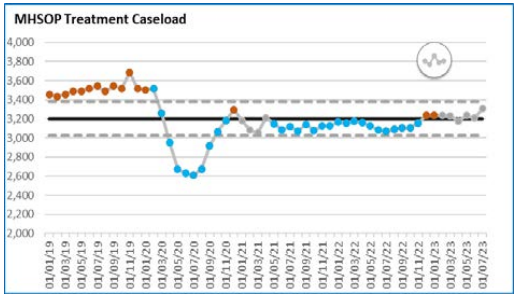


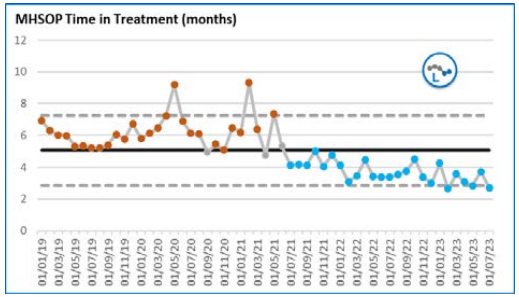


ICB Area	What the charts tell us	Issues	Actions	Mitigation
Adult Community Mental Health Services Herts & West Essex	Referral demand remains high across the ICS. The caseload in community services continues to increase in Herts but remains stable in West Essex. The time it takes from referral to assessment has increased in line with high referral volumes and caseloads in Herts. The target for carrying out initial assessments within 28 days of referral is not met; delayed recovery in southwest herts due to continued difficulties in recruitment. EPUT continue to meet the 28 day target. Overall time spent on treatment pathways remains stable.	Across the ICS, sustained high demand continues, impacting on waiting lists for initial assessments in Herts. Despite good recovery in other parts of Herts, recovery in southwest quadrant is delayed due to significant issues in recruiting to vacancies and increased demand. Increased referrals for adult ADHD diagnosis impacting on capacity which is a recognised trend across the NHS.	Additional assessments slots being provided weekly, including out of hours clinics. Continue to use agency resources to improve capacity. Recruitment deep dive into areas most challenged with access. Additional admin support to community MH teams in Herts. Demand and capacity review being undertaken in Herts as part of the community transformation programme. ADHD review is ongoing with commissioners with a view to provide a proposal to address increased demand. HPFT is implementing digital solution to support initial assessments. Focus on effective and efficient triage to increase the numbers of people being signposted to more appropriate services from SPA, rather than being signposted following initial assessment. Deep dive informed by CQI principles into key drivers and actions for Southwest ACMHS to recover and improve within 6 months.	Robust waiting list management and risk management protocols in place with daily and weekly reviews. Recovery of performance in the Herts southwest quadrant is expected in Quarter 3, however, increased referrals and ability to recruit to vacancies present a risk to recovery.

Mental Health – Older Adults Services

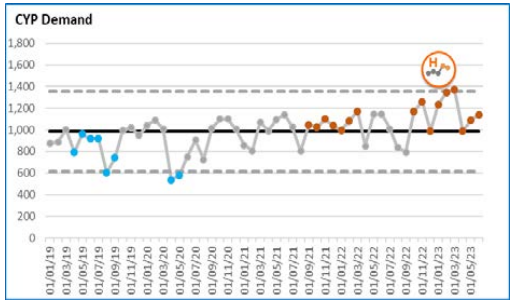


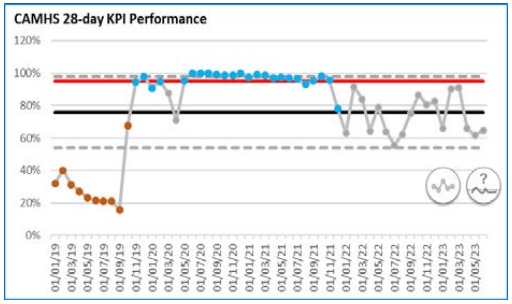


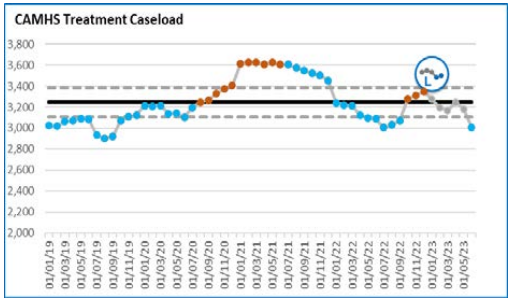


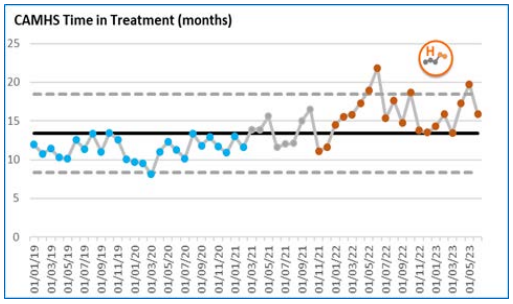
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Older Adult Community Mental Health Services Herts & West Essex	Demand has stabilised for a number of months at a higher level across the ICS, however random variation continues. Caseloads continue to be stable. Hertfordshire performance against providing a diagnosis within 12 weeks referral remains below target in Herts, but performance has improved significantly. Overall time spent on treatment pathways has improved. West Essex continues to meet 6 week to dementia diagnosis appointment ambition. in addition to early identification via the new Mild Cognitive Impairment (MCI) pathway.	In Herts pressure from the backlog of diagnosis continues. Recruitment to vacancies continues to be a significant issue across the ICS. In Herts demand for dementia diagnosis remains high. There is still a significant waiting list for dementia diagnosis but it is gradually decreasing in line with the recovery trajectory.	A recovery plan remains in place in Herts, which includes providing additional clinic appointments and primary care diagnoses from nurses. MD led recovery programme continues with fortnightly planning meetings in Herts and weekly reports on progress. A primary care transformation plan is underway to diagnose more people in primary care in Herts. This will go through the coproduction board and the dementia strategy workstream.	Risk review and prioritisation for service users who have been waiting. Additional clinics for evening and weekends to improve waiting times.

