Public Trust Board

Online via Teams

10/07/2024 09:30 - 12:00

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For noting

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For noting

23.	Date of Next Meeting	Trust Chair

Wednesday, 11 September 2024

East and North Hertfordshire NHS Trust

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday, 1 May 2024 at 9.30am in Room 2 & 3 Hertford County Hospital, North Road, Hertford SG14 1LP

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

No	Item	Action
24/045	**PATIENT STORY**	

The Divisional Director of Nursing & Quality – Planned Care Division and the Deputy Divisional Director of Nursing & Quality for Cancer presented this item.

The wife of the patient narrated his story to them:

"A was 68 years old when he died and in the words of his wife he died in pain and agony following 2 years of being passed from pillar to post and appearing to fall through many holes within our NHS pathways of care.

A had a previous diagnosis of cancer but was advised to see his GP and got a face-to-face appointment in September 2021. He examined his anus and was very upset to tell us he was almost

certain it was ‘going to be bad news’ and to be prepared for the worst.

After many tests, A was seen by a CNS Bowel Cancer on the 22 October 2021 who informed them that A had bowel cancer, which had also spread to his liver and he had a node on his lung. They were informed that it was inoperable and incurable and he would need a stoma bag, that would vastly improve a quality of life – it did not!

The main issue for A was discharge from his rectum. Discharge was so severe at times that the bed required changing 3 times per week and 3 changes of clothes per day as it was worse when he stood up.

The operation went ahead in November 2021, a number of mishaps with A being sent to the wrong building at the start and having to wait for notes to arrive from the QE2 but the operation went well and he was discharged home 4 days later!

Unfortunately, due to this being during Covid although A had been assessed as competent to care for his stoma, his wife had no experience. They really struggled with A suffering with severe diarrhoea post-operatively and the only nurse they saw was on the 17 November 2021. They eventually saw another nurse at the end of November to remove stitches, who suggested they had been in too long and rather than poke around she would leave them in to ‘rot’ – which left A and his wife petrified that he was going to get sepsis.

All during this time A had no follow up appointment with the surgeon, in fact they never saw or heard from him again.

In December, A started chemotherapy – he came home a new man! A had no discharge for a couple of days, some of his strength returned and he just felt really well – so much that he attended his son’s wedding for a few hours in January 2022.

Chemo continued and improved A’s health for approx. the next year, alongside some radiotherapy. Until Jan 2023, when he went to get out of the chair one day and no feeling in his right leg and his foot was stone cold and purple. A became too unwell to attend appointments and despite many phone calls, no-one from the Macmillan cancer service rang to enquire why? No-one answered calls or messages left, no GP would come out and see A.

On the 12 March whilst A’s wife had A over her back, dragging him on his good foot to get him to the toilet, they collapsed and she could not get A up from the floor. Paramedics attended and saw how seriously ill A was and what they were doing to try and get by.

Within hours A had physio's (well they attended once, went off sick and never returned), carers and nurses turning up at the door. Equipment arrived too including a zimmer frame, a commode and eventually a hospital bed – though they never had a GP visit.

Eventually the Garden House Hospice Angels arrived and their care was amazing – starting with a daily check in and ending with 4 times per day visits to support both A and his wife.

Unfortunately, nothing got on top of A's pain from his foot, days were gruelling listening to A crying and writhing around in pain. Eventually a driver was fitted to try to manage the pain and sedate A. A nurse came to change the driver, but the prescription was incorrect and could not go into the driver. She sat up all night syringing medication into the side of A's mouth, whilst he lay in the final stages of death. At no point did anyone offer to stay with her, help her through those final hours. Once again, she was left to care for A on her own, just her and him.

Alison Paterson and I sat and listened to A's wife while she told us her and A's story, with a picture of A on the table. It was difficult to listen to how healthcare professionals had not gone the extra mile, asked a question, wanted to listen to an answer or just show some curiosity about a patient in their care. This appears to have resulted in them both falling through many holes and not receiving care and compassion that should have been available to them at this time and resulting in A not receiving the death that I would hope all of us feel every human should be allowed, a dignified one".

Members were informed that when A attended the Trust for treatment, he was probably terminally ill but that did not appear to have been explained to the family. It was during Covid which meant that the rules during the pandemic did not allow family members to attend the hospital to visit patients.

It was noted that a side effect of A's diagnosis was him having a discharge each time he stood up. This limited his movement and in time he developed vascular injuries.

His wife felt that she was unable to help him achieve a peaceful death due to her not being in the know.

A attended Lister Macmillan Cancer Centre Medical cancer centre for over a year and when he stopped attending no one asked about him.

It was explained that 'knowing your patient' was one of the initiatives being put in place at the cancer centre and staff were encouraged to be curious about their patients. Due to staff changes, the clinic that A would have ordinarily been reviewed in

had had some cancellations and appointments weren't rebooked. There had been no follow up of patients no longer attending the cancer centre and work was ongoing to return to fundamentals of care. Administrative staff are now contacting CNS teams when patients do not attend for appointments' so the teams can follow up.

It was noted that having an overview of a patient was important and there were now support workers in place supporting clinicians which would be another layer to avoid a similar scenario re-occurring.

A non-executive director asked how confident the team were that triangulation of service provision was now happening in Cancer Care Services. In response it was noted that the risk remained as some parts of patient care were still fragmented with no access to shared records. However, there was a new ICB development which would enable the sharing of system care records and it was believed that this could be used to track patients.

A clinical non-executive director explained that bowel cancer was a disability that affected people in different ways. Regarding continuity of care, there was a lot of reliance on family members which was absent during the Covid period and led to harm.

Board members commented that end of life journeys needed to be explained better to patients. They also asked if all professionals involved had been debriefed as they needed to hear this account so that lessons were learnt.

The Board was advised that A's wife had written a brief which would be shared and the brief would also be utilised at the rolling half day training programme.

It was noted that routinely it was now flagged when patients did not turn up to appointments and escalated if required.

The Board was further advised that the gold standard framework was about clinicians asking the question 'will I be surprised if this patient dies within the year'. The answer to the question would then determine what the clinician says to the patient and/or their family.

There was a request that operational staff should also be included in the shared learning.

The Chair thanked Caroline Dilks, Divisional Director of Nursing & Quality – Planned Care Division and Alison Paterson Deputy Divisional Director of Nursing & Quality for Cancer for presenting A's story and for the actions now in place. The Board requested that their appreciation be shared with the patient's s wife.

The Chief Executive commented that Alison Paterson, Deputy Divisional Director of Nursing & Quality for Cancer had written a piece for the clinical column on the importance of bowel cancer screening in the Comet newspaper and thanked her for this.

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

24/046 APOLOGIES FOR ABSENCE

Apologies were received from Anita Day, Trust Chair and Jonathan Silver, Non-Executive Director.

24/047 DECLARATIONS OF INTEREST

There were no declarations of interest.

24/048 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 6 March 2024 were **APPROVED** as an accurate record of the meeting

24/049 ACTION LOG

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

24/050 QUESTIONS FROM THE PUBLIC

Parking at the Lister

The below was passed on by Hertfordshire County Council and treated as a question from the public.

Question:

There is not enough parking at the hospital. The spaces are poorly marked. Catalytic converters are often stolen from cars at the site. Staff are regularly fined by SABA. The multi-storey car park is poorly designed and results in damage to cars.

In response, the Chief Executive stated that:

"We recognise that car parking on the Lister site is a cause of concern for staff and it is an area of focus for the Trust to improve. It is a subject taken very seriously, particularly in terms of the impact on the wellbeing of staff at the start and end of their working days. As such, an independent survey was undertaken with a professional traffic management team. While recognising the time

of peak periods of pressure on the surface car parking spaces for staff at Lister, the survey showed the overall current utilisation of available parking was at 85%, including the off-site car park at the garden centre (compared to 90-95% which is deemed to be full capacity).

At present, the survey data did not support the need for a significant expansion of capacity that a new multi-storey car park would provide. What was shown was the need for better distribution of the current staff parking spaces at the site while exploring all options for alternative parking. The Trust was currently taking the following actions to better use existing capacity and to secure some additional capacity:

1. Finalising negotiations with landowners for some additional parking spaces adjacent to the hospital

2. Relining staff surface car parking spaces to make the most of current space (including more clearly marked bays) and create additional spaces

3. Reallocating staff permits between staff car park spaces to balance the use of all spaces

4. Negotiating over the use of additional offsite parking with a more frequent and extended shuttle bus service

5. Implementing increased hybrid-working and flexible working to reduce the demand for staff parking, particularly at peak times

The Trust recently made improvements to staff car parking as part of its investment in maintenance.

Catalytic converter theft is a national issue with approximately 3,000 - 4,000 reported stolen per year. Fewer than 10 had been reported stolen over the last 24 months at Lister Hospital. However, we had increased security patrols, worked closely with the police, and shared recommendations with staff on how to protect their vehicles.

Parking tickets were issued in line with Trust and car parking policies, and an appeals process was in place. Tickets were issued for not correctly parking in bays, or not displaying a valid permit.

To maintain safe access in case of emergencies it was essential that vehicle owners parked in designated areas and only where they were permitted to do so.

The multi-storey car park was designed and built by construction experts in line with design guidance. Regrettably damage was caused to vehicles in all car parks. Between January and April

2024, 115,000 cars entered the multi-storey car park. In the same time period, 10 accidents were reported to SABA or the Trust.

Taking into account all of the above, which the Chief Executive believed responded to all points in the public question, he emphasised to staff and patients that both himself and the Board heard the feedback about parking and the impact it was having on staff and patients. As such, wanted to reassure staff and patients that improving parking at Lister was one of his main goals over the next year."

It was also noted that the Board recognised the concerns about parking and supported the Chief Executive's response to the question.

It was advised that the response to the public question would be available on the ENHT website.

24/051 CHAIR'S REPORT

Policy on policies

The Board was advised that the Policy on policies was approved under the Standing Orders' urgent decision-making provision so that it could be submitted to CQC.

It was reviewed and approved by the Chair and Chief Executive having consulted the Deputy Chair, Karen McConnell and the Audit and Risk Committee Chair, Jonathan Silver as two of the Non-Executive Directors on the Audit and Risk Committee.

The Board **ENDORSED** the decision to approve the policy on policies.

24/052 CHIEF EXECUTIVE'S REPORT

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

Quality

The Board was informed that there was a national programme initiated by NHS Improvement to develop networked pathology services. Following a procurement exercise, Health Services Laboratories (HSL) had won the tender.

In response to a question, it was noted that we already outsourced parts of the pathology department work and that where relevant

staff would be transferred under TUPE. Staff in the department were thanked for their continued hard work and dedication.

The Board was advised that Theresa Murphy, our Chief Nurse became a Trustee of Dementia UK and that she would manage her new role as a Trustee for Dementia UK alongside her position as Chief Nurse at the Trust.

Thriving People

It was noted that the Trust had developed and launched a new management competency framework. The aim in introducing the framework for line managers within the Trust, was to build on the NHS England national work by clearly defining what good looked like in our organisation.

On 5 April 2024, Iftar was celebrated at Lister hospital which was an annual event and formed part of our inclusion agenda.

Seamless service

The Board was informed that despite a significant increase in urgent and emergency attendances (up 13.6% in March 2024 compared to 2023) the numbers of those being discharged or admitted within four hours continued to improve. It was noted that performance in March compared to December 2023 was the 14th most improved across the country.

The Board was reminded that due to the requirement to replace the reverse osmosis water plant at the Bedford Renal Unit, patients undergoing dialysis needed urgent reprovision at other centres between 29 February and 14 April 2024, as well as other sites across the Trust. It was also noted that assistance was offered from sites in Oxford and Northampton. The Chief Executive informed the Board that he had written to Oxford and Northampton to thank them.

Continuous improvement

The ENH Production System (ENHPS) recent activities were outlined. It was noted that once the programme had been finalised, it would be rolled out to all staff.

In the last published data (April 2023 – January 2024) the Trust was the 7th highest in NHS in England for the increase of planned care delivered compared to pre-Covid levels.

Some non-executive directors remarked that they had attended the recruitment workshop and it was well delivered.

Val Moore, People and Culture Committee Chair commented that when she first arrived seven years ago, in the Pathology

department, the partnership arrangement had collapsed it was therefore good to see that the department had forged ahead.

In response to a question, the Chief Executive commented that the new model in the Pathology department was a shift and that the change would be good for staff. The laboratory would be better and there would be support for staff.

Directors were also assured that HSL would bring in new ways of working which would be better and provide a more stable environment. Clinicians would also get a more responsive service.

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

24/053 2024/25 STRATEGIC GOALS

The Chief Kaizen Officer presented this item. He outlined the approach used to frame the eight new proposed goals ensuring that each goal articulated a clear vision that was translatable across the whole organisation for both clinical and non-clinical staff.

The Board was assured that if the strategic goals were agreed, there was a pre-determined timeline, and the objectives would be cascaded to all departments, teams and individuals.

A discussion ensued. During discussion, it was noted that the Deputy Chair, Karen McConnell and Nina Janda, Associate Non-Executive director attended the session where the senior leadership team in the Trust agreed the objectives. They commented that it was a high energy event which utilised the 'bottom up' approach to the development of shared objectives.

It was suggested that under the guiding theme 'seamless services' in the first goal, the words 'we will' be removed.

The Chief Executive commented that the goals might not change every year, but they will be revisited on an annual basis. He remarked that there was the need to direct the organisation rather than micromanage it.

During discussion it was noted that some teams including the People team had had their away day.

The Board **RECEIVED** and **APPROVED** the strategic goals subject to 'we will' removed.

24/054 ENHT TEACHING HOSPITAL APPLICATION

The Medical Director and Partnership Manager presented this item. The many endorsements from organisations that we had worked with including political support for the application were welcomed.

The Deputy Chair thanked everyone for their involvement.

It was noted that this item was reviewed at the Quality and Safety Committee meeting held in April and that members of the committee were impressed with the application.

Board members were re-assured that the cost of the name change was minimal. Some signage would change but that it would be gradual.

The Chief Executive requested that it be added to our recruitment brochure that would be sent to applicants. This was agreed.

The Board **APPROVED** the submission to the Department of Health.

24/055 STAFF SURVEY

The Chief People Officer presented this item. It was reported that the response rate was 45% of the Trust's workforce which was in line with the national average.

The Chief People Officer outlined our areas of improvement and areas that needed to be worked on.

During discussion, it was noted that the staff survey linked in with the equality, diversity and inclusion strategy.

Board members were advised that a delivery plan had been developed and its implementation would be reported to the People and Culture committee who would have oversight.

The Chair of the People and Culture committee commented that there would be a programme of inviting divisions to attend the committee throughout the year. Also, that the committee would support the People team in co-designing how improvements would happen across the Trust.

A Non-Executive Director asked that learning from other trusts with greater engagement with the staff survey be considered.

The Board **NOTED** the staff survey responses.

24/056 DIGITAL STRATEGY

The Chief Information Officer presented this item.

The Board was advised that the Trust Digital strategy was being delivered in 5 programme streams each with its own senior responsible owner (SRO) and that it started on 1 April 2024.

The digital team programme structure was outlined.

It was noted that work was ongoing with the patient hub and that there was funding for it. Good patient engagement with the digital hub was also noted.

It was stated that system partner's gold standard framework was in place and we would have a shared care record in Herts and West Essex.

Artificial intelligence (AI) was in use where appropriate and it was explained that there was a human sitting behind its use. AI funding would be available.

The Board was told that the ICS was putting in the single cancer system and that this would be beneficial to us.

The Chair asked about the external communication around the patient portal and if there was any communication with patients to explain why some documentation for some services was on the hub and some still being sent out as hard copy. The Chief Information Officer responded that it was a challenge and that clinic letters would be sent out in hard copy as well as being on the hub for now. For the foreseeable future we will also still send text messages as reminders of appointments.

The Board **RECEIVED** and **NOTED** the Digital Strategy.

24/057 PAEDIATRIC AUDIOLOGY SERVICES

The Chief Nurse presented this item.

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

The Board was advised that in July 2023, the Trust partnered with Guys and St Thomas's (GSTT) Paediatric audiology service to benefit from their subject matter expertise. In addition to commissioning a UKAS inspection.

A discussion ensued. It was noted that there remained a national shortage of audiologists.

In response to a question, it was explained that ENHT had identified vulnerable children, as part of the harm review process.

The Medical Director commented that it was important for members of the Board to note that Healthcare Scientists were working with medical and nursing staff on this issue.

The Chief Executive informed the board that CQC wrote to chief executives asking that they report to boards as this was a national concern. On the subject of accreditation, members were informed that we had reached out to Guys and St Thomas's (GSTT) and that not many audiology departments were accredited but we were looking to becoming an accredited centre in the future.

There will be formal oversight by the Quality and Safety Committee.

The Board **RECEIVED** and **NOTED** the Paediatric audiology service update.

24/058 2024/25 BOARD ASSURANCE FRAMEWORK

The Head of Corporate Governance presented this item. The Board noted changes to the proposed board assurance framework (BAF).

The Board **RECEIVED** and **NOTED** the BAF.

24/059 LEARNING FROM DEATHS

The Medical Director presented this item and thanked the Mortality Improvement lead and the Associate Medical Director for their work on this report.

The Board was advised that the software used by the Trust for structured judgment reviews would no longer be provided for free by NHSE and we were signing a contract with a private provider to pay for this.

It was noted that Biliary tract disease was a new cumulative sum (CUSM) alert. A member requested that when we report the alerts we include the total number of patients with the condition to allow the board to understand the denominator.

Action: Include the number of patients with each condition mentioned in CUSM alerts in the report going forward.

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

East and North Hertfordshire NHS Trust

24/060 INTEGRATED PERFORMANCE REPORT

The Executive Directors gave an update on their respective areas.

The Chair thanked everyone for their involvement in cost improvement programme (CIP) and the elective recovery fund (ERF).

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

24/060a MATERNITY ASSURANCE REPORT

The Head of Midwifery and Divisional Director of Operations presented the item.

The Board advised that the number of births in the UK had been decreasing for the fifth consecutive year. Complexities of births however, were increasing and for many women caesarean section was becoming an increasing choice of mode of birth. In response to a question, it was noted that this was the picture reflected across much of the country.

It was noted that the vacancy rate within maternity had significantly improved, and full establishment would be achieved following recruitment of ENHT student midwives due to qualify in September 2024. 25 had expressed an interest in joining the team as a Band 5 midwife.

It was remarked that the division was working through the maternity safety support programme and that they were making significant progress and were working towards an exit strategy.

On the culture issues previously discussed, an equality, diversity and inclusion board had been set up and work was underway to improve the experience of the teams working within the service.

Board members commented that it was good news on the recruitment, as a huge investment had gone into maternity services, sustainability and retention was therefore key.

In response to a question, it was noted that one to one care in labour was a midwifery red flag and was being monitored and there was a clear way of escalation.

Ensuring the provision of safe high quality antenatal and postnatal care to women booking with the Trust and birthing at the Trust but lived out of area, was an ongoing challenge and the leadership teams across sites were working together to ensure that the transition to electronic maternity records did not impact this further.

The Board noted that there were more midwives in post but fewer births. It was explained that the increasing complexities within the maternity pathway alongside the increase in supporting women's choice meant that an increase in midwifery clinical staffing in collaboration with specialist roles was required.

Action: The team were asked to look into the makeup of the future workforce.

The Board **RECEIVED** and **NOTED** the maternity assurance report.

24/061 SYSTEM PERFORMANCE REPORT

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

The Board was informed that the Trust was currently discussing the possibility of the HCP becoming a joint committee with the other provider Trusts and the Council.

It was noted that if this was supported by the respective Chief Executives, any proposed delegation of powers would require Board approval.

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

BOARD COMMITTEE REPORTS

24/062 AUDIT AND RISK COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Audit and Risk Committee meeting held on 9 April 2024.

24/063 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 27 February, 26 March and 23 April 2024 respectively. The Chair noted that the items recorded as Alerts for the Board in the April FPPC report had been picked up during the discussion on the IPR.

24/064 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on 27 March and 24 April 2024.

24/064a

REVIEW OF THE TERMS OF REFERENCE (ToR) of the QUALITY AND SAFETY COMMITTEE

The Committee Chair advised the Board that during discussion on committee effectiveness item held during the meeting on 27 March, it was agreed that the:

- number of meetings per year be reduced to at least nine meetings a year; and
- Chief Executive be removed as a core member.

The Board **APPROVED** the updated terms of reference of the Quality and Safety committee.

24/065 PEOPLE AND CULTURE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the People Committee meeting held on 19 March 2024.

It was noted that the name of the committee would change to People and Culture committee and that the terms of reference would be brought to the July Board meeting.

The Board **ENDORSED** the name change.

24/066 CHARITY TRUSTEE COMMITTEE REPORT TO THE BOARD

The Board **RECEIVED** and **NOTED** the summary report from the Charity Trustee Committee meeting held on 4 March 2024.

24/062 ANNUAL CYCLE

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

24/063 ANY OTHER BUSINESS

The Board was notified that the Seal would be used on the contract for the lease of Hillingdon Hospital at the Mount Vernon site.

East and North Hertfordshire NHS Trust

24/064 DATE OF NEXT MEETING

The date of the next meeting is 10 July 2024 online via Teams.

Mrs Karen McConnell
Deputy Trust Chair
May 2024

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

Agenda item: 5

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
1 May 2024	24/059	Learning from deaths	Include the number of patients with each condition mentioned in CUSM alerts in the report going forward.	This is part of the report presented.	Medical Director	**Completed**
1 May 2024	24/060a	Maternity Assurance report	The team to look into the makeup of the future workforce.	This will form part of the future work plan going to July QSC before coming to September Board.	Director of Midwifery	**September 2024**

East and North Hertfordshire NHS Trust

Chief Executive's Report

July 2024

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

Quality

The Care Quality Commission have rated Hertfordshire County Council as good for its provision of adult social care. Staff from the Trust were interviewed as part of the process and of particular note is the rating for partnerships of 'an exceptional standard'.

We know that waiting times for emergency care remain a major concern for patients as well as for staff in the Trust. Despite real improvements in performance against the 4-hour standard in ED, we are determined to continue this improvement. We have invited the Getting it Right First Time (GIRFT) team to visit the Trust this month to review the progress we have made and offer suggestions for further improvements. They will be accompanied by the Emergency Care Intensive Support Team as part of the visit.

Thriving people

The first week in July saw our annual Thank You Week where we paid particular attention to thank our staff for what they do week in, week out and coincided with the NHS 76th birthday on Friday 5 July.

The week is for teams and departments to reflect, appreciate and celebrate the achievements they have made. We put some activities and plans in place to support celebrations – including free food, prizes, activities, and as always, a chance to see our favourite therapy animals!

Thank you to everyone who has helped organise the events and to our hospitals' charity for funding the week.

Tomorrow sees the annual staff awards where we celebrate individuals and teams who have been nominated by both the public and their colleagues. I am certain that it will again be a fantastic evening where we celebrate excellence from across the Trust.

Our hospitals' charity would like to thank the public and staff who took part and helped out at Rainbow Run in June. It was a fantastic day and raised an amazing £20,000 for our hospitals to be used for the benefit of patients and staff. We hope to see many of you at next year's event!

Seamless services

A priority for the Trust this year is working with partners in community services, primary care and the voluntary and community sector to better provide care for those in our population affected by frailty. A particular focus for the Trust is to provide increased care in an ambulatory setting with the aim to return patients to their usual place of residence rather than admit them to an admit them to an inpatient bed that can lead to deconditioning with greater levels of mental and physical deterioration.

An internal frailty programme has been established and the Trust joined partners in a workshop focussing on care closer to home in which frailty formed a significant part.

Continuous Improvement

Work has continued on two of our major programmes of work across the Trust.

The fieldwork for our Orbis Electronic Patient Record system has continued. We have appointed Shella Sandoval as our new Chief Nursing Information Officer (CNIO) and clinicians from across the Trust are forming the team to shape the system to ensure that it is best aligned to support our aim of delivering consistently outstanding care.

Training in the ENH Production System (ENHPS) is being rolled out across the Trust. Our central improvement team, or Kaizen Promotion Office, have been certified to teach the method, we have commenced delivering the Introduction to ENHPS workshops and the ENHPS for Leaders programme is starting this month. Our next area for targeted improvement focus has been selected and we will be running our next two improvement workshops in Ophthalmology later this year.

Adam Sewell-Jones
Chief Executive

Board

East and North Hertfordshire NHS Trust

Meeting	Trust Board			**Agenda Item**	9
Report title	Public and Patient Engagement Strategy 2024-2026			**Meeting Date**	10 July 2024
Presenter	Eilidh Murray, Director of Communications and Engagement				
Author	Eilidh Murray, Director of Communications and Engagement				
Responsible Director	Adam Sewell-Jones, Chief Executive			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

This strategy seeks to set out the Trust ambitions in relation to public and patient engagement over the next 2 years. This includes engagement with our public, local communities, stakeholders, voluntary and community sector, and our patients.

It seeks to outline a framework for listening, collating, and sharing feedback and insight from our communities.

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

Impact: where significant implication(s) need highlighting

This strategy seeks to address improvement in how the Trust listens to and involves our communities, to drive increased engagement in the following areas as highlighted by the Care Quality Commission:

- Sharing views to shape and improve services and Trust culture, including people from a range of equality groups
- Actively engaging people who use Trust services in decision-making to shape services and culture
- Increasing openness and transparency with all stakeholders about performance

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

Without increased engagement and involvement of our communities and patients in our services, the Trust risks a lack of focus on what matters most to our public as we improve and develop our services.
The Trust must also ensure that engagement work is aligned with our local system partners to avoid duplication and multiple demands on certain communities.

Report previously considered by & date(s):

Trust Management Group – 27 June 2024.

Recommendation	The Board/Committee is asked to approve the strategy.

To be trusted to provide consistently outstanding care and exemplary service

June
2024

East and North Hertfordshire
NHS Trust

Public and Patient Engagement Strategy 2024 - 2026

Background

The NHS touches everyone's lives – there in some of the darkest and also most joyful times. It is crucial that we listen to, involve and act upon the voices of our patients and communities to improve and better support them during these life changing experiences

In 2013, the Francis Inquiry on Mid Staffs found 'A culture focused on doing the system's business – not that of the patients' and concluded that 'There must be real involvement of patients and the public in all that is done.'

Not only is engaging our patients, the public and our stakeholders the "right thing to do", it is crucial for improving the quality of our care, the patient and carer experience, and for ensuring that we use our resources in the most valuable ways.

Our legal duty to engage:

We have a to involve patients, as laid out in the National Health Services Act 2006 (as amended by the Health and Care Act 2022.

A requirement to involve the public is also a service condition in the NHS Standard Contract for Providers:

- The Trust must comply with the Accessible Information Standard
- The Trust must actively engage, liaise and communicate with service users (and, where appropriate, their carers and legal guardians), staff, GPs and the public in an open, clear and accessible manner in accordance with the Law and Good Practice, seeking their feedback whenever practicable. In communicating with a Service User (and, where appropriate, their Carer and/or Legal Guardian), the Provider must have regard to their health literacy in order to support them to make informed decisions about the Service User's health, care and wellbeing.
- The Trust must involve service users (and, where required by law or otherwise appropriate, their carers and legal guardians), staff, service users' GPs and the public when considering and implementing developments to and redesign of services.

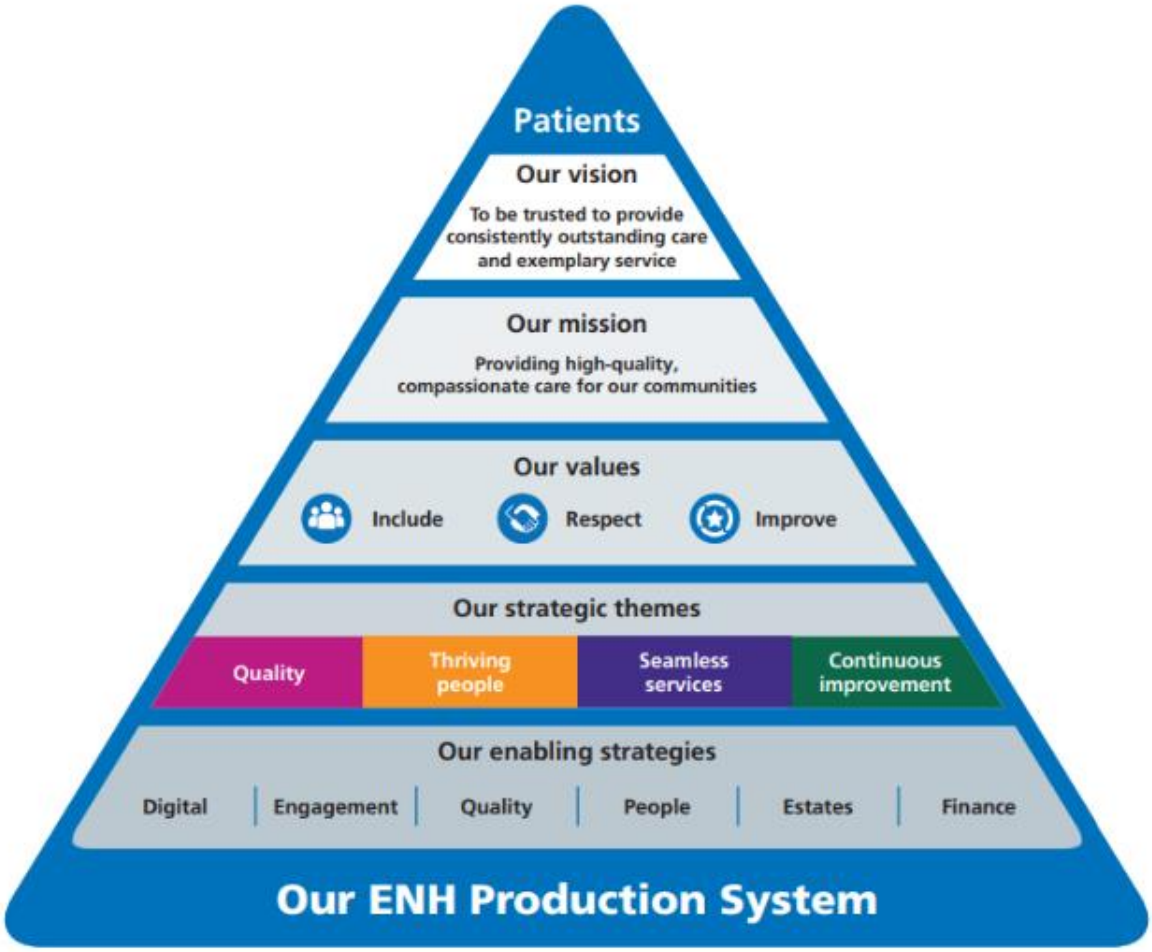
Indeed, there are situations where the Trust (or the Trust with our commissioners) is legally obliged to formally consult our patients and publics – rather than simply engage with them. This strategy does not cover formal consultation, and teams who are considering changes to how a service is delivered or accessed should immediately contact:

- The Trust's communications and engagement team
- The Trust's contracting team

As well as legal considerations, the trust should take account of the Gunning principles, not only in formal consultation but in engagement:

- Consultation must take place when the proposal is still at a formative stage
- Sufficient information and rationale must be provided
- Adequate time must be given
- The product of consultation (and / or engagement) must be taken into account

Our Trust Strategy – a summary



Engagement with our patients, public and stakeholders is essential at all points throughout the work of our Trust.

Our vision **to be trusted to provide consistently outstanding care and exemplary service** can be broken down into three sections, each with patients at the centre:

Trusted: That the manner and outcomes of our services means our communities trust us with their care.

Consistent: No matter where, when or how people access our services, their experience should be of consistently outstanding care.

Exemplary service: Ensuring that our patients and communities receive a high standard of service in addition to their clinical care – from the first contact to the last.

Only by asking our patients, communities and public, and listening, will we know when we have achieved this.

And as the foundation of our new way of working, our East and North Herts Production System (ENH PS) puts patients at the very heart of decision-making, governance, and improvement.

Our key principles of engagement

The Trust will align with the principles of engagement as set out by NHS England in its statutory guidance, and with our local system partners as part of the Hertfordshire and West Essex Integrated Care System:

1. We will put the voice of people and communities at the centre of decision-making and governance at the Trust.
2. We will start engagement early when developing plans, and we will feed back to people and communities how their engagement has influenced activities and decisions.
3. We will listen to understand the needs of our communities, their experiences, and aspirations.
4. We will foster and build relationships with community groups, particularly those affected by inequalities, to ensure all voices are heard.
5. We will work in partnership with our local NHS and public sector partners and stakeholders, Healthwatch, and the voluntary, community and social enterprise sector.
6. We will provide clear and accessible public information about our vision, plans and progress.
7. We will work with our partners to use community development approaches that empower people and communities.
8. We will use insight, engagement and co-production to improve our services.
9. We will learn from what works, and build on the work of our partners – co-ordinating networks, relationships, and activity.

This strategy seeks to address each of these principles, and shares our Trust plans for improvement.

How we will engage

The image above shows our framework for engagement – from public and community engagement, through to more focused engagement, to the individual patient and family experience.

1. Public and community engagement

We want all of our communities to feel listened to and able to contribute to shaping the future of their local Trust services. Later in this document we share plans about how we will focus our engagement efforts and increase representation of our patient voice. This section focuses on our wider public engagement with all of our communities.

Public engagement

We will continue to provide time and space for our public and communities to find out more about our Trust, to feed back on our progress, and find out how to get more involved. We will:

- continue to hold an inclusive and interactive annual general meeting (AGM) to update on our progress, welcoming both online and in - person attendance from our patients, the public, stakeholders and our staff. We will use the AGM period as a focus for public engagement, hosting topic-based in-depth webinars chosen by our members and the public. In the past these have included topics such as digital developments, our green plan, and progress in cancer treatments.
- continue to engage with the public to support us in recognising our staff, for example by promoting and increasing public nominations for the People's Staff Award, and through the Daisy Awards.
- improve how we respond to, collate and share public and patient feedback on online platforms.
- work with partners and stakeholders to identify and plan public engagement opportunities and partnerships, including through our hospitals' charity.

Patient information

Providing accurate, helpful, and accessible information is crucial for our patients, families and carers. We will:

- work with our services, and with patient and public representatives to improve our information for patients, families and the public, including:
    - online on our website and social media.
    - our patient letters, text messages and apps.
    - our patient information leaflets.
- hold ourselves to the highest standards of accessibility in the information that we share with the public, online and in print. This includes ensuring that information is written in Plain English and is accessible to those who use adaptive technology (for example screen readers or those who need subtitles). And we will continue to make information available in different formats and languages to allow our different communities to access information more easily.
- work with our patients and public, including the ICB reader panel, in a planned and prioritised way, to ensure our information is fit-for-purpose and centred on patient needs.

Developing our membership

Our Trust Members number around 500 people, who have elected to be involved in our Trust – receiving information, taking part in surveys and on site assessments, and participating in committees and improvement projects or patient groups. We will:

- better clarify our offer to members – asking them how they would like to participate. From being kept informed, and providing high level feedback, to indicating interest in particular topics to get involved in shaping through co-production and improvements.
- improve our newsletter for members, better using data on stories to understand interests and the topics which most matter to our members.
- ensure that our membership is representative of the communities that we serve, including proactively seeking representation from those communities who currently have less of a voice
- create a council of members, representative of our local communities, to support decision-making and improvements in the Trust.

Media and social media

Our local media and social media communities allow us to listen to, and respond to our public – and to share information through networks. We will:

- engage with the local media in a more proactive way, sharing our performance, plans and progress openly and transparently. We will continue to welcome members of the media at our Board meetings, providing briefings and media responses to ensure that our local communities are well informed.
- continue to engage with our local communities on social media – sharing news and information, and listening to feedback to identify any themes or areas of focus, and sharing progress.
- We will share online details of our public Board meetings – with papers shared further in advance, and Board meetings livestreamed for online viewing.
- work with our partners and stakeholders to engage in our conversations and share them with their own communities.

2. Engaging with our partners and stakeholders

It is more important than ever to work with our partners and stakeholders to deliver services for our communities – sharing information about what matters, sharing resources, and planning services in partnership.

Working with our NHS partners

Collaboration with our NHS partners will mean that we can ensure a better representation of views, feedback and engagement opportunities. We will:

- work with the ICB to create a community of practice for engagement, sharing information, engagement opportunities, and insight.
- continue to develop engagement with GPs – through the Trust GP Liaison service, our GP Update email bulletin and engagement meetings – and increase sharing of GP experiences to drive improvements for patients
- increase our engagement with patient participation groups at GP practices

Working with our stakeholders and the voluntary, community, faith and social enterprise sector

Our many stakeholders have views, rich insights and often better engagement with some of the communities we seek to engage. We will:

- ensure that we allocate time to build positive, mutually beneficial relationships with our stakeholders, to better share insights and work together for the benefit of our local communities.
- invite stakeholders to visit the Trust to see, and feedback on, services – and share feedback and progress on actions.
- work with local authority partners to engage with communities.
- work with the ICB to plan engagement with community groups in a co-ordinated and prioritised way to avoid duplication.

Working with our political partners

As elected representatives of our local communities, we will build on existing partnerships and improve our relationships with our political partners. We will:

- increase regular updates for local authority colleagues, including leaders, councillors and CEOs – including a planned programme of visits to the Trust.
- continue to include, inform and involve the Hertfordshire Health Overview and Scrutiny Committee, openly and transparently, to share progress, risks and issues – in collaboration with our system partners.
- continue to offer quarterly briefings to all members of parliament, working with them to establish the most effective format.

3. Focused engagement

Wide engagement can offer rich conversations, insight, and relationships. However healthcare is very personal, and the Trust will seek to engage with groups who regularly use our services, or who have particular views or insights which will support us to further reach our vision.

We will:

- use examples of good practice in the Trust in engaging patients, service users and communities – for example those with long term conditions and carers – and use this practice to explore future options for patient groups, to complement or support those that exist in the voluntary and charity sector.
- increase the voice of our young people in services, to help us to understand the needs of our patients of the future. We will form a Trust Youth Council, to work alongside the ICB Youth Council, to focus on hospital specific issues and young patients and giving an opportunity for work and volunteer experience.
- use data to identify key issues impacting the Trust and create specific engagement plans around specific topics or communities to increase awareness, engagement and equality.
- increase information shared with, and encourage feedback from, families through local authority and other system channels such as schools bulletin.
- increase representation of communities that are less-often heard, working with our partners to focus on the areas highlighted by NHS England in the core 20 plus 5 approach.

4. Co-production

Co-production exists in many forms in our Trust, from patient member representatives on our Patient and Care Experience Group, to involvement in quality improvement programmes and initiatives.

However we know that co-production is not consistent across the Trust, and the representation of those participating must better represent the communities we serve. Our new East and North Herts Production System (ENH PS) way of working will embed co-production in all improvement projects and programmes.

We will:

Clarify:

Create a framework for the identification of opportunities for patients and the public to get involved, and support our teams to clarify the role, benefits, and skills and experience required if applicable.

Promote:

Support our teams to share opportunities with our communities, in a co-ordinated way, ensuring patients involved represent the communities we serve, and that will support increased equality.

Support:

Ensure that there is a fair, transparent process for our patients and public to get involved in co-production.

Share:

Ensure that our patient experts have the support they need to carry out their role. Be open and transparent with our shared progress, including where things need to improve.

Listen:

Increase the patient voice at our official committees, Board and governance meetings.

5. Patient, family and carer experience

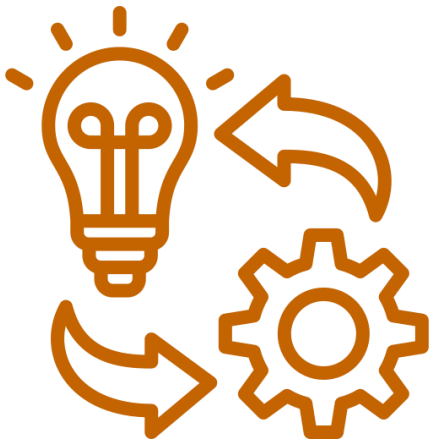
There are many ways in which we gather information and insight about the experience of our patients, families and carers using our services – from clinical conversations, friends and family tests (FFT), feedback to the Patient Advice and Liaison Service (PALS), and complaints.

The Trust is committed to listening and acting on feedback, sharing results of actions taken. We will:

- commit to improving the quality of conversations and communications between our staff and patients, families and carers – making each contact count.
- prepare for and respond to Care Quality Commission (CQC) patient surveys: working with specific patient groups to monitor compliance with and responses to patient surveys and FFT issues.
- increase sharing of intelligence of existing patient groups, patient partners, and volunteers – and using their networks – with a wider organisational reach.
- explore systems for better collation of feedback from all sources – for example online, complaints, PALs – to triangulate common issues and also share good feedback in a more systematic way – internally and externally.
- commit to sharing data, trends and themes of all feedback and actions taken – publicly.
- use the stories of individual patients, families and carers to share progress and improvements.

6. How will we know if we are improving?

We will measure our progress against this strategy by asking our patients and communities to tell us how we are doing, along with our stakeholders and partners.



We will embed evaluation and measurement at each stage of our engagement, and ask our patients families and carers to let us know what improvements they see. We will measure the number, engagement and representation of our Trust Members.

We will use data from many sources, including national patient surveys, our friends and family tests, our PALS and complaints, and our online conversations and feedback.

We will commit to sharing our progress, and inviting suggestions for where we can improve further.

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	10
Report title	2023/ 24 Strategic Objectives Review			**Meeting Date**	10 July 2024
Presenter	Chief Kaizen Officer				
Author	Chief Kaizen Officer, Head of PMO				
Responsible Director	Chief Kaizen Officer			**Approval Date**	16 May 2024
Purpose *(tick one box only)* [See note 8]	**To Note**	☒	**Approval**		☐
	Discussion	☐	**Decision**		☐

Report Summary:

This report provides an annual review of progress towards delivering the Trust's 2023/ 24 strategic objectives with the evidence demonstrating considerable improvements achieved across each of the four strategic themes.
It is notable Trust performance benchmarked positively across a range of metrics throughout the period as reported through the NHSE Model Hospital Portal. In addition our elective recovery activity compared to pre-pandemic was reported in the top ten nationally despite ongoing industrial action and wider pressures in urgent and emergency care pathways. The Trust also reported a significantly improved ED performance in the latter part of the year following the opening of our new Lister Urgent Treatment Centre.
Despite these many successes, work will continue in the areas where we have not yet met our stretch targets we set ourselves at the beginning of the year, and work will continue to therefore build on the progress already made.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

2023/ 24 marked the second year following a Trust refresh of our strategy and vision and the introduction of annual strategic objectives in this format. These continue to be cascaded across the organisation with each department and team asked to develop their own aligned objectives as part of the Grow Together process. As part of 2024/ 25 planning we have worked with our improvement partner to continue to develop this process alongside roll-out of our new improvement method, as we build towards strategic alignment across all areas.

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):

TMG January 2024.

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 Objectives Review

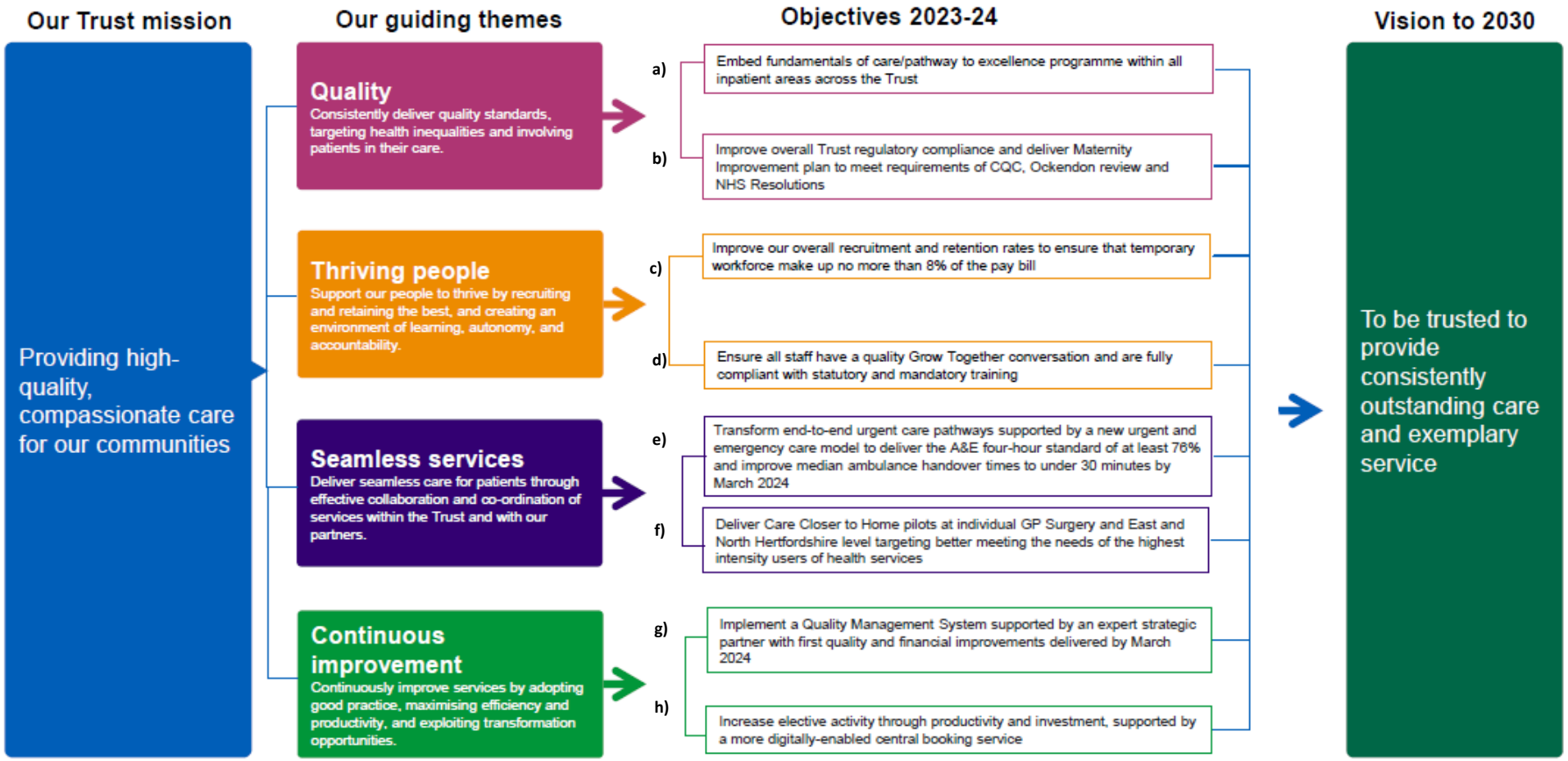
East and North Hertfordshire NHS Trust

Public Trust Board
Agenda Item 10
10 July 2024

Kevin O'Hart, Chief Kaizen Officer

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 and now contains two parts. Part one is aligned to the CQC compliance standards and includes 71 fundamental standards of care, with part two including standards relating to clinical excellence. Wards only progress to part two of the framework when a minimum of 85% of all fundamental standards are achieved. All 71 fundamental standards of care must be achieved, and the 'clinical 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 accreditation status.

There was a phased approach to launching the revised framework with inpatient wards separated into two cohorts. This phased approach enabled focused advice and support to be provided to wards with weekly drop-in sessions and monthly divisional meetings to discuss progress, next steps and actions required.

Cohort 1, comprising 12 inpatient wards, commenced the CEAF in April 2023. During the pre-assessment period between April-July wards had the opportunity to work to improve fundamental standards of care. The formal assessment period then took place between August-October, where the independent assessment team evaluated compliance by observing practice, talking to staff and patients, and reviewing documentation, performance data and the CEAF staff survey responses. Individual ward reports were then prepared detailing the assessment and outcome for each standard, to share with the CEAF panel.

The CEAF panel, chaired by the chief nurse, met in January 2024 to review Cohort 1 wards where it was agreed Barley ward had provided evidence that they were meeting at least 85% of the fundamental standards of care. The ward team had been able to demonstrate high quality and compassionate care towards patients. The panel observed how Barley ward performed distinctively better in fundamental standards relating to person centred care, dignity and respect, safe care and treatment and nutrition and hydration. The ward team has now commenced work on part two, 'clinical excellence' standards, which includes adopting research and quality improvement, shared decision making and staff recognition into day-to-day practice.

AMU-1, SSU, ACU, Ward 6A, 6B, 7A, 8A, 10B were assessed and are required to continue to work on their improvement plans with ongoing regular meetings with the ward managers focussing on common challenges and support. A range of specialist teams have been invited to join these forums to share their expertise.

Ward 5A, 5B, 7B are required to commence a more formal action plan where fortnightly action tracker meetings provide the opportunity to ensure wards are supported, in a collaborative approach, to improve compliance against fundamental standards of care which are not being achieved.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Quality / Objective A – Fundamentals of Care *(continued)*
SRO – Theresa Murphy , Chief Nurse
Throughout the CEAF process the following cases of good practice have been shared, to encourage and support learning across all inpatient areas- Medicines management project: installing intravenous medication cupboards in each bay. Communication with patient families: establishing a call log and arranging a call back to ensure patient Next of Kin and relatives are receiving necessary updates. Task allocation board: allocation of roles and responsibilities each shift to ensure effective safe care and treatment. Cohort 2, comprising all 12 remaining inpatient wards (excluding maternity), commenced the CEAF process in July 2023. Their pre-assessment period ran from July - October, and their formal assessment period took place between November - January 2024. As soon as all independent assessments were returned, individual ward reports were prepared detailing the assessment and outcome for each standard. The CEAF panel met again in May 2024 to agree the outcome for the Cohort 2 wards. Pirton, SSU and Swift achieved 85% and commenced part 2 in June 2024, with a three-month timeframe to achieve 100% compliance. Wards not achieving 20 fundamental standards or less are now on an improvement plan which will be monitored through divisional meetings and CEAF process. Those wards not achieving 20 standards or more, will move to a formal action plan. Cohort 1 wards that remain on an improvement plan or formal action plan were reviewed in May and work continues with the divisions to drive improvements and sustainability.
Strategic Theme Thriving People / Objective C – Temporary Workforce
SRO – Thomas Pounds , Chief People Officer
At the start of the year, the Trust set up its structured programme known as ‘Great for 8(%)’ which introduced a range of measures and inputs to better control the cost of our workforce through reducing the percentage of the pay bill on temporary staffing (bank and agency) to 8%. The programme had four main workstreams and defined high impact actions under each. These included targeted vacancy reduction – specifically for areas of high-cost agency, enhancing the bank and agency control environment, improved staff deployment systems and practices, and improved absence management including sickness days lost. A governance structure was set in place to monitor progress with reporting going to both Finance, Performance and Planning Committee and People Committee.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Thriving People / Objective C – Temporary Workforce (Continued)

SRO – Thomas Pounds , Chief People Officer

The 8% target was derived from the workforce plan submitted at the start of the year which had assumed a reduction of over 100 full time equivalents (FTE) over the year. However, workforce establishment grew by 134 FTE in large part due to the investment in the urgent and emergency care pathways, as well as to meet increased activity in certain specialties to support elective recovery plans.

In addition, the Trust needed to increase its temporary workforce to manage the impact of industrial action which continued throughout the year. Without this impact, the Trust has predicted that the percentage of pay bill would have been 8.8% as at the end of February 2024. The actual position at the end of February 2024 is 12.4%, down from 15.9% in March 2023. Over the year the average bank percentage came down from 9.5% to 9.1% and agency came down from 3.6% to 3%, therefore temporary staffing reductions were demonstrated over the year despite the establishment changes and industrial action.

Key developments and achievements of the programme include:
17 FTE reduction in agency utilisation with several ‘hard to recruit’ substantive medical posts secured.
The Trust remains free of ‘off-framework’ agency.
Analysis completed of ‘above price cap’ agency usage suggests all breaches are within current market rates.
Service led meetings in place to triangulate budget, vacancy and temporary staffing data.
22-point health roster improvement plan for the organisation is underway reporting through to workforce utilisation and deployment group.
Care support worker spend review in place with daily roster oversight with clinical professional judgement.
Resource control panel in operation as gateway for substantive and temporary placement ensuring criteria is consistently applied.
Turnover has reduced from 11.6% to 9.8%.

Strategic Theme Seamless Services / Objective E – Urgent & Emergency Care

SRO – Lucy Davies, Chief Operating Officer

To improve performance against the 4-hour standard, the Trust embarked on a multi-project programme, based on ideas generated from front-line staff, to develop a new emergency care model. The national 4-hour standard requires 76% of patients arriving at the Emergency Department (ED) to be admitted to hospital, transferred to a more appropriate care setting, or discharged home within 4 hours. In April 2023 the Trust’s 4-hour performance was 64.2%. The ambition of the programme was to transform emergency care pathways to provide alternatives to the ED where appropriate, thereby reducing the volume of patients in ED and improving patient flow and experience.

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

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

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

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

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

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

In March 2024 the Trust's 4-hour performance standard increased to 73.18%. Many of the improvement initiatives did not commence until January 2024 therefore it is anticipated that as new pathways and services embed performance will continue to improve in this area but will remain under close observation.

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, Chief Kaizen Officer

The East and North Hertfordshire Health and Care Partnership (ENH HCP) developed the 'care closer to home' strategy in 2022/23 to provide the strategic direction for how integrated pathways and services would be delivered in the future, ensuring equity across the whole of East and North Hertfordshire. Its mission was to develop a co-ordinated, high-quality, and joined-up range of services that met the local needs of people, reduced pressure on the health and care system, and improved working conditions for staff.

Central to this strategy was the development of Integrated Neighbourhood Teams (INT's) involving a radical shift to a more co-ordinated, integrated, and proactive model of health and care for residents across East and North Hertfordshire. INTs will use population health data to target specific cohorts of people and use risk stratification to target those residents most at risk of poor outcomes. The model places people at the centre, with wrap-around individualised care and services that focus on key 'touch' points including local authority (e.g. care homes, schools, libraries), primary care (e.g. general practice, pharmacy, opticians), and VCFSE (e.g. community organisations, Age UK, HILS, community centres, churches etc.). Multidisciplinary services and skill mix will involve a core, integrated community and primary care team led by complex care coordinators, with specialist support from secondary care, public health, mental health, and voluntary sector co-opted in as required.

INT development formed part of wider work undertaken to ensure the East and North Hertfordshire Healthcare Partnership Strategy objectives strongly correlated with the priorities and ambitions outlined in the Hertfordshire and West Essex Integrated Care Strategy. This programme aligns with the ICB Strategic Delivery Plan involving a new primary care target operating model and an increasing ambition to drive change at local neighbourhood team level; using an established infrastructure at place that naturally lends itself to support the desired service wrap-around approach.

To support roll-out it was agreed to run proof-of-concept pilots involving initial vanguard PCNs in Welwyn Garden City and Hoddesdon Broxbourne, this incremental approach would allow learning to be shared across other PCNs which will ultimately enable INTs to adopt and spread core components of the new model at pace , whilst allowing flexibility based on local population health needs and existing service provision to ultimately define the final detail. There are now five PCNs involved with recent expansion to include Hitchin and Whitwell and Stevenage North and South. The ICB aim is for all INTs to be operationalised by October 2024/5.

This programme has involved significant organisational change for all partners and requires moving away from an historical NHS internal market competition to one of collaboration. Evidence shows that taking the time to really embed clinical engagement is circular to the success of the INT, and adjusted timeframes reflect this. Work to understand and co-design the model for co-opting secondary care into INTs has not yet started, though it is anticipated this will evolve during 2024/25. This will be assisted by a recent system level agreement to prioritise resident and patient cohorts from frailty, end of life and dementia pathways.

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective G – Quality Management System

SRO – Kevin O'Hart, Chief Kaizen Officer

In August 2023/24 the Trust commenced a three-year improvement partnership with the Virginia Mason Institute (VMI), a US-based healthcare system who have developed an internationally recognised and proven system for successfully establishing an organisational culture for continuous improvement. Our journey began in September with a cultural readiness assessment process led by VMI, which involved feedback from over six hundred staff following a range of interviews, engagement events, observations, and surveys. Learning from this process assessed the Trust's current state for improvement using a scientific method across a range of technical, cultural and leadership themes essential for fostering a successful learning and improving organisation. This feedback subsequently informed the development of our implementation plan which was signed off in December by the Trust Guiding Team, the leadership oversight group.

To support the design and ongoing roll-out of our new continuous improvement method, which we have called the East and North Hertfordshire Production System (ENH PS), we bought together existing improvement teams under one new Kaizen Promotion Office (KPO). Kaizen is a compound of two Japanese words that broadly translate as 'good change' or continuous improvement'. The KPO will oversee and maintain the purity of the improvement method in how it is applied, as well as supporting wider training, education and coaching in the new way of working.

The underlying foundations of ENH PS is by focusing on value and eliminating waste, we will improve quality and safety for our patients and staff and reduce costs. It represents a long-term philosophy and set of working practices that puts the patient first, aspires toward harm free care and focuses on improvement which is led and delivered by those who do the work, where the work is done.

The KPO commenced an intensive Advanced Process Improvement Training programme delivered by VMI in early January 2023/24, and this accreditation process will continue over eighteen months. The team are already using their initial learning and applying new tools and techniques (i.e. waste walks and 5S) alongside front-line staff across a range of areas. The scale and pace of this work will increase as the KPO and frontline teams unlearn old ways of working and become more fluent and confident in the new method.

In March 2023/24 we held our first large improvement event called a Rapid Process Improvement Workshop (RPIW), this was the first time we applied the new tools and techniques from our ENH PS to deliver improvement across a large Trust-wide process. We focused on recruitment following feedback from staff and recruiting managers. An RPIW is designed around the Plan-Do-Study-Act method and includes a rigorous twelve-week preparation schedule ahead of the event itself. Significant work was undertaken by the KPO involving the real-time observation and analysis of recruitment processes from the perspective of users and staff

2023/24 Strategic Portfolio Report

East and North Hertfordshire NHS Trust

Strategic Theme Continuous Improvement / Objective G – Quality Management System (Continued)

SRO – Kevin O'Hart, Chief Kaizen Officer

This information was then used to highlight areas of opportunity and focus during the RPIW, with the team subsequently generating and testing a range of ideas for improvement during the week that will be captured within an implementation plan. This includes agreed targets to reduce the overall lead time for recruitment processes, as well as a new defect rate, used as an overarching marker of quality in any given process.

As part of ENH PS, the Resourcing team, supported by KPO, will now be invited to share their progress against their implementation plan at thirty, sixty and ninety days back to the organisation via a new Report Out communication method. This ensures accountability for delivery is maintained at a local level and agreed changes are embedded and supported through new techniques involving standard work and daily management.

The implementation plan for 2024/25 involves an incremental roll-out and expansion of ENH PS leadership training and daily management techniques across the organisation , to support teams to know their service, run their service and improve their service.

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. Overall performance places ENHT in the top 10 hospitals nationally (7th) with elective activity levels recorded at 120% compared to pre-pandemic levels. This achievement is against the backdrop of the national industrial action which has taken place on 11 occasions during 2023/24, necessitating appointments are either not booked or require rescheduling for a later date due to workforce cover issues.

Compared to other NHS acute hospitals in England ENHT compares favourably on the utilisation of theatre time (83% 2023/2024 performance against a peer average of 81%) and the number of patients the Trust sees per every operating theatre list (2.6 ACPL). 83.8% of operations take place in a day case setting meaning that patient can go home on the same day.

The Trust continues to focus on maximising available operating time to ensure that patients on the waiting list are seen faster. Activity plans are developed in collaboration with all surgical specialties to maximise core capacity, reduce late starts and embed a mantra of 'Right Place, Right Procedure'.

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
Digital and pre-operative assessment teams (POA) are collaborating on a project to digitise a health questionnaire form used to determine the level of POA input required and support improved triage of patients. The digitalisation will remove the existing manual process providing a more efficient data capture method. The Trust continues to perform well on key outpatient metrics compared to other hospitals nationally. Over 25% of outpatient appointments continue to be delivered remotely since the COVID-19 pandemic leading to fewer patient journeys to the hospital and less reliance on transport services. This results in an overall positive contribution to the Trusts' Carbon Net Zero target. Patient Initiated Follow Up (PIFU) offers patients alternative ways to their traditional follow up care and as a result each month 1500 patients are offered this alternative. This has meant that fewer patients have missed their appointments as these are arranged at a time of need and convenience to the patient. The implementation of a new digital patient Hub allows patients to view, accept, and where necessary change, appointments to a convenient time for them and supports improvements in our missed outpatient appointment rate. The Patient Hub has been launched in fourteen services with a full launch planned in the second half of 2024.For those specialities that are already live, 75% of patients contacted are accessing appointment letters digitally. A new dashboard is being developed to allow the patient contact centre teams to pro-actively fill available capacity using digital processes rather than manually reviewing capacity. Over time, this will support an increase in the number of patients attending appointments per clinic. The Trust will continue to build on our excellent performance in this area and we plan to further increase our ambitions in terms of the level of activity delivered compared to pre-pandemic during 2024/25.

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	11
Report title	Freedom to Speak Up Annual Report (2023/ 24)			**Meeting Date**	10 July 2024
Presenter	Freedom to Speak Up Guardian				
Author	Freedom to Speak Up Guardian				
Responsible Director	Chief Nurse			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The purpose of the report is to give the Board the opportunity to hear directly from the Freedom to Speak Up Guardian and to provide an overview of the progress and development of the Speak Up service including:

- Continued commitment to support 'Speaking up' and promote a just, restorative and learning culture that proactively encourages conversations. Over the last 12 months majority of staff have Spoken Up to their line manager and contacted Freedom to Speak Up Guardian either because they did not believe they were heard or there was no meaningful response.

- Continued focus on local resolution, responsiveness, and organisational learning from Freedom to Speak Up (FTSU) concerns raised

- Thematic analysis and learning for the last financial year (2023/24) from FTSU concerns raised including:

  43% concerns relate to *inappropriate attitudes or behaviours*, primarily incivility

  34% concerns relate to *worker safety or wellbeing* (majority of these cases related to breakdown of relationship between line manager and employee, 10% relate to failure to follow systems and processes, 5% relate to health and safety including staff experiencing aggression and violence from service users and 8% relate to perceived inequality and discrimination)

  18% concerns relate to *patient safety and quality*

  5% concerns relate to *Bullying and Harassment*

- Ethnicity breakdown of staff Speaking Up is 56% black, brown and minority ethnic group compared with 41% white British and other white ethnicity group.

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, Thriving People, Seamless Services, Continuous Improvement.* *CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources*
This work directly impacts: • On our delivery of the People Promise, enabling improved staff survey and satisfaction at work results. • On patient safety, standards of care and service user experience • On work culture including lived values • Indirectly reduced levels of complaints and legal cases raised by staff against the Trust.
Risk: *Please specify any links to the BAF or Risk Register*
Poor speaking up arrangements and lack of psychological safety is likely to increase risk of patient safety incidents, drop in accepted standards set within policies and guidelines. This may have negative impact on service user experience Poor staff experience could increase negative staff survey results, increase turnover, sickness absence rates and on-going recruitment costs.
Report previously considered by & date(s):
N/A

Recommendation	The Board is asked to note, discuss and support actions.

To be trusted to provide consistently outstanding care and exemplary service

Introduction:

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

Background:

This report reflects the second year of increased Freedom to Speak Up (FTSU) service. The improved capacity and structure has enabled 'Speaking Up' support to be accessible any 5 days per week including weekends. The increased investment in supporting our colleagues to Speak Up demonstrates a positive shift within our Trust to building an open, transparent and psychologically safe work environment.

Our Chief Nurse, Theresa Murphy, and Non-Executive Director (NED) Val Moore are responsible for providing oversight and guidance to the FTSU service. Governance is provided by the People Committee, offering assurance in relation to process and clear connectivity to the People Priorities and People Promise.

1.0 Operational function of the service includes:

1.1 FTSU Guardian's role in supporting and resolving issues:

- Being available and responsive to staff is vital to FTSU Service. All staff receive a response within 48 hours of contacting the FTSU Guardian. Staff are always offered the choice of where/ how and when they wish to meet the guardian which can be on site or off site/ in person/ on teams or via phone
- As the aim is to make Speaking Up business as usual, staff are always encouraged to speak to their immediate or second tier line manager in the first instance unless there are sound reasons for not doing so. If staff member feels unable to do this on their own, then, with consent from both parties, the FTSU Guardian has helped facilitate a meeting with their manager, or the individual involved.
- Staff are advised at the start of the discussion that should their concern have elements of patient, staff safety or safeguarding, the concern must be escalated immediately.
- Support is provided by listening, coaching and encouraging staff to raise their concerns directly with their manager. Sometimes listening to understand is all that was required.
- FTSU Guardian has helped identify range of options when staff member has raised concerns. Often staff are unable to see the full picture when they are absorbed in the issue. By exploring options, staff are sometimes able to see a solution to their concerns. This has been reflected in the publication of the Speak Up policy 2023.
- FTSU Guardian has played a crucial role in de-escalating issues by supporting local resolution and linking in with Trust OD team to enable development at a practical level with individuals, teams, and services.

1.2 Raising awareness of Freedom to Speak Up

Speaking Up helps improve patient safety, quality of care and has a positive impact on service user and staff experience.

Therefore the FTSU Guardian has ensured that:

1. Staff members who have approached FTSU Guardian with concerns are thanked for Speaking Up and supported in speaking up.
2. Any barriers to speaking up are addressed promptly
3. Helped influence a positive culture of speaking
4. Issues raised are used as opportunities for learning and improvement.
5. Any clinical or immediate safety concerns are escalated appropriately, while supporting staff who have spoken up. Where necessary ensuring incident reporting episodes completed.

1.3 Speak Up Champions:

The last financial year, 12 Speak Up Champions were recruited and trained, bringing the total number of Speak Up Champions to 38. Recruitment has been inclusive, reflecting our diverse workforce and representing variety of staff groups, grades, and ethnicity to include all professional streams (Nurses, Midwives, Doctors, Therapists, Operation Department Practitioners, Radiographers, Health Care Support Workers, Administration and Clerical Staff).

Staff Group	**Numbers**
Additional Professional Scientific & Technical	3
Additional Clinical Services	5
Administrative & Clerical	9
Allied Health Professionals	5
Medical & Dental	7
Nursing & Midwifery Registered	9
Total	**38**

Speak Up Champions help influence the Speak Up culture within their departments, signpost colleagues who wish to speak up and help address barriers to Speaking Up. The Champions meet monthly to network, share learning and generate awareness to issues experienced by our People

1.4 Training:

All staff are assigned Speak Up training module on ENH academy. 87% staff have completed Speak Up training. All managers are assigned Speak Up and Listen Up training modules. 83% managers have completed Listen Up training module.

1.5 Freedom to Speak Up Month:

October 2023 was promoted as Speak Up month and used a variety of avenues to share information:

- Each week in October was promoted with a theme in line with NGO (Speak Up for Safety, Speak Up for Civility, Speak Up for Inclusivity and Speak Up for Everyone)
- Anonymised learning and feedback from Speak Up case was shared in Trust newsletter
- Trust Civility video was promoted within clinical departments to generate 'Civility Saves Lives' awareness.
- FTSU Guardian facilitated reflective learning session at leadership forum by sharing anonymised Speak Up case. This session generated discussion on how we can learn as an organisation and leaders made commitments to creating a psychologically safe environment within their team
- FTSU Guardian also delivered talks and presentations on Speaking Up; Psychological Safety, and influencing just, restorative and learning culture at Leadership Forum, Quality Huddle, departmental governance sessions, divisional meetings, rolling half day audit meetings and team meetings
- FTSU Guardian attended senior managers meetings, staff network groups, People Committee, Trust Partnership, Quality and Safety meetings to work collaboratively with the wider organisation to create and promote a Speaking Up culture
- Training delivered to 6 Speak Up Champions including 1 doctor.
- Speak Up Champions pledges poster was displayed in staff experience hub to promote the importance of Speaking Up.
- FTSU Guardian visited departments Trust wide and cross site to introduce 'Speaking Up' and build connections with staff and managers
- The promotion of Speak Up month reflected a rise in staff raising concerns

1.5 Regional and National Networking:

FTSU Guardian has networked outside the Trust including attending regional meetings and has set up regular meetings with FTSU Guardian at neighbouring Trusts to share learning. FTSU Guardian attended annual Speak Up conference hosted by the NGO

The next section of this report provides the statistical data of matters raised to the FTSU Guardian, assessment of the issues and themes, areas where issues are being raised, as well as outlining actions taken or underway.

2.0 Annual review of issues 2023/24

2.1 Assessment of Issues

Speak Up Cases over last 3 years.

Year	**2021/2022**	**2022/2023**	**2023/2024**
No. of Speak Up Cases	90	191	270

FTSU Guardian facilitated weekly drop-in sessions within specific departments including Critical Care Unit, Emergency Department, Maternity and Mount Vernon Cancer Centre to increase opportunities for staff to interact with FTSU Guardian. These drop-in sessions and staff consultations within various departments contributed to rise in Speak Up cases.

Number of Speak Up cases for each quarter (2023/24):

	Q1	Q2	Q3	Q4	Total
Total Cases	54	69	68	79	270
Cases Closed	54	69	67	75	265
Cases Open	0	0	1	4	5

Open cases are actively monitored, and regular contact is maintained by the FTSU Guardian with the staff member.

2.2 Themes:

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

Themes	Number 2022/23	Percentage 2022/23	Number 2023/24	Percentage 2023/24
1. Worker Safety or Wellbeing	119	62%	93	34%
2. Inappropriate attitudes or behaviours	43	23%	115	43%
3. Patient Safety/ Quality	15	8%	49	18%
4. Bullying and Harassment	14	7%	13	5%
5. Disadvantageous or demeaning treatment because of Speaking Up	0	0	0	0
Total	191	100%	270	100%

2.3 Who is speaking up?

Concerns raised by staff groups (as defined by NGO)

Staff Group	Number of Concerns Raised 2022/23	Percentage 2022/23	Number of Concerns Raised 2023/24	Percentage 2023/24
Additional Professional Scientific & Technical	9	5%	10	4%
Additional Clinical Services	39	20%	32	12%
Administrative & Clerical	39	20%	71	26%
Allied Health Professionals	7	4.5%	14	5.5%
Estates & Ancillary	0	0%	7	2.5%
Healthcare Scientists	0	0%	5	2%
Medical & Dental	12	6%	31	11%
Nursing & Midwifery Registered	84	44%	92	34%
Students	0	0%	3	1.1%
Unknown (anonymous)	1	0.5%	4	1.5%
Other	0	0	1	0.4%
Total	191	100%	270	100%

2.4 Who is speaking up by Ethnicity?

Ethnicity	Number 2022/23	Percentage 2022/23	Number 2023/24	Percentage 2023/24
Asian	45	23.5%	82	30%
Black	42	22.5%	68	25%
Mixed (Asian & White British)	6	3%	2	0.7%
Mixed (Black & White British)	12	6%	3	1%
Mixed (other)	3	1.5%	0	0%
White British	70	37%	106	40%
White (other)	12	6%	5	1.8%
Unknown	1	0.5%	4	1.5%
Total	191	100%	270	100%

2.5 Themes in more detail:

1. **Worker Safety or Wellbeing:** This relates to cases where there is a risk of adverse impact on worker safety or wellbeing including work related stress. Majority of cases relate to breakdown in relationship between line manager and employee. Both managers and employees need to be supported with resolving the issue and moving forward. In some circumstances, early mediation may have stopped issues from escalating to a formal complaint process. 10% of cases relate to failures in following due process when dealing with either employment or performance issues and 5% cases relate to health and safety including staff experiencing aggression and violence from service users and environmental safety including water supply. 8% cases relate to perceived inequality and discrimination

   Action: Managers need support to manage performance and attendance issues to ensure that any action taken is just and restorative. Training is available on ENH academy to help managers gain skills required to manage people. This is self-directed and does not provide opportunity for discussions with peers. Training with a group of managers may be more effective and supportive.

   Managers need coaching/ training to gain people management skills including skills to have difficult conversations and respond to conflict between team members. As part of learning from Speak Up cases, coaching has commenced for some managers. This needs to be expanded and provided to all managers as part of our people strategy ‘help our people thrive and grow’

   Staff in patient/ service user facing areas must complete Breakaway training. Majority of staff in high risk areas have accessed this training.

   Posters to be displayed in public areas discouraging verbal or physical abuse against staff. Poster design approved by Trust Communications team and will be displayed from July 2024.

   To continue Cultural Intelligence work that has started within the organisation including training, reverse mentoring, inclusion ambassadors and staff network streams.

2. **Behavioural / Inappropriate attitudes (Incivility):** 43% concerns raised related to interactions that lacked civility and respect and dignity. This contributed to poor psychological

safety within teams. All grades of staff including managers were impacted by this. Majority of staff who experienced incivility reported that it had a negative impact on their well-being and their ability to promote patient safety when working as part of the multidisciplinary team to deliver safe care. Some staff reported they felt anxious and dreaded coming to work.

Actions:

- Healthy Teams action plan in progress to set the cultural tone in line with Trust values and facilitate departmental values and behavior charter. Almost 60% of teams have participated proactively in sessions to define values and behaviors that underpin these values. More work is needed on how to hold peers and colleagues accountable compassionately for behaviors not in line with Trust values.
- Provision of timely supportive feedback and coaching to staff involved to help them develop communication style that reflects our Trust values. Conflicting operational pressures have created barriers in provision of timely feedback. There is improved access to coaches within our Trust and over time this should have a positive impact on standard of communication within our Trust.
- Managers need coaching/ training to gain team management skills to embed psychological safety within their team.

3. Patient safety concerns:

Patient safety concerns primarily related increased demand and limited resources to meet this demand.

- Staffing shortfall including poor skill mix – predominantly within nursing teams working inpatient areas.
- Insufficient equipment- this included equipment needed to deliver clinical care
- Deviation from agreed clinical standards
- Induction for newly qualified nurses does not include introduction to IT systems including patient pathways.
- Patient allocation within wards for nursing team does not include adjustment for dependency and skill mix. This was across inpatient areas within Lister hospital.

Action:

- Support and encourage staff to report instances where care provision was not in line with agreed policy/ standards. This action is aligned with Patient Safety Incident Response Framework (PSIRF) and plan to deliver training to clinical staff is in progress.
- Insufficient equipment and deviation from standards must be reported via incident reporting system Enhance to initiate due process, review and learning. This action is again aligned with PSIRF and proposed training to all clinical staff.
- Staffing reviews must identify areas that consistently RAG rate as Amber to seek reassurance on patient safety and quality. This action will need to be agreed by Quality and Safety Committee in line with safe staffing standards. Daily escalations occur through senior nurse site safety review.
- Training on Trust IT systems (Nerve Centre, EPMA, ICE etc.) to be built into induction for newly qualified nurses. Discussion commenced with practice development teams to supporting newly appointed staff to become familiar with appropriate IT systems have.
- Ward managers and matrons to review patient allocation against shift skill mix to ensure allocation promotes patient safety and quality. To be discussed and agreed at matrons and ward managers meetings.

4. Bullying and Harassment:

13 members of staff raised concerns about bullying and harassment. 6 staff members decided to leave the organisation as they did not trust the investigation process. 7 staff members have raised concerns with Employee Relations Advisory Service (ERAS) via Trust grievance process.

Action: Managers need pastoral support when allegations of bullying and harassment are made against them. To be discussed and agreed with ERAS team

Managers need coaching/ training to gain people management skills. To be discussed and agreed as part of Grow Together conversations.

Early interventions including mediation and facilitated conversations can help resolve issues and heal workplace relationships. Therefore, it is essential that managers seek advice promptly from People Team when allegations of bullying/ harassment are made.

3.0 Concerns raised via other avenues:

3.1 Speak In Confidence: Staff within our organisation can raise concerns anonymously via the Work in Confidence (WIC) platform. To use this, staff initially need to register and then start a conversation anonymously with a named manager who is listed as conversation recipient. The manager emails their response to WIC and the staff member is able to see that as a message on the platform and can continue the dialogue to resolve the issue they have raised.

In the financial year 2023 /24 there were 10 concerns raised via WIC:

- Employment Terms and Conditions (1)
- Bullying & Harassment (3)
- Staff Support measures (5)
- Leadership and Management (1)

Each case was managed in line with Trust policies.

As majority of our people access the Freedom to Speak Up service, WIC platform had very limited usage. The Trust has therefore decided to discontinue the service and use our incident reporting system ENHance to facilitate raising concerns anonymously. In addition to this, FTSU Guardian welcomes caller withheld phone calls for staff who wish to Speak Up anonymously.