Mental Health – CAMHS Services



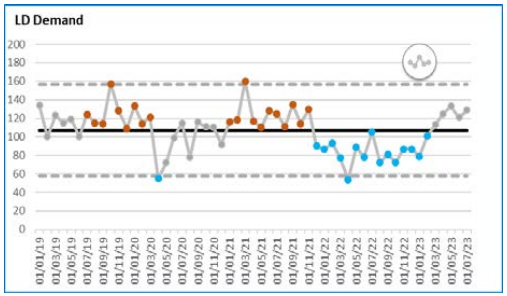


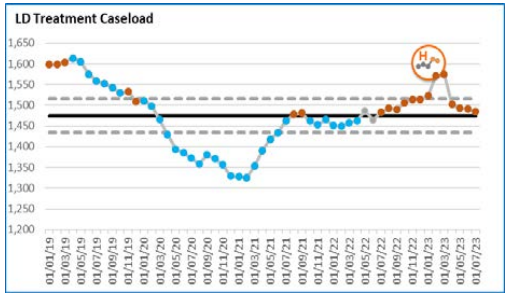


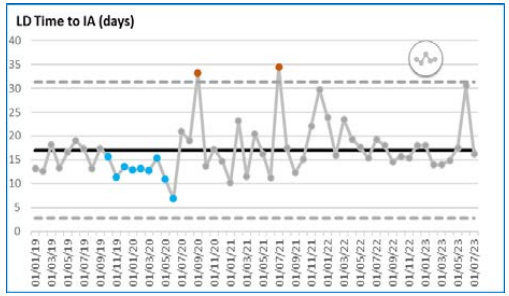


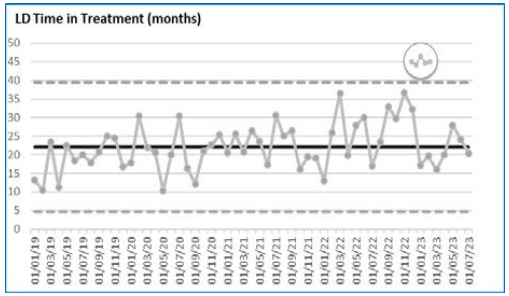
ICB Area	What the charts tell us	Issues	Actions	Mitigation
CAMHS Herts and West Essex. The CAMHS 28 day KPI Performance target relates to Herts only	CAMHS referrals received into the Single Point of Access (SPA) were high at the end of 2022/23, and although a reduction was seen in April demand remains significant. 28 days from referral to initial assessment target in Herts remains below target. Although West Essex does not have a KPI for 28 day, this is being monitored in contract management meetings. Treatment caseloads show early signs of improvement and time in treatment continues to remain high.	Some services in West Essex & Hertfordshire have seen unexpected demand (e.g. Specialist CAMHS ED, Crisis, and Children Looked After) in recent months. Although these have now recovered. Active issue regarding recruitment to vacancies across Herts and West Essex impacting on capacity and performance. There has been successful recruitment in West Essex CAMHS, but will take time for the post to start and embed within the service to have an impact. Service remains under business continuity. East quadrant in Herts continues to have significant vacancies impacting on performance which is an area of focus.	Ongoing focus on recruitment and retention in both HPFT/NELFT, including recruitment incentives in NELFT. Weekly recovery meeting led by MD in Herts to monitor East and Southwest Quadrant progress, including cover and replacement for current vacancies and job planning for individual care professionals.	SPA Triage Tool improved to meet 5 day pass on to teams target in Herts. Ongoing job planning in all quadrants to ensure qualitative approach in Herts. Caseload and resource management across quadrants to support areas under pressure in Herts. Hertfordshire recovery for referral to assessment times to 28 days expected at the end of Q4 2023/24. However the ability to recruit to vacancies continues to present a risk to recovery. West Essex business continuity arrangements are expected to be lifted following recruitment to senior clinical roles.

Mental Health – Learning Disabilities Services









ICB Area	What the charts tell us	Issues	Actions	Mitigation
Learning Disabilities Service Herts and West Essex for demand and caseload LD services are 18+ years and includes those with a learning disability who may have a diagnosis of Autism	Referrals remain stable, and caseloads are reducing following a spike last winter. Service Users are seen consistently within 28 days of referral. As part of the North Essex services which includes west Essex – 97.3% of patients started treatment within 18 weeks. Time in treatment is subject to common cause variance. Within the LD&F Care Group there is a wide range of treatment times ranging from many years to a few days.	Frailty is a very clear area of focus, particularly on interactions between mental and physical health needs for our LD care group and the associated reasonable adjustments based on the outcome of LeDeR reviews and find. Quality of annual health checks needs ongoing improvements including having consistent health actions plans for adequate follow up. Increase in referrals to LD services for adults in Q1 – Essex Wide. June saw 26 referrals compared to 10 received in April – although 5 related to West Essex and nearly half being North East Essex, the referral numbers from other areas impacts on services overall.	Service user and carer engagement and involvement programme continues aimed at improving care planning, service delivery and outcomes for LD service users across Herts and Essex. Enhanced physical health clinics, health co-ordination. Increased working relations with primary care leads to support GP practices with annual health checks. Review of Essex services with system partners across all age and identify wider impact at place.	Continuing work with commissioners to ensure that GPs are aware and know how to refer directly into LD services.

Mental Health – Learning Disability (LD) Health Checks

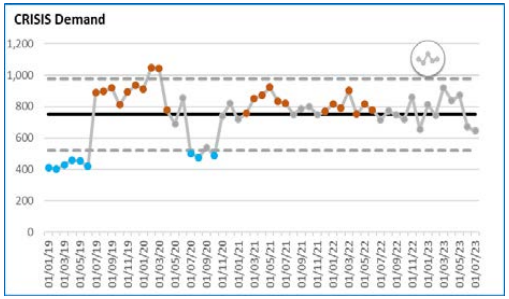
LD Health Checks June 2023	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to June 2022
NHS Hertfordshire and West Essex ICB	**7,351**	**728**	**19**	**6,604**	**9.9%**	**11.6%**
East & North Hertfordshire	3,026	335	9	2,682	**11.1%**	**13.4%**
South & West Hertfordshire	3,254	271	6	2,977	**8.3%**	**9.9%**
West Essex	1,071	122	4	945	**11.4%**	**11.5%**

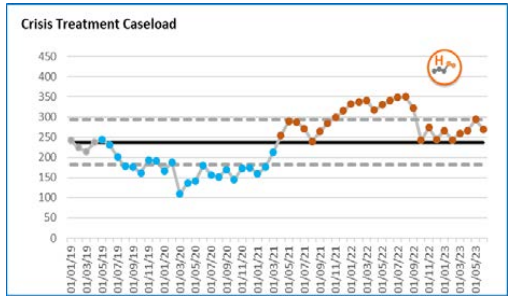
*** 75% Year End Target**

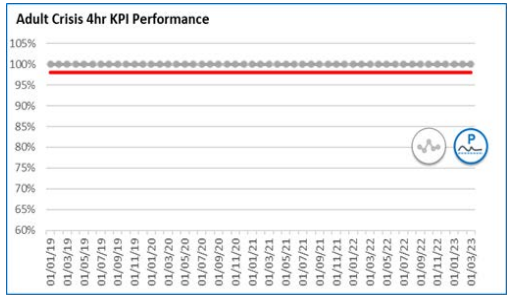
- It is challenging to forecast end of year performance against the 75% LD Health Checks standard, as a large proportion of health checks are carried out towards the end of the year, and particularly in Quarter 4