3.2 Anonymous concerns raised with Care Quality Commission (CQC):

23 concerns were raised anonymously in the year 2023/24

2021/2022 – 2022/2023 Comparison

Year	April 2021 – March 2022	April 2022 – March 2023	April 2023 – March 2024
Number of anonymous concerns	4	4	23

Between November 2023 and February 2024, there was a cluster (22 in total) of anonymous whistleblowing letters to CQC raising concerns around maternity service including culture, bullying and harassment and maternity leadership performance. FTSU Guardian facilitated planned drop in session to listen to Staff Voice. Our Trust commissioned an external maternity review and action plan is in place to implement recommendations from that review.

1 anonymous CQC letter related to Critical Care Unit (CCU) and raised concerns around team working and discrimination. The CCU leadership team and FTSU Guardian facilitated listening events for staff. Every concern was logged for appropriate action including support for wider team.

3.3 Ask Adam email inbox: Staff within our organisation can contact our CEO directly to raise concerns by emailing ask.adam@nhs.net.

The concerns raised directly with our CEO fall under the following themes:

- Parking: availability, maintenance of staff parking, lack of disabled parking
- Wayfinding: patients getting lost, confusion between Treatment Centre and Lister's Urgent Treatment Centre
- Concerns in ED
- Cleanliness and maintenance of areas and buildings

These issues were addressed on a case-by-case basis.

4.0 Achievements:

- New Speak Up policy in line with recommendations made by NHS England and NGO, approved via Trust policy governance process and endorsed at Trust Board
- 5 Year Speak Up strategy discussed and endorsed at Board seminar in October 2023
- Rise in Speak Up cases from our people, reflecting our diverse workforce and representing variety of staff groups, grades and ethnicity
- NHS Staff Survey: 3% increase (classed as significant) in staff having confidence that if they Speak Up, the Trust will address their concerns
- Increase in local resolution/ facilitated conversation/ mediation
- 87% staff have completed Speak Up training and 83% managers have completed Listen Up training module.
- Speaking Up is part of corporate induction and included in a variety of meetings including Leadership Forum, Quality Huddle, consultant induction, medical trainee induction, local negotiation committee and junior doctor forum
- Sustained increase in cross-site visibility of FTSU Guardian including site specific all staff team briefings and departmental meetings
- FTSU workshop delivered at Mount Vernon Cancer Centre, Lister Hospital, Queen Elizabeth II and Hertford County Hospitals.

5.0 Learning and Improvement:

1. Fear continues to be a barrier to Speaking Up. The need to develop healthy teams and embed psychological safety within teams continues. There are several positive streams of work in play within our organisation including Healthy Teams, Values and Behaviours and What Matters to You. We need to connect these initiatives to ensure effective delivery on Trust strategy. In addition to this, training is available to help staff to gain skills to Speak Up and for managers to Listen Up. It is essential that all staff access this training to promote speaking up within the organisation.

2. Observation and learning from FTSU service has highlighted ongoing communication gaps that could support early de-escalation of interpersonal conflict. This increases risk of prolonging the ongoing interpersonal challenges as opportunities for early resolution are missed.
3. Support for leaders/ managers: Over the last 12 months, majority of staff who contacted FTSU Guardian had Spoken Up to their line manager. The escalation occurred either because staff did not believe they were heard or were not convinced there was a meaningful response. All ward managers and department leadership teams need support to listen and respond to staff voice. This needs to be assessed individually as part of Grow Together conversations to plan individualised support.
4. To work towards our goal of making Speaking Up business as usual, managers need to include FTSU within their agenda for team meetings biannually and invite either FTSU Guardian or Speak Champion to join their meeting
5. As civility saves lives, it is essential that the Trust video on civility is shared widely across our Trust with teams, followed by a reflective session facilitated by our civility campaign champions or OD/ Cultural team to support shifting our organisational culture to a place where our values of Include, Respect and Improve are lived
6. More maturity is required for workforce appreciation of expectations when raising a concern, or responding to a concern
7. The FTSU Guardian will continue to contribute to the NGO mission. Part of this work is to submit and support requirements from the NGO. These include quarterly submissions, regional meetings and other surveys.

6.0 2023/24 Recommendations:

1. All staff complete Speak-Up training available via ENH Academy
2. All managers complete Listen Up training in addition to above
3. Grow Together conversations for all line managers should include a plan to support individual managers to listen and respond to Staff Voice
4. Speak up cases are reviewed through the lens of learning and improving, ensuring meaningful actions and sustained improvement.
5. All teams to work in partnership with Trust OD team to draw up a team charter including behaviours that reflect our values with biannual reflections on how team members are encouraged to live our Trust Values.
6. FTSU Guardian continues work stream that has started to grow staff confidence in ‘Speaking Up’
7. FTSU Guardian continues to link in with OD to enable development at a practical level within individuals, teams and services
8. FTSU Guardian, OD and Governance work collaboratively to embed learning for Speak Up themes

The Board is asked to:

- Consider and comment on the themes, trends and issues arising from this report
- Support the drive for cultural change, including living our new values (Include, Respect and Improve) by scrutinising the organisations approach to leadership development and people management and seek assurance there are clear plans and resources in place to support this.

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	12
Report title	**Board Assurance Framework (BAF)**			**Meeting Date**	10 July 2024
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:

- Following May Board approval of the risks for the 24/25 BAF, the agreed changes have been progressed and the two completely new risks the Board asked to be added to the BAF (Risk 1: investment and Risk 9: the future of cancer services) have been fully developed and reviewed by their respective lead committees QSC and are presented for particular consideration and feedback. The new risks scores are:
  - New Risk 1: Investment: 12
  - New Risk 9: Future of cancer services: 16

- The previous separate workforce BAF risks (1 and 4) have been combined into a single risk, presented for the first time as BAF Risk 4.

- FPPC discussed the potential ramifications of the system financial deficit risk to the Trust and are recommending BAF Risk 3 (financial constraints) be amended to incorporate both the system and internal risk (the Chair and Chief Executive have expressed support for this amendment) and be called “System and internal financial constraints”. The proposed new risk description is: If far-reaching financial savings are required (either due to system financial instability or internal pressures), and we do not deliver greater efficiencies Then we will need to make difficult decisions that could have a negative impact on quality and delivery of our strategy Resulting in poorer patient outcomes, longer waiting times; reduced staff morale, reputational damage and not delivering all of our strategy. If the Board agree the revised risk description, it is likely that the risk score will increase to reflect the broader ramifications.

- Now the Care Group restructure has taken place, the Autonomy and Accountability Risk has transferred from FPPC to People Committee with the lead owner changing from the Chief Operating Officer to the Chief People Officer.

- Proposed changes to the BAF format to improve understanding of the level of assurance and traction on actions are presented on the ENH Pharma risk 11, which if supported by the Board will be rolled out to the other BAF risks. The changes most significantly introduce an assurance rating and new columns for action leads and timescales to help ensure these are clear and included. Risk appetite has also been

added to the summary page as an aide for where the Board is more or less willing to tolerate risks materialising to achieve its objectives.	
Impact: where significant implication(s) need highlighting	
Covered above	
Risk: *Please specify any links to the BAF or Risk Register*	
N/A - BAF	
Report previously considered by & date(s):	
Since the BAF was reviewed at the last Board, the BAF risks have been reviewed by their respective lead committees, bar People Committee-owned risks which will be reviewed at the next People Committee on 16 July.	
Recommendation	The Board is asked to **NOTE** the BAF update

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East and North Hertfordshire NHS Trust

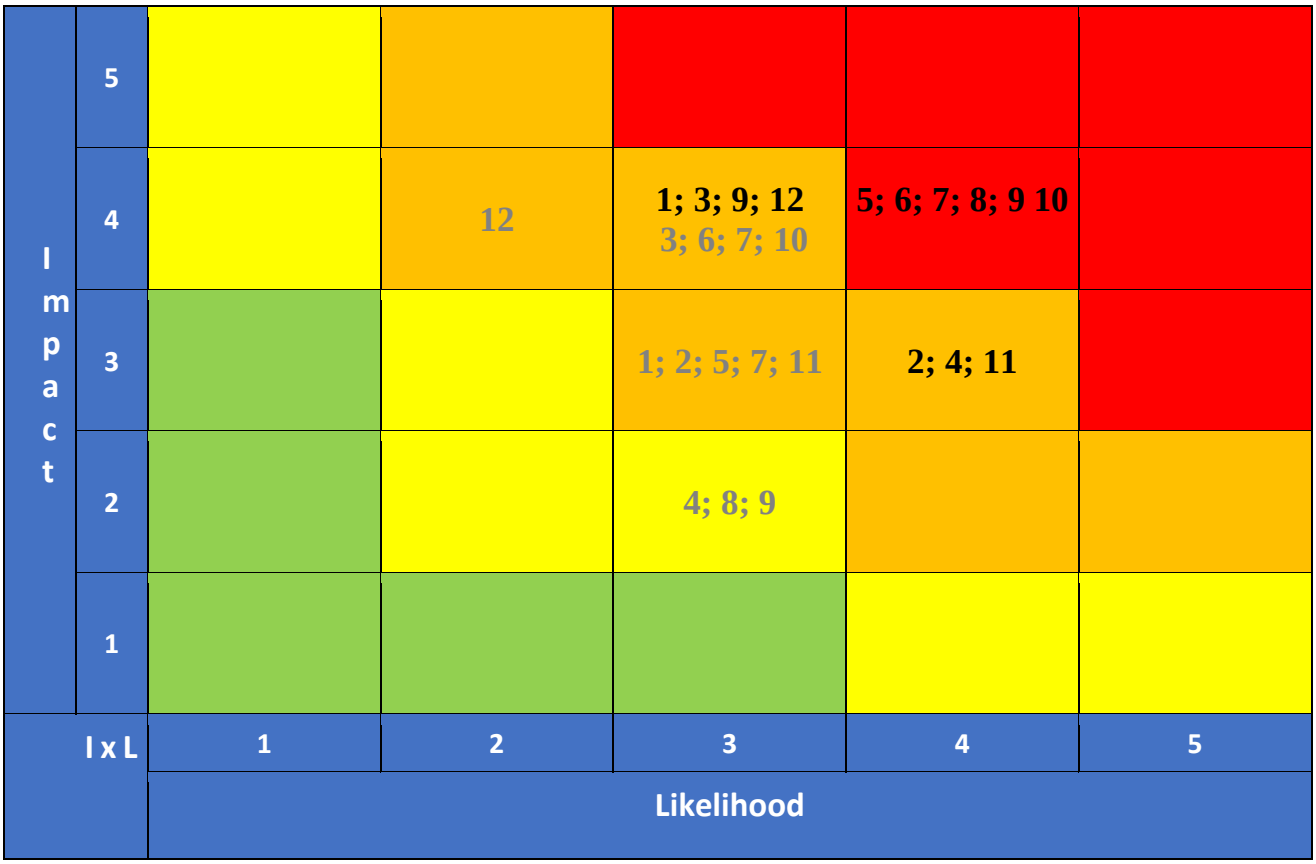
BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

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

Section 2 Strategic Risk Heat Map

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



Section 3 Risk Appetite

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

Risk Scoring Guide

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

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

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

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

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.

Annual goals 2024-25

- Eliminate avoidable waits through innovation to consistently deliver the best patient outcomes and experience
- Strive for zero harm by using our production system (ENPS), actively learning from incidents, research, innovation and evidence
- Maximise the potential of individuals and teams by providing the tools and skills to deliver a high-quality service
- Build and recognise leadership capability at all levels to create an inclusive culture and environment that enables everyone to thrive
- Use insight from our patients and communities, working in partnership to better understand their experience and improve our services
- Work as one with all our partners to build and grow equitable, high quality, compassionate services
- Transformation of patient flow and standardising processes to reduce waste, create a patient record and real time data leveraged by technology
- Achieve best use of resources and opportunities for investment by continuously focusing on identifying and eliminating waste and maximising productivity

Vision to 2030

To be trusted to provide consistently outstanding care and exemplary service

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

	Impact	Likelihood	Score	Risk Trend
Inherent	4	3	12	
Current	4	3	12	
Target	3	3	9	

Risk Lead	Chief Financial Officer	Assurance committee	FPPC

Controls	Assurances reported to Board and committees
Strategies and Plans - Digital and Estates Strategy (draft) - Approved Financial & Capital Plans 24/25 - HWE ICS – Capital Investment Plan - Provider Collaborative Network **Operational Systems and Resources** - HWE annual operating plan - System Medium Term Financial Plan (MTFP) - Trust LTFM **Governance & Performance Management Structures** - Board seminar sessions (include strategy review) - Monthly Capital Review Group meetings - Monthly FPPC meetings - Monthly Divisional Performance Review Meetings - ICS Directors of Finance - Trust Management Group	**First (front line) and second line (corporate) assurances** - Monthly Capital Plan Reports - Business Case Review Group - Internal Annual Business Guidelines - Business Planning Review Group **Third line (external/independent) assurances** - Model Hospital / GIRFT benchmarking - ERIC benchmarking returns

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
• Transformational solutions to addressing the system financial gap	• The System is evaluating options to structure transformation programmes across the system, and the potential commissioning of consultancy resource to pump prime delivery
• Confidence in the appropriate deployment of resources across place and providers	• The system has invested in a PHM system that can generate data to support analysis of the distribution of system resources. Consultancy deployment may be required. Timeline TBC
• Estates strategy to address aging infrastructure	• The Trust is presently refreshing its estates strategy. The refresh process was review by the Trust Board at the April Seminar, with an update to be presented at the May meeting. An agreed strategy will support local capital investment decisions and inform
• Long Term Financial Planning Infrastructure	• Trust to refresh its LTFM (linking to system MFTP) to clearly set out options for resource utilisation within the

	context of national and local drivers and strategies. Complete during 2024.
• Responding to in year investment opportunities	• In addition to the annual planning process, the Trust will establish a month 'Investment Review Group'. This will provide a forum to consider in year opportunities for affordable investment as they arise

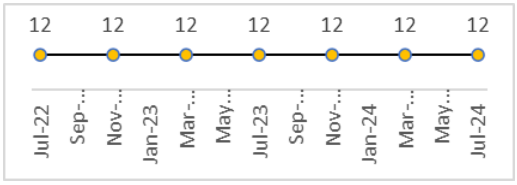
Current Performance – Highlights
The following points are highlighted from the Integrated Performance Report: • The Trust workforce has expanded significantly since COVID. This represents a significant financial investment, although activity delivery and productivity has declined. • The Trust has agreed a £15m capital investment plan for 24/25.

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

Strategic Priority: **Consistently deliver quality standards, targeting health inequalities and involving patients in their care**		Risk score 12
Strategic Risk No.2: **Health inequalities & patient expectations**		
If we do not address health inequalities nor meet the expectations of patients and other stakeholders	***Then*** population/stakeholder outcomes will suffer	***Resulting in*** 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 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 • CN attends LEDER (local authority LD meetings) **Strategies and Plans** • Quality Strategy • National Patient Safety Strategy • National patient Experience Strategy **Systems and Resources** • QlikView Quality dashboards • Quality Oversight System 'EnHance'. **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 • Appointment of Deputy Medical Director with specific responsibility for health inequality agenda **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 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 for Follow Up processes • Waiting list initiative payment model Quality governance assurance framework re-design (no surprises)	• Transformation programme is in place to support improvement in FUP processes • PSIRF transition phase in progress, planning for implementation phase underway, aiming for operational launch Q12024/25 • Pro-active Communication plan with public and partners– patient safety partner recruited. 2 more to be recruited by Apr 2024. • Getting to Good – service level governance structures agreed to support care group operational model. Development programme shall be designed and delivered following care group launch by Q2 2024/25 • Report to QSC on unwarranted variation relating to waiting lists • Access and equity discussion with specialist teams due has started, to scope patient involvement. • Development of health inequalities work programme for 2024/5
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 planning stage.* *Done first line review of long waits.* *Add to the QSC annual cycle – harm reviews of waiting lists* *Detailed paper for QSC focused by specialties – starting Jan 24 (first one)*
Clearer processes required for harm reviews relating to time waited for procedure	~~Implement and embed quality assurance framework - Methodology for harm reviews – by Feb 24 [progress being clarified]~~*QSC agreed that harm reviews for time wait~~ed for procedure will not be undertaken, plan to audit documented incidents for 6 monthly reporting to QSC.*
Delayed inpatient information of non-cancer diagnosis	Improvement priorities focusing on clinical outcome letter processes, to be embedded by end of August 2024. 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.
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 – completed Renal services patient engagement best practice model key lessons shared via PACE Committee National stroke PROM data now with divisional team.
Family liaison in patient safety incidents/bereavement	PSIRF plans include family liaison roles and responsibilities - part of operationalising PSIRF see above

Patient-centred decision-making	Patient co-design and engagement plans in progress, scoping underway to imbed in patient co-design framework, embed within PSIRF by Q4 2023/24 Revised business-case process to cover patient impact/input New UTC – Dec 23 - complete

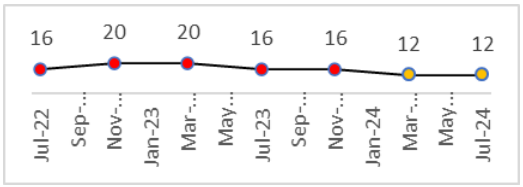
Current Performance - Highlights
The following points are highlighted from the IPR most recent Board report: • On average 94% of complaints are acknowledged within 3 working days • Overall complaints responded to within agreed timeframe remain below agreed target and a priority for improvement • Benchmark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

Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3027	Risk of Regulatory Non-compliance within Audiology Service	20
1923	Overcrowding in the Emergency Department (ED) and lack of assessment space including waiting room care	20
3028	Risk of delay in transfer of deteriorating patients from Mount Vernon with co- morbidities as a result of inadequate onsite acute facilities to support patient care.	20
0066	Risk of microbial colonisation due to inadequate hot water temperatures as a result of equipment failure & temperatures falling below required levels	12
3079	Disrepair of the Building Fabric and unmet electrical needs and mechanical requirements relating to Bluebell Ward & Bramble Day Services.	20

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

	Impact	Likelihood	Score
Inherent	5	4	20
Current	4	3	12
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 24/25 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 • Productivity / Service Line Reporting Framework • Monthly Finance Reports • Outturn Forecast report to TMG, FPPC and System • Detailed bridge analysis of performance drivers • Triple Lock Pay & Non Pay controls • Rostering system **Governance & Performance Management Structures** • Monthly FPPC & TMG 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 Income Recovery 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 Update to TMG • Monthly Finance Report / Key Metrics to FPPC • CIP report & productivity report to FPPC • Outturn Reports to TMG, FPPC and Board **Third line (external) assurances** • 24/25 Financial plan submitted to and approved by NHSE • Monthly financial reporting to NHSE & HWE System • Monthly ICS Financial Recovery Board • 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 that Industrial Action significantly reduces the volume of elective activity performed, income earned and increases unplanned medical staffing costs.	• The Trust has established mechanism to capture the cost of additional IA costs incurred and estimate the impact of lost income and activity should it occur.
• 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 • Trust ERF reporting framework adopted by ICS • Monthly official ERF reports from NHSE

• Risk of significant overspend against elements of the Trust's workforce establishment –	• Utilisation and Recruitment tools developed for use by nursing managers. • Resource Panel / Triple Lock arrangements in place • Weekly and Monthly deployment frameworks
• Risk around absence of a short and long-term financial strategy for the system and stakeholders to address underlying deficit	• The Trust has generated a medium terms financial plan based upon agreed national and local assumptions. Finance Strategy to be reviewed at the May TB seminar
• Significant reductions in Trust productivity 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 24/25. This is formalized in a specific strand of budget setting activity. Further 'Establishment Growth' review sessions to take place in June and July. • Productivity report, with an emphasis on the development of a 'Productivity Index, to FPPC. Productivity QV app deployed to assist service line level productivity reviews.

Current Performance – Highlights

The following points are highlighted from the Integrated Performance Report:

- The Trust reports a YTD deficit of £1.4m, this is adverse to plan by £0.8m
- As at Month 1 the Trust CIP plan is significantly behind plan
- Variable SLA income is behind plan at Month 1

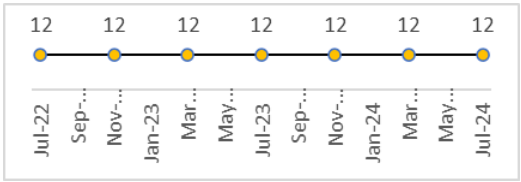
Associated Risks on the Board Risk Register

Risk no.	Description	Current score
0025	Risk of non-delivery/ failure to achieve agreed Financial Plan and Cost Improvement Programme (CIP)	12
3026	Unavailability of safe medical equipment	16
0036	Risk of delay in patient treatment within plastics as a result of same day clinical appointment cancellation due to inadequate clinical space for paediatric plastics	15
0044	Risk of delays in delivery of emergency surgery caused by a lack of Emergency General Surgery list capacity	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 12
Strategic Risk No.4: **Workforce shortages and skillset**		
If we fail to have sufficient high-quality staff, with the right technical and professional skillset, given the local, national and global workforce challenges in healthcare	***Then*** we will not be able to achieve the required number of skilled staff to meet the needs of the local populations	***Resulting in*** poor patient and staff experience, as well as potentially compromising health outcomes, quality of care and reputation.

	Impact	Likelihood	Score
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 • EDI Strategy • Estates 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 focusing on qualifying students cohorts and domestic staff, with minimal international recruitment for 24/25.~~supported by international recruitment plans~~ • National and regional 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 • Training needs analysis reviews (capability building) • Pre and post reg training programs • Training on appraisals **Recruitment and Retention** • Workforce Plans aligned with Financial budgets and agreed establishments • Intelligent deployment of NHSP staff and Care Support Worker Development programme in place ~~and international recruitment~~ • Armed Forces accreditation for 24/25 underway • Various return to work schemes e.g. retire and return • ~~Drive for 5% - recruitment and retention steering group~~	**First (front line) and second line (corporate) assurances** • 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, Performance Review Meetings, Divisional Boards • Deep dives with focus on specific workforce areas to People Committee • Freedom to Speak up prevalence thematic analysis reports • Positive leadership rounds • Safer staffing paper quarterly to QSC/TMG **Third Line (external/independent) assurances** • Equality data for workforce (WRES/WDES) • Staff survey results • EDS 2 Assessment • Care Quality Commission engagements session feedback reports

• Great for 8% - workforce deployment and bank/agency pay bill reduction programme. • ICS retention pathfinders working groups **Staff Engagement & Wellbeing** • Thank you and engagement interventions • Staff Survey • Absence and referral rates • Take up of wellbeing services **Governance & Performance Management Structures** • Medical establishment oversight working group • Clinical oversight working group • Recruitment and retention group • Workforce reports – time to hire, pipeline reports • Executive Programme Board • Education committee • Resource Control Panel	
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	• 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	• Change in Care Group Structure and appointment to clinical roles with protected time build into job plans to increase level of clinical leadership.
• Apprenticeship maximization	• Plans being developed in line with Long term workforce plan to increase uptake of apprenticeship numbers, maximise levy utilisation to a target of 90% (currently circa 60-70%)
Recruitment and retention plans required for professional groups with identified high vacancy rates, e.g. Theatres, Maternity ~~pharmacy, administration~~	• E-roster establishment review completed and aligned with approved financial budgets for 24/25 • E-roster rules and global settings review in progress to maximize deployment and utilization of staff • Introduction of Resource Control Panel for all substantive/bank/agency activity (meet daily) • Introduction of NHSE led 'Triple Lock' governance processes to reduce overall spend at organization/system level • Management competency framework launched with first cohort • ENH Production System training launched with both introductory as well as more intensive programme.

	• Nutrition and Hydration improvements have started to improve out of hours access for staff and visitors
National and local cost of living and employment picture, which may make recruitment more challenging	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

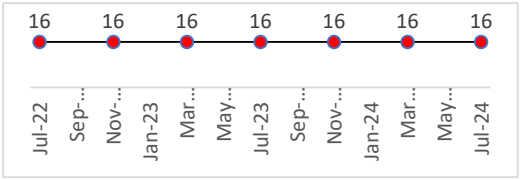
Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Successful recruitment drive for newly qualified nurses trained in the UK with increased attraction from outside of region and for key areas such as Emergency Department~~x~~ • Significant numbers of Care Support Worker applicants with a renewed focus on assessment standards to ensure skills correctly align with role • System-wide engagement event held in Hertfordshire promoting opportunities for working in the NHS

Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
0051	Risk of delay in the ophthalmology service recovery	16
0070	Insufficient midwifery staffing levels due to current vacancy and absence	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 (include staff network) • Leadership Development Plans • Engagement Strategy **Learning and Development** • Core Management Skills & Knowledge • Healthy Leadership, Care Support Pyramid • Civility and Kindness Matters • East of England Hub- Mentoring and coaching programmes • Mandatory learning around inclusion, management and development of people • Speak up training • Talent Management Strategy • 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 • Inclusion Ambassadors **Staff Engagement and 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	**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 • Divisional performance reviews **Third Line (external) assurances** • National staff survey results • EDS2 return • WRES/WDES • Published equality data

• Internal communications - all staff briefing, in brief and newsletter **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	• Healthy Teams work is being implemented in Gynae, Maternity, Theatres, paediatrics and ED. to support leaders and teams develop a good leadership rhythm and build healthy culture • Staff survey action plans support improvements happening locally and results are used to identify priority areas and specific support to low score areas - Team talks on staff survey and also on values charters remain active within divisions. These are now based on the Care Support Pyramid (4 dimensions that make a difference to staff experience) this makes the intervention organizationally consistent but locally owned and accountable. • Cultural development work continues with senior leadership team - CQ workshops and the first phase of reciprocal mentoring has concluded while action learning sets continue to work on delivering improvements.
• 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. Pilots with local events, bitesize and development coaching in order to use time effectively. Use of rolling half day and leadership forum as an opportunity for development. • 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. • Introduction to ENH Production System and ENH Production System for leaders now launched with participants supported to attend
• Ability to resolve staff complaints quickly and easily	• People Policy review completed and list of priority policies identified for further development and a rolling programme for training managers in investigation
• Investment and support levels organisationally for EDI programmes and resources restricts progress	• Management competency framework now launched and being promoted across the organisation – EDI is one of the main pillars for learning and development • EDI strategy now launched. It will launch with a 3 year delivery plan in place. EDS2 published Mar 24 with action plan to be delivered throughout the year and longer term – prep work for 24/25 process will emerge as we embed the process as BAU for ENHT.

	• 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

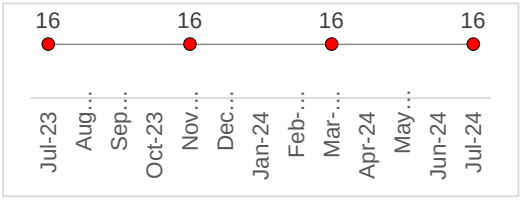
Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Updated 2023 staff survey results are being issued with local cascade and progression of actions and renewed focus • A suite of leadership and cultured development work is underway 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
	N/A	

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

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

Risk Trend



Risk Lead	Thom Pounds, CPO	Assurance committee	People

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 • Reciprocal mentorship programme	
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 • Consultation process has commenced
• 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 – plan complete~~
• Revised SFIs providing the framework for devolved financial decision-making with accountability	• Producing revised SFIs (Deputy Finance Director) – by Oct 23 – completion date revised to Nov 24
• 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

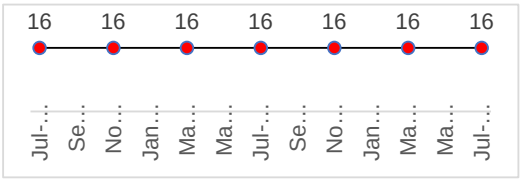
Current Performance - Highlights
The following key performance indicators are highlighted from Integrated Performance Report: • Speaking up • Complaints responded within agreed timeframe • Appraisal rate • CIPs achieved • Staff Survey results

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

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score 16**
Strategic Risk No.7: **System inertia**		
If effective system working does not develop at pace	***Then*** the issues the Trust needs system solutions to resolve will perpetuate	***Resulting in*** in enduring areas of sub-optimal health services and patient outcomes and costs.

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

Risk Trend



Risk Lead	Deputy Chief Executive	Assurance committee	FPPC

Controls	Assurances reported **to Board and committees**
Strategies and Plans • Trust Strategy and Trust objectives • Joint strategic needs assessment • ICB and HCP strategies and priorities • HCP agreed development plan **Financial Controls** • Cross System pathway transformation commissioning priorities at HCP/ICB/ICS **Governance & Performance Management Structures** • NHSE East of England oversight of ICS • ICB Board • HCP Partnership Board • Scrutiny committee • Health and wellbeing board • ENH Tactical Commissioning Group • System governance leads network	**First (front line) and second line (corporate) assurances** • Escalation reports to: Quality and Safety Committee; People Committee: Clinical Audit & Effectiveness sub-committee **Third line (external/independent) assurances** • System performance report to Board • NHSE Board feedback forums • Feedback from ICB CEO attending Board

Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
• How is the Board currently assured/updated on progress with system working	• The Board receives regular performance and delivery reports from the ICS. The CEO provides updates to the Board. System and place leaders are invited to Board briefing session
• Ability for the Trust and Board to be able to influence and inform system development and thinking	• The CEO jointly chairs the HCP partnership board, and attends system CEO meetings and the main ICS Board. Portfolio Directors attend corresponding system based working group meetings.
• Trust objectives linking and helping deliver the ICB strategy	• The Trust annual plan seeks to deliver targets and aims that are embedded within the ICB short and long term plan.
• ICB BAF does not include effective system-working	• ICS to address this gap

Current Performance - Highlights

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

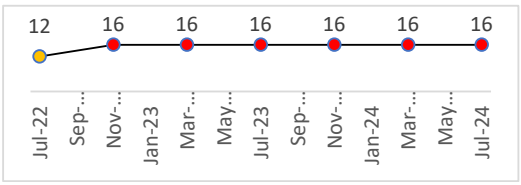
- The over arching system financial plan targets achievement of £30m deficit in 24/25.

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

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		Risk score 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 24/254 • Trust roll out of validated~~new~~ ptl from June 24 • Cancer Strategy and Cancer recovery plan, refreshed for 2~~43~~/254 • ~~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~~ • Lister UTC operational from 15/1/24 • HPFT Mental Health Urgent Care Centre first phase operational from 31/1/24 • UEC Improvement ~~Transformation~~ Programme (including culture and leadership, ~~ambulance handovers,~~ WTBS, discharge processes, paediatric ED, Frailty), refreshed for 2~~43~~/254 • 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~~ participated in EoE ED Peer Review (Dr Leilah Dare) in ~~scheduled for 25~~ May 2023; Dr Dare invited to review progress and support further improvement, May 2024 • New clinical and operational leadership being ~~to be~~ appointed as part of Trust Operat~~i~~ng Model Change (introduction of care groups)~~onal Restructure~~ from ~~May~~ 24~~17 April~~ – ~~Trust Director of Operations & Performance~~ • Deputy Chief Nurse working from ED March – June 2024 • 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 • New ICB Access policy approved and in active use **Performance Information Controls** • IPR	**First and second line (internal) assurances** • Board (IPR; transformation reports) • FPPC (IPR &~~-~~deep dives~~deep dives~~) • Board Seminars • ~~Newly formatted~~ Dd~~i~~visional 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. ENHT now de tiered for elective and cancer. HWE system remains at Tier 2 for UEC. • ~~National Tiering system~~

• Annual recovery trajectories and weekly demand and capacity meetings • ~~Spotlight items at FPPC 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 consultation complete and implementation underway ~~underway~~ to further develop clinical and operational leadership, clear accountabilities, shared learning, QI approach • ENH Production System opportunities for process improvement • ~~Transformation programmes at the Exec Programme Board~~ • Divisional Performance Reviews • Divisional Board meetings • Regular tumour group meetings and improvement workstreams • System-wide Cancer Board chaired by Lead Divisional Director for Cancer • Specialty exception meetings	
Gaps in Controls and Assurances	Actions and mitigations to address control / assurance gaps
• New NHSE performance metrics (62 days cancer and 65 weeks waits)	• 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. • National cChanges with the reporting of community paediatrics, this will continue to be monitored internally but will be externally reported through the community dataset
• Scope of validation of Patient Tracking Lists	• To commence contacting patients every week through use of Netcall - commenced and weekly messages now going out to patients as BAU • ~~Working with digital on PTL to include diagnostic information~~ • Working with digital on PTL to include diagnostics • Plans to roll out validated~~new~~ ptl Trust wide in June ~~Working with BI on new PTL dashboard with focus on follow up~~
• 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. • EEAST Local Operations Cell participation in HWE System Coordination Centre
• 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 • E referral introduced for Hospital @ Home • Work ongoing with system partners on discharge processes.

	Further work required to prevent admission for frailty patients to include a frailty assessment unit in EDNew pathway with Garden House Hospice for frailty patients. • Appointment of Hospital@Home nurse working within the unplanned care division to increase utilisation
• 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 – commenced • Recruitment into ultrasound / MRI / CT / echo and neurophysiology • Clear recovery trajectories created with action plans to deliver compliance by March 25 (-excluding MRI) • Robust plan for MRI outsourcing to bridge gap in demand • Optimise use of community diagnostic capacity • Spotlight on diagnostics as part of the Trusts demand and capacity work
• 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 • 28 day faster diagnosis • 78 weeks RTT • 65 weeks RTT • Ambulance handovers • ED 4 and 12 hour performance • Diagnostic waits • 2 week waits • Stroke performance • Patients not meeting the criteria to reside

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

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

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

Risk Lead	Chief Operating Officer	Assurance committee	QSC

Controls	Assurances reported **to Board and committees**
Strategies and Plans • Clinical Strategy **H&S controls** • Cancer divisional risk register (up to date with no overdue risks and all risks have mitigation actions) • Fabric improvement capital investment to address the sites two year backlog maintenance priorities (partial but not a long-term control) • Mortality and morbidity meeting oversight of risk **Governance & Performance Management Structures** • NHSE Sustainability meetings and dashboard • 30 day SACT mortality data to mortality committee	**First (front line) and second line (corporate) assurances** • Sustainability dashboard to Divisional Board/RMG ICB/NHSE monthly • Standing Board updates on progress with the Mount Vernon transfer • Cancer services deep dives to QSC and FPPC • H&S assurance report to FIP Programme Board & Divisional Governance Forum and H&S Committee • Cancer performance measures in IPR **Third line (external/independent) assurances** • CQC MV assessment (but last one was 2016) • Benchmark of cancer clinical outcomes through clinical alliance • National annual cancer patient experience survey • IRMER/MHRA/EA compliance review
Gaps in Controls and Assurances	**Actions and mitigations to address control / assurance gaps**
• Clear ownership and roles and responsibilities for making decisions on the future of the current service and ENHT's role in this • Fragmented decision-making between ICB and NHSE which could make decision-making more challenging	• Add to agenda/ensure continued visibility on joint ICB/NHSE cancer contract meetings to push for prompt decision-making • Being clear what is the role of ENHT in the future of the service and this being understood all key stakeholders • Add to agenda/ensure continued visibility on joint ICB/NHSE cancer contract meetings to push for prompt decision-making
• Access to specialist oncology advice at local DGH sites for those that cannot access Mount Vernon	• Need a clinical oncology strategy for Lister once Mount Vernon transfers
• Business continuity plan should acute MV services need to close suddenly	• Business continuity/evacuation plan pre-agreed with other cancer providers (UCLH, Circle, Watford, Hillingdon etc)

• Outcome of service options to NHSE to enable Trust planning	• Obtaining answer from NHSE/ICB about capital and revenue plans to sustain current services
• Lack of a financial mitigation plan for sudden loss of services or significant interim costs whilst awaiting a decision	• Work with NHSE to identify interim funding opportunities that address investment above and beyond NHS contract negotiations
• Assurance gap: Improving QSC oversight of the Mount Vernon strategic plans/patient pathways	• Introduce regular assurance/progress reports to QSC until this risk is resolved

Current Performance - Highlights
The following key performance indicators are highlighted from the Integrated Performance Report: • 62 and 31 day cancer performance standards • Faster diagnosis standard • 30 day SACT mortality data • COSD cancer data

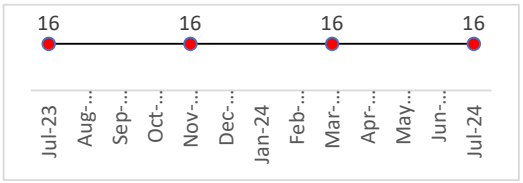
Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
3028	Risk of delay in transfer of deteriorating patients [from Mount Vernon] with co- morbidities as a result of inadequate onsite acute facilities to support patient care.	20

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**	Risk score 16
Strategic Risk No.10: **Digital transformation**	

If the necessary digital transformation improvements are not prioritised, funded or delivered	***Then*** the Trust will lack the digital means to deliver its plans including using obsolete legacy systems that are unsupportable	***Resulting in*** 1) not delivering transformation plans that are crucial to improving efficacy and productivity 2) not achieving the nationally mandated minimum digital foundations

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

Risk Trend



Risk Lead	Chief Information Officer	Assurance committee	FPPC

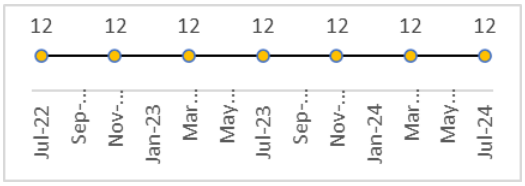
Controls	Assurances reported to Board and committees
Strategies and Plans • Board approved 23/24 Strategic Objectives • 23/24 Digital Roadmap • 2021 Digital Strategy Outline Case (SOC) methodology **Governance & Performance Management Structures** • Clinical Digital Design Authority **Quality Management 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 • Trust funds identified to fund EPR programme. • Fully mitigated for EPR
• 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. • Digital Roadmap presented to FPPC January 2024~~Successful Negotiation with EPR providers to establish licence models compliant with the Capital revenue mix available to the Trust.~~ • Digital programme commenced April 2024~~Digital programme started on 1/4/24~~

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

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

	Impact	Likelihood	Score	Assurance	Risk Trend
Inherent	4	4	16	*[TBC from Limited Adequate or Substantial]*	
Current	3	4	12		
Target	3	3	9		

Risk Lead	Chief Kaizen Officer	Assurance committee	People

Controls	Assurances against stated controls, with assurance level *1st line (front line); 2nd (corporate); 3rd (independent)*	Assurance score
Strategies and Plans		
Trust Strategy, Vision and Annual Goals	Board report – annual progress (2)	
People Strategy	Board report – annual progress (2)	
EDI Strategy	Board report – annual progress (2)	
Freedom to Speak Up Strategy	Board report – annual progress (2)	
Operational Systems and Resources		
PSIRF	QSC quarterly updates (2)	
Governance & Performance Management Structures		
TGT oversight of ENH Production System programme	TGT monthly (2)	
Staff survey	Board report – annual (3)	
Annual transformation continuum assessment	TGT annually (2)	
Improvement Partnership contract management	TGT monthly (2)	
Executive Value Stream Guiding Teams	TGT monthly (2)	

Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Single improvement methodology not established across the organisation	• ENH PS 18-month work plan approved via TGT. • Intro to ENHPS training programme. • Establish 'Report Out' framework to celebrate kaizen successes and spread learning.	• KOH • KOH • KOH	• Mar 25 • Sept 24 • Nov 24
• Leaders acting as coaches and learning to become problem framers, not fixers	• Executive LEIPA development programme. • Deliver three cohorts ENH PS for Leaders. • Positive leadership rounds.	• TP • KOH • KOH	• Oct 24 • Mar 25 • July 24
• Managers understanding their duties and responding to resolve issues and	• Management competencies framework and training programme.	• NN • TP	• Dec 24 • Dec 24

concerns raised by staff (i.e. Freedom to Speak Up framework)	• Identified as a key priority in response to the staff survey therefore included as part of the 'team talk' discussions where actions are being developed and delivered locally. • Freedom to speak up training included in required learning for all staff on ENH Academy. • Reciprocal mentoring programme in place to develop greater appreciation and understanding of colleagues from different personal and professional background.	• TP • TP	• Sept 24 • Mar 25
• Variation in ward to Board quality governance structures and operational procedures	• Embed new Divisional model and deliver developmental training programme for leadership teams. • Implement daily management via the ENH PS for Leaders programme. • Roll-out weekly Positive Leader Rounds initiative. • Introduction of leader standard work.	• LD • KOH • KOH • KOH	• Sep 24 • Dec 24 • Sept 24 • Dec 24

Current Performance – Highlights from the Integrated Performance Report:
• KPO team successfully achieved Advanced Process Improvement Training certification via VMI in May. • Intro to ENH PS launched via ENH Academy across all main sites from April. • First Rapid Process Improvement Workshop for Recruitment completed March. • Executive Masterclass in Standard Leader Work facilitated by VMI delivered April. • PDSA for new Leader Standard Rounds commenced June. • Phase 1 LEIPA 360 questionnaires and feedback sessions completed. • Nominations and programme confirmed for three ENH PS for Leaders cohorts to commence July.

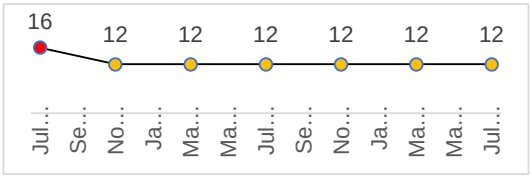
Associated Risks on the Board Risk Register		
Risk no.	Description	Current score
	N/A	

Strategic Aim: **Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities**	Risk score 12
Strategic Risk No.12: **Clinical engagement and change**	

If the conditions for clinical engagement with best practice and change are not created and fostered	***Then*** we will be unable to make the transformation changes needed at the pace needed	***Resulting in*** not delivering our recovery targets or improved clinical outcomes; not building a financially sustainable business model; and being unable to contribute fully to system-wide transformation

	Impact	Likelihood	Score
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 • 'ENHANCE incident reporting system' • GIRFT • KOPs programme **Governance and Performance Management Structures** • Operational committees e.g. Patient Safety Forum, Mortality surveillance committee • New operational model introduced in May '24 that provides additional clinical leadership capacity **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 • Patient Safety Incident Framework • Quality Improvement service • Transformation service • Reward and recognition • ENH Production System **Training and sharing best practice** • Royal College of Nursing Clinical Leadership Programme • Clinical Directors development Programme • Clinical Directors' Away Days • New Consultants development programme • Improvement and transformation capability sessions • Quality Improvement coaching • Leadership and human factors development programmes • Research programmes	**Internal Committee-level assurances** **Sub Board Committees** • Quality and safety Committee report • Education committee escalation report • Clinical Audit and Effectiveness Committee escalation report Safety Culture survey **Third line (external) assurances** • Annual and Pulse staff survey results • Care Quality Commission assessment process • ICB / Place Quality Surveillance Group escalation report • NHS patient survey results • Peer assessment review report and action plan • External/ internal audit programme reports and action trackers • Getting it Right First Time national programme • GMC Survey • HEE National Education & Training Survey

• Mentoring for new and existing consultants programme **Staff engagement and well being** • Here for you health at Work • Values and behaviour programmes • Freedom to speak up guardian / network • 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 • *Introduction of ENH Production system 23-25 onwards*
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 • Introduction of additional clinical leadership within the care group structure
Unwarranted variation in quality assurance framework	Redesign quality assurance framework *by end of Q3 22/23* [OVERDUE]
Current national safety Incident framework	*Patient Safety Incident Framework: introduced, in early stages*
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, 2024~~2023-4~~ *[originally due for Q1 23/24]*
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) currently being ~~to be~~ implemented ~~by Q4 23-24~~ which 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	

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	13
Report title	Summary Learning from Deaths Report			**Meeting Date**	10 July 2024
Presenter	Medical Director				
Author	Mortality Improvement Lead				
Responsible Director	Associate Medical Director for Reducing Unwarranted Variation			**Approval Date**	12 June 2024
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, Thriving People, Seamless Services, Continuous Improvement. 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 – 12 June 2024 (approval of full report)

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

To be trusted to provide consistently outstanding care and exemplary service

1. Executive Summary

1.1 Summary

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

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

1.2 Impact

1.2.1 Strategic ambitions

The Trust has developed a framework of strategic objectives to support and drive continuous improvement. These are detailed on the front cover of this report. Additionally, a set of mortality focussed objectives has been developed to echo and support the overarching Trust's strategic ambitions. These are due to be refreshed over the coming months.

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 Q4 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 June 2024.

1.2.3 Potential impact in all five CQC domains

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

Figure 1: Learning from deaths and CQC domains of care

1.3 Risks

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

Table 1: Current risks

Risks	Red/amber rating
SJRPlus review tool With only 2 weeks' notice, in mid-March NHSE indicated that from 1 April the SJRPlus review tool would no longer be hosted by NHS Apps, with a proposed transfer to Aqua (an NHS health and care quality improvement organisation working across the NHS, care providers and local authorities). While the transfer has now successfully taken place, and we have indicated that in principle we would like to sign up to continue using the review tool, there was a delay to Aqua providing a DPIA for our review/approval, resulting in a delay to us confirming the agreement. In the interim we have had to suspend the conduct of reviews. The reporting tools associated with the structured judgement review tool currently remain on the NHSE Making Data Counts workspace. With the transfer of the Better Tomorrow team/SJRPlus App to Aqua, Aqua has not yet been able to confirm how long the report tools will continue to be supported by NHSE.	
Cardiology: recurrent HSMR and SHMI alerts (especially AMI) Following recurrent MI mortality alerts and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was agreed. This work remains ongoing. The latest update to the Mortality Surveillance Committee in April indicated there are still mis-matches between clinical activity and coding in a significant percentage of cases. The update also looked at heart failure and reported a significant mis-recording of HF among patients admitted under General Medicine. A further update has been agreed for September.	
Implementation of the Patient Safety Incident Response Framework (PSIRF) Work remains ongoing to ensure cohesion between our SJR process and the new patient safety framework. We continue to work closely with the PSIRF implementation Lead, checking that relevant policies and procedures align.	
ENHance: Using for escalation, reporting/learning/sharing There have been delays and issues experienced regarding the transfer of other Trust systems onto ENHance. While an early conversation has taken place regarding the potential of developing an ENHance mortality module, this possibility will not be fully investigated until all core Trust systems have been embedded on ENHance.	
Medical Examiner Integration & Community expansion The statutory date for the Service has been announced and will commence on 9 September 2024. Work continues with the 9 remaining GP surgeries who have yet to start referring deaths to us. There are also 3 independent care providers that we will be the ME office for – Pinehill, Spire and One Hatfield. Discussions with these providers have commenced.	
Ovarian Cancer SACT 30 Day Mortality: External review findings In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report has been submitted for approval.	

2. Context

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

2.1 Headline mortality metrics

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

Table 2: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 0.97% for the 12-month period to April 2024 compared to 1.11% for the latest 3 years.
HSMR: (data period Mar23 – Feb24)	HSMR for the 12-month period is **84.08, 'First quartile'.**
SHMI: (data period Jan23 – Dec23)	Headline SHMI for the 12-month period is **94.12, '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.

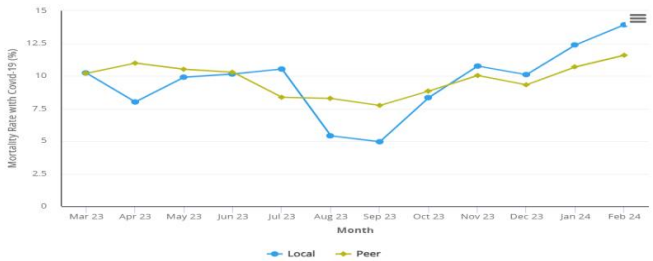
Rolling 12-month SHMI stands at **94.12** to December 2023. This represents a decrease from the last reported 97.48 for the 12 months to September 2023 (which was unusually high due to a data submission error which has been corrected). At the same time, it represents an increase from the previous 12-month period to November, which stood at 91.9. An element of change had been expected as the latest data is based on newly revised SHMI methodology, which included a number of changes to the dataset.

2.2 COVID-19

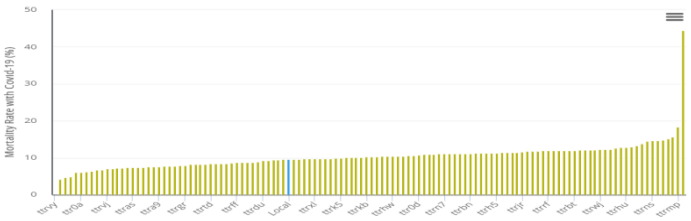
The following charts provided by CHKS show how the Trust's mortality rate for Covid compares with our national peers.

Figure 2: Covid-19 Peer Comparison: March 2023 to February 2024

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 Q4.

2.3.2 HSMR CUSUM alerts

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

2.3.3 SHMI CUSUM alerts

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

Table 3: SHMI Outlier Alerts December 2022 to November 2023

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths	Included Spells
108 - 198, 199, 200: Skin disorders	273.63	25	9	16	318
79 - 131: Respiratory failure; insufficiency; arrest (adult)	180.34	34	19	15	71
100 - 156, 158: Nephritis; nephrosis; renal sclerosis, Chronic renal failure	295.51	17	6	11	323
35 - 50: Diabetes mellitus with complications	203.49	20	10	10	279
90 - 146, 147: Digestive, anal and rectal conditions	293.72	14	5	9	403
58 - 101: Coronary atherosclerosis and other heart disease	339.71	12	4	8	247

The skin disorders group has recently been reviewed with information regarding patients admitted to hospital with pressure ulcers shared with the safeguarding team and the Community. It is being monitored by the Head of Coding, with a further report scheduled to be provided to the Mortality Surveillance Committee in July. Collaborative work remains ongoing between Coding and the relevant services regarding the Nephritis diagnosis group and Coronary atherosclerosis. A coding review of the Digestive, anal and rectal conditions deaths followed by the SJR of two of the deaths gave rise to no concerns, so no further review will be conducted at this point in time. Coding reviews are in progress for the Respiratory failure and Diabetes groups.

2.3.4 Other external alerts

There are no current active external alerts.

2.3.5 Key Learning from Deaths Data

2.3.5.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q3 2023-24.

Table 4: Q4 2023-23: Learning from deaths data

	Jan-24	Feb-24	Mar-24
Total in-hospital deaths (ED & inpatient)	146	108	116
Deaths with SJR completed to date (at 30/04/24)	38	23	19
Patient safety incident escalation from SJR (by month of death) (at 01/02/24)	9	3	5
SJR outcome: Deaths more likely than not due to problem in care (≥50%)	0	0	1
Learning disability deaths	0	2	2
Mental illness deaths	3	2	0
Stillbirths	1	0	1
Child deaths (including neonats/CED**)	0	0	0
Maternity deaths	0	0	0
PSIIs declared regarding deceased patient	0	1	0

SIs approved regarding deceased patient	1	0	2
Complaints received in month regarding deceased patient	3	5	3
Requests received in month for a Report to the Coroner	16	11	13
Regulation 28 (Prevention of Future Deaths)	0	0	0

* One of these stillbirths was a late foetal loss (22+0 to 23+6)
* *Medical termination of pregnancies where the baby is born with signs of life are not included in these figures

2.3.5.2 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 transition from our old in-house mortality review tool to using the SJR*Plus* tool and approach, presents a reporting challenge, as the data aligns differently. In the short term, the dashboard will not be used. Now that we have 12 months of data on the new system, work is commencing to develop a new contextual dashboard.

3.0 Scrutiny to SJR

3.1 Medical Examiner Scrutiny

Table 5: Medical Examiner scrutiny data: Q4 2023-24

Scrutiny detail	Jan	Feb	Mar	Q4 total
Number of ENHT deaths scrutinised by ME	140	106	99	345
Number of MCCDs not completed within 3 calendar days of death	9	8	10	27
Number of ME referrals to Coroner	35	24	15	74
Number of deaths where significant concern re quality of care raised by bereaved families/carers	4	4	5	13
Number of patient safety incidents notified by ME office as a result of scrutiny	1	0	0	1
Number of ME referrals for SJR	30	28	23	81

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 continuing to embed the use of the new tool and processes, the focus is now on developing supporting documentation and appropriate reporting tools for the new methodology.

With only 2 weeks' notice, in mid-March NHSE indicated that from 1 April the SJRPlus review tool would no longer be hosted by NHS Apps, with a proposed transfer to Aqua (an NHS health and care quality improvement organisation working across the NHS, care providers and local authorities).

While the transfer has now successfully taken place, and we have indicated that in principle we would like to sign up to continue using the review tool, as Aqua has only recently provided their DPIA for our review/approval. As soon as this have been approved, we will confirm the agreement. In the interim we have had to suspend the conduct of reviews.

3.2.2 SJR and deaths YTD headline data

Table 6: 2023-24 Deaths and SJR headline data to the end of Q4

Data count	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Total
Total in-patient deaths	103	109	85	111	95	79	102	107	149	134	98	110	1282
Total ED deaths	6	5	7	5	6	6	3	13	17	12	10	6	96
SJRs completed on in-month deaths (at 30.04.24)	26	41	30	24	40	32	34	32	28	38	23	19	367

The above table shows that to date, 29% of hospital deaths have received a formal structured judgement review. This positions us well against the 15-20% suggested by the Better Tomorrow team (now part of Aqua) as being needed to provide robust learning/assurance.

3.2.3 Learning beyond SJR

3.2.3.1 SJR patient safety incident escalations

Table 7: Year to end of Q4 Patient Safety Incidents reported following SJR

Escalations for deaths in month (30/04/2024)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Safety Incident Escalations from SJRs	3	13	6	9	11	9	12	4	7	9	3	5	91

For deaths in the current year which have been subject to an SJR, 91 cases have been escalated as a patient safety incident. When we adopted the SJR format and revisited our internal quality and governance processes, it was agreed with our patient safety team, that there are three triggers in the SJR which should result in the case being logged and investigated as a patient safety incident. These criteria for further review are broader than those historically used to identify ACONs (areas of concern) which means more cases may be identified for further scrutiny, but some will involve a lower level of concern, but still provide valuable opportunities to learn.

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

5 cases concluded using the new process were discussed at March Mortality Surveillance. Summary detail is provided below:

Table 8: Q4: Concluded Escalated Cases Summary

SJR/SI	Death Preventability (Final MSC decision)	Incident category	Learning themes
SI (HSIB Investigation	Definitely not preventable	Maternal Death	N/A
SI	Possibly: <50:50	Delay in investigations	Assessment, investigation or diagnosis
SI	Definitely not preventable	Poor discharge	Medication/IV fluids/Electrolytes/Oxygen Treatment/Management Plan
SJR	Possibly: <50:50	Deteriorating Patient	Medication/IV fluids/Electrolytes/Oxygen
SI	Definitely not preventable	Medication	Infection Prevention/Control

As the Trust transitions to the Patient Safety Incident Response Framework (PSIRF), it will be vital that internal pathways for review and investigation are revisited and clarified to ensure a seamless fit that ensures effective processes that combine to maximise learning potential. Discussions have commenced and will continue in parallel to PSIRF development work.

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.

As a starting point, from December 2023 a quarterly presentation is created focussing on a particular aspect of SJR data. Badged as “Food for thought”, the intention is that while these are easily digestible, they may provoke curiosity and further consideration of review outputs. The latest looked at preventability of death SJR data for the 2023-24 year. This will be shared at Mortality Surveillance Committee, Divisional Q&S meetings as well as Rolling Half Day.

4.0 Improvement activity

4.1 Focus areas for improvement/monitoring

Table 9: Focus Areas for Improvement

Diagnosis group	Summary update
Ovarian Cancer	In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. With completion of the assurance work, a final SI report has now been submitted for approval. The Mortality Surveillance Committee will continue to monitor ongoing work until all actions on the remedial action plan have been completed.
Cardiology diagnoses	Following recurrent MI mortality alerts and a report by the Cardiology Clinical Director, Cardiology committed to a joint initiative with Coding to review all cases with an admitting diagnosis, or cause of death, of acute MI, to identify and exclude ‘coding error’ cases and ensure appropriate learning. This work remains ongoing with regular updates provided to the Mortality Surveillance Committee, as initial findings indicated that a miss-match between clinical activity and coding in a significant percentage of cases.
Sepsis	While HSMR performance relative to national peer remains extremely well placed, achievement of sepsis targets remains variable. The sepsis team continues to develop multiple initiatives aimed at improving compliance.
Stroke	The Trust currently has a SSNAP rating of B for the period Oct-Dec 2023. After a long delay, SSNAP has finally provided an updated risk adjusted mortality report covering the 2-year period April 2021 to March 2023. While this indicated that the Trust is not an outlier for mortality, it also showed no improvement since the last reported risk adjusted metric for 2019-20. At the same time HSMR and SHMI have both showed significant improvements since the April 2021-March 2023 period. It is likely to be some time before we can see whether the SSNAP metric follows a similar trajectory. As our SSNAP risk adjusted mortality is not well placed versus our national peers, mortality performance will continue to be monitored, with a further update to Mortality Surveillance Committee by the service,

	scheduled for the Autumn. The recent focus has been on working with the national team on the Thrombolysis in Acute Stroke Collaborative (TASC) project which is a national programme to work with selected Trusts to improve their Thrombolysis rates. Collaborative working at a regional level with the East of England Integrated Stroke Delivery Network (ISDN) remain ongoing. This continues to focus on the National Optimal Stroke Imaging pathway (NOSIP) and Trust team members from nursing, medical and radiology teams recently attended a regional event focussing on CT perfusion scanning.
Emergency Laparotomy	While focussed improvement work continues, case ascertainment remains a challenge. To meet the Best Practice Tariff, we need a case ascertainment above 90%. Good news includes the fact that the service considers we are well placed to achieve the new BPT requirement of completion of risk documentation and geriatric input for 40% patients, indicating that in this regard we are amongst the top performing Trusts. The long-anticipated re-establishment of the Surgical Assessment Unit commenced from mid-January 2024 and has improved emergency surgical patient flow, thereby significantly improving the care for NELA patients. Collaborative deaths review work is also ongoing with the Coding department, aimed at improving the quality of coding and thereby improving the accuracy of submitted HES data, which forms the basis of mortality indicators. The benefits from this work will take time to show in published metrics. From April 2024 the NoLap Audit has been introduced. This is a national mandatory audit which will include cases meeting NELA criteria, but which were not included in NELA as the patient was too high risk to be operated on. For the first year the two main inclusion criteria are bowel perforation and ischaemia.

5.0 Preventable deaths

Currently we are here referring to those deaths that have been judged more likely than not to have been preventable on the basis of an SJR. It must be remembered that the question of the preventability of a death is the subjective assessment of an individual reviewer on 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. For cases that are further subject to patient safety investigation, with final consideration at Mortality Surveillance Committee, preventability will be revisited in the light of the investigation. This final score will be used for annual Quality Account reporting.

The table below provides Q1-Q4 deaths/SJR/Preventability data (detailing SJRs conducted up to 30/04/24). The outcome of investigations and actions relating to these deaths will be discussed by the Mortality Surveillance Committee.

Table 10: 2023-24 SJR preventable deaths data to the end of Q4

Data count (at 30/04/2024)	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Total
Hospital deaths (ED & inpatient)	109	114	92	116	101	85	105	120	166	146	108	116	1378
SJRs completed on in-month deaths	26	41	30	24	40	32	34	32	28	38	23	19	367
% of deaths subject to SJR to date	24%	36%	33%	21%	40%	38%	27%	27%	17%	26%	21%	16%	27%
Deaths judged more likely than not to be due to a problem in healthcare	0	0	1	0	1	0	1	0	0	0	0	1	4
% SJRs assessed ≥50:50 preventable	0%	0%	3%	0%	3%	0%	3%	0%	0%	0%	0%	5%	1%

6.0 Options/recommendations

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

ITEM 14: INTEGRATED PERFORMANCE REPORT - Performance Highlights

East and North Hertfordshire NHS Trust

Quality

- *C difficile (C diff.)* - There has been a decrease in the number of cases this month compared to the previous month by 36% (4 cases). Although this remains above the monthly threshold.
- MRSA BSI - There were zero MRSA BSI in the month of May with an annual threshold of 0.
- Friends and Family Test (FFT) - Positive feedback on the Trust's inpatient facilities is consistently passing the target; Emergency and Outpatient department remains mixed.
- Proportion of complaints acknowledged within three working days is consistently passing the target.
- The rolling 12-month crude mortality rate continued to decrease in May-24, HSMR remained below 100 and SHMI has seen an increase in their latest respective publications.

Operations

- Urgent and Emergency Care - The monthly attendances saw further increases with the continued presentation of high acuity reducing the performance to 68.37% in May.
- Cancer Waiting Times - The Trust achieved the 28-day Faster Diagnosis and 62-day referral to treatment standards in Apr-, but not the 31-day decision to treat to treatment. All three are statistically likely to have mixed performance (passing and failing) from month to month.
- Referral To Treatment (RTT) 18 weeks - Numbers of patients waiting over 65, 78 and 104 weeks for treatment (excluding Community Paediatrics) continued to show Improving trends in-month.
- Diagnostics - The proportion of patients waiting more than six weeks for diagnostic tests remains higher than the target, with statistically significant trend in May.

Finance

- The Trust submitted a revised 2024/25 plan in June of £1m surplus. This plan continues to assume the delivery of a £33.8m (5%) cost improvement programme. The plan phasing assumes that there will be a step up in CIP delivery in the second half of the year.
- At Month 2 year to date, there was a planned deficit of £1.1m, actual performance is in line with the plan. Whilst the year to date position is in line with plan this includes significant non recurrent reserves.
- ERF delivery has improved in May, after a slow start in April, however variable income is still £0.6m adverse to plan year to date.
- Pay was £0.6m adverse to plan in month, excluding the impact of reserves. High levels of Waiting list initiative payments accounts for £0.3m of the variance.
- The Trust has a challenging CIP target of £33.8m this year. To date the Trust has delivered £4.7m savings against a £4.7m plan.

People

- The vacancy rate increased to 9.3% (632 vacancies). Recruitable establishment decreased by 8.5 WTE. There are 122 more staff in post than a year ago.
- 'Grow Together review (GTR)' compliance this month shows a slight increase. Ongoing GTR completions continue, though some groups that should have completed their GTRs by end May still remain non-compliant.
- Mandatory training shows a very slight decrease compared to the previous month, though still on target.
- Continued focus on management of short and long term sickness absence results in more consistent reductions supported through regular divisional board review and occupational health supporting work and early advice is making a consistent positive difference.

Month 02 | 2024-25

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 02 | 2024-25

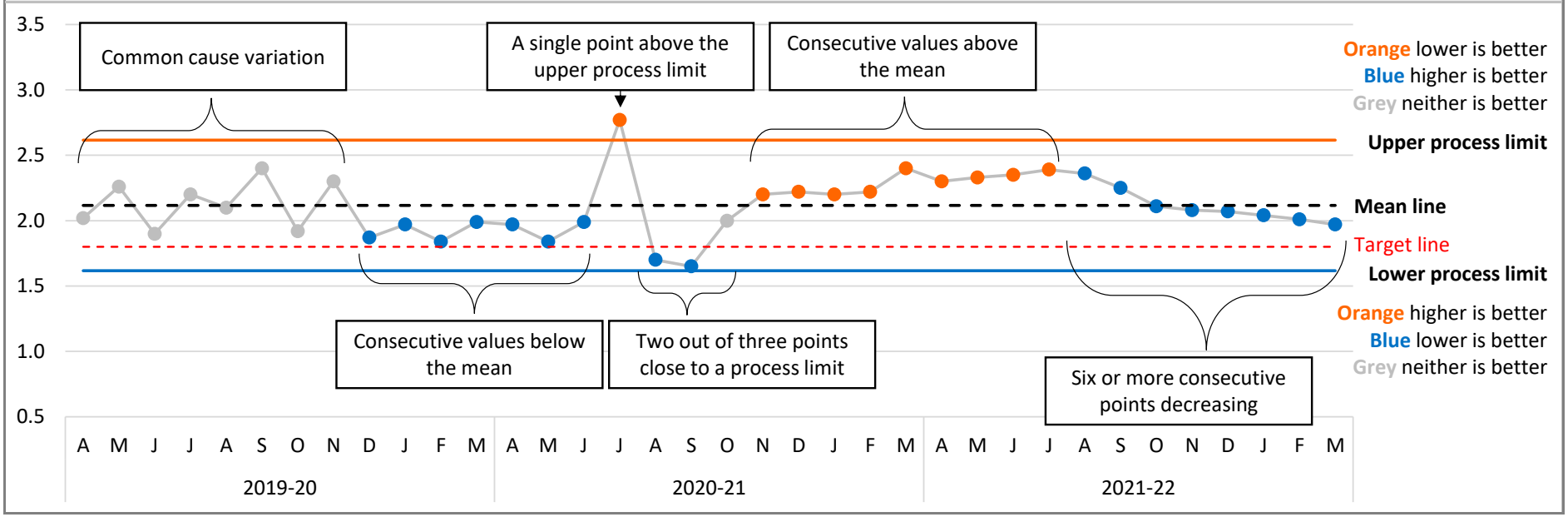
	P	?	F
H, L	1	7	8
	7	43	10
H, L	1	5	2

Data correct as at 20/06/2024

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

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

Assurance

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

NHS
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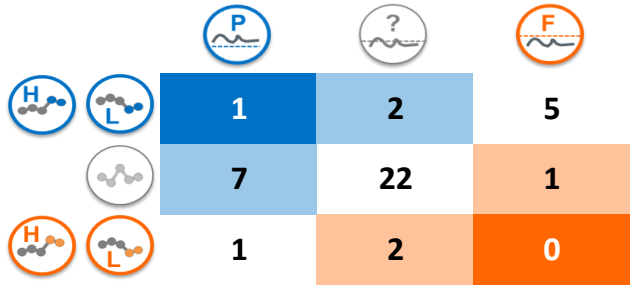
NHS Trust

Quality

Month 02 | 2024-25



Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	May-24	n/a	1,223			Common cause variation No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	May-24	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	May-24	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	May-24	0	3		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	May-24	0	6		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	May-24	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	May-24	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	May-24	0	0	L	?	19 consecutive points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	May-24	80%	92.7%	H	P	9 points above the mean Metric will consistently pass the target
Safer Staffing	Overall fill rate	May-24	n/a	85.6%	H		9 consecutive points above the mean No target
	Staff shortage incidents	May-24	n/a	15			11 consecutive points below the mean No target

Month 02 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	May-24	n/a	0.76			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	May-24	n/a	1.09			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	May-24	95%	50.0%	L	?	10 points below the mean Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	May-24	95%	50.0%	L	?	12 points below the mean Metric will inconsistently pass and fail the target
	ED attendances receiving IVABs within 1-hour of red flag	May-24	95%	91.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	May-24	95%	75.0%		F	Common cause variation Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	May-24	85%	89.1%	H	F	3 points above the upper process limit Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	May-24	n/a	106			7 points above the mean No target
	Number of HAT RCAs completed	May-24	n/a	22			Common cause variation No target
	HATs confirmed potentially preventable	May-24	n/a	0			Common cause variation No target
PU	Pressure ulcers All category ≥2	May-24	0	9		?	Common cause variation Metric will inconsistently pass and fail the target

Month 02 | 2024-25

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	May-24	n/a	3.7			Common cause variation No target
	Proportion of patient falls resulting in serious harm	May-24	n/a	0.0%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	May-24	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Feb-23	6.0%	5.8%			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	May-24	95%	96.4%		P	Common cause variation Metric will consistently pass the target
	A&E positive feedback	May-24	90%	84.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	May-24	93%	97.7%	H	F	4 points above the upper process limit Metric will consistently fail the target
	Maternity Birth positive feedback	May-24	93%	100.0%	H	F	1 point above the upper process limit Metric will consistently fail the target
	Maternity Postnatal positive feedback	May-24	93%	96.0%	H	F	9 points above the upper process limit Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	May-24	93%	100.0%	H	F	9 points above the upper process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	May-24	95.0%	97.4%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	May-24	n/a	427		-	Common cause variation No target

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Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	May-24	n/a	54		-	Common cause variation No target
	Number of complaints closed in-month	May-24	n/a	78		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	May-24	75%	95.6%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	May-24	80%	54.1%		?	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	May-24	60 - 70%	69.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	May-24	3.3%	1.7%	H	P	7 points above the mean Metric will consistenly pass the target
	3rd and 4th degree tear vaginal	May-24	2.5%	2.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	May-24	4.5%	1.1%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear instrumental	May-24	6.3%	5.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	May-24	6.0%	5.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	May-24	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

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Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	May-24	12.5%	6.2%		P	Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	May-24	2.3%	5.1%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	May-24	50.5%	75.8%		P	Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	May-24	72.7%	80.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Number of serious incidents	May-24	0.5	0	L	?	7 points below the mean Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	May-24	12.8	9.3		?	common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	May-24	12.8	9.2			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Mar-24	100	83.7		?	Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Mar-24	100	82.8			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Dec-23	100	103.1		?	Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Dec-23	100	94.1			Rolling 12-months - unsuitable for SPC

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Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Mar-24	n/a	762			Common cause variation No target
	Rate of emergency re-admissions within 30 days of discharge	Mar-24	9.0%	6.6%		P	Common cause variation Metric will consistently pass the target
Length of Stay	Average elective length of stay	May-24	2.8	2.3		P	Common cause variation Metric will consistently pass the target
	Average non-elective length of stay	May-24	4.6	4.5		?	Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	May-24	n/a	86.8%			Common cause variation No target
	Individualised care pathways	May-24	n/a	32			Common cause variation No target

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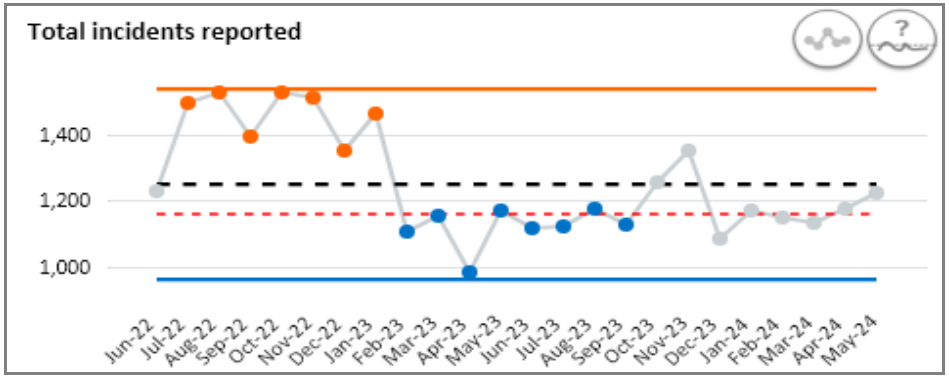
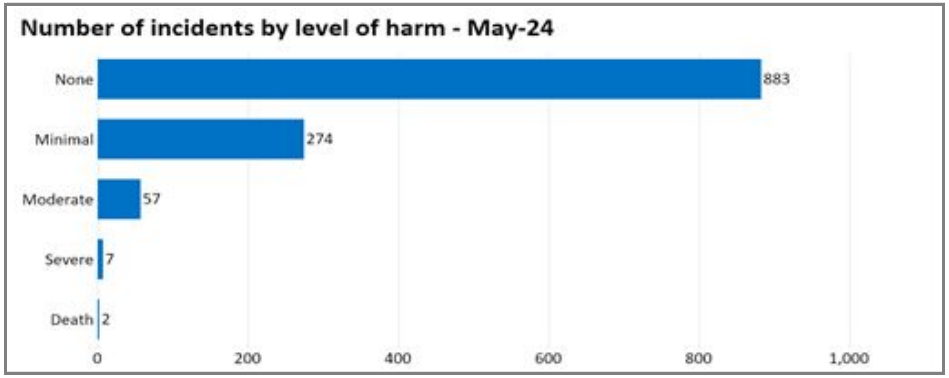
Quality

Patient Safety Incidents

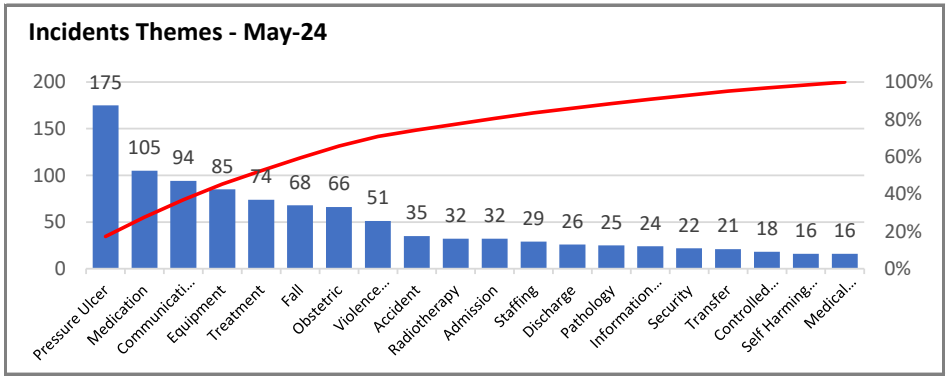
East and North Hertfordshire NHS Trust

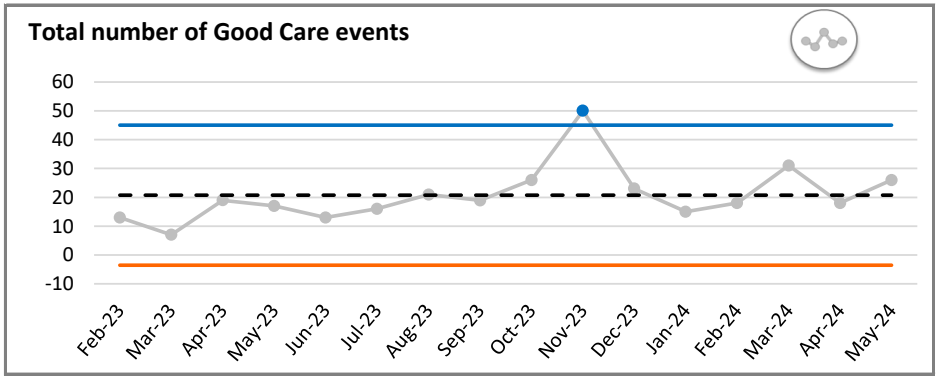




Key Issues and Executive Response

- Normal variation in the number of incidents reported
- Of the incidents reported in month, 50% related to Unplanned Care, 18% were Planned Care, 21% W&C and 10% Cancer Services
- Of the incidents reported in month (1223), 43 have been closed with 198 awaiting the final quality assurance prior to closure. 639 are still open being investigated and 367 are awaiting Divisional lead sign off.
- Divisional teams are aware of high open incident numbers and the need for improvement
- The incident that resulted in death relates to patient who died at home whilst undergoing home dialysis. Hot de-brief undertaken and incident discussed through incident review process (DISH) Family meeting to be held.
- ED continues to be the highest reporting specialty of incidents followed by Acute Medicine, Obstetrics.
- 4 open SI ongoing, all relate to Paediatric Audiology review.
- No new PSII commissioned.
- Never Event PSII draft report completed and due for SIRP review 25 June
- Ongoing development of SIRP oversight role.
- Successful AAR conductor training day with ENHT AAR support pack now being developed.





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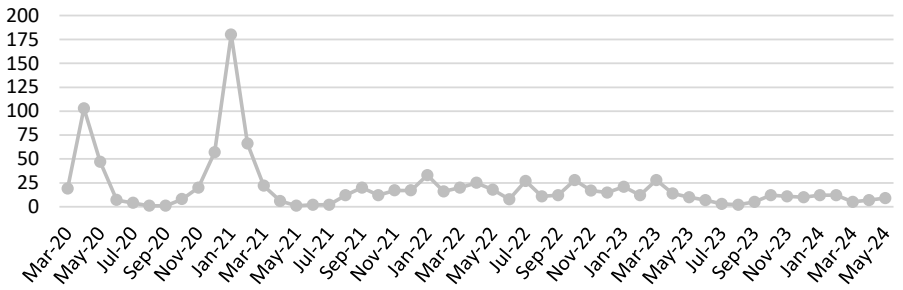
Quality

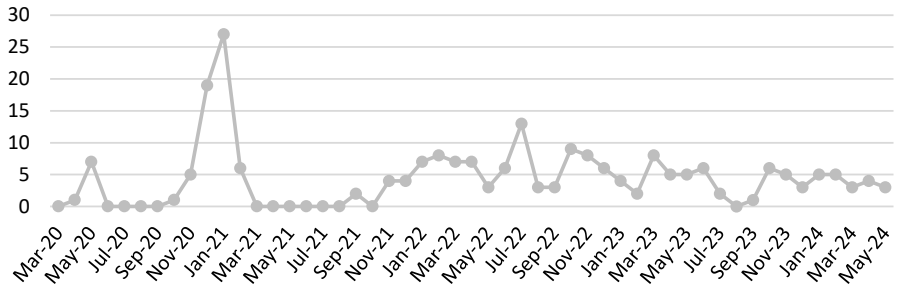
COVID-19

East and North Hertfordshire NHS Trust

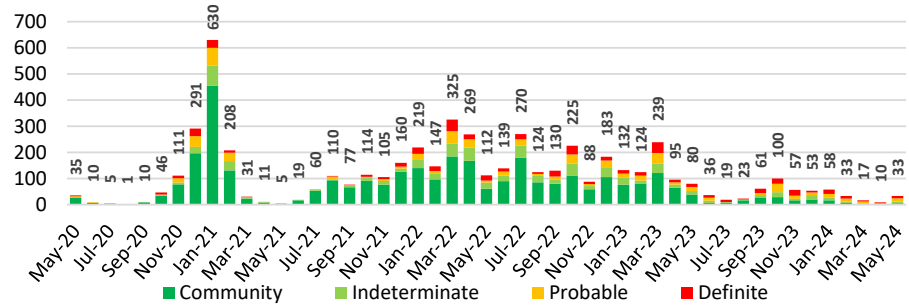
Number of deaths from COVID-19



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 May was 33 out of these cases, 5 were attributed to community onset, with 9 definite, 7 indeterminate and 12 probable cases.
- PCR testing is only utilised for symptomatic patients for clinical treatment purposes only - This will include diagnostics and treatment. In addition, Lateral Flow Devices can be used for placement purposes to support emergency and acute admission pathways. This means PCR test in emergency services can be done via Cambridge university hospital testing and not point of care testing.
- If the patient is due to be admitted to the Lister oncology wards, Respiratory wards and Critical Care, an LFD test is required on admission.
- There were 9 COVID-19 deaths reported in the month of May 3 of theses were Hospital-acquired. These patients experienced multiple-co-morbidities, and appropriate review of patients will be carried out for all the patients.