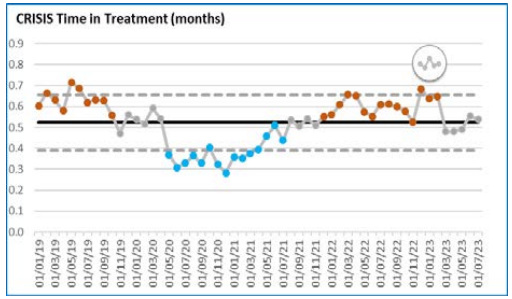
- At June 2023, all three Places are slightly behind their equivalent 2022 positions

Mental Health – Crisis Services



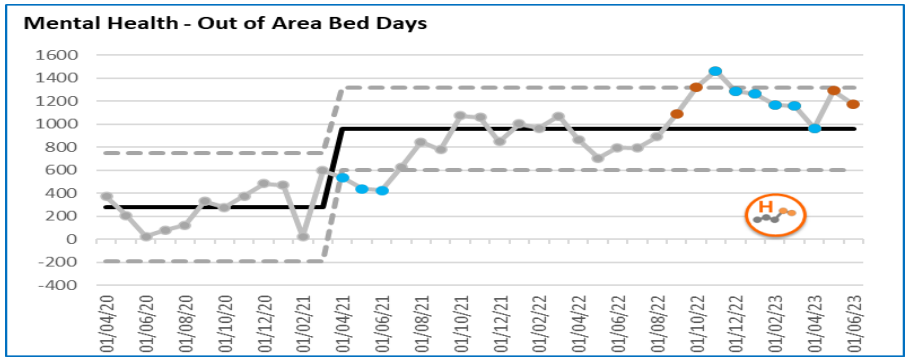


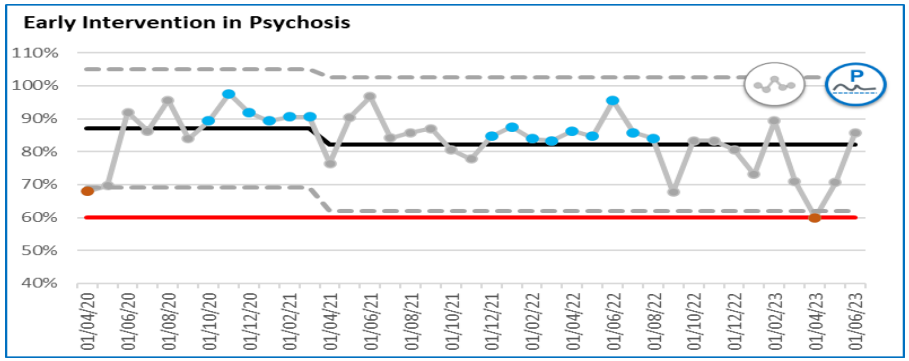




ICB Area	What the charts tell us	Issues	Actions	Mitigation
Crisis Services – Adults and Older Adults West Essex data included in Demand and Time in Treatment charts only chart only. Addition of the remaining data is being worked on	Crisis demand remains high against historical baselines, but remains stable. Caseloads are now stabilising, but remain higher than historical levels. May and June performance on 4 hour waiting time standard is not available whilst the service migrates from manual recording to electronic recording against the new national 4 hour and 24 hour waiting time standards. The average time under caseload management in the Crisis and Home Treatment Team is 1 month.	Recruitment to vacancies continues to be a significant issue across the ICS. HPFT Crisis teams are currently using manual process for recording and reporting against the contractual four-hour response target. Last reporting above is from March 23. The service is migrating to electronic recording and reporting of the activity in line with the new 4 hour and 24 hour waiting time standards. Reporting will resume with August data. Increasing footfall into PAH ED for those in MH crisis (both Herts and Essex residents), however usage of West Essex 24/7 crisis line has dipped.	Ongoing focus on recruitment to vacancies and retention of existing staff. Development and implementation of a digital solution in HPFT to improve efficiency and quality of the reporting against the new waiting time standards. Review of community mental health caseloads to improve flow. ICB wide communications piece to be developed to promote 24/7 crisis lines (through NHS 111 for public and dedicated professionals lines).	Continue to identify DTCs on crisis caseload. Ongoing monitoring and MDT discussion to identify treatment pathway, discharge plan and PDDs.

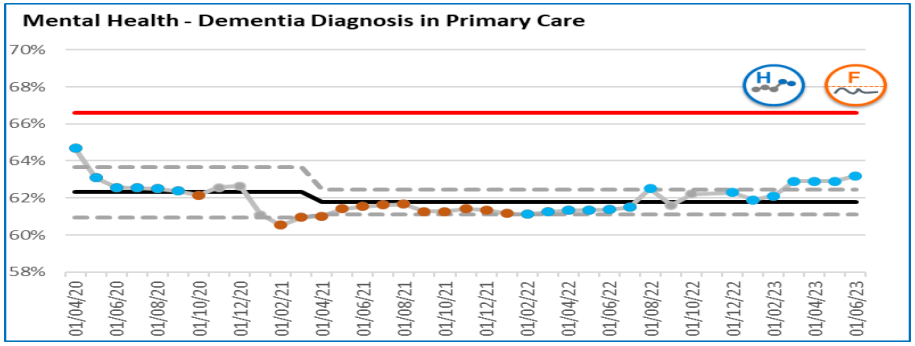
Mental Health – Out of Area Bed Days and Early Intervention in Psychosis (EIP)

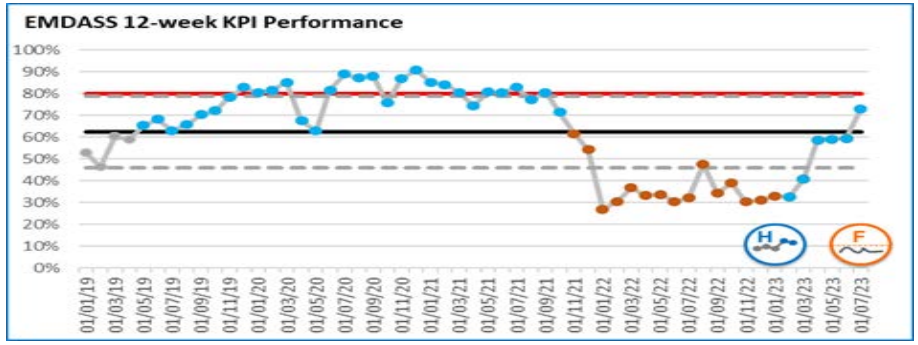




ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex	• Higher than historic use of OOA beds from April through to June. Likely to continue through peak summer	• A national shortage of MH beds and use of OOA beds very likely to continue	• Review of Essex bed stock continues with system partners • Further development of the new Accommodation Pathway contract • Review of West Essex Community Rehab requirements	• Out of Area Placement (OOAP) Elimination & Sustainability Impact System Group (Essex wide) in place to monitor the impact of the NHSE OOAP Action Plan • Continued engagement with national Getting It Right First Time (GIRFT) programme to identify areas of improvement • Bed management system being deployed in Herts and new arrangements in place to monitor demand and capacity
Herts	• Out of Area Bed Days reduced from the peak in November 22, but has seen an increase in May and June	• Demand in June exceeded capacity • Low number of beds per population • A national shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Challenges finding suitable placements for service users with complex needs who are clinically ready for discharge • Inpatient and Community recruitment	• Daily OOAP reviews / dedicated clinical ownership for OAP • Gatekeeping process; on call gatekeeping consultant and clear reasons for admissions • Consultant-led bed management meetings 3 per day, 5 days per week • COO sign-off for all out of area placements introduced • Introduction of Enhanced Discharge Team, dedicated to supporting discharge pathways • Review DTCs and plan discharges with ongoing MADE type events • Block beds in place to improve flow across the system • Enhanced community offers for rehab and assertive outreach • Introducing further alternatives to admission – Crisis House	
EIP	• Performance achieved above the national target within Herts	• No specific issues	• Ongoing monitoring	• Consistently compliant • SWH performance was recovered to 67% in May