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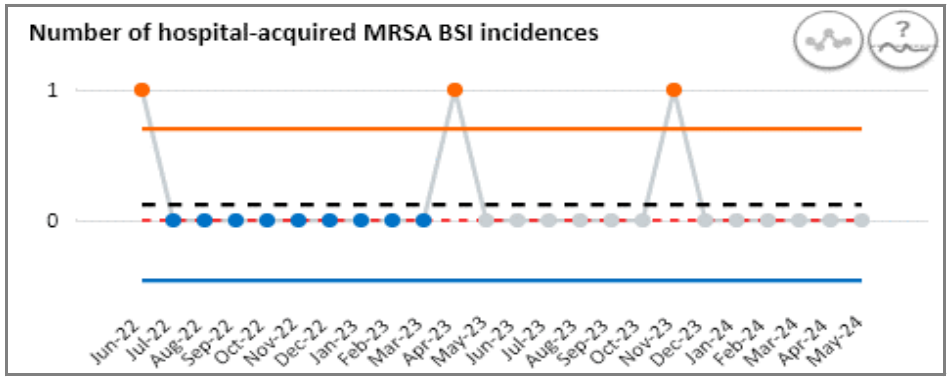
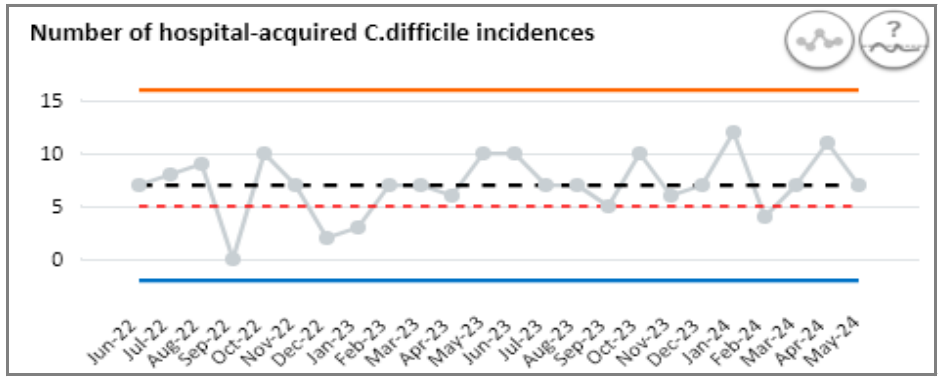
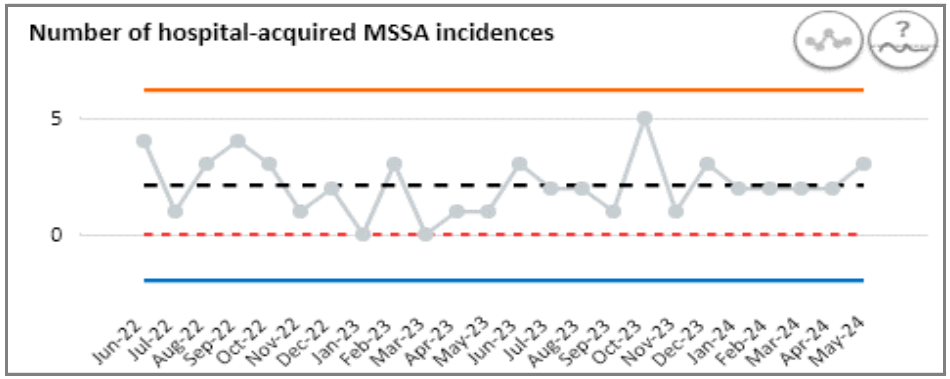
Quality

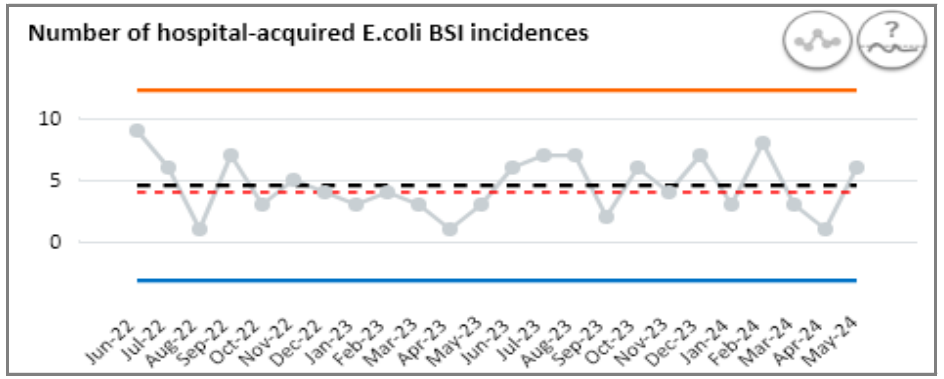
Infection Prevention and Control

East and North Hertfordshire NHS Trust









- *C difficile (C diff.)* - there has been a decrease in the number of cases this month compared to the previous month by 36% (4 cases). Although this remains above the monthly threshold. *C difficile* virtual MDT as well as the *C diff* HCAI review chaired by the Medical Director and Chief Nursing Officer/Director of IPC commenced in May with satisfactory representation from the treating teams. These process allows for a prompt review of current inpatient *C diff cases* and an opportunity for clinicians to discuss treatment management with consultant microbiologist and antimicrobial pharmacists.

- *C diff* continuation - Since the MDT, a significant number of *C diff* carrier had been identified and antimicrobial stewardship is strengthened.
- MRSA BSI - there were zero MRSA BSI in the month of May'24 with an annual threshold of 0
- MSSA BSI - there were three cases in May'24
- *E.coli BSI* - the Trust is two cases above monthly threshold for the month of May'24

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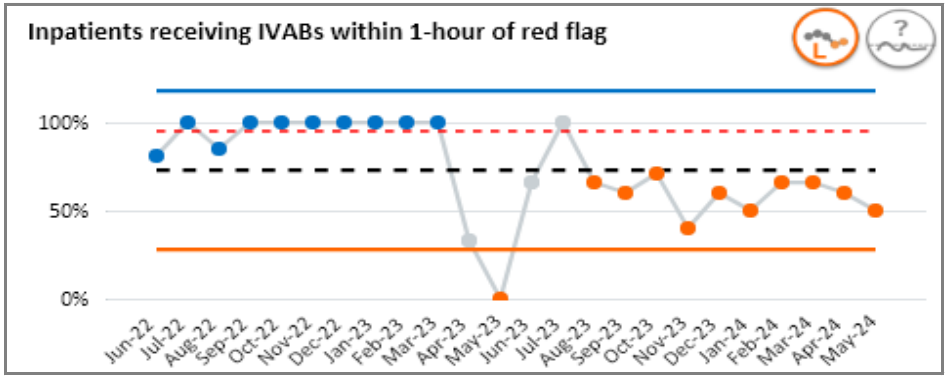
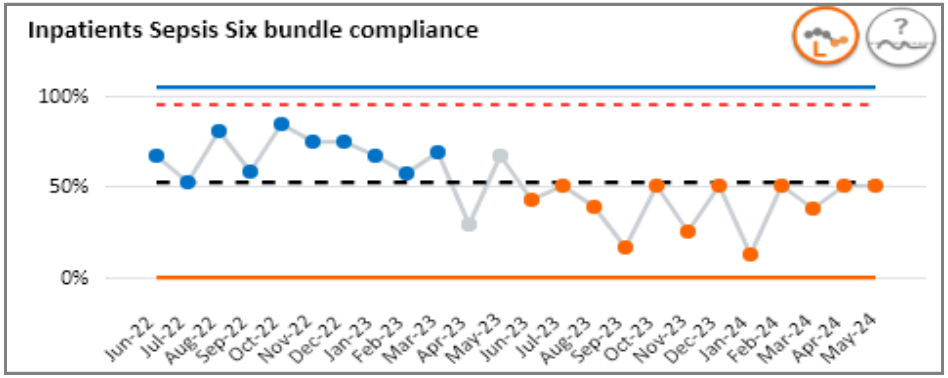
Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust





Themes

Sepsis IP	2023-24										2024-25	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	69%	67%	80%	64%	83%	75%	78%	57%	100%	63%	78%	88%
IV antibiotics	83%	100%	67%	60%	71%	60%	60%	50%	75%	67%	60%	50%
IV fluids	50%	56%	55%	57%	56%	71%	83%	57%	100%	100%	67%	71%
Lactate	54%	58%	65%	64%	83%	57%	60%	25%	86%	63%	89%	100%
Urine measure	64%	75%	59%	42%	83%	71%	60%	50%	57%	75%	89%	88%

Key Issues and Executive Response

Themes

- IV antibiotic compliance sits at 50% (2/4) in May, and remains a priority of the task and finish group. ENHance have been completed for both delays.
- IV Fluid compliance sits at 71% (5/7) in May, a slight improvement to April.
- O2 administration remains at 100%, whilst urine balance monitoring remains stable at 88% (89% in April).
- Lactate and blood culture compliance has been up-trending, sitting at 100% and 88% respectively.
- The Sepsis Team was not informed of any serious harm or patient incidents related to sepsis throughout May.

Response

- The Sepsis Team has upcoming sepsis sessions with planned care and is liaising with unplanned to include them too.
- The team have arranged further teaching for doctors working in frailty for August
- Sepsis/AKI link nurse study days to continue with a second one in June.
- The Sepsis Team continue to be a visible presence in inpatient settings assisting with recognition and management of septic patients.
- The Sepsis task and finish group has been set up to collaborate, discuss and plan ways of improvement compliance and patient safety with regards to sepsis recognition and management.
- Continued teaching on BEACH courses and at trust inductions.

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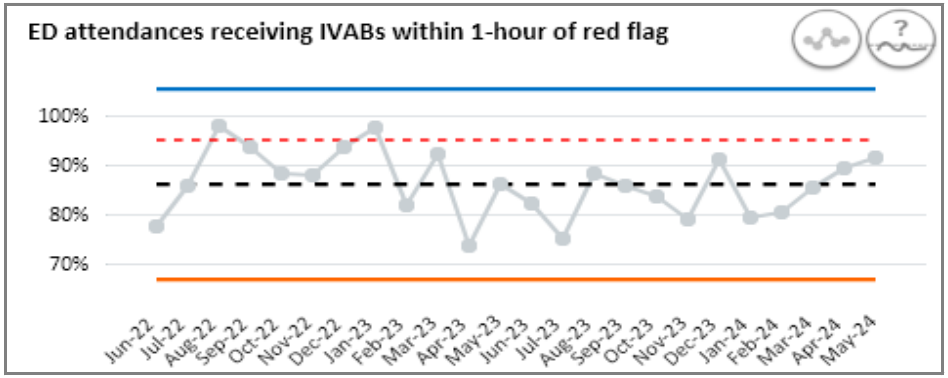
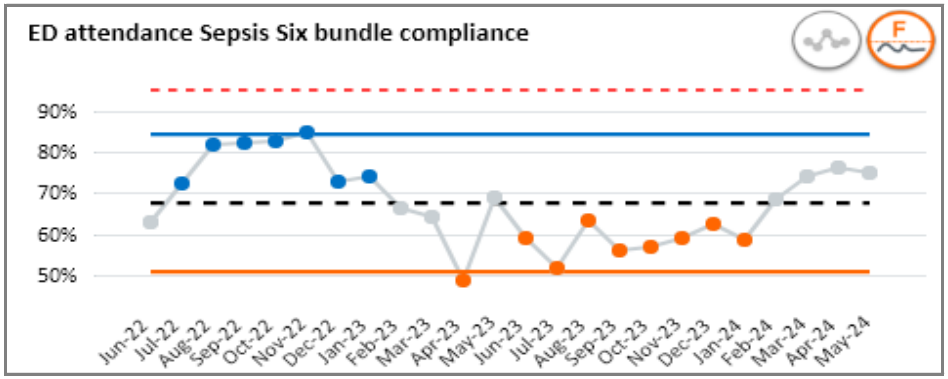
Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust





Themes

Sepsis ED	2023-24										2024-25	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Oxygen	100%	98%	94%	100%	98%	100%	100%	100%	96%	100%	100%	100%
Blood cultures	90%	87%	89%	88%	87%	93%	91%	92%	100%	97%	97%	91%
IV antibiotics	82%	75%	88%	86%	84%	79%	91%	79%	80%	85%	89%	92%
IV fluids	79%	81%	83%	89%	88%	87%	92%	82%	85%	84%	91%	92%
Lactate	96%	95%	96%	100%	97%	93%	95%	98%	100%	98%	100%	100%
Urine measure	74%	68%	72%	64%	63%	64%	67%	66%	78%	86%	79%	83%

Key Issues and Executive Response

Themes

- IV antibiotic compliance sits as 92% in May.
- Average time to IV antibiotics is 34 minutes which is within Trust timeframe of 1 hour.
- IVF compliance sits at 92% remaining steady, with an average time to fluids remains within trust targets at 31 minutes.
- Lactate and Blood culture compliance sit at 100% and 91% respectively and continues to meet trust targets.
- Fluid balance sits at 83% with fluid balance continues to remain a trust wide priority.
- The Sepsis Team was not informed of any serious harm to any patients in relation to sepsis in March.
- There is a smaller data sample for ED in May due to staffing shortfall within the sepsis team.

Response

- The Sepsis Team continue to provide bedside education to newer/junior staff, often attending to sepsis patients in ED and going through the Sepsis Screening Tool with ED nurses and doctors in real time.
- Encouragement and education surrounding the importance of fluid balance monitoring and using the digital fluid chart is continuing.
- The Sepsis task and finish group has been set up to collaborate, discuss and plan ways of improvement compliance and patient safety with regards to sepsis recognition and management.
- Continued engagement from the ED team including the introduction of posters has improved the amount to sepsis screens undertaken.
- ED resus project to create a sepsis drawer.

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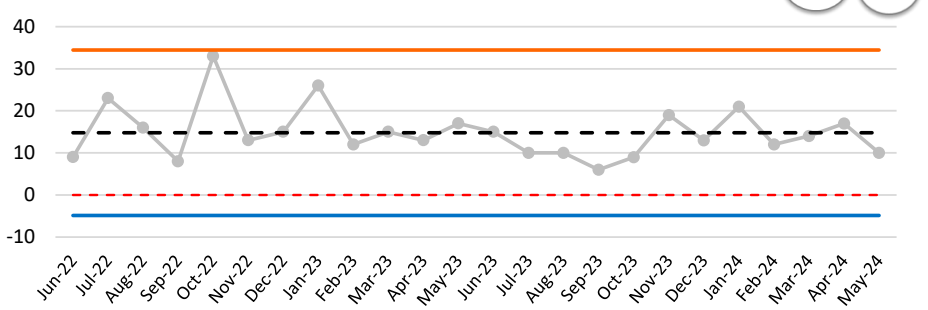
Quality

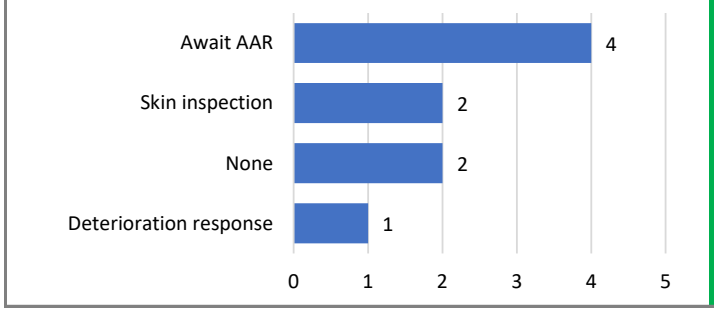
Pressure Ulcers | VTE

East and North Hertfordshire NHS Trust

Number of hospital-acquired pressure ulcers



Themes - May-24

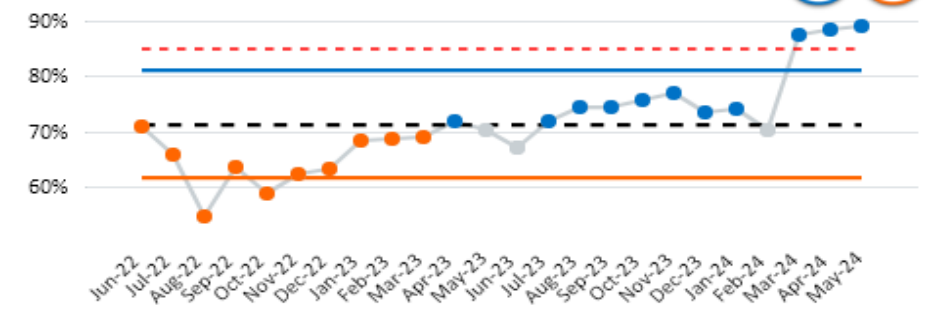


340

days since last category 4

as at 19/06/2024

VTE risk assessment stage 1 completed



Key Issues and Executive Response

Pressure Ulcers

- Ward 10B attended an ICB/ICS HWE QI Event to showcase a poster informing of their QI project to reduce the number of New PU
- Ward managers have started to conduct After Action Reviews (AAR). Tissue Viability Team is providing support by continuing to validate the skin damage. Ward managers will gradually be assisted to start validating pressure ulcers at some point, as part of PSIRF.
- PSIRF plan three main themes: device related care, repositioning and skin inspection. **The Leading theme in 2024 is Skin Inspection**
- TVT is currently compiling Data for **CQUIN 4th and final quarter**
- TVT Actions FOR 2023/24:
  - Risk assessment and pressure ulcer prevention care planning improvement project within CDU in ED;
  - 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. (Awaiting approval to start this from digital).

VTE

- Auditing parameters reviewed in February in preparation for NHSE audit relaunch in July 2024 and adjustments implemented to mimic VTE exemplar centres - resulting in improved compliance rates
- Continue sustained improvement in local QI projects.
- Reports are continuously being analysed to provide focused data-driven quality improvement projects in specific areas and specific teams.
- Quarterly VTE and Anticoagulation Newsletter distributed in April to feedback ward and specialist data.

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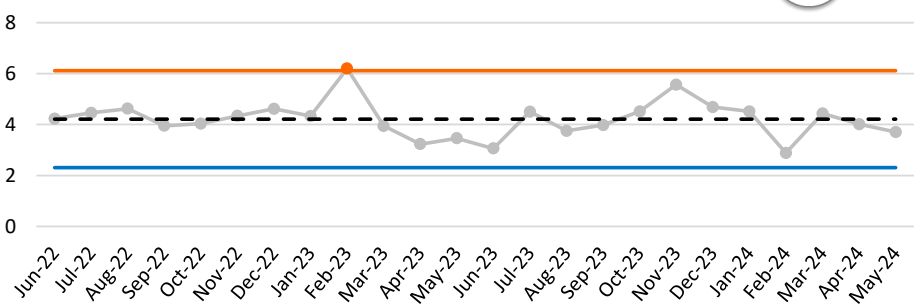
Quality

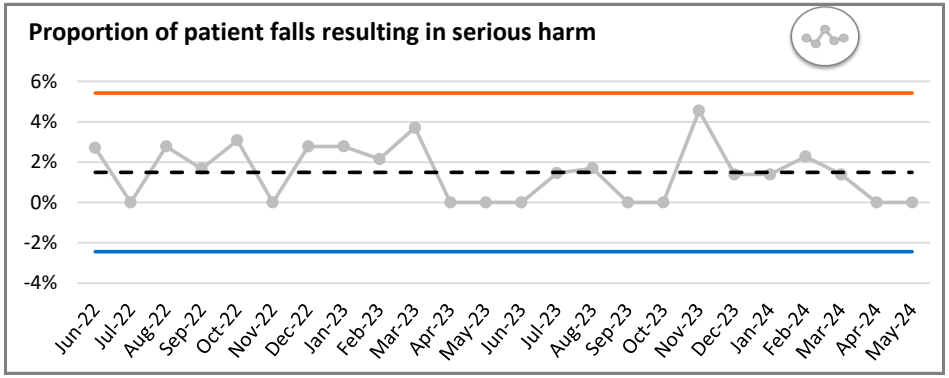
Patient Falls

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

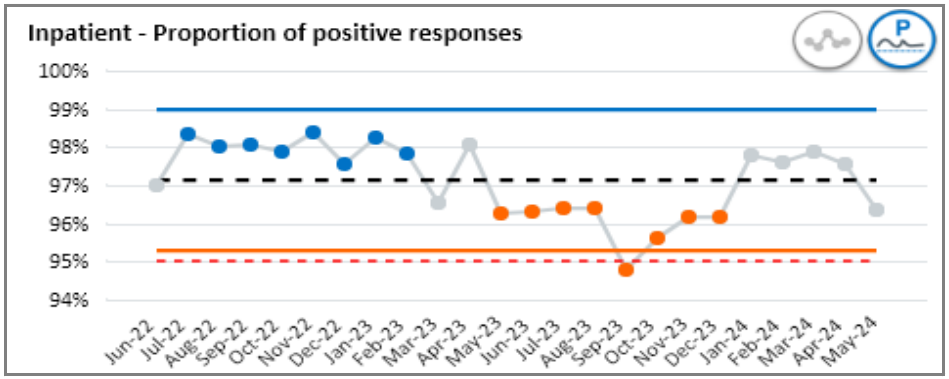
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- No Inpatient Falls with harm recorded for the month of May
- Falls Dashboard now Live on Enhance. This is now a tool we will be using in looking at trust falls data and can be utilise for falls training and data sharing.
- Falls will be one of the data being captured on Ward Dashboard that are currently being explored which will be useful on huddles and handovers.
- Falls claims are being used in bite size training which gives staffs some insights on the reasons for claims and how we can effectively reduce the claims by raising more awareness.

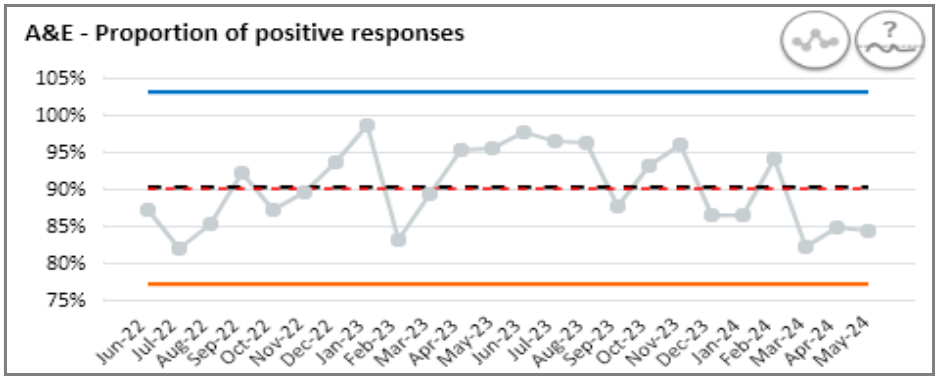
Month 02 | 2024-25

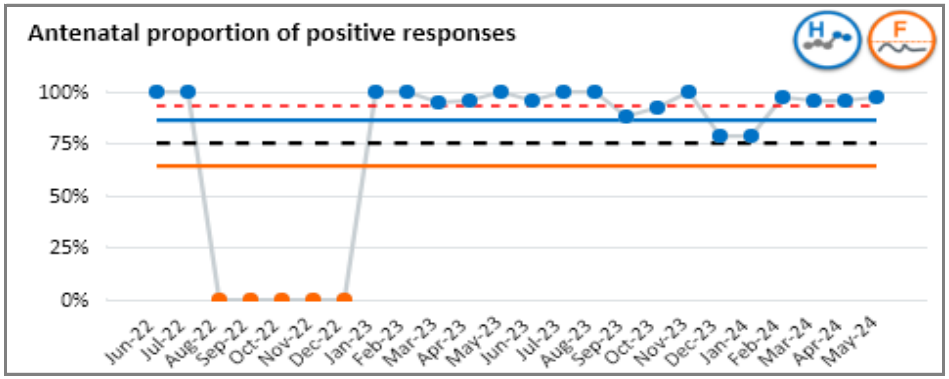
Quality

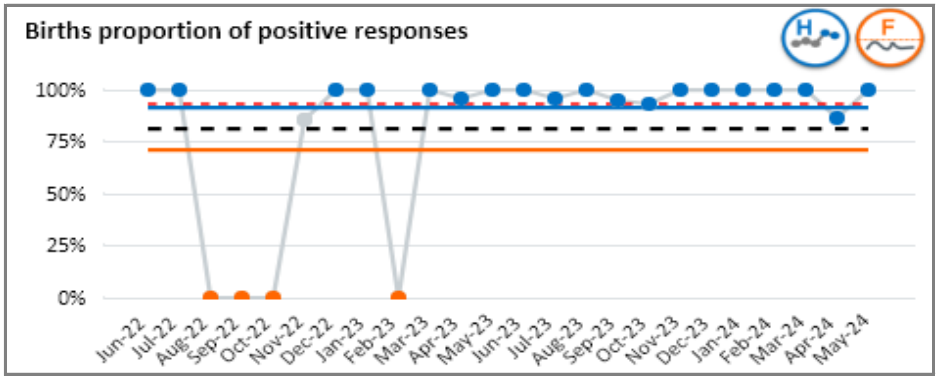
Friends and Family Test

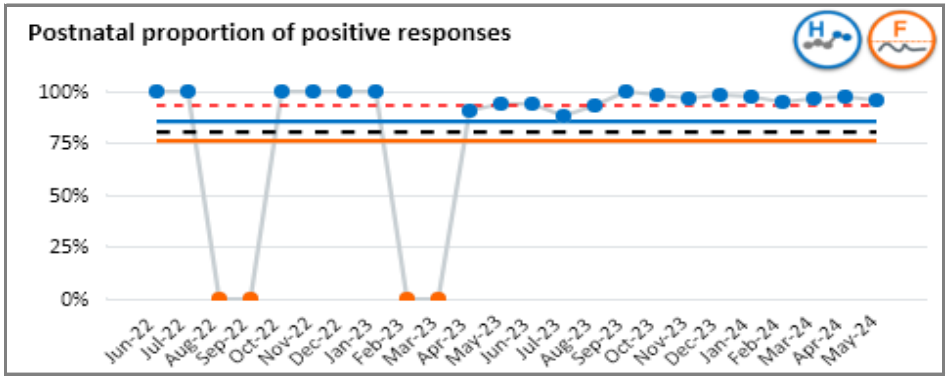
East and North Hertfordshire NHS Trust

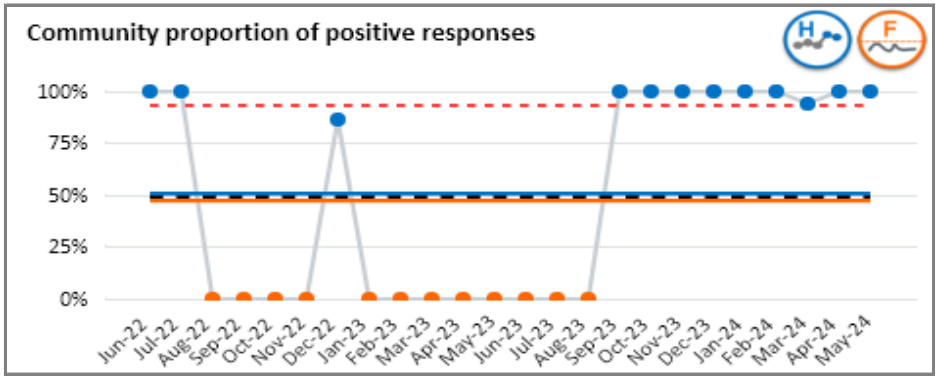










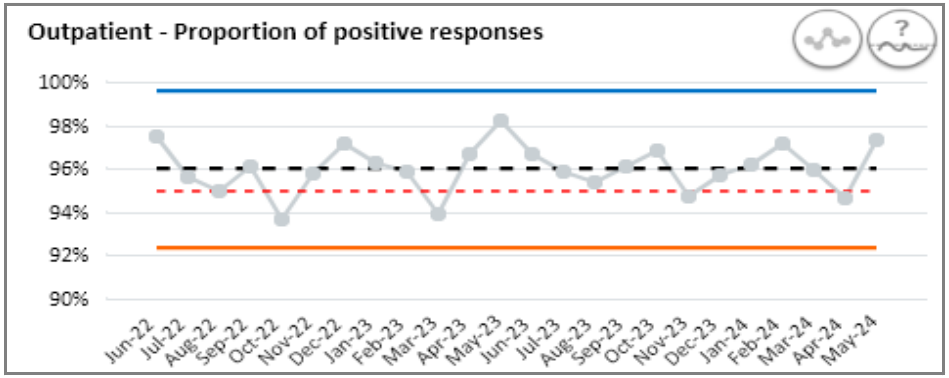


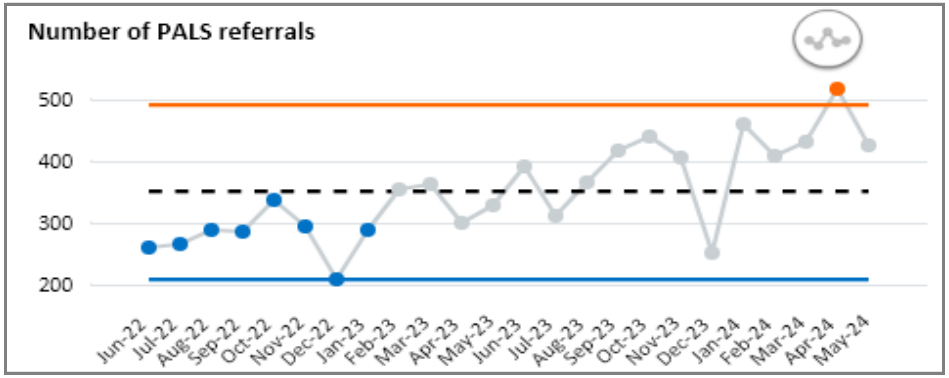
Month 02 | 2024-25

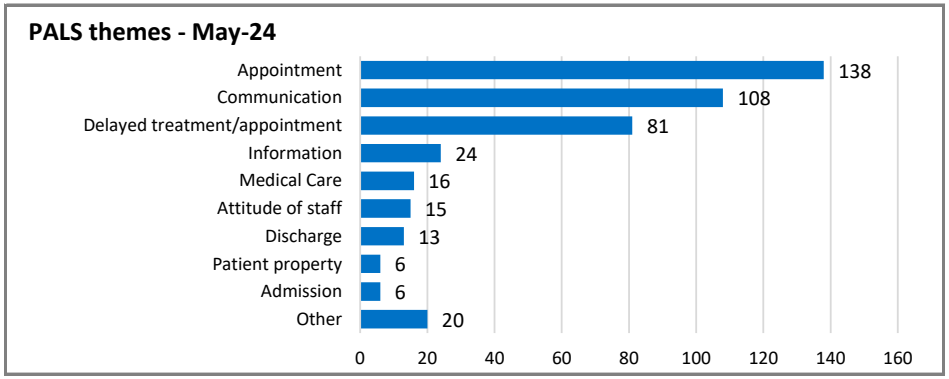
Quality

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

- Inpatient satisfaction score continues to decrease since March 2024. 5A, 6B,10B and SSU all below 90% in May. The total of patients being asked has also decreased by 200 in May across the Trust. There is only a small amount of 'poor and very poor' but it seems the option of 'neither good nor bad' has been used this month, and as such the scoring has dropped again. This has been raised to the Divisions with services within this section during May PACE Group.

Patient Advice Liaison Service

- 130 enquires currently in the inbox to action with the maximum of 28 days for turn around time frame. However, all enquiries are screened on a daily basis and prioritised accordingly. Following screening, urgent enquiries are picked up on the day during the working week.
- Audiology remains a concern and had been escalated. High volume of distressed patients and families that are experiencing significant delays.
- Time in which it takes to get through to contact centre and outpatient services still remains a frustration for patients and as such the PALS service is used for appointment queries.
- More staff are needed to support the service which includes reviewing divisional secondments and pending outcome of the previously submitted business case.

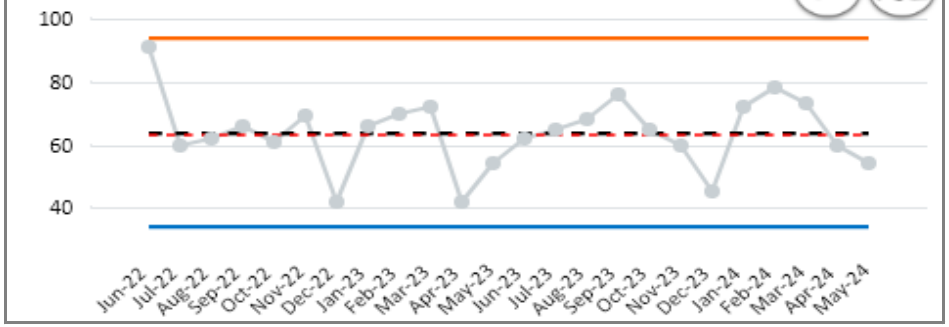
Month 02 | 2024-25

Quality

Complaints

East and North Hertfordshire NHS Trust

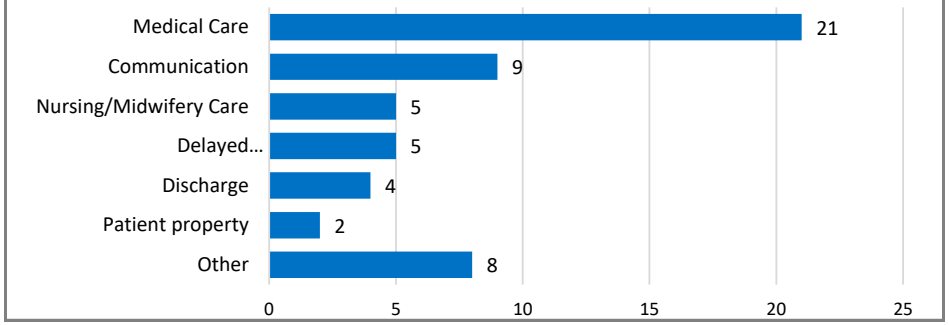
Number of written complaints received



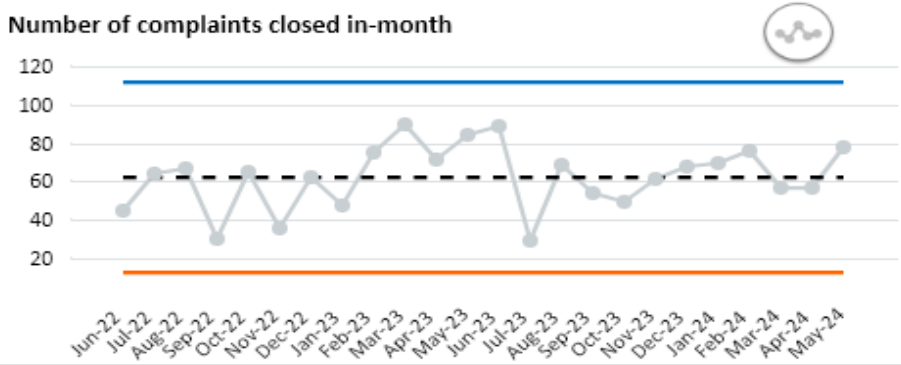
Key Issues and Executive Response

- At the time of writing, the Trust has 180 open complaints, with 20 complaints awaiting for scope confirmation.
- Complaints responded to within the timeframe increased in May due to an extra staff member covering for maternity leave. This indicates the need for an additional case handler to enhance capacity. Currently, there are only three case handlers managing nearly 200 complaints and attending early resolution meetings.
- The above narrative also relates to the increase in the amount of complaints closed within the month.