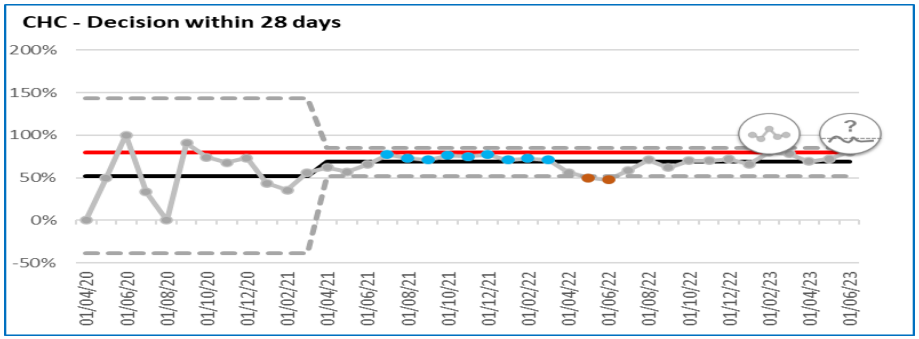
Mental Health – Dementia Diagnosis in Primary Care & Herts EMDASS Service

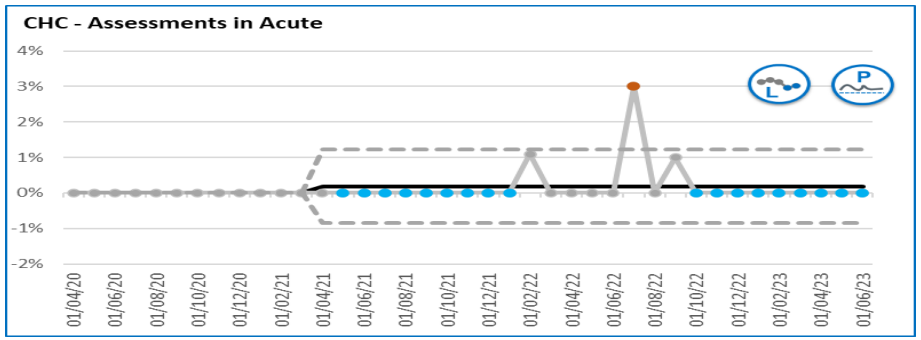




ICB Area	What the charts tell us	Issues	Actions	Mitigation
Dementia Diagnosis in Primary Care **&** **Herts EMDASS Service**	• As at June 2023 the Dementia Diagnosis rate for Herts was 61.4%, 8946 people aged 65 and over diagnosed with dementia out of an estimated prevalence of 14566.7. • The estimated prevalence rate of people with dementia increases month on month - constant growth. • The dementia diagnosis rate for Herts is steadily increasing. • West Essex is consistently achieving the national target	**Herts:** • There is still a significant waiting list for dementia diagnosis but it is gradually going down. • Issue with the quality of referrals from GPs to SPA & EMDASS which causes delays. • The above issue has impacted on the many referrals waiting in SPA to be triaged. • System reliance on diagnosis by consultants in secondary service (EMDASS). Need to diagnose more in primary care • Quality of the referrals from GPs to SPA & EMDASS need improvement.	**Dementia Diagnosis Herts:** • A recovery plan remains in place which includes providing additional clinic appointments and primary care diagnoses. • Weekly MD led meetings continue to monitor progress. A weekly performance report is produced. • A Primary Care Transformation plan is underway to diagnose more people in primary care. This will go through the Coproduction Board and the Dementia Strategy workstreams.	**Herts:** • Herts EMDASS recovery expected in Q3 2023/24 remains on track.

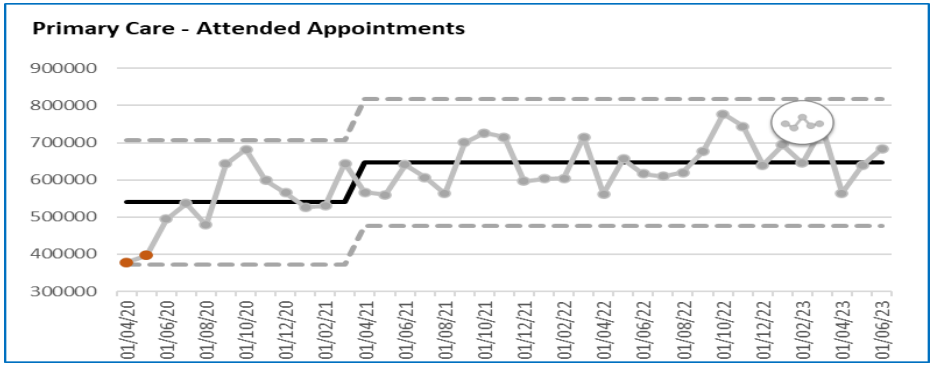
Continuing Health Care (CHC)

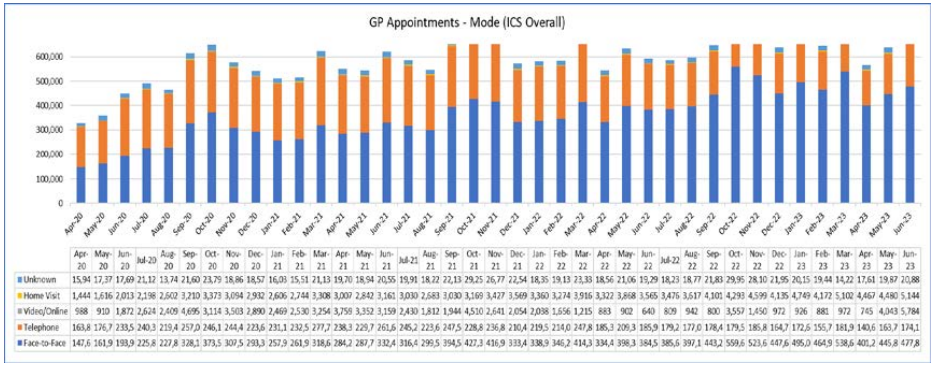




ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Continued compliance with the 28 day assessment standard • Zero assessments in an acute setting	• Ongoing increasing backlog of CHC, FT and FNC reviews due to prioritising new assessments and D2As. New reviews project paused due to number of D2A assessments coming through. New nurse has started and will help with this backlog as they become more confident	• The West Essex CHC Team continues to work alongside EPUT to provide additional resource and support • Mentorship for new staff in role • Weekly tracking of 28 day assessment ongoing. EPUT full engaged with this process	• SWH action plan in place, supported by NHSE- improving • Performance standards continue to be monitored, issues escalated and risks mitigated • Agency cover reducing • Setting trajectory and drive on clearing cases over 28 days
South West Herts / WHTHT	• Performance against decisions within 28 days significantly improved, however target not yet being met • Zero assessments in an acute setting	• Workforce improving. Majority of band 6 Nurse Assessors are now substantive- however are junior in role • Ongoing backlog of CHC & FNC reviews due to prioritising new DSTs and checklist completion • Referrals numbers continue to be high which impact on 28 day performance	• Ongoing recruitment and prioritisation of fast track and 1:1 reviews • Allocation and weekly tracking of 28 day assessments remains a priority • Case management in place for all cases over 6 weeks • Collaborative working with system partners; weekly meetings • Timely decision making panels, verification & monitoring of recommendations • Focus on checklist completion, resulting in backlog reducing	
East & North Herts / ENHT	• 28 day standard compliance continues • Zero assessments in an acute setting	• Workforce issues such as sickness and annual leave • Ongoing delays continue receiving signed assessment paperwork from community, particularly Mental Health, may impact performance going forward	• Weekly tracking of referrals over 28 days by caseload and CHC manager • 28 day case backlog reducing- expected to meet target by end of quarter	

Primary Care





ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• Total appointments are variable but fluctuate within common cause variation limits • The proportion of face to face appointments is steady at just over 70% since Q3 2022/23. There is however variation at practice level • Data does not include appointments delivered at hub sites as part of Extended Access	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • Significant pressure from Respiratory illness • Rapid increase in 'spot booking' hotels • New 23/24 contractual requirement for an offer of assessment, an appointment, signposting to occur when the patient contacts the practice	• Data sets shared with practices / PCNs via Ardens and developing patient questionnaires to support analysis • Continue to implement offsite storage of notes • Access dashboard now available and used by MDT group – updated regularly and available to PCNs via Teams shared work space • Offer of 3m extension for to achieve QOF targets to recognise prioritisation of on the day demand over winter • Engagement with the National Access Recovery Plan including: • Cloud Based Telephony transition support – 28 practices identified as high priority as still using analogue systems • National GP Improvement Programme (NGPIP) o Webinars re 5 key priority areas. Advice on making practical changes and improvements in general practice o Intermediate/Intensive/Hands On facilitated support. Place teams encouraging practice & PCN engagement o Care navigation training: each practice can nominate one member of staff for training – details awaited • Support Level Framework (SLF) o Self assessment tool delivered through a facilitated conversation with members of the practice team to support in gaining an understanding of what they do well, what they might wish to do better, and where they might benefit from development support. Aim for all practices to have had a facilitated discussion using the SLF during the year • Transformation support funding o Indicative £13.5k per qualifying practice. ICB offer sent to all practices setting out requirements to access this funding • Other o Comms. to support ICB and practice websites, media statements and patient comms re the Delivery Plan o Attendance at NHSE regional weekly drop-in sessions to escalate any issues or questions for clarification • All PCNs supported by place teams to develop their Access plans, to be submitted to the ICB for review	• ECF reviewed and streamlined for 23/24 • Trend analysis to identify individual practices with poor access via complaints and patient contacts • PCCC and Primary Care Board oversight of the GPPS results, and action plan developed through the Access MDT Group • Recruitment & Retention of Primary Care Workforce. Initiatives for Primary Care Workforce to support recruitment and retention which are supported by the HSE ICB Training Hub • Continued funding for spot booking hotels for health checks and MDT site visits agreed by PCCC at the February meeting • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices continuing • Continued work to promote use of the Community Pharmacy Consultation Service (CPCS) • Oversight of all Access plans as submitted and sharing of best practice across the ICB

Appendix A – Performance Dashboard

June 2023

Area	Activity	Target	Herts & West Essex ICS (Commissioner) Latest published data	Data published	Trend *1	Variation	Assurance	NATIONAL position (ICB vs National)	REGIONAL position (ICB vs EoE Region)	ICB Ranking	ICS Aggregate Provider	Trend *1	Individual Trust ENHT	Trend *1	PAH	Trend *1	WHTHT	Trend *1
111	Calls answered < 60 seconds	95%	58.0%	June 23	✓ 10.63%			60.74% (Worse)	54.81% (Better)	16th lowest	58.0%	✓ 10.63%						
	Calls abandoned after 30 seconds	5%	8.3%	June 23	✓ -27.68%			8.73% (Better)	7.85% (Better)	15th highest	8.34%	✓ -27.68%						
A&E	% Seen within 4 hours	76%	65.1%	July 23	✗ -0.092%			73.99% (Worse)	72.34% (Worse)	7th lowest	65.08%	✗ -0.09%	65.16%	✓ 0.79%	55.49%	✓ 3.26%	71.30%	✗ -2.51%
	12 Hour Breaches	0	95	July 23	✓ -51.58%			23,934	2,111	11th highest	95	✓ -51.58%	3	✓ -2133.33%	92	✗ 16.30%	0	– 0.00%
Cancer	2ww All Cancer	93%	83.5%	June 23	✓ 3.70%			80.52% (Better)	72.21% (Better)	20rd highest	85.69%	✓ 4.71%	94.75%	✗ -1.03%	83.21%	✓ 15.74%	78.96%	✗ -0.35%
	2ww Breast Symptoms	93%	92.9%	June 23	✓ 0.83%			74.75% (Better)	66.88% (Better)	4th highest	94.12%	✓ 1.67%	98.84%	✓ 7.03%	89.09%	✗ -0.33%	95.28%	✗ -1.07%
	31 day First	96%	93.9%	June 23	✗ -1.26%			91.35% (Better)	91.66% (Better)	11th highest	94.62%	✗ -1.72%	96.20%	✓ 2.06%	87.04%	✗ -10.30%	97.02%	✗ -2.44%
	31 day Sub Surgery	94%	89.7%	June 23	✓ 3.40%			79.05% (Better)	77.39% (Better)	6th highest	93.42%	✓ 5.19%	91.30%	✓ 3.21%	80%	– 0.00%	100%	✓ 5.88%
	31 day Sub Drug	98%	98.5%	June 23	✗ -0.99%			97.98% (Better)	96.57% (Better)	20th lowest	99.57%	✗ -0.43%	100%	– 0.00%	96.67%	✗ -3.45%	100%	– 0.00%
	31 day Sub Radiotherapy	94%	73.3%	June 23	✓ 3.44%			86.63% (Worse)	87.20% (Worse)	6th lowest	65.73%	✓ 7.99%	65.73%	✓ 7.99%	N/A		N/A	
	62 day First	85%	61.7%	June 23	✗ -7.26%			59.24% (Better)	56.48% (Better)	16th highest	64.65%	✗ -6.34%	81.71%	✗ -6.28%	40.29%	✗ -8.74%	60%	✓ 1.96%
	62 day Screening	90%	71.4%	June 23	✓ 34.12%			62.23% (Better)	68.91% (Better)	8th highest	74.14%	✓ 26.43%	90.91%	✓ 42.38%	42.86%	✗ -3.70%	77.27%	✓ 16.81%
	62 day Upgrade	85%	69.3%	June 23	✓ 7.82%			72.88% (Worse)	69.94% (Worse)	15th lowest	72.59%	✓ 9.92%	77.42%	✓ 10.37%	66.25%	✓ 9.43%	76.36%	✓ 11.29%
	28 days Faster Diagnosis	75%	73.9%	June 23	✓ 7.15%			73.49% (Better)	68.72% (Better)	17th highest	75.24%	✓ 7.76%	76.44%	✓ 9.41%	74.68%	✓ 4.72%	74.83%	✓ 9.10%
RTT	Incomplete Pathways <18 weeks	92%	56.3%	June 23	✗ -1.05%			59.2% (Worse)	55.7% (Better)	14th lowest	52.76%	✗ -0.91%	49.83%	✗ -0.11%	53.48%	✓ 1.25%	55.49%	✗ -2.79%
	52 weeks	0	12,602	June 23	✗ 0.91%			383,083	57,240	6th lowest	10,184	✗ 3.33%	5,400	✗ 1.70%	2,280	✗ 7.98%	2,504	✗ 2.60%
	65 weeks	0	3,557	June 23	✗ 2.14%			97,275	14,788	6th lowest	3,013	✗ 6.01%	1,673	✗ 3.11%	816	✗ 13.36%	524	✗ 3.82%
	78 weeks	0	567	June 23	✗ 2.47%			7,177	1,364	2nd lowest	597	✗ 3.18%	553	✗ 3.80%	37	– 0.00%	7	✓ -28.57%
Diagnostics	6 week wait	5%	31.1%	June 23	✓ -4.89%			25.16% (Worse)	28.01% (Worse)	16th lowest	33.59%	✓ -6.08%	39.68%	✓ -5.39%	32.72%	✓ -4.55%	23.96%	✓ -10.48%