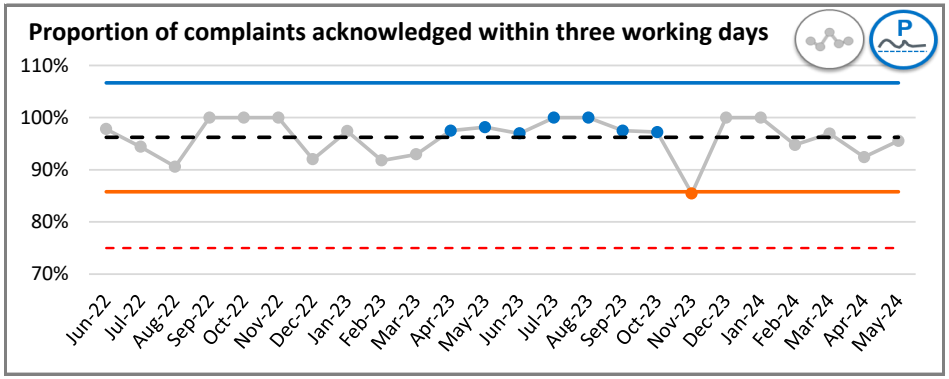
Complaints themes - May-24



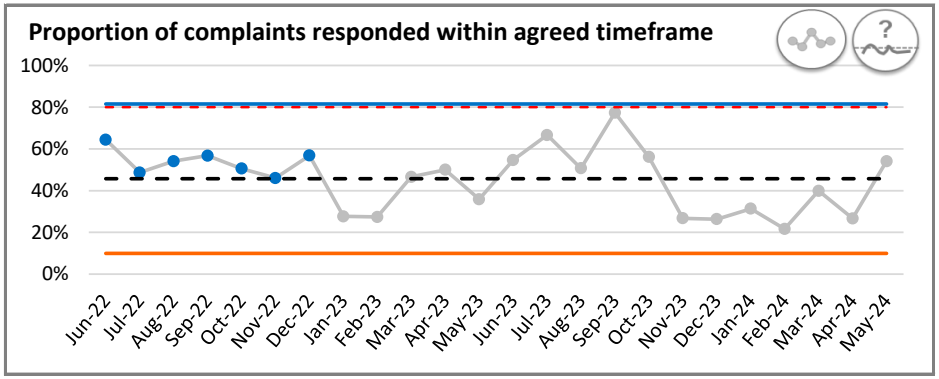
Number of complaints closed in-month



Proportion of complaints acknowledged within three working days



Proportion of complaints responded within agreed timeframe



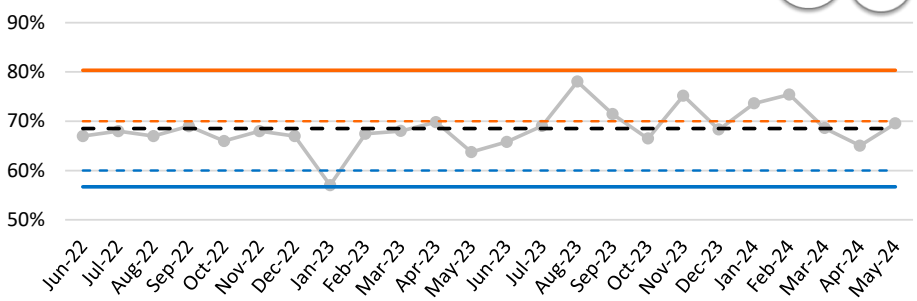
Month 02 | 2024-25

Quality

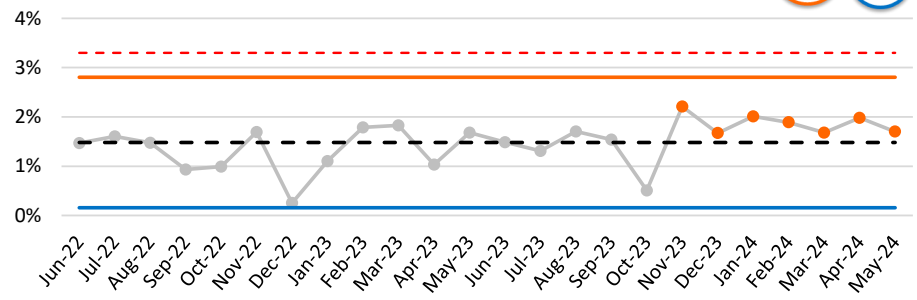
Maternity | Safety Metrics

East and North Hertfordshire NHS Trust

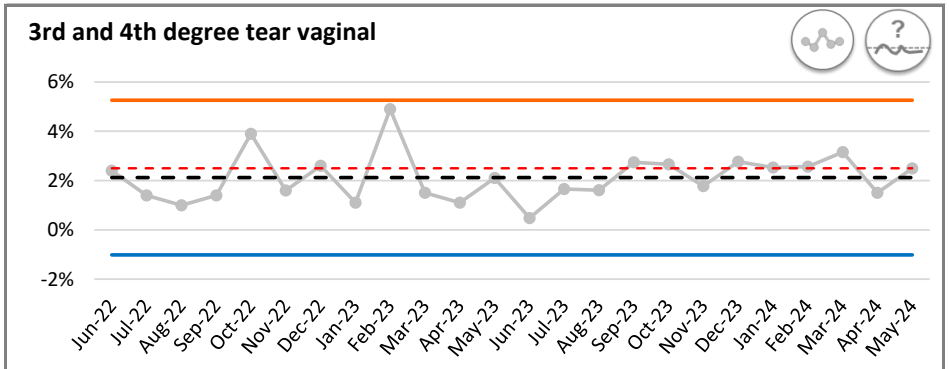
Total caesarean section rate from RG1, 2 and 5 combined



Massive obstetric haemorrhage >1500ml vaginal



3rd and 4th degree tear vaginal



Key issues and executive response

- No PSII declared between January and May 2024.
- 3rd / 4th degree tears - normal variation noted. 2023 Cases remain significantly below 2022 numbers. Monthly audit continues. Working party in place to implement the Obstetric Anal Sphincter injury (OASI) 2 care bundle in line with national recommendation. Training package produced - awaiting integration as part of MMD annual training , planned launch Autumn 2024 and during bespoke team meetings. Adaptation of existing guidance in progress to align with care bundle.
- Massive Obstetric Haemorrhage (MOH) - normal variation continues however overall rate increased. Thematic review by the Labour Ward Consultant Lead and Risk Management MDT continues on a monthly basis. Regional working party to feedback (general rise within LMNS).
- Breast Feeding initiation and discharge rates above national average.
- Term admissions to the Neonatal unit at a rate within goal limits (<6%) and below the national average. No avoidable admissions for the month of May 2024.

Robson Group Criteria

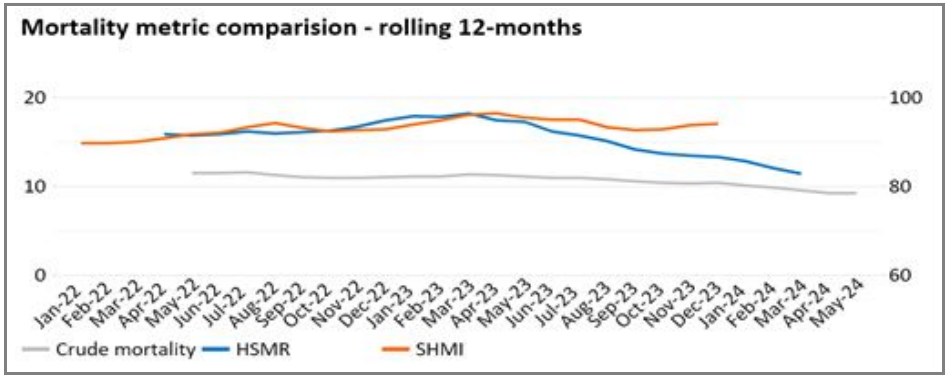
- This considers the obstetric variables to enable classification into one of 10 groups. This categorisation assists in understanding the reasons for the increasing trend in caesarean section rates:
  - **Robson group 1:** Nulliparous singleton pregnancy > 37 weeks with spontaneous labour onset.
  - **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 two thirds of all CS performed in most hospitals. For month 02 the combined rate is 69%.

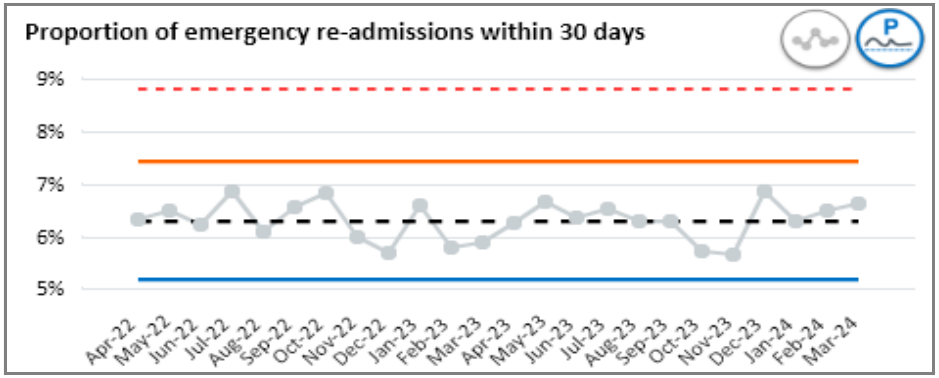
Month 02 | 2024-25

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/in line with those seen prior to the pandemic.
- We have continued to be well placed for both HSMR and SHMI vs national peers. Following an upward trend, rolling 12-month HSMR has been on a downward trend since the start of 2023. Rolling 12 month SHMI (which lags behind HSMR) had increased for several months, has shown a relatively level but fluctuating trend.

Learning from Deaths

- With very little notice NHSE withdrew support for the SJRPlus online tool at the end of the financial year. Aqua (Advanced quality Alliance) has adopted this. While we have agreed in principle to continue to use the tool under a new contract, there is currently an interruption in service while we seek appropriate IG assurance regarding the new platform.
- Following concerns raised in the external review commissioned on the back of the Ovarian Cancer SACT mortality alert (in the 2017-20 national Systemic Anti-Cancer Therapy audit report) remedial work has culminated in submission of a final SI report, with actions ongoing throughout this year.
- Quarterly thematic reviews using SJR data continue to be shared in various arenas including Mortality Surveillance Committee, Divisional Q&S meetings and corporate RHD sessions.
- Planning for the next iteration of the Learning from Deaths Strategy has commenced.
- We are awaiting further news regarding the ICB's intention to establish a system-wide learning from deaths forum.

Re-admissions

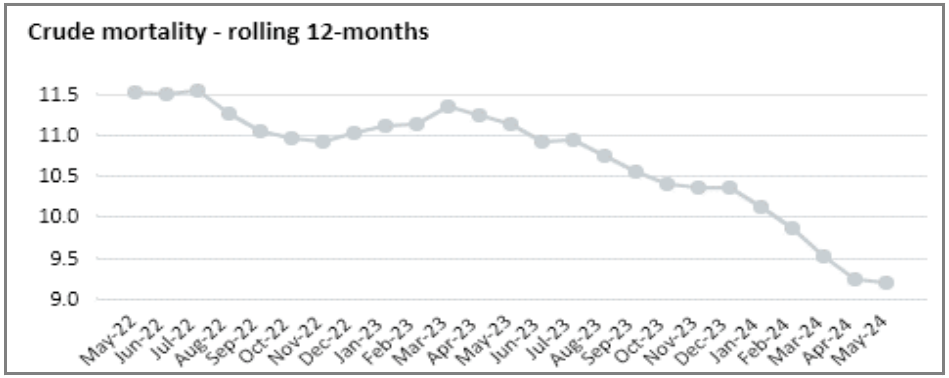
- The Trust's performance for both readmissions within 30 days and for the rate of readmissions within 30 days has remained inconsistent showing common cause variation over recent months.
- The Trust's performance is well positioned in comparison to national and our Model Hospital peer group.

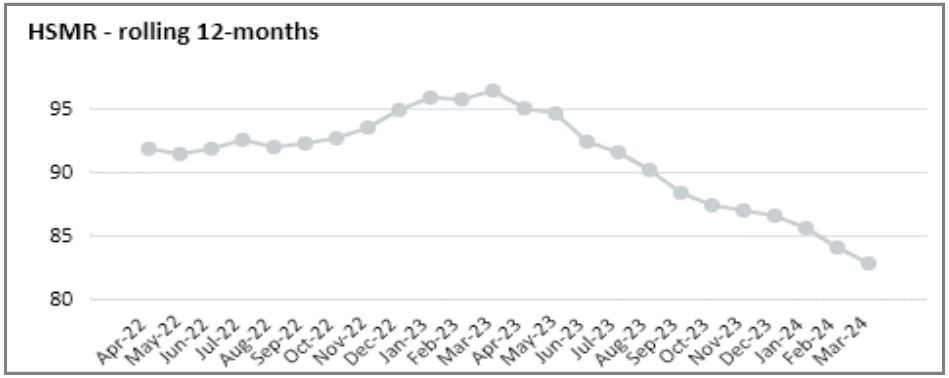
Month 02 | 2024-25

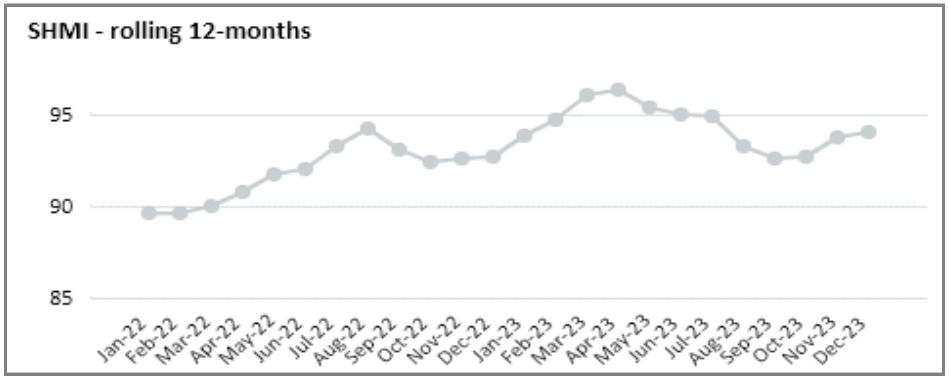
Quality

Mortality

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

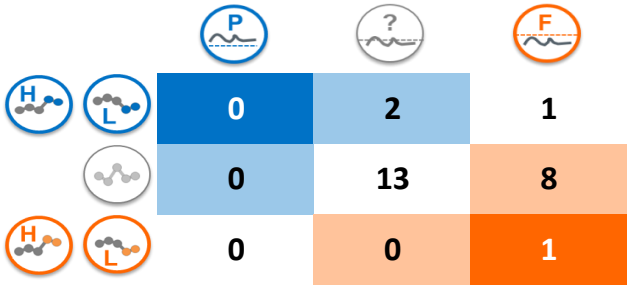
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was been during the COVID pandemic, when the usual correlation has been weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues.
- The general improvements in mortality prior to the COVID-19 resulted from corporate level initiatives such as the learning from deaths process and focussed clinical improvement work. Of particular importance has been the continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average.
- 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. R12M HSMR has now been on a downward trend since the start of 2023.
- Current rolling 12-month HSMR stands at 82.8. While this positions us in the first quartile of trusts nationally, it should also be noted that national peer currently stands well below 100 at 91.9. CHKS has confirmed that their HSMR is due to rebase in the coming months.
- There are currently no 3SD outlier diagnosis groups.
- Latest NHSD published rolling 12-month SHMI has updated to January 2024 and shows a decrease from 94.12. to 93.45
- This is the second release based on the revised SHMI methodology. Contrary to our initial interpretation of the SHMI methodology change, CHKS has confirmed that MVCC data is still included in our overall Trust figure. However, a site-level SHMI value will no longer be provided for MVCC in view of its specialist nature.
- We are still positioned us in the first quartile of trusts nationally.

Month 02 | 2024-25

East and North Hertfordshire NHS Trust

Operations

Month 02 | 2024-25



Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	May-24	95%	68.4%		F	Common cause variation Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	May-24	2%	7.8%		F	Common cause variation Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	May-24	65%	12.2%		F	Common cause variation Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	May-24	80%	48.6%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	May-24	240	208.2		?	Common cause variation Metric will inconsistently pass and fail the target
	Average (mean) time in department - admitted patients	May-24	tbc	594.7			Common cause variation No target
	Average minutes from clinically ready to proceed to departure	May-24	tbc	275	L		11 points below the mean No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	May-24	92%	57.3%	H	F	1 point above the upper process limit Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	May-24	0%	47.9%		F	Common cause variation Metric will consistently fail the target

Month 02 | 2024-25

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Apr-24	85%	85.8%			Common cause variation Metric will inconsistently pass and fail the target
	31-day decision to treat to treatment standard	Apr-24	96%	95.6%			9 points above the mean Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Apr-24	75%	77.5%			8 points above the mean Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Apr-24	7%	16.0%			Common cause variation Metric will consistently fail the target
	Number of cancer PTL waiting more than 104 days	Apr-24	16	117			11 points above the mean Metric will inconsistently pass and fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Apr-24	0	8.0			Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for suspected cancer	Apr-24	93%	88.9%			Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Apr-24	93%	92.1%			Common cause variation Metric will inconsistently pass and fail the target

Month 02 | 2024-25

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

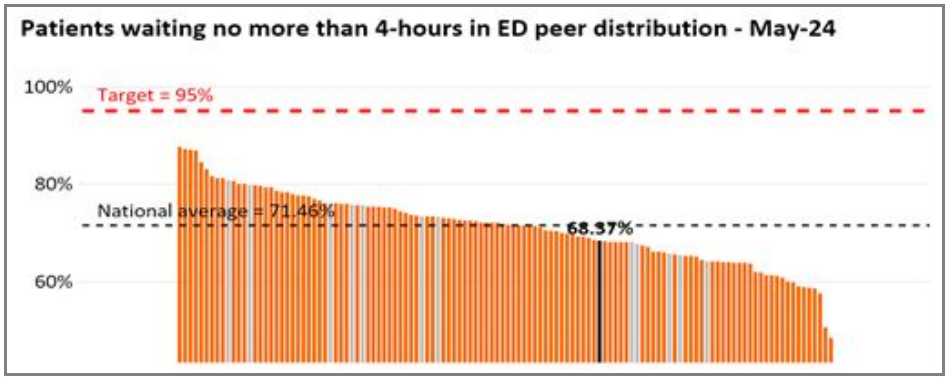
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q4 2023-24	A	B			
	4-hours direct to Stroke unit from ED	May-24	63%	17.6%		F	Common cause variation Metric will consistently fail the target
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	May-24	80%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	May-24	63%	19.7%		F	Common cause variation Metric will consistently fail the target
	Number of confirmed Strokes in-month on SSNAP	May-24	n/a	87			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	May-24	80%	80.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	May-24	50%	56.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Scanned within 12-hours - all Strokes	May-24	100%	96.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	% of all stroke patients who receive thrombolysis	May-24	11%	20.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	May-24	70%	41.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with JCP	May-24	80%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Discharged with ESD	May-24	50%	66.7%		?	Common cause variation Metric will inconsistently pass and fail the target

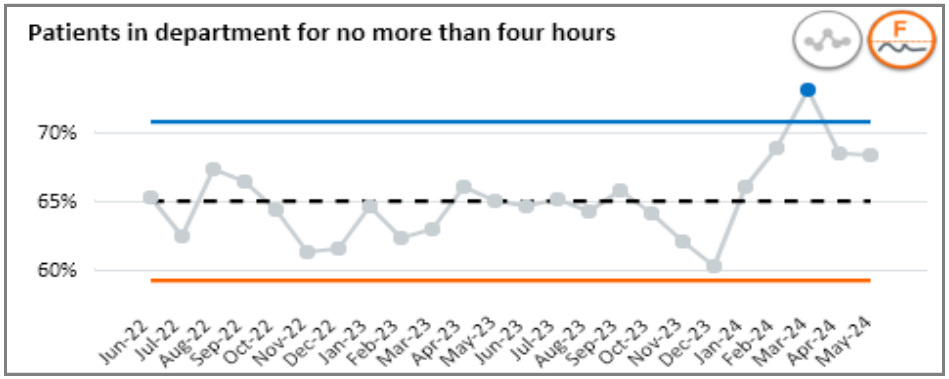
Month 02 | 2024-25

Urgent and Emergency Care

Emergency Department

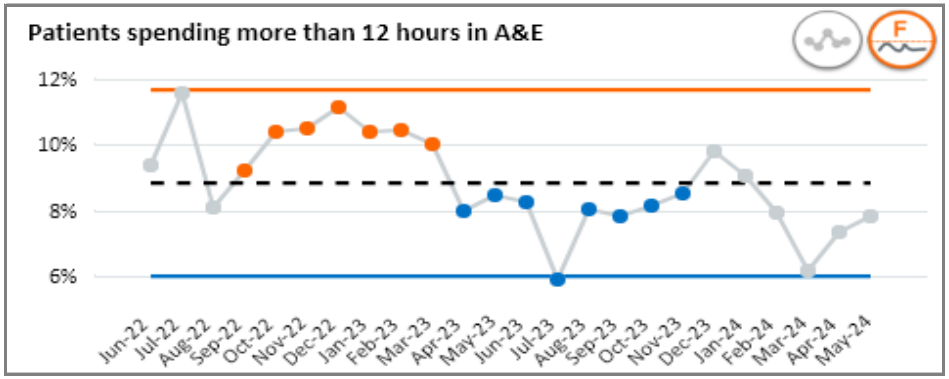
East and North Hertfordshire NHS Trust

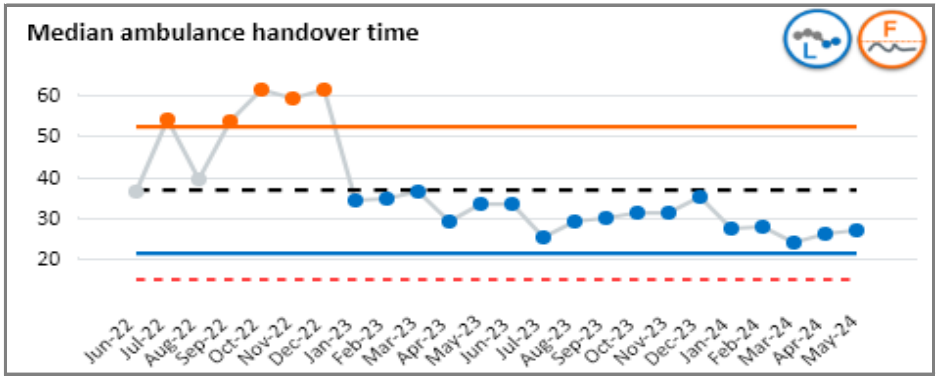




Key Issues and Executive Response

- The monthly attendances saw further increases with the continued presentation of high acuity.
- 12 hour LOS in ED increased which was impacted by acuity and waits to be seen along with waits for CRTP patients to leave the department.
- The reduction of ambulance handover delays was sustained and demonstrated further improvement within the number of handovers within 30 minutes.
- The patients not meeting the criteria to reside increased along with bed occupancy in comparison to previous month impacting flow and compliance with the emergency professional standards.
- Increase in Medical SDEC activity in comparison to previous month and ongoing improved trend.
- 4HR performance remained the same as previous month however working with system partners reviewing and improving pathways and emergency professional standards





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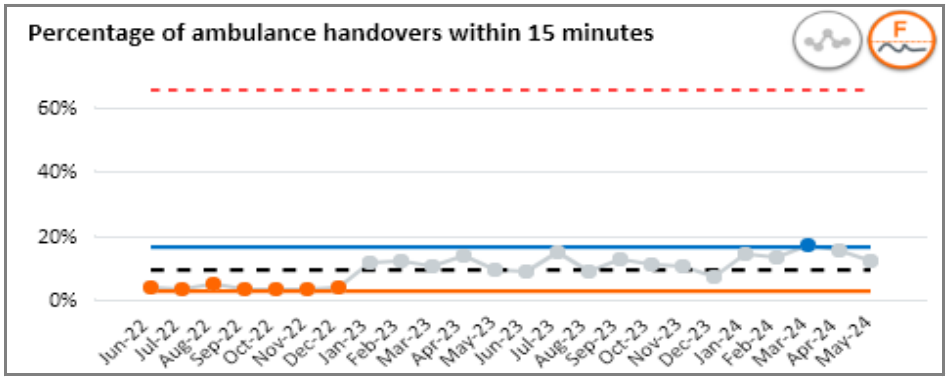
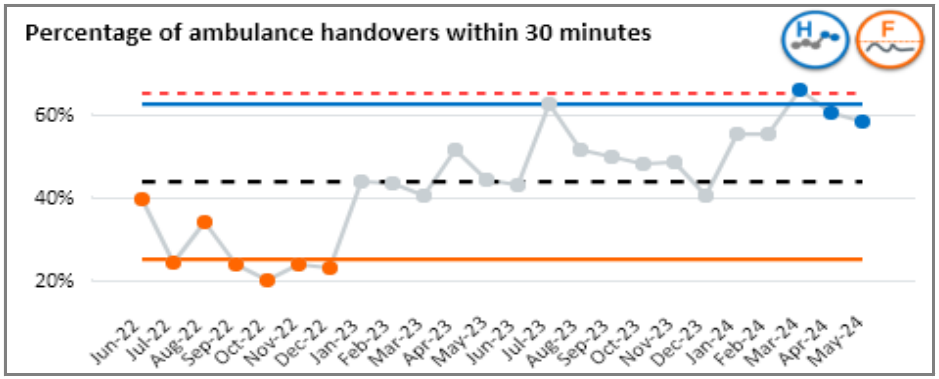
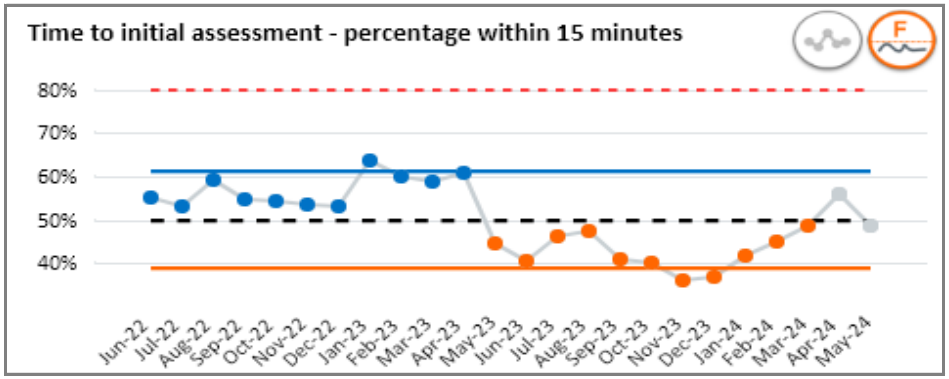
Urgent and Emergency Care

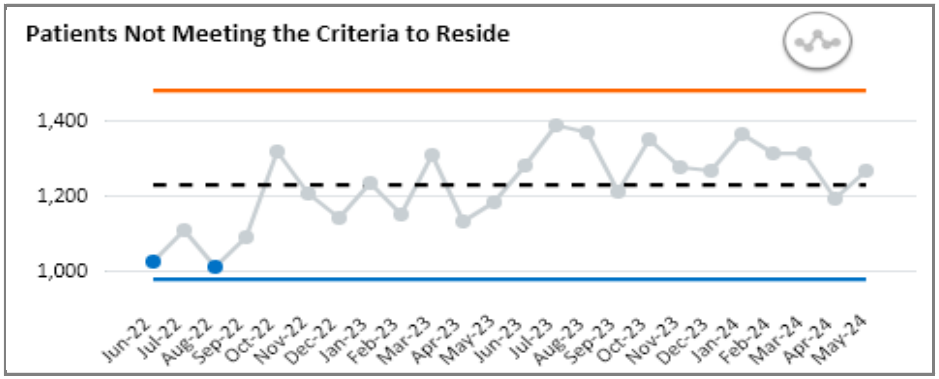
Emergency Department New Standards

East and North Hertfordshire NHS Trust







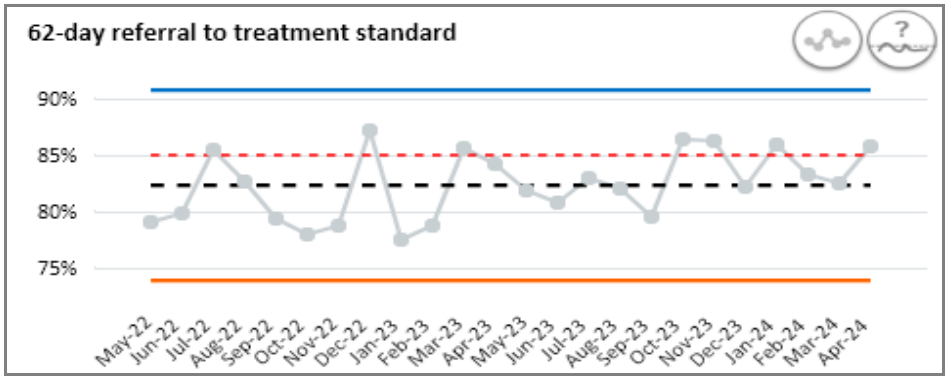


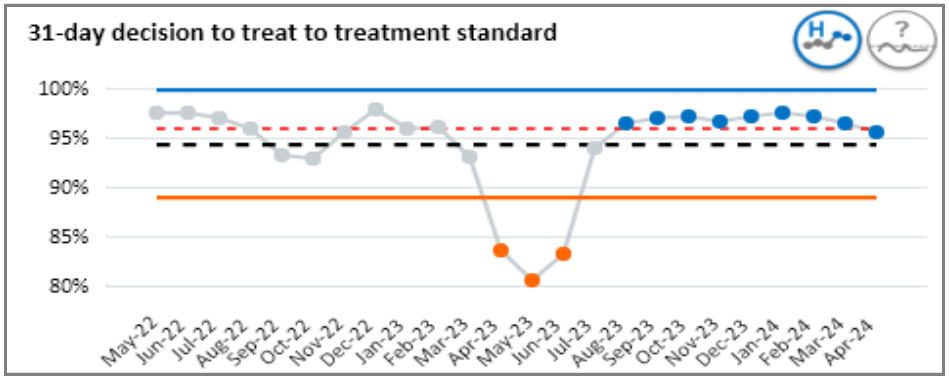
Month 02 | 2024-25

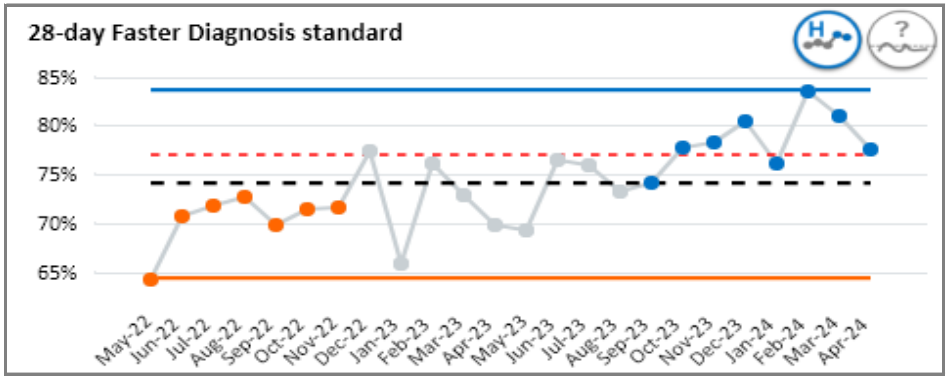
Urgent and Emergency Care

Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- The 62-day backlog increased in May, due to a combination of late referrals from other providers, patient choice in urology (15 pts), short-term admin sickness and Consultant admin turnaround time delays. Services continue to work to clear the backlog and new trajectories to be set up for 24/25.
- The Trust has reported on the new CWT standards but still monitors the previous 9 standards.
- We achieved 2 of the 3 national targets in April 24 with compliance in the 28 General Faster Diagnosis Standard (FDS), 62-Day General treatment standard, and non compliance in the 31-Day General treatment standard.
- The 31 day General treatment standard performance is non compliant due to staff sickness and recruitment in radiotherapy physics team.
- Work continues with the operational teams to sustain and improve CWT performance for the Trust.
- Work continues with Intensive Management Support (IMAS) around pathway analysis, to identify constraints in tumour level pathways and whole Trust cancer training. The pathway analyser tool has improved UGI FDS standards to compliance over the past 4 months.
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning.

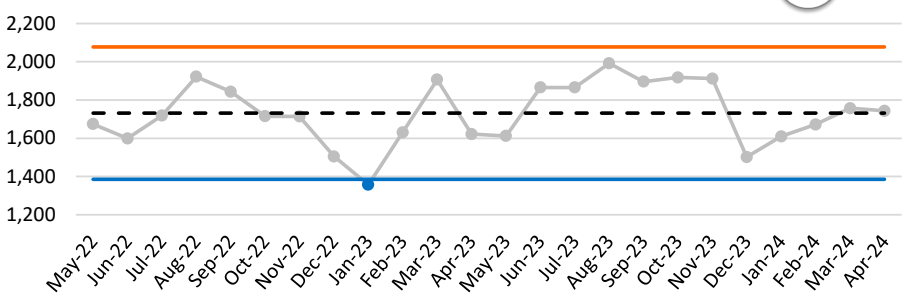
Month 02 | 2024-25

Urgent and Emergency Care

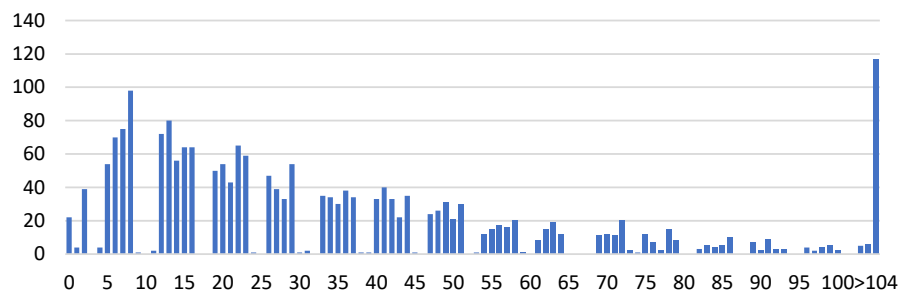
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

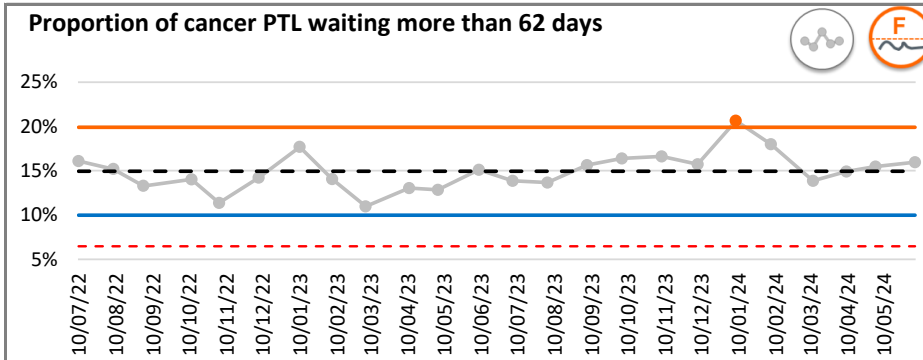
Suspected cancer referrals



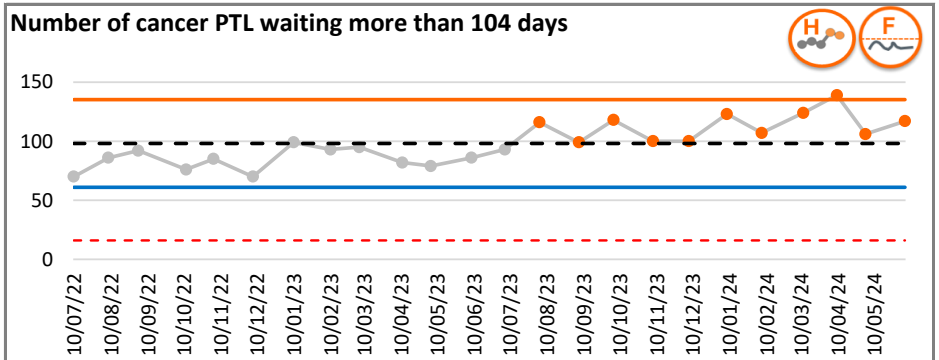
62-day PTL as at 05/06/2024



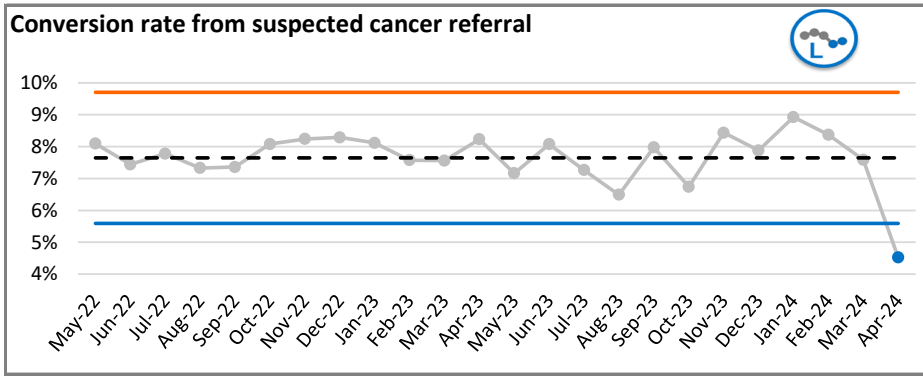
Proportion of cancer PTL waiting more than 62 days



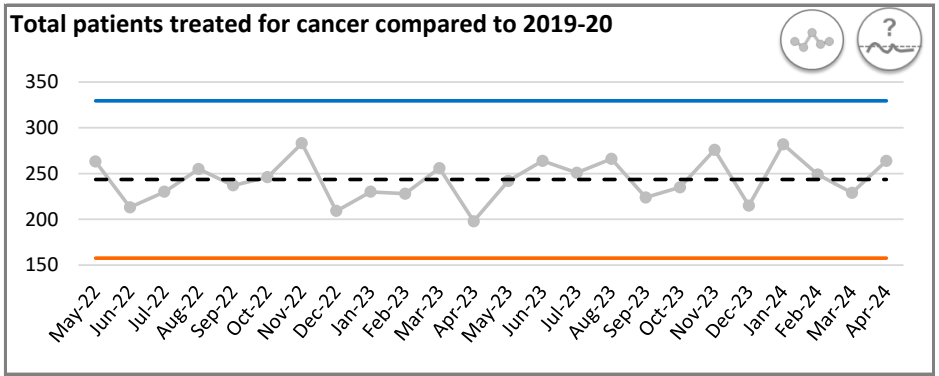
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