Area	Metric	Target	Herts & West Essex ICS (Commissioner) Latest published data	Data published	Trend *1	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking	ICS Aggregate Provider	Trend	Individual CCGs East & North Herts	Trend *1	South & West Herts	Trend *1	West Essex	Trend *1
111	Calls answered < 60 seconds	95%	58.0%	June 23	✓ 10.63%			60.74% (Worse)	54.81% (Better)	16th lowest	N/A		57.98%	✓ 9.94%			58.28%	✓ 13.48%
	Calls abandoned after 30 seconds	5%	8.3%	June 23	✓ -27.68%			8.73% (Better)	7.85% (Better)	15th highest			8.24%	✓ -24.94%			8.75%	✓ -38.05%
Mental Health	Dementia Diagnosis rate	66.6%	63.2%	July 23	✓ 0.50%			63.5% (Worse)	61.3% (Better)	19th lowest			61.31%	✓ 1.07%	61.51%	✓ 0.37%	69.85%	✗ -0.17%
	OOA placements	0	1,171	June 23	✓ -10.33%			n/a	n/a	n/a			938	✓ -4.48%			233	✓ -33.91%
CHC	% of eligibility decisions made within 28 days	80%	80.3%	June 23	✓ 10.22%			73.94% (Better) *2	79.42% (Better) *2	16th lowest *2			82.14%	✗ -5.29%	73.58%	✓ 16.15%	87.88%	✗ -3.90%
	% of assessments carried out in acute	15%	0.0%	June 23	– 0.00%			n/a	n/a	n/a			0%	– 0.00%	0%	– 0.00%	0%	– 0.00%

LEGEND On/above target | Below target | ✓ Improvement on previous month's performance | ✗ Decrease on previous month's performance | – No change on previous month's performance

Appendix B: HWE Adult Community Services

Elective & Specialist	E&NH	S&WH	West Essex
Cardiac Rehab	HCT/ENHT	CLCH	EPUT
Diabetes	HCT	HCT	EPUT
Continence services	HCT	CLCH	EPUT
Nutrition and Dietetic Service	HCT	HCT	EPUT
Speech and language therapy	HCT	CLCH	EPUT
Podiatry	HCT	CLCH	EPUT
Specialist palliative care	HCT	CLCH	EPUT
Heart failure service	-	CLCH	EPUT
Lymphoedema	HCT	CLCH	HCT
Tissue Viability	HCT	CLCH	EPUT
Leg Ulcer	HCT	CLCH (Herts one)	EPUT
Respiratory	HCT/ENHT	CLCH/WHHT	EPUT
MSK	HCT	Connect	EPUT
Chronic pain management	HCT	Connect	EPUT
Community Neuro/rehab	HCT	CLCH	PD/MS only
Pulmonary Rehab	HCT	CLCH	EPUT
Specialist Dentistry	HCT	HCT	-
Community Dermatology	HCT	-	GP Fed
Community ENT	-	Communitas	-
Community Gynaecology	-	The Gynaecology partnership	-
Long Covid	HCT	CLCH	EPUT
Diabetes eye screening	ENHT	HCT	Health intelligence Ltd
Sexual Health Services	CLCH	CLCH	Provide

Urgent & Emergency Services	E&NH	S&WH	West Essex
2 hour urgent response	HCT	CLCH	EPUT
Hospital at home/rapid response	HCT	CLCH	EPUT
Discharge to assess (at home)	HCT	CLCH	EPUT
Virtual ward/hospital	HCT	CLCH/WHHT	EPUT
Inpatient rehab beds	HCT	CLCH	EPUT
Inpatient stroke Neuro rehab beds	HCT	CLCH	EPUT
Respiratory services	HCT	CLCH	EPUT
Stroke (Early supported discharge)	HCT	CLCH	EPUT
Neuro ESD (NETT)	-	CLCH	-

Core community Services	E&NH	S&WH	West Essex
District Nursing	HCT	CLCH	EPUT
Community therapies (OT/PT)	HCT	CLCH	EPUT
Frailty clinics	HCT	CLCH	PAH
Enhanced health in care homes	HCT	CLCH	EPUT

Appendix B: HWE Children's Community Services

Children's Services within Hertfordshire and West Essex ICS is complex with a range of existing governance forums and a broad range of services provided primarily by NHS Trusts, but with a number of independent and 3rd sector organisations

Service	E&NH	S&WH	West Essex
ADHD	ENHT	HPFT	HCRG
Advocacy	KIDS	KIDS	Rethink / Open Door
Allergy	ENHT	WHHT	HCRG / PAH
ASD	ENHT	HCT	HCRG
Asthma Nurse specialist	n/a	HCT	To be established
Audiology	ENHT	HCT	PAH
Wellbeing Practitioners	HCT	HCT	HCRG
CHIS	HCT	HCT	Provide
Com. Nursing	ENHT	HCT	HCRG
Comm Paeds	ENHT	HCT	HCRG
Continence	n/a	HCT	HCRG
Continuing Care	ENHT	HCT	HCRG & Various Independent
CSAIS	EPUT (s/c HCT)	EPUT (s/c HCT)	EPUT
CYP Counselling	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT
CYP Therapies	HCT	HCT	HCRG (SLT inclusive of dysphagia, PT inclusive of MSK)
Designated Medical Officer for SEND	ENHT	HCT	HCRG
Diabetes Nurse Specialist	ENHT	WHHT	PAH
Dietetics	HCT	HCT	HCRG / PAH
Eating Disorders	HPFT	HPFT	NELFT / BEAT
Epilepsy Nurse Specialist	ENHT	WHHT	PAH
Equipment	HCT	HCT	EPUT
Eye Care	ENHT	HCT/WHHT	PAH

Service	E&NH	S&WH	West Essex
Family Hubs/Children's Centres	Family Centre Services/Family Support Services/ HCT	Family Centre Services/Family Support Services/ HCT	HCRG
Health Visiting	HCT	HCT	HCRG
Hospice Care	Keech	Keech/Noah's Arc/ Rennie Grove	Haven House, EACH
Infant Mental Health	HCT	HCT	EPUT
LAC	HCT	HCT	HCRG
Lymphoedema	HCT	n/a	HCT
Mental Health Support Teams	HPFT/HCT	HPFT/HCT	West Essex Mind (mainstream) / HPFT (special schools)
Neuro-Rehab	Specialist commissioned	Specialist commissioned	Tadworth Children's Trust
Palliative Care Respite Service (EPIC)	Noah's Arc	Noah's Arc	Little Haven's
Palms	HCT	HCT	n/a
Parenting Support	HCC	HCC	Triple P (YCT from April)
Perinatal Mental Health	HPFT	HPFT	EPUT
School Nursing	HCT	HCT	HCRG
Sickle cell	HCT	HCT	PAH
Special care dentistry	HCT	HCT	PAH
Specialist CAMHS	ENHT	HPFT	NELFT
Specialist Healthcare Tasks	n/a	n/a	Provide
Specialist school nursing	ENHT	HCT	HCRG
Step 2 Service	JHCT	HCT	n/a
Therapeutic Health Based Coaching	n/a	n/a	NOW
Tier 4 CAMHS	HPFT	HPFT	EPUT
Transition coordinators	HCT	HCT	HCRG
Weight Management & other wellbeing services	Beezee Bodies	Henri/ Beezee Bodies	Provide

N.B. Virgin Care has now been transferred to HCRG Care Group

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	Audit and Risk Committee 10 October 2023 highlight report			**Meeting Date**	1 November 2023
Chair	Jonathan Silver – Committee Chair and Non-Executive Director				
Author	Debbie Okutubo – Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- VFM 2022/23
- Internal Audit summary internal controls assurance (SICA) report
- Internal Audit recommendation tracker
- Anti-Crime progress report
- Anti-Fraud and Bribery policy
- ENH Charitable Fund 2022/23 audit update
- ENH Pharma 2022/23 update
- Risk Report & Corporate Risk Register
- Board Assurance Framework
- Cyber Security Report
- Data Quality and Clinical Coding
- Estates and Facilities Premises Assurance Model (PAM) outcome 2022/23.

Alert:

- There is ongoing work to effectively align operational risks held on the register to the Board Assurance Framework (BAF).
- Further communication to be cascaded to the Trust highlighting work been done to dissuade fraud.

Advise:

N/A

Assurance:

- An unqualified opinion had been issued on the Trust's financial statement for the period ending 31 March 2023.

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

- An update on the data quality and clinical coding be taken to the January ARC meeting.

Items referred to the Board or a committee for a decision/action:

- The draft Estates strategy to be taken to the Board seminar in December.

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**	19
Report title	Finance Performance and Planning Committee – Highlight report 26 September 2023	**Meeting Date**	1 November 2023
Chair	Karen McConnell - Committee Chair and Non-Executive Director		
Author	Chloe Milton – Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- RTT spotlight
- Finance Report Month 5
- Trust Outturn Forecast and System position.
- Medium turn financial plan
- Business Planning 2024/25 – Process and timetable
- Productivity and ERF Report
- Costing Programme update
- CIP Programme update (Women's and Children's focused)
- Capital Programme update.
- Trust Infrastructure Development update
- Green Plan Update
- Performance Report
- Winter Planning

Alert:

- The Trust is not on track to achieve compliance with RTT 78 week waits mainly as a result of industrial action. There are continued concerns relating to community paediatrics and ophthalmology.
- The target to have a first appointment by 31/10/2023 for all 65-week waits is being actively managed and additional capacity and booking resources have been deployed. Risks remain in Community Paediatrics, Ophthalmology, ENT and Gastroenterology.
- The System faces significant financial challenges. DoFs have been working together to set out the anticipated forecast outturn position together with a range of opportunities that may deliver an improved position.

Advise:

- RTT for Community Paediatrics is being monitored separately from other RTT. Breaches of the seventy-eight week wait target stood at 678 in September. However, progress is being made despite there being no national or system wide solution to date.
- Outsourcing of Trauma and Orthopaedics has improved with the assistance of NHSE.
- Performance against the 4-hour standard was consistent with last month but patients spending more than 12 hours in the department increased.

- The forecast outturn for the Trust reflects the significant risks relating to CIP performance, medical staffing overspends, CSW forecast spend and ERF variance. Mitigating workstreams are being developed. - The reported position for month 5 includes the impact of the August industrial action. The net impact of industrial action costs, lost ERF income and increase in the fixed cost baseline is £4m adverse year to date. - Medical staffing was £0.6m adverse in month excluding the impact of industrial action. Significant hotspots are in Women's services, Childrens services, Microbiology and Orthopaedics. Work is ongoing to develop mitigations to reduce this overspend. - Overspend against CSW budget continues with a £0.2m in month overspend. The Trust have successfully recruited additional permanent CSW's over recent months but are yet to manage bank spend within the budget. A review is underway of this area. - Capital Programme was behind plan but was tightly managed from CRG. -	
Assurance:	
- At Month 5 the Trust planned for a deficit of £6.8m and the actual deficit was £6m. The year-to-date CIP performance is favourable against plan. However, the plan significantly increases in the second half of the year. The Business Planning Approach for 24/25 has been agreed. - The system has agreed to adopt the BLMK model for its MTFP. - Good progress has been made against the Green Plan	
Important Items to come back to committee:	
Items referred to the Board or a Committee for decision or action:	None.