Total patients treated for cancer compared to 2019-20

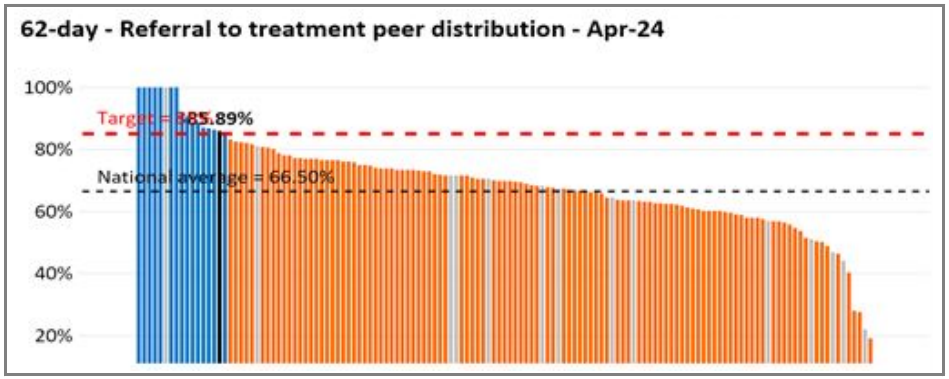


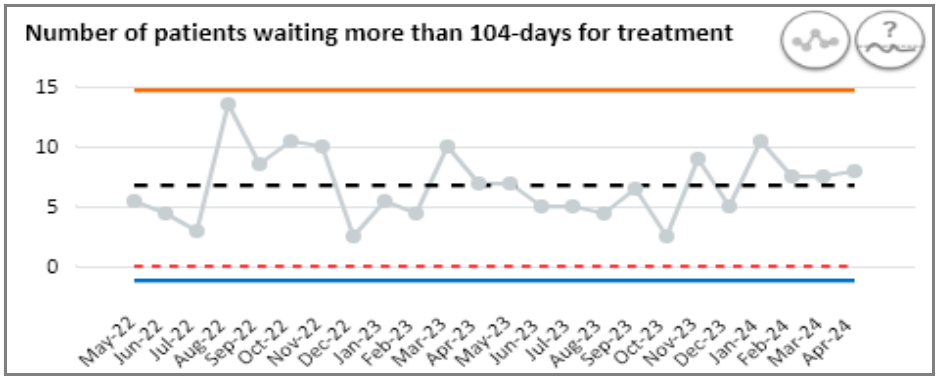
Month 02 | 2024-25

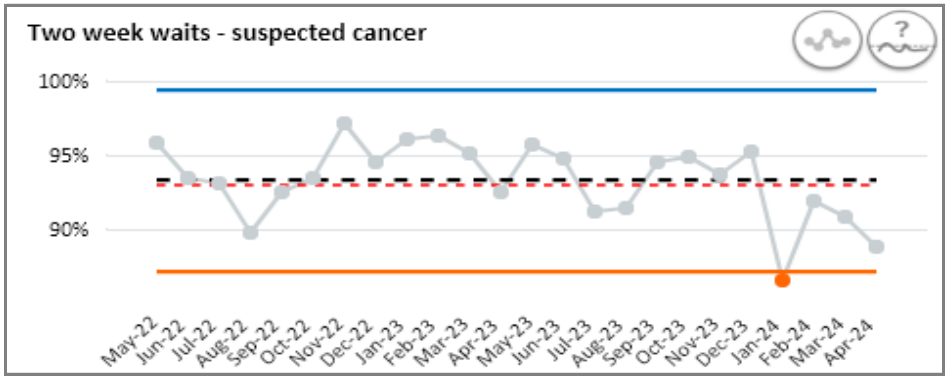
Urgent and Emergency Care

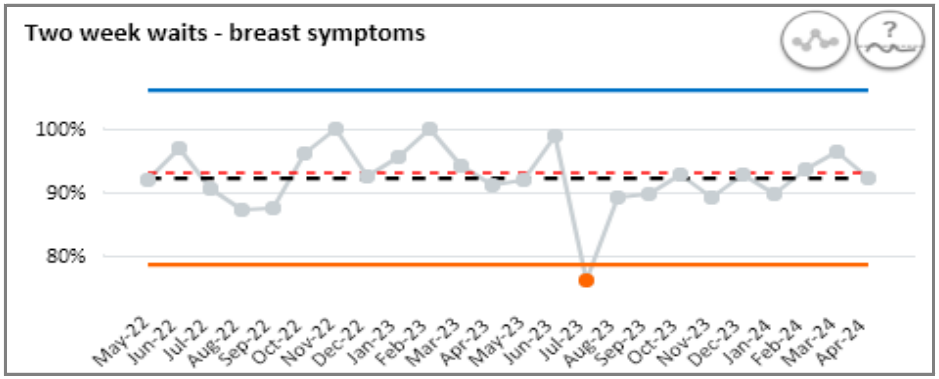
Cancer Waiting Times | Supporting Metrics

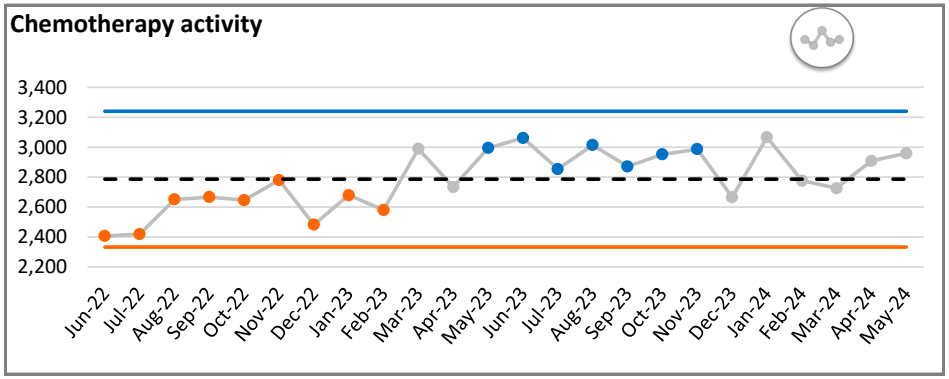
East and North Hertfordshire NHS Trust

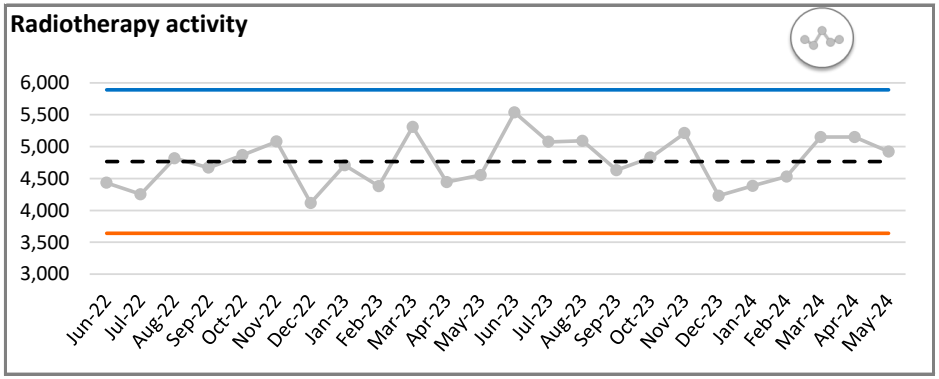










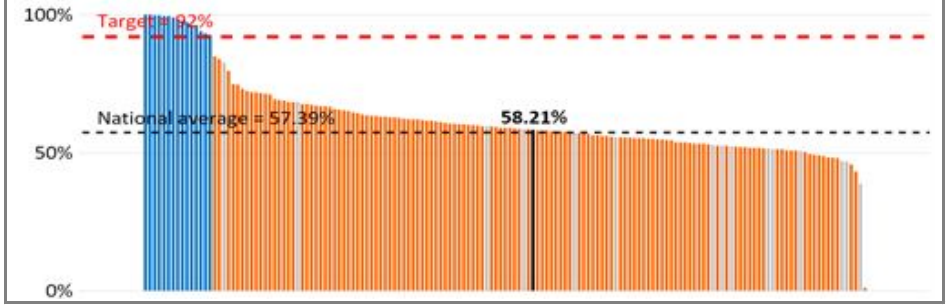


Month 02 | 2024-25

Urgent and Emergency Care

RTT 18 Weeks

East and North Hertfordshire NHS Trust



Key Issues and Executive Response

Community Paediatrics

- **104 Weeks** - There were 569 x Community Paediatric patients waiting over 104 weeks at the end of May. Due to known capacity issues in the service, this will continue to increase .
- **78 Weeks** - There were 1,771 patients waiting over 78 weeks at the end of May, compared to 1,619 the previous month, an increase of 152 patients.
- **65 Weeks** - There were 3,066 patients waiting over 65 weeks.
- Community Paediatrics is now reported via the Community Data Set.
- The waiting list continues to increase, driven by referrals for neuro diversity which is reflected in the increase in over 18 week wait.
- Transformation work is ongoing to change pathways both internal to E&N Herts and as part of the system transformation work
- This includes a standardised system-wide referral form and a single point of administrative triage. Improved reporting through developing a CSCD reporting and coding dashboard.

Key Issues and Executive Response

Excluding Community Paediatrics

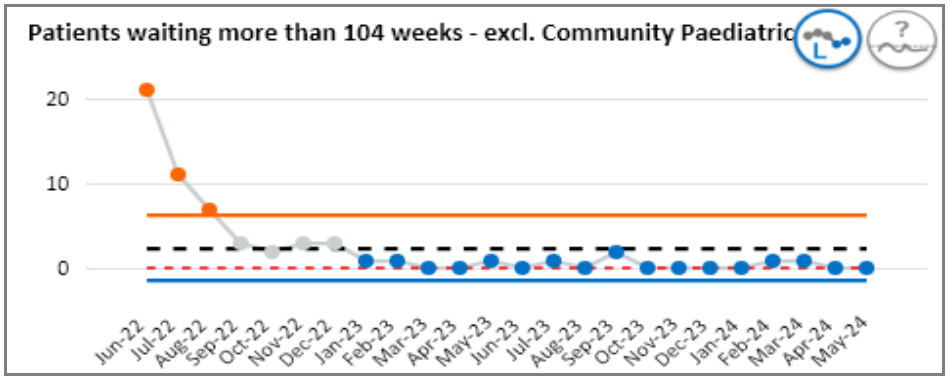
- Overall 18 week performance has increased from 54.73% to 57.29%. Excluding community paediatrics, the Trust will be reporting a position of 61%.
- **78 Weeks** - There were 18 patients waiting over 78 weeks at the end of May. This was due to patient choice, complexity and capacity delays in Trauma and Orthopaedics (11), Pain (4), Gastro (1) Urology (1) and General Surgery (1). This accounts for 0.03% of the incomplete waiting list.
- With the exception of T&O and patient choice/complexity, these should all be treated in June.
- A small number of patient choice and complexity issues (less than 10) in Orthopaedics, Pain and Oral Surgery have resulted in anticipated compliance with 78 weeks at the end of July.
- **65 Weeks** - There were 379 patients waiting over 65 weeks for first definitive treatment at the end of May. This has increased by 6 patients in month.
- Due to challenges nationally, the Trust have submitted a revised plan to be compliant with this target from the end of September 2024.
- Many services are already compliant, however there will be phased compliance for the more challenged services :-
  - May 2024 -- General Surgery (5 x 65 week breaches)
  - Future - June 2024 -- ENT, Vascular, July 2024 -- Ophthalmology, Pain, Urology, August 2024 -- Gastro, Oral, September 2024 -- T&O
- **52 Weeks** – There were 2,502 patients waiting over 52 weeks. This has reduced by 194 patients in month.

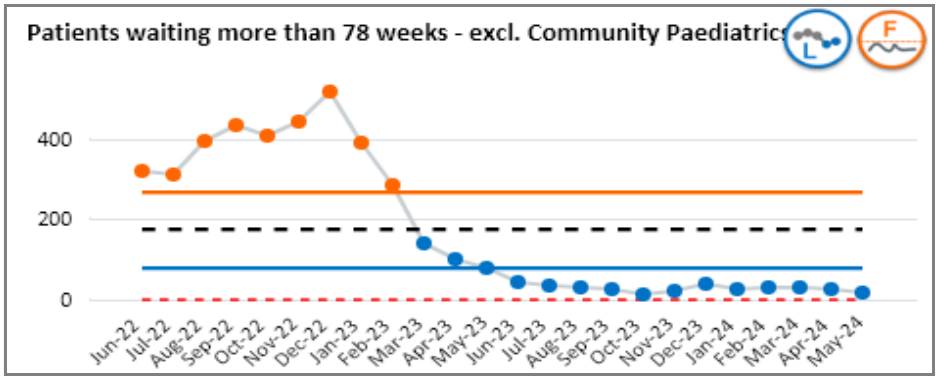
Month 02 | 2024-25

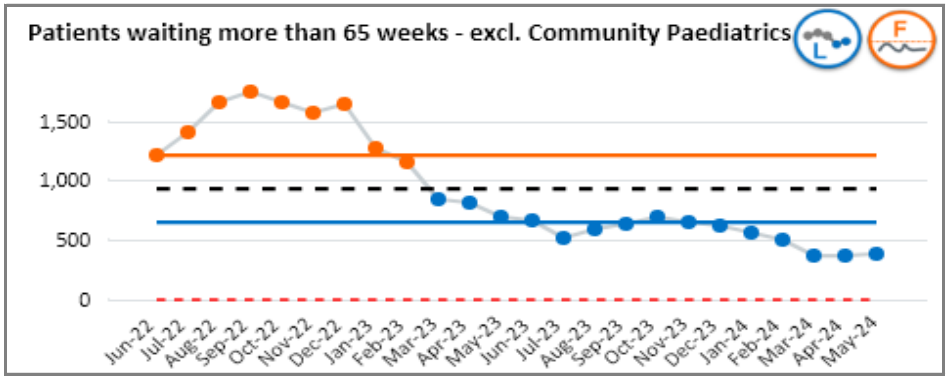
Urgent and Emergency Care

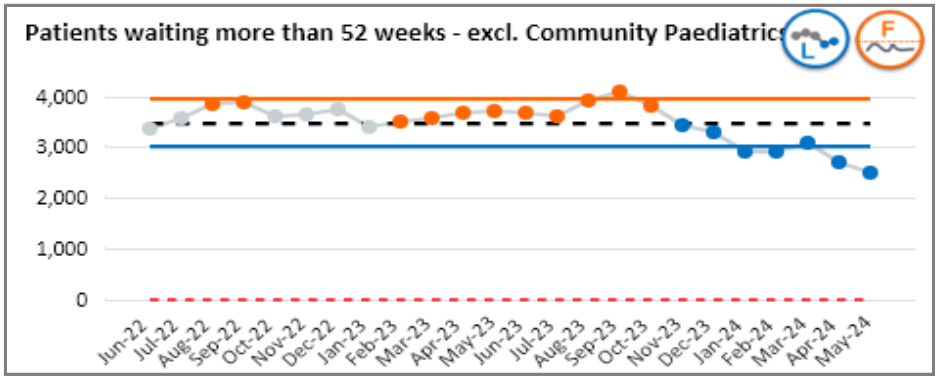
RTT 18 Weeks

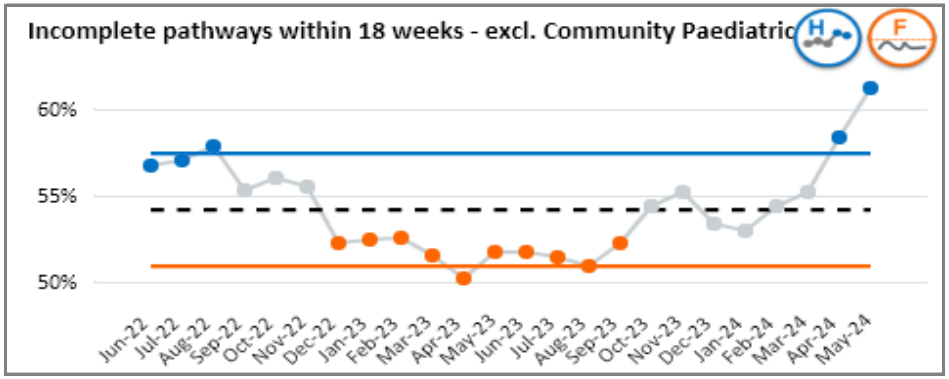
East and North Hertfordshire NHS Trust











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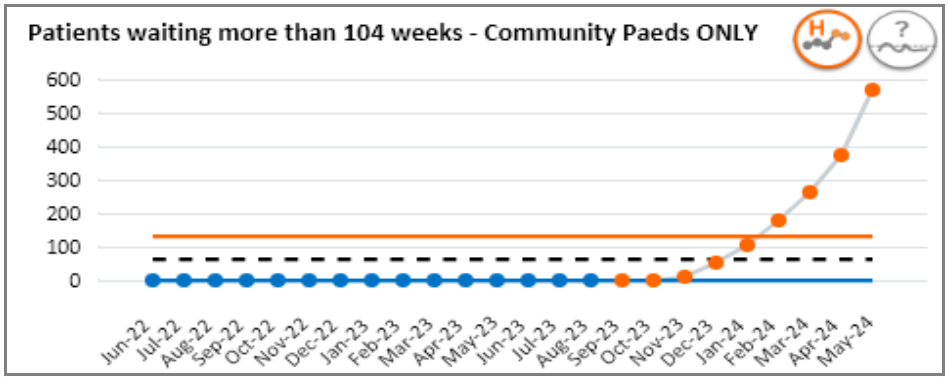
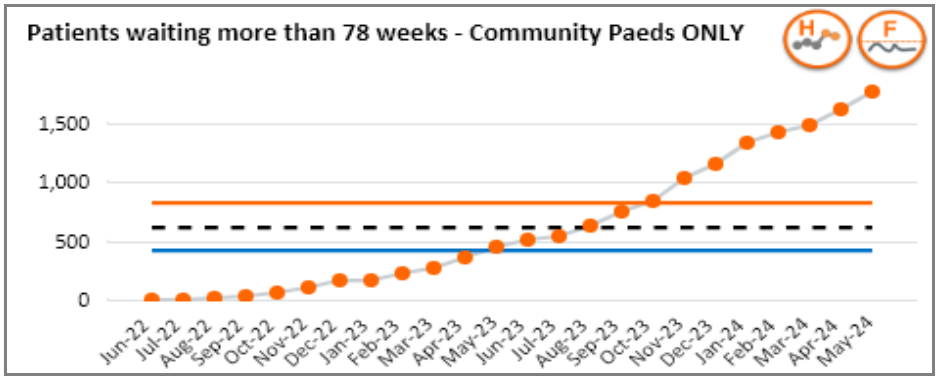
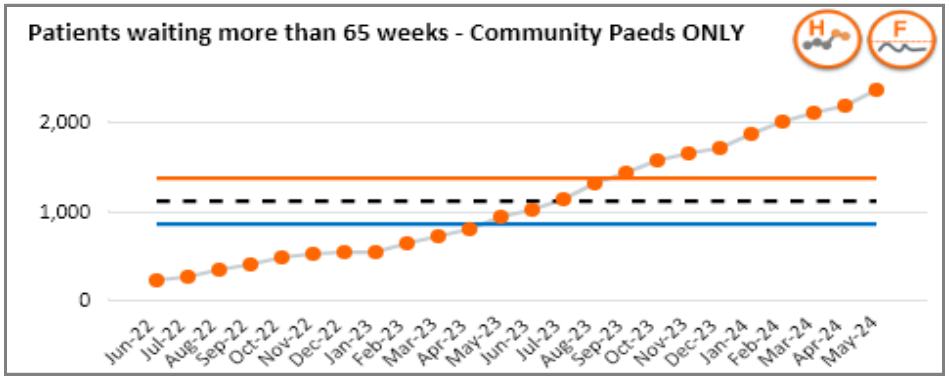
Urgent and Emergency Care

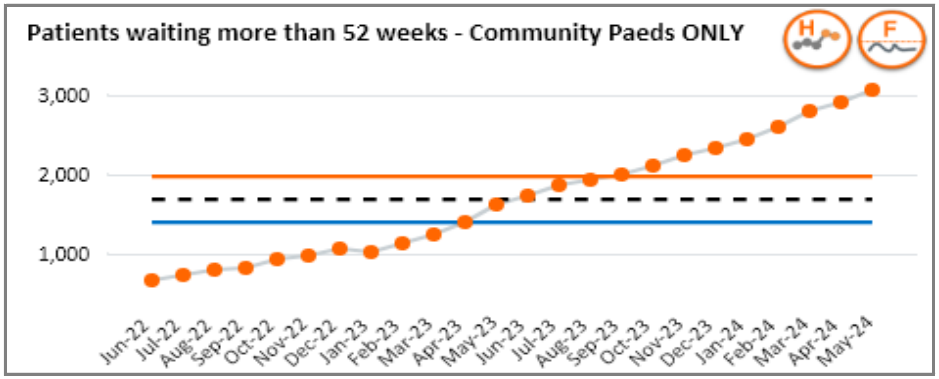
RTT 18 Weeks

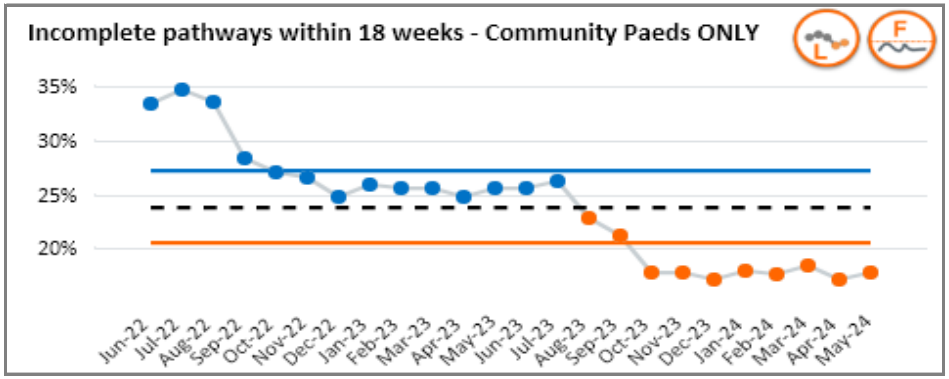
East and North Hertfordshire NHS Trust









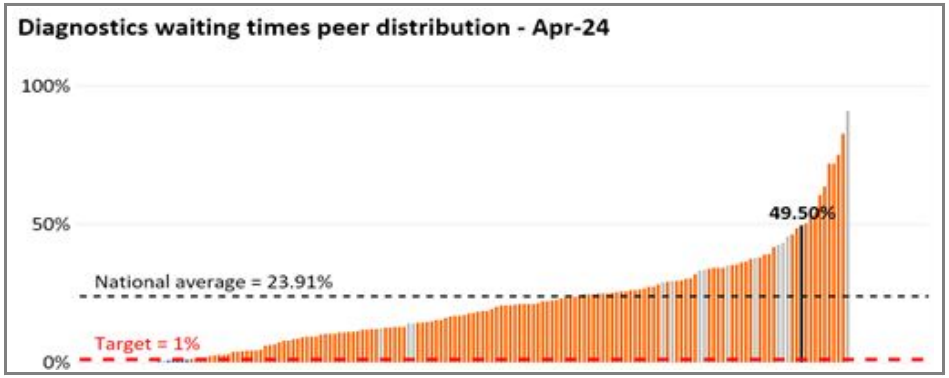


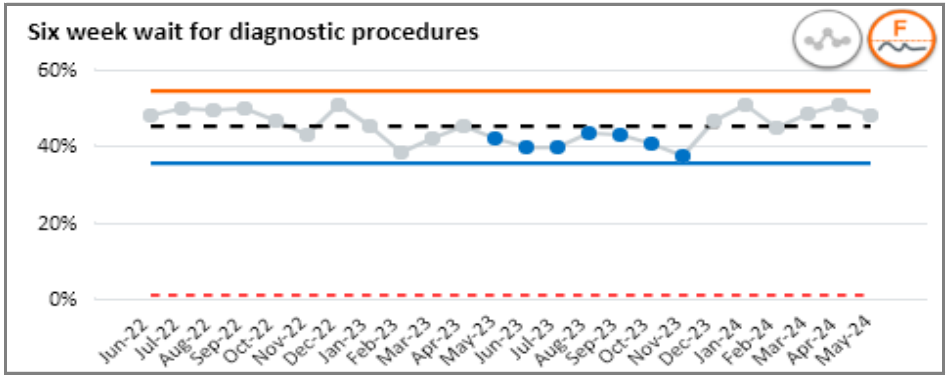
Month 02 | 2024-25

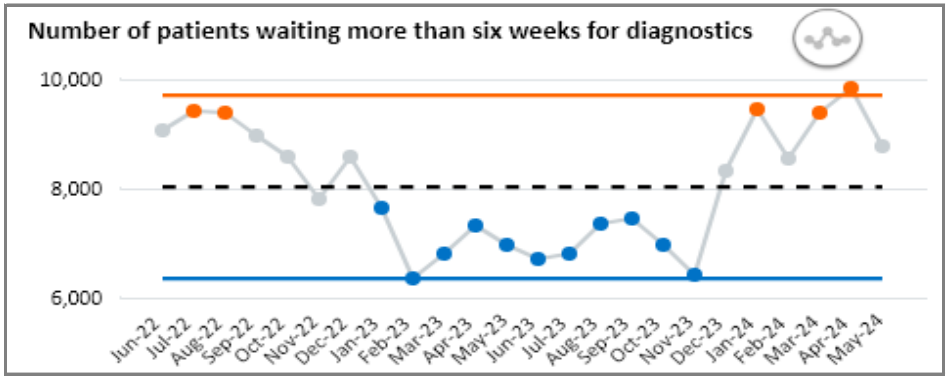
Urgent and Emergency Care

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Improvements

- May DM01 performance improved from 49.5% to 46.36%.
- May demand for Imaging (13,065) 1% higher than April (12,972)
- 86.5% of the demand was completed in month (11,304/13,065). This is 4.4% higher compared with last month's.
- DM01 performance for Diagnostic Imaging in May is 50.34% which is 2.6% better than April.
- May DM01 performance for Endoscopy shows continued improvement to 5.41% in May.
- Significant improvement in performance for urgent and routine Cardiology ECHOs, from 21.49% in April to 4.32% in May.
- CT Scans for all patients above 13 weeks are now booked.

Challenges

- Community Diagnostic Centre (CDC) met plan, except for DEXA.
- Significant MRI capacity gap in house to meet service demand and DM01 compliance by March 2025. T&O long waiters being outsourced and also Urology MRI.
- Audiology back on reporting and actions to address performance concerns need prioritisation following initial focus on quality and safety actions for the service.
- Increase of referrals for Sleep studies has caused capacity gap, plan to arrange additional WLI to reduce delays.
- Increased Cardiology CDC demand leading to a delay in consultants reporting results following diagnostics. Activity review and risk stratification in place to support recovery.

Actions

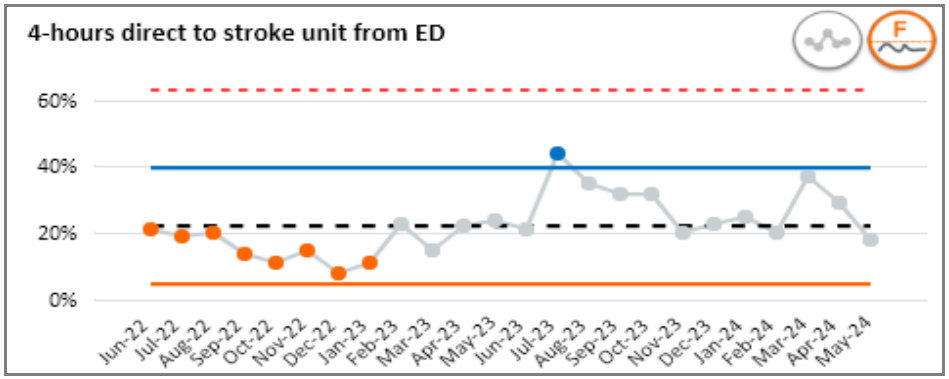
- Weekly DM01 PTL meetings commenced to track delivery against DM01 recovery trajectories by modality and ensure access in chronological order.
- Facilitate implementation of actions detailed in the Audiology Improvement committee
- Work with partners to promote GP uptake of community diagnostic capacity.
- Agree full outsource capacity with Pinehill for MRI up to 120 scans a week.

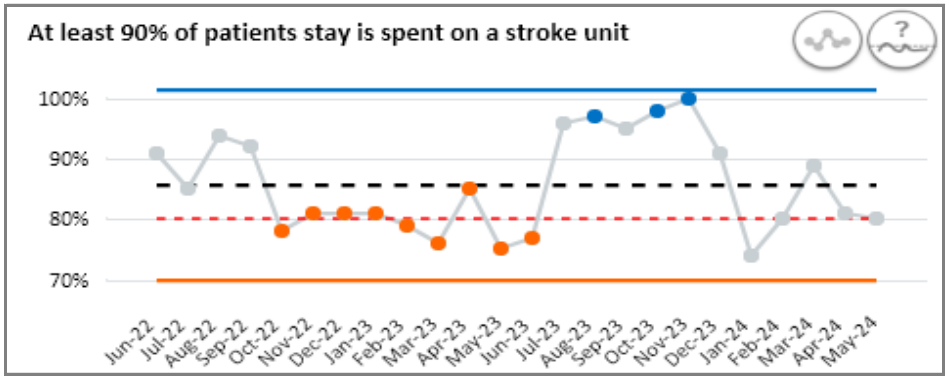
Month 02 | 2024-25

Operations

Stroke Services Supporting Metrics

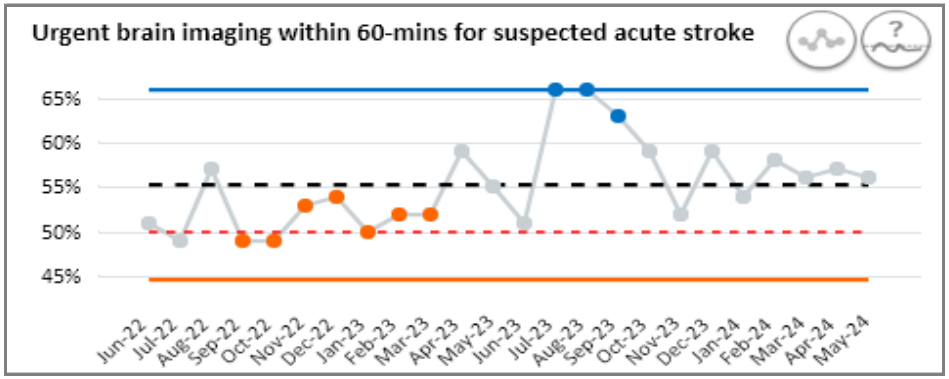
East and North Hertfordshire NHS Trust

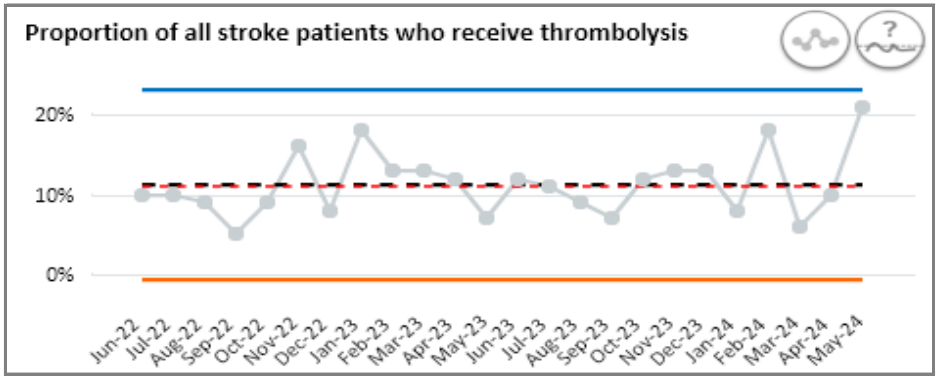




Key Issues and Executive Response

- The SSNAP rating for Q4 (January - March) remained at B. However, planned changes to the SSNAP dataset from 1st July 2024 are expected to negatively impact performance, with stricter key performance indicators. This will also increase workload, particularly within the SLT and data team due to data recording changes.
- Thrombolysis in Acute Stroke Collaborative (TASC) project underway to support improvement in Thrombolysis performance rate to 14%.
- Significant improvement in proportion of patients given thrombolysis (20.7%), exceeding the 11% target.
- Ongoing challenges out of hours to support 4 hour direct to stroke target. 4-ring-fenced beds remain established.
- Risk to maintaining a B due to therapies establishment and challenges with recruitment. Currently forecasted to drop to an E from a C in Q1 . Joint business case submitted to increase therapy, nurse, and medical establishments to align to new clinical guidelines and 7-day service.
- Digital Nerve Centre project is ongoing to support MDT working and goal setting to improve SSNAP data collection. Escalated to board due to lack of digital support.





Month 12 | 2023-24

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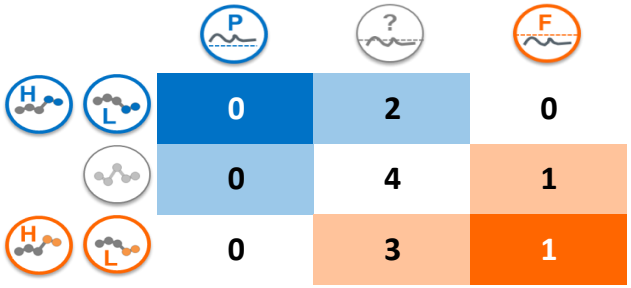
Finance

Month 02 | 2024-25



Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	May-24	-2.4	0.31		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	May-24	1,245	3,323			Common cause variation No target
	Cash balance	May-24	77.9	43.6	L	F	1 point below the lower process limit Metric will inconsistently pass and fail the target
Key Financial Drivers	Income earned	May-24	45.3	55.2	H	?	8 points above the mean Metric will inconsistently pass and fail the target
	Pay costs	May-24	29.5	34.2	H	?	8 points above the mean Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	May-24	15.5	20.7		?	Common cause variation Metric will inconsistently pass and fail the target

Month 02 | 2024-25

Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	May-24	24.9	29.8	H	?	10 points above the mean Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	May-24	0.9	5.0		F	Common cause variation Metric will consistently fail the target
	Agency costs	May-24		1.1			Common cause variation No target
	Unit cost of agency staff	May-24		11.7			Common cause variation No target
	Bank costs	May-24	3.7	3.3		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	May-24	0.5	0.9	H	?	12 points above the mean Metric will inconsistently pass and fail the target
Other Financial Metrics	Private patients income earned	May-24	0.4	0.5	H	?	9 points above the mean Metric will inconsistently pass and fail the target
	Drugs and consumable spend	May-24	2.8	3.4		?	Common cause variation Metric will inconsistently pass and fail the target

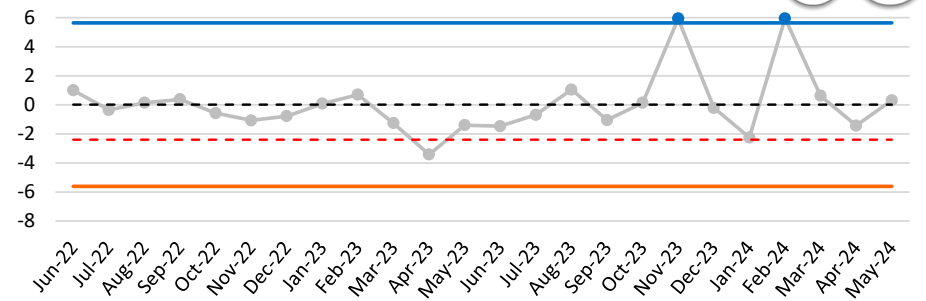
Month 02 | 2024-25

Finance

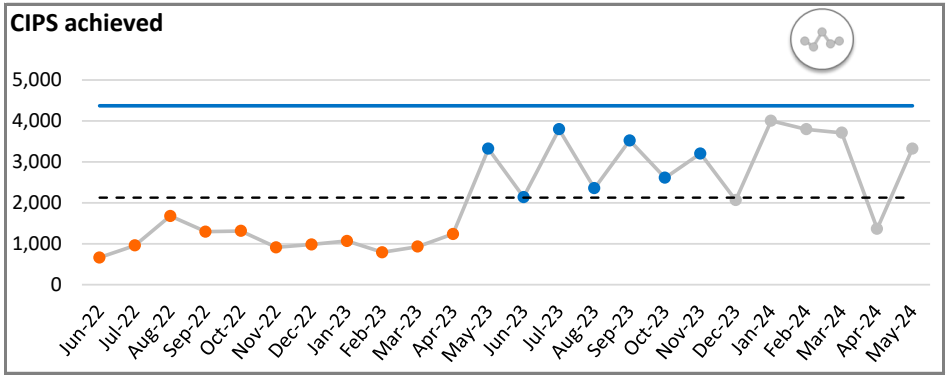
Summary Financial Position

East and North Hertfordshire NHS Trust

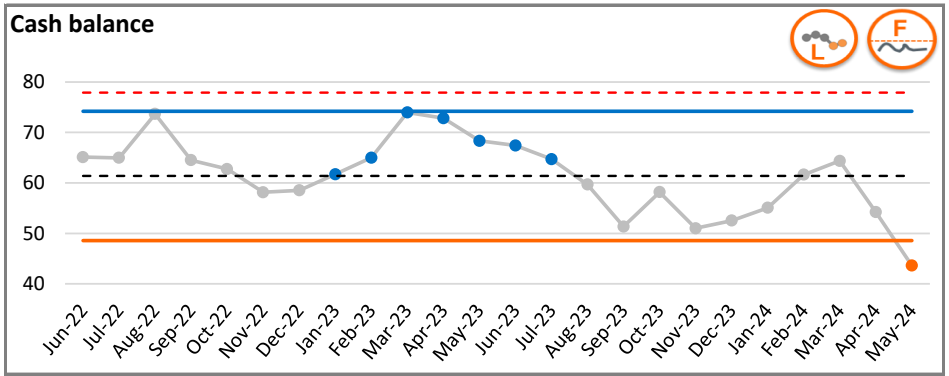
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- In May the Trust submitted a surplus plan of £1.0m for 24/25. This plan assumes that both a £33.8m cost improvement programme will be delivered, and ERF performance of 138% will be achieved
- At Month 2, the Trust has reported an actual deficit of £1.1m. This is in line with plan phasing.
- The YTD position reports a material shortfall in elective activity delivery compared with plan. Daycase and Inpatient Elective gaps were of particular concern, and reflects a delay in mobilising additional capacity.
- Pay budgets report a YTD overspend of £0.9m. A number of hotspots of concern have also emerged in respect of management of medical, nursing and admin spend staffing spend.
- CIP savings are to date in line with plan expectations, although a series of non recurrent benefits have offset the impact of shortfalls in elective activity delivery.