Recommendation	The Board is asked to **NOTE** the Finance, Performance and Planning Committee report.

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	20
Report title	Quality and Safety Committee 27 September 2023 highlight report			**Meeting Date**	1 November 2023
Chair	Peter Carter – Committee Chair and Non-Executive Director				
Author	Debbie Okutubo – Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Safe, Care, Effective Report
- Ophthalmology Update
- Audiology Update
- Learning from Deaths Report
- Combined Compliance, Clinical Audit and Effectiveness Report
- Maternity Assurance Report
- Risk Management Report and Corporate Risk Register
- The Complaints/Patient Experience annual report
- Estates and Facilities Premises Assurance Model (PAM)
- Waiting Lists
- Responsible Officer/Revalidation Annual Report + Organisational Audit Report
- Escalation Reports
- Electro-Bio Medical Engineering (EBME)

Alert:

- In the Ophthalmology division, patient feedback and complaints mostly centred around waiting times.
- Paediatric audiology service was paused due to concerns relating to patient harm. However, referrals continued to be received in the service.

Advise:

N/A

Assurance:

- ENHT Maternity division was compliant with 8/10 Safety Actions from Year 4.

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

- Patients needing to go back to theatre.

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	Quality and Safety Committee 25 October 2023 highlight report		**Meeting Date**	1 November 2023
Chair	David Buckle – Committee Chair and Non-Executive Director			
Author	Debbie Okutubo – Deputy Company Secretary			
Quorate	**Yes**	☒	**No**	☐

Agenda:

- Safe, Care, Effective Report
- Maternity Assurance Report
- Board Assurance Framework
- Risk Management & Quarterly Integrated Compliance Report
- Estates and Facilities Premises Assurance Model (PAM)
- Incident and Complaints Triangulation report
- Management of complaints and concerns policy
- Escalation Reports.

Alert:

- Safety Incidents are now being manged through PSIRF

Advise:

N/A

Assurance:

- ENHT Maternity division are continuously monitoring the Stillbirth and Neonatal death rates, by means of the PMRT (perinatal mortality review tool) and provided a summary of the outcomes and actions for the second quarter of 2023/2024 (Jul-Sept) to the committee.

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

- None

Items referred to the Board or a committee for a decision/action:

- Staff training plan and delivery to be reviewed by the People Committee.

Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report.

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	21
Report title	People Committee 12 September Highlight Report	**Meeting Date**	1 November 2023
Chair	Val Moore - Committee Chair and Non-Executive Director		
Author	Chloe Milton – Committee Secretary		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- People Report
- Divisional Update, Planned Care
- EDI Strategy
- Network Update
- Learning and Development
- Resourcing
- Temporary Staffing
- Grow Together
- NHS Long Term Plan
- Board Assurance Framework

Alert:

- Statutory mandatory training has reached 90% but unfortunately this was not achieved in time for CQC.
- EDI strategy going to December Board Seminar and Board in the new year for approval.

Advise:

- Grow Together reviews had been conducted, divisional team asked for a highlighted focus for these to be completed over September.
- The People team are now analysing the modifications made to the fit and proper person check in order for a test run to commence.
- Sickness absence rates moving in a positive direction with highlighted caution on growing covid variant.
- An apprentice strategy had been developed which included a learning strategy group to work on driving apprenticeships through the trust.

Assurance:

- Staff surveys have been distributed and assurance given that staff who are off work will receive a paper copy for them to complete.

- Assurance was advised in relation to resourcing as all works are moving in a positive direction. - Learning and Development performance now measuring above average - Assurance on policies to do with restricted duty/ suspensions/ engaging the police following the recent Lucy Letby case. - No change advised to Board Assurance Framework	
Important Items to come back to committee:	- EDI strategy coming back to People Committee in November.
Items referred to the Board or a Committee for decision or action:	None.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	22
Report title	Charity Trustee Committee	**Meeting Date**	1 November 2023
Chair	David Buckle - Committee Chair and Non-Executive Director		
Author	Chloe Milton – Committee Secretary		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- Charity Finance Report
- External auditors Report
- Investment Portfolio Report
- Approvals in Excess of £5000
- Charity Highlight Report
- Mass Participation Events Preparation Report
- Major Projects update – Sunshine Appeal
- Legacy Strategy

Alert:

- Charity fundraising was 32% above budget in Month 4.
- The Sunshine project went out to tender but came back with high costs, mainly due to the high inflation level presently associated with the building industry.

Advise:

- Rathbones is in the process of acquiring Aveztec which will result in minor changes to their online systems.
- The Cancer centre has been changed to unrestricted funds.
- At the end of July the Charity's cash balance was £600k with a fund balance of £1.2m.
- Mount Vernon Cancer Centre are considering requesting an extension for the self-recovery ranger because the contract is due to end in November.
- The Charity received a £39k grant from CERA foundation.
- The committee APPROVED the following applications over £5000.

Area	Project	Cost	Funding solution	Representative
Cancer	To develop a series of information videos with specific information about the SACT pathway at both Mount Vernon Cancer Centre (MVCC) SACT unit and the Lister Macmillan Cancer Centre (LMCC)	£18,672	Karen Harrold	From a mix of designated funds, already raised

Assurance:	
N/A	
Important Items to come back to committee:	None
Items referred to the Board or a Committee for decision or action:	None

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

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Board Annual Cycle 2023-24

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework				X				X				X
Corporate Risk Register		X				X				X		
Patient/Staff Story (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		
Trust Strategy refresh and annual objectives												X
Strategy delivery report				X [previous year]						X		
Strategic transformation & digital update				X				X				X
Integrated Business Plan								X				

Board Annual Cycle 2023-24

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Annual budget/financial plan												X
Digital Strategy Update				X				X				
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)		X		X		X		X		X		X
Estates and Green Plan								X				
Workforce Race Equality Standard										X		
Workforce Disability Equality Standard										X		
Equality, Diversity and Inclusion												
Clinical and Quality Strategies												X
People Strategy										X		
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report				X								
Review of Trust Standing Orders and Standing Financial Instructions		X										
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review												X

Board Annual Cycle 2023-24

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Finance, Performance and Planning Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report				X								
Quality and Safety Committee												
Complaints, PALS and Patient Experience Annual Report						X						
Safeguarding and L.D. Annual Report (Adult and Children)								X				
Staff Survey Results		X										X
Learning from Deaths		X				X		X		X		
Nursing Establishment Review										X		
Patient Safety and Incident Report (Part 2)		X						X				
University Status Annual Report				X								
QSC TOR and Annual Review				X								
People Committee & Culture												
Workforce Plan								X				
Trust Values refresh				X								
Freedom to Speak Up Annual Report								X				
Staff Survey Results		X										
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
People Committee TOR and Annual Report								X				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X						X		