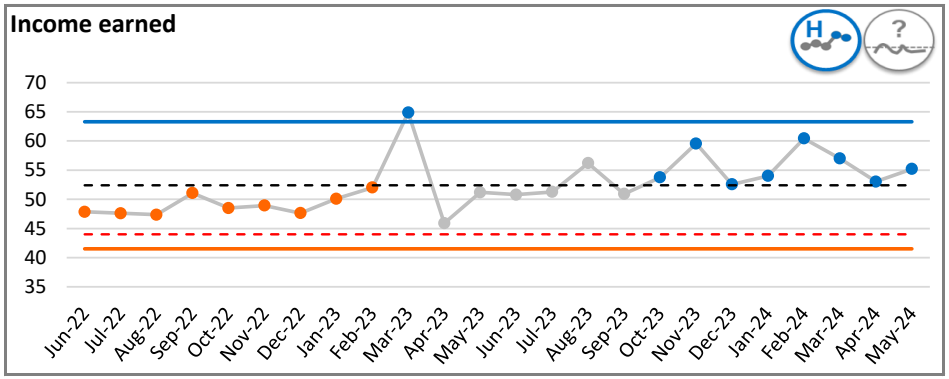
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	655.5	108.0	108.2	0.2
Pay	-403.5	-67.6	-68.5	-0.9
Non Pay	-217.1	-35.9	-35.5	0.4
EBITDA	**34.8**	**4.5**	**4.3**	**-0.2**
Financing Costs	-33.8	-5.7	-5.4	0.2
Surplus / Deficit (excl Fin Adj's)	**1.0**	**-1.1**	**-1.1**	**-0.0**

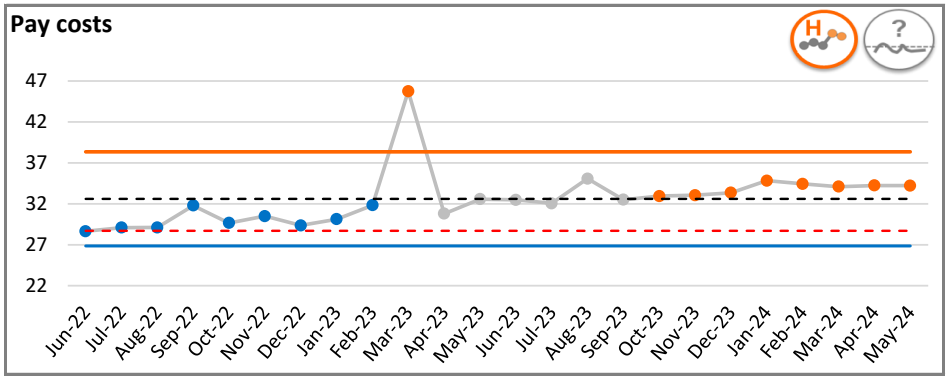
Month 02 | 2024-25

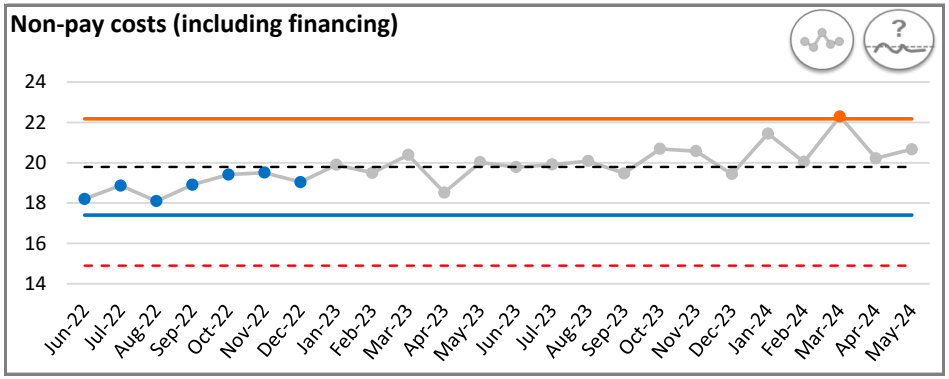
Finance

Key Financial Drivers

East and North Hertfordshire NHS Trust







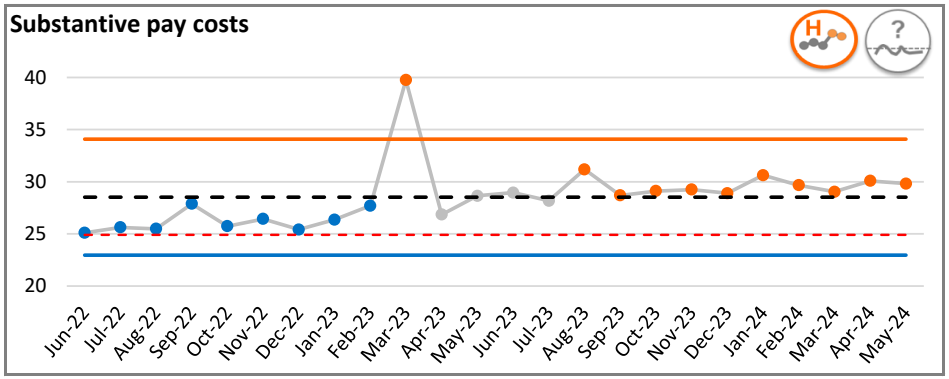
- The Trust submitted a revised 2024/25 plan in June of £1m surplus. This plan continues to assume the delivery of a £33.8m (5%) cost improvement programme. The plan phasing assumes that there will be a step up in CIP delivery in the second half of the year.
- At Month 2 year to date, there was a planned deficit of £1.1m, and an actual position of £1.1m. Whilst the year to date position is in line with plan this includes significant non recurrent reserves.
- ERF delivery has improved in May, after a slow start in April, however variable income is still £0.6m adverse to plan year to date.
- Pay was £0.6m adverse to plan in month, excluding the impact of reserves. High levels of Waiting list initiative payments accounts for £0.3m of the variance.
- High cost locum usage for medical staff within the ED department, Orthopaedics and Childrens services resulted in a further £0.2m adverse variance in month. Within nursing and clinical support workers, there was higher than budgeted use of bank staff within Maternity, Renal and ITU.
- Agency expenditure was within the 3.2% target set by NHSE in month, but is 3.3% year to date. This 3.2% target is where further central controls will be applied by the 'triple lock' process. The Trust is urgently reviewing, and identifying exit plans, for all high cost agency staff, particularly where they are procured 'off of framework'.
- There was significant pressures in month for pathology tests charged from other Trusts, which resulted in a £0.2m pressure. This is being urgently reviewed to ascertain whether the charges or correct or to identify and change in clinical practice.
- The Trust has a challenging CIP target of £33.8m this year. To date the Trust has delivered £4.7m savings against a £4.7m plan, however, much of the delivery is through non recurrent schemes. A detailed analysis of the CIP position is presented in a specific CIP paper to FPPC.

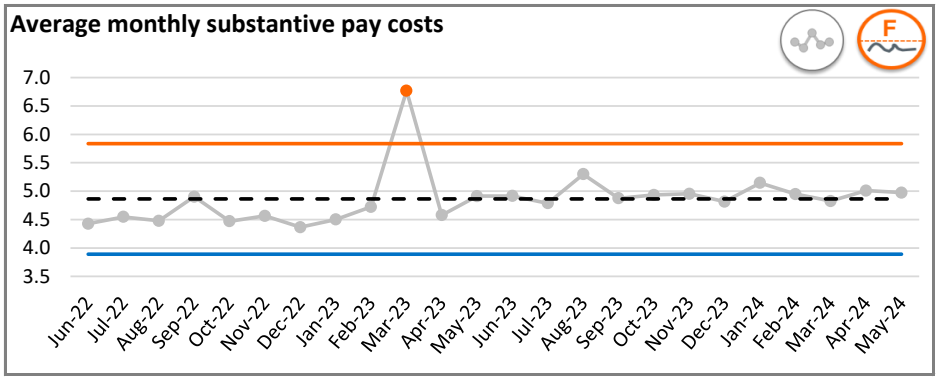
Month 02 | 2024-25

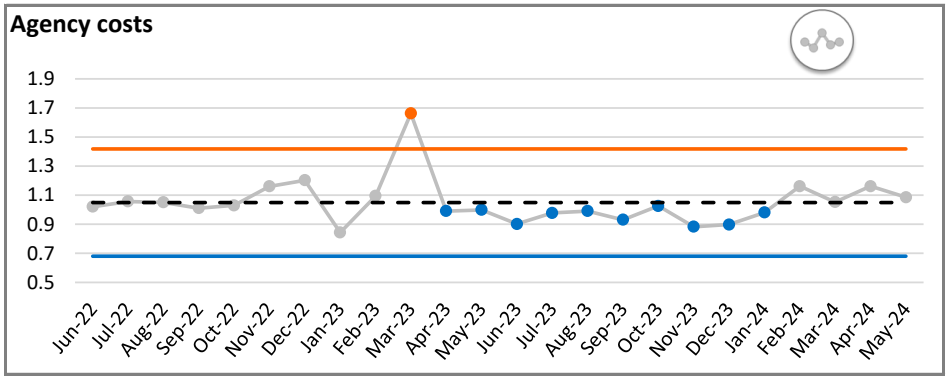
Finance

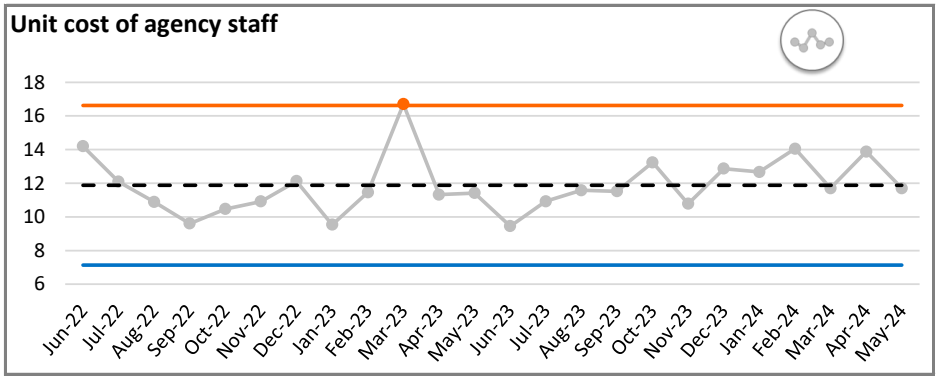
Other Financial Indicators

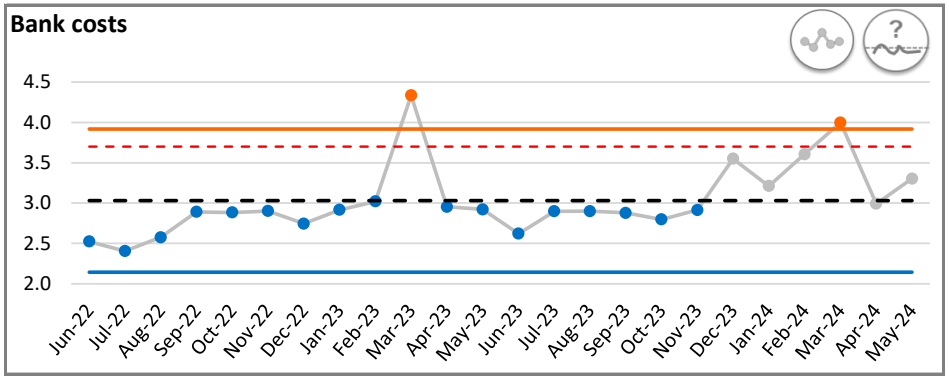
East and North Hertfordshire NHS Trust

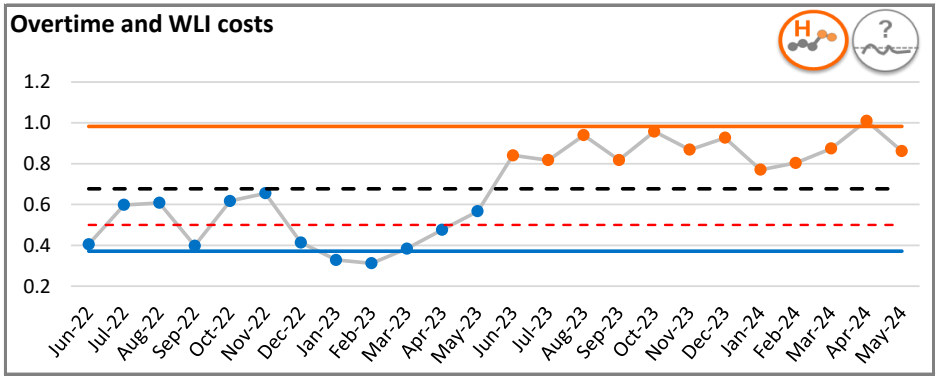










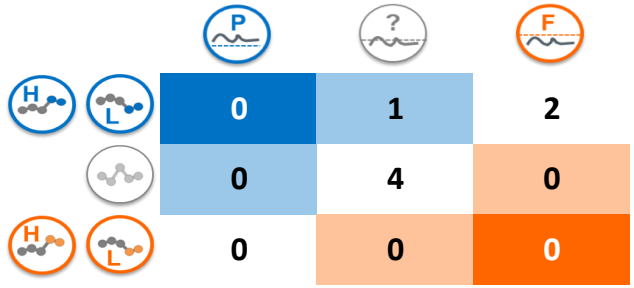


Month 02 | 2024-25

East and North Hertfordshire NHS Trust

People

Month 02 | 2024-25



People

Summary

East and North Hertfordshire NHS Trust

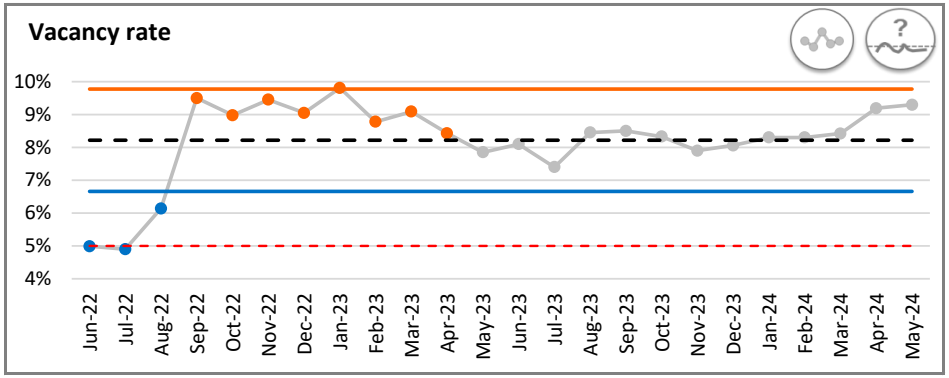
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	May-24	5%	9.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	May-24	5%	9.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	May-24	3%	3.1%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	May-24	90%	90.0%	H	F	11 points above the mean Metric will consistently fail the target
	Appraisal rate	May-24	90%	80.2%	H	F	10 points above the upper process limit Metric will consistently fail the target
Thrive	Turnover rate	May-24	11%	9.4%	L	?	7 points below the lower process limit Metric will inconsistently pass and fail the target
Care	Sickness rate	May-24	3.8%	4.3%		?	Common cause variation Metric will inconsistently pass and fail the target

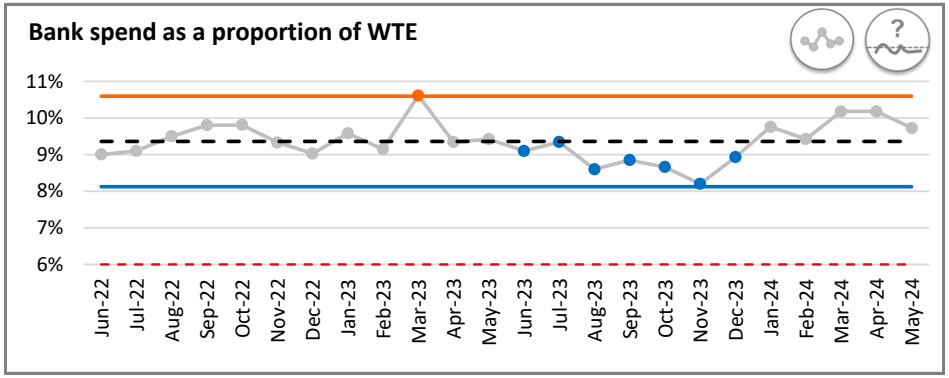
Month 02 | 2024-25

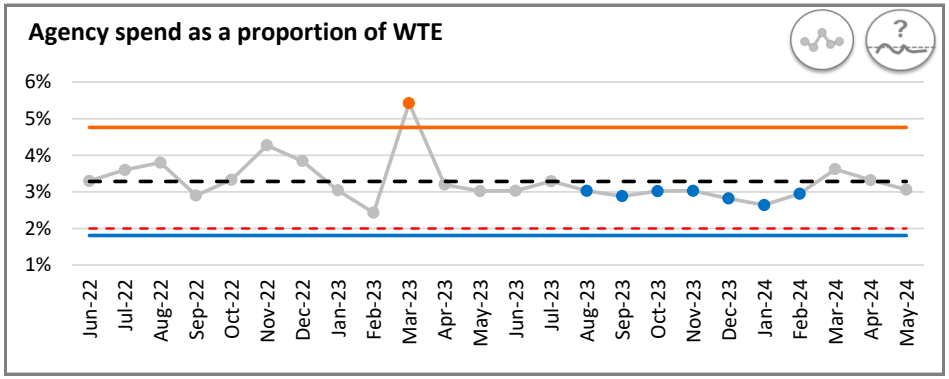
People

Work Together

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- The vacancy rate increased to 9.3% (632 vacancies). Recruitable establishment decreased by 8.5 WTE. There are 122 more staff in post than a year ago.
- Nursing & Midwifery vacancy rate increased to 10.5%.
- Continued focused on domestic nurse recruitment - 21 registered nurses in the pipeline. 7 newly qualified paediatrics nurses offered.
- Great response from student nurses to our newly qualified nurse vacancies, good attendance to market stall event held in May and 68 invited to interview throughout June.
- 15 CSW started in month, with a further 62 in the pipeline
- Medical vacancy rate has increased to 5% (52 vacancies). recruitable establishment increased by 34 WTE.
- There are 321 candidates in the resourcing pipeline.
- 'Great for 8%' temporary staffing pay bill reduced to 12.9%- proactive actions remain underway between Resourcing, Temporary Staffing and Finance triangulation to improve metrics.
- 19 agency staff in non clinical/medical roles are in discussion for exit/migration as part of continued control measures on agency.
- 'Triple Lock' controls commenced for Trusts within HWE ICB - ENH falls into the 'light touch' scrutiny i.e. only newly created posts are subject to ICB/NHSE review/approval. M2 workforce tracker submitted to the ICB.
- 91% of clinical staff are on eRoster. Audiology implementation nearing completion. Working with Radiology to phase implementation of rostering within service.
- 89% of Doctors are rostered. Work has commenced in June to implement Acute Paediatrics (63 Headcount).
- Enquire (chatbot functionality) has been shortlisted for a HPMA Capsticks award for Innovation people award (1 of 3 nationally) with awards ceremony planned for October.

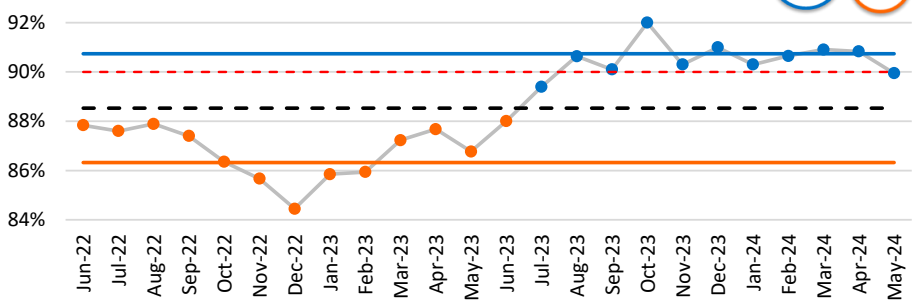
Month 02 | 2024-25

People

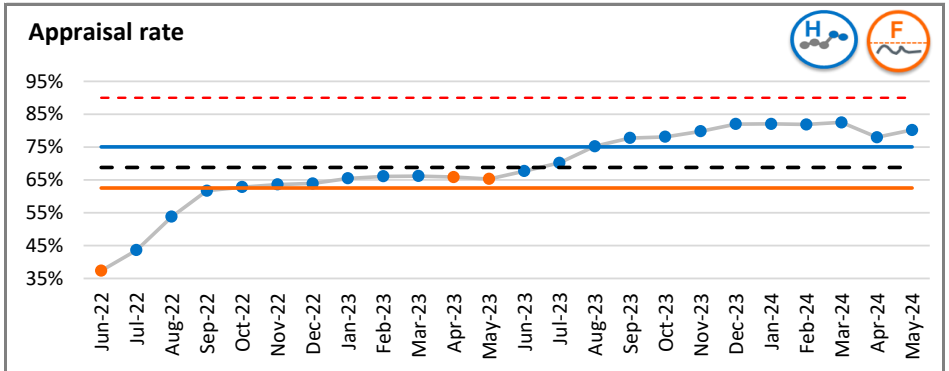
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- 'Grow Together review (GTR)' compliance this month shows a slight increase. Ongoing GTR completions continue, though some groups that should have completed their GTRs by end May still remain non-compliant.
- With 2 months into the GTR window only circa 17.7% of GTRs have been completed so far against an expected target of at least 30%, by this period. Reminders are being sent to relevant services and leads.
- It is however acknowledged that the GTR due dates for Executives and staff in bands 8c and above, was extended from April to May, which will have a knock-on effect.
- Mandatory training shows a very slight decrease compared to the previous month, though still on target.
- From 10th June the Trust became fully aligned with the NHS core skills training framework (CSTF) requirements for Equalities and Diversity and IPC Level 2 refresher, with a change to refresher dates. The reminders to staff over the last year to complete training has had the desired effect and we do not expect a significant detriment/ impact on compliance figures from this change.
- In terms of training hotspots, Moving and handling and Resuscitation training (in person) remain low, with a higher proportion of medical staff not meeting compliance requirements. Targeted action is required to address this, with issues impacting on compliance relating to availability of training room spaces.
- Training and education space is being factored into the estates strategy development, as it is acknowledged that training facilities need to be considered and improved. Ongoing discussions are taking place between estates teams and education leads to understand requirements.

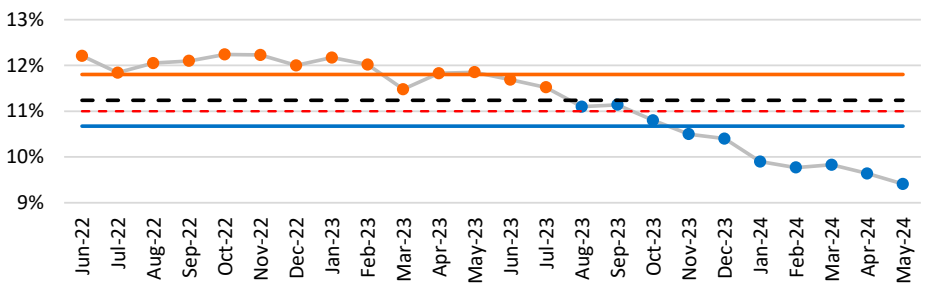
Month 02 | 2024-25

People

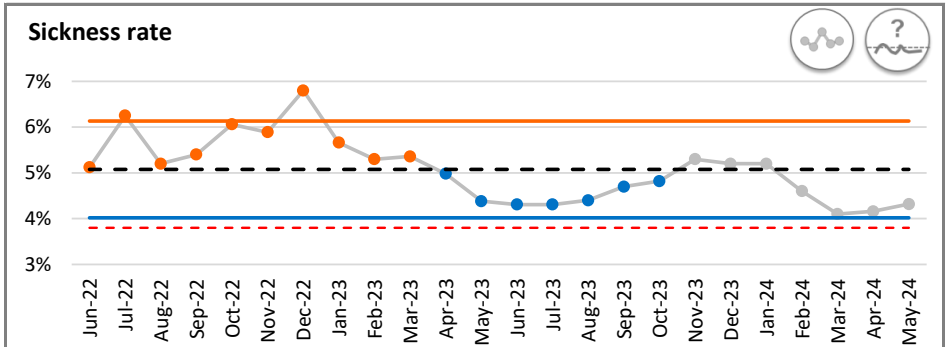
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

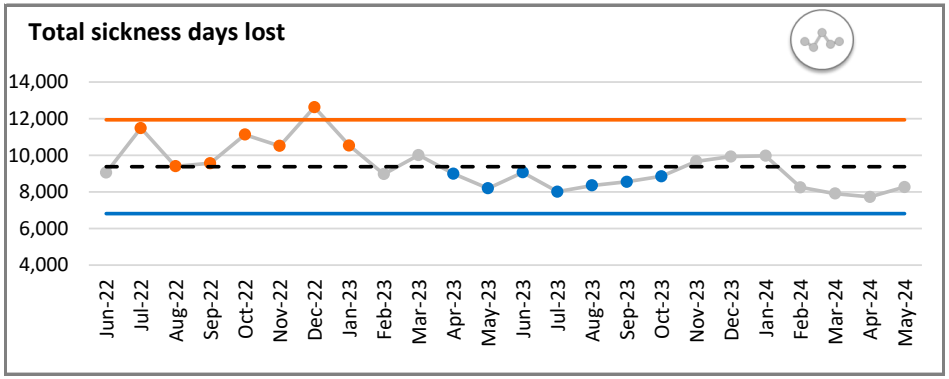
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Due to case closures, the monthly average for disciplinary and grievance has reduced. Maintaining the above 48 days for disciplinary and 58 days to resolve a grievance will meet our target and the team is focussing on where delays arise and are actively managing these to retain the performance.
- There have been no suspensions in the least 4 months in the trust and we are improving on redeploying staff where that are unable to continue to work in their area whilst investigations take place, this improves wellbeing and engagement for all involved.
- EDS work is now completed and domains 1 and 2 for submission.
- Pro-active EDI work planned for ED, Critical Care and Renal.

Care Together

- We are seeing traction in long term sickness cases and are undertaking the same approach in active review and support to divisions for short term sickness over the summer months, regular master classes are taking place in absence management.
- Relative likelihood for white applicant being shortlisted and appointed over BAME or disabilities applicant warrants a deep dive. This is now commissioned to understand more, and recruitment of additional inclusion ambassadors is underway to increase cover and the number of trained staff to participate on recruitment panels.
- ENH able guest speaker focused on supporting workplace adjustments and work that is happening around making the workplace more inclusive for disabled staff within EOE.
- Planning of themed menus, a book club and set up for Windrush day WC 17-22ND OF June and South Asian Heritage Month Steering has started and with plans underway.

Month 02 | 2024-25

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	14.1
Report title	Maternity Assurance			**Meeting Date**	10 July 2024
Presenter	Director of Midwifery Divisional Medical Director Women's & Children's Services				
Author	Director of Midwifery Divisional Medical Director Head of Midwifery Lead Midwife for governance Assurance and Compliance				
Responsible Director	Chief Nurse			**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 the Trust Board attention:

- Dashboard and Perinatal Quality Surveillance Model Tool content and exceptions.
- Maternity Safety Support Programme (MSSP) Update
- Digital Transformation project update.
- To note the content and exceptions within the materntiy Integrated performance report.

The Trust Board is asked to:

- Receive and discuss the content of the report.
  Note any key risks identified.

Impact: where significant implication(s) need highlighting

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

Report previously considered by & date(s):

N/A.

Recommendation	**The Trust Board is asked to**: • Receive and discuss the content of the report. • To note the progress with the sustainability action plan and the Plan for exit from the MSSP. • Note any key risks identified.

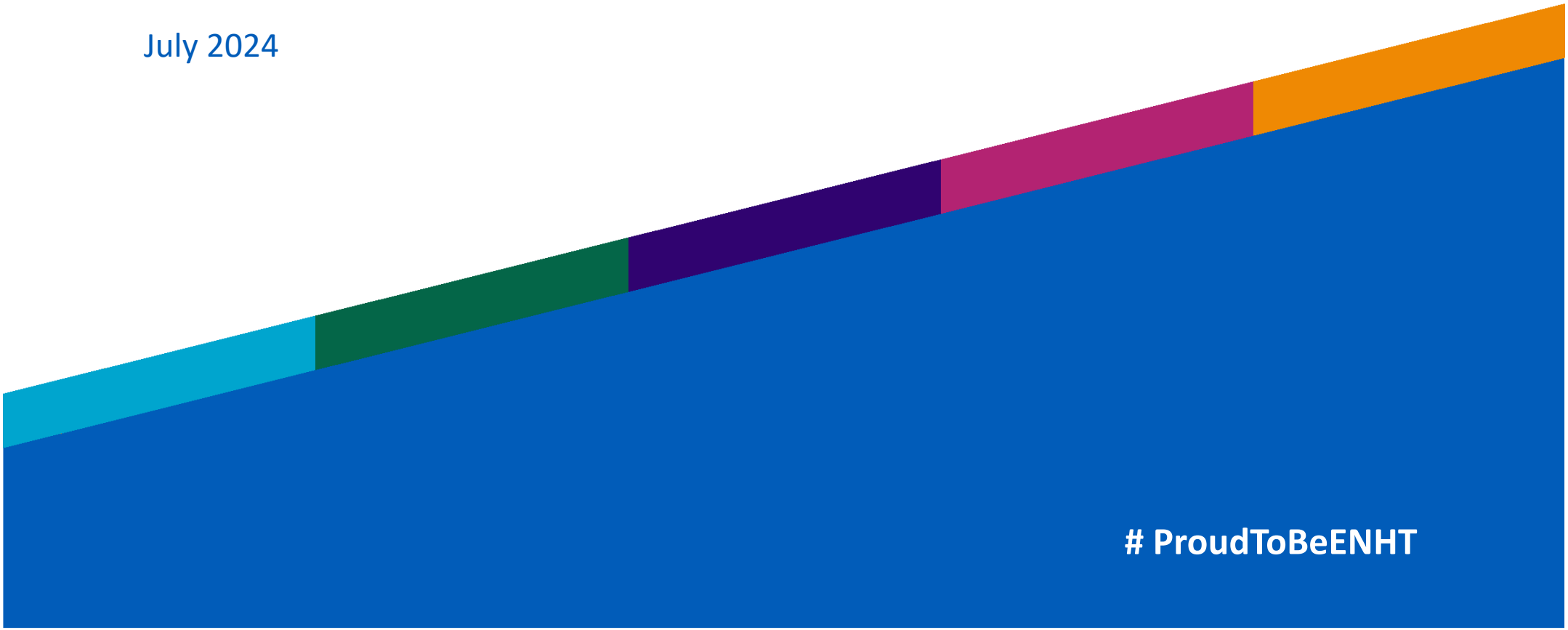
To be trusted to provide consistently outstanding care and exemplary service

Division- Women's Services

Maternity Assurance Report

July 2024

East and North Hertfordshire NHS Trust



Purpose of the Report:

Recognising the requirement for Maternity services to give 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, this will be presented in one assurance report.

For discussion this month:

- Dashboard , Perinatal Quality Surveillance Model Tool and Risk Register escalations.
- Maternity safety support programme (MSSP) Update and progress with the sustainability action plan and exit plan.
- Digital Transformation project update

Actions required by the Board:

- Receive and discuss the content of the report.
- To note the progress with the sustainability action plan and Plan for exit from the MSSP.
- Note any key risks identified.

Executive Summary:

East and North Hertfordshire NHS Trust

Culture

The Rebekah Giffney Consulting company has been commissioned to deliver a comprehensive coaching, leadership and development programme for the senior midwifery leadership team which will take place over the following 6 – 9 months.

NHSR Maternity Incentive Scheme:

Year 6 of the scheme launched on the 2nd April 2024. The 10 safety standards are unchanged from previous years of the scheme. Year 6 of the scheme will run until March 2025, with data submission at 12 noon on the 3rd March 2025.

Monthly meetings are now in place with the accountable officers for each standard with the Director of Midwifery as SRO supported by the Quality and safety Manager as PMO.

Key points of note:

Production of board planner is in progress and will be shared with the committee to provide oversight and assurance to the Trust Board of reporting and sign off timeframes for each safety action.

Digital Transformation

- The proposed Go-Live date is on schedule for launch in July 2024.
- Staff training is making good progress throughout the MDT. Target of >90% midwives (180) achieved as of 12/06/24.
- Operational demands scoped and timetable being produced to provide hands on support 24/7 for staff during the two weeks following launch, including daily K2 support 9-5 and Super-user support for evenings and weekends.

Executive Summary:

East and North Hertfordshire NHS Trust

Maternity Safety Support Programme (MSSP) update.

Representatives from NHSE, LMNS, and MNVP undertook a site visit on 20th May in the form of a supportive review and assessment to advise whether the service is now in a position to commence the exit process from the MSSP. The significant progress made in improving our vacancy position, strengthened leadership and governance structure, Improved medical staffing position and improvements to estates and environment was praised.

During the visit, it was identified that there were some items of out-of-date equipment located within some ward areas which was noted as a cause for concern. Service leads immediately responded by addressing the servicing of the out-of-date equipment alongside reviewing the systems and processes implemented in 2023 following the introduction of the Section 29A safety notice from the CQC.

Areas for improvement were identified to strengthen these processes and prevent a reoccurrence. To ensure oversight is maintained bi-monthly meetings led by the Head of Midwifery have been initiated with attendance by service leads from both maternity and estates and facilities. Governance and compliance reporting within the division have also been strengthened.

There were 3 areas identified by the team where greater assurance of sustainable improvement is needed.

1) Systems and processes for repair and replacement of equipment
2) Increase in recruitable headroom to reflect the time needed for midwifery competency and core skills training.
3) Creation of a nurse staffing model in maternity theatres and recovery that mitigates the need for midwives to undertake scrub duties in theatre (Risk ID1140)

Next steps:

Director of Midwifery to plan an assurance report in preparation for September Trust Board that will then be shared with the regional and national team with a recommendation to exit the programme.

Executive Summary

East and North Hertfordshire NHS Trust

Midwifery staffing

20 WTE ENHT student midwives have been offered positions as Band 5 midwives and are due to join the team in October 2024. This will result in the Midwifery workforce being fully established.

Challenges continue with regard to decreasing bank spend within the service. Weekly bank spend review meetings are in progress to better understand the reasons for this which include backfill to support the supernumerary time of newly qualified and internationally educated midwives. Bank spend is being further exacerbated by the training requirements of the K2 digital EPR system in preparation for the launch in July

Theatres and recovery:

Maternity shift plans are in the final stages of sign off which is significant progress for the service. Discussions and proposals have progressed that consider the decline in birth rate since the last maternity establishment review. All recognise the the need to plan staffing to maintain high quality safe care and consider the increase in both acuity and supporting women's choice. The service need to ensure any changes still meet the requirements of the Maternity Incentive Scheme for year 6.

A comprehensive maternity Recruitment and Retention strategy is due for divisional sign off this month.

Service Closures:
The unit had no episodes of divert during May.

Division - Women's Services

Dashboard and Exception Report June 2024

June 2023 to May 2024 data

East and North Hertfordshire NHS Trust

ProudToBeENHT

		Updated/unchanged Goal	Updated/unchanged Red Flag	Data Source	Jun-23	Jul-23	Aug-23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Exception Reporting
Scheduled Bookings	No of women EDD 4 months hence (projected births 4 months ahead)	5500(458 to 539)	<458/ >540 per month	CMIS	409 (Oct)	412 (Nov)	358 (Dec)	394 (jan)	378 (Feb)	363 (Mar)	358 (apr)	383 (may)	363 (June)	348 (July)	386 (Aug)	404 (Sep)	The number of births in the UK has been decreasing for the fifth consecutive year and is at its lowest level since 2002. The current birth rate in the UK for 2023 is 11.267 births per 1000 people, a 0.49% decline from 2022.
Bookings in month	The number of women booked in month	≥5760/480	≤5760/480 or ≥6600/550	CMIS	482	463	465	438	469	456	362	526	466	435	475	430	As above.
Bookings by 9+6 weeks gestation	The gestation at which women booked in month	≥50.5%	<50.5%	CMIS	75.20 %	74.08 %	77.27 %	76.00 %	80.00 %	78.40%	72.09%	72.81%	74.67%	78.62 %	71.37 %	75.81 %	
Bookings < 12+6 weeks gestation	The gestation at which women booked in moth		<80%	CMIS	88.75 %	88.76 %	92.21 %	88.00 %	91.04 %	92.90%	85.91%	89.73%	86.90%	90.80 %	89.47 %	87.91 %	
IOL	Total rate	≤34%	>36%	CMIS	32%	36%	33%	33%	33%	37%	38%	37%	35%	35%	29%	32.58 %	Reduction noted and returned within goal limits.
Births (mothers birthing)	Benchmarked to 5500 per annum including home birth	5500(458)	>490	CMIS	404	381	411	390	389	361	359	397	369	358	353	353	Reflective of declining UK birth rate (as above).
Births (babies born)	Number of babies born in month	No target		CMIS	410	387	417	398	400	363	365	399	377	363	358	357	
Born before arrival (BBA's)	Births not attended by a midwife	<0.2%	>1%	CMIS	1.20%	0.00%	0.50%	0.76%	0.51%	1.10%	0.82%	1.30%	0.81%	1.11 %	0.28 %	0.85 %	BBA due to precipitate birth and little notice to attend. Audit ongoing, all response and care deemed appropriate.
Home births	Percentage of women birthing at home	≥2%	<1%	CMIS	1.70%	1.84%	1.50%	1.79%	1.50%	0.55%	1.40%	2.50%	1.35%	2.79 %	2.55 %	3.12 %	
MLU Births	Benchmarked to 1500 per annum	≥15%	<12.5%	CMIS	13.60 %	14.20 %	11.40 %	9.70%	11.00 %	12.70%	15.00%	12.30%	14.60%	11.70 %	11.00 %	12.46 %	Reduced admissions to MLU reflective of increased induction of labour and caesarean section rates.
MLU transfer to CLU	Primip	≤ 40% per month	>45% per month	CMIS	48.70 %	50.00 %	50.00 %	56.00 %	46.60 %	47.0%	40.0%	32.30%	36.00%	30.00 %	41.00 %	58.00 %	There were a high number of primigravida transfers for May 2024, Senior MW for MLU reviewed all transfers, all of which were appropriate, . High number of preceptors on MLU at present which could have had an impact on these figures due to lack of experience.
MLU transfer to CLU	Multip	≤ 13% per month	>15% per month	CMIS	12.20 %	5.30%	15.00 %	14.80 %	9.10%	8.50%	6.00%	3.50%	3.00%	15.00 %	15.00 %	9.00 %	All multigravidae transfers to CLU were reviewed by Senior MW for MLU and found to be within target limits and appropriate.
Midwife Led Births	Combined homebirth and MLU Births	≥17%	≤13.5% per month	CMIS	15.30 %	16.04 %	12.90 %	11.49 %	12.50 %	13.25%	16.40%	14.80%	15.95%	14.49 %	13.55 %	15.58 %	The midwife-led births are impacted by the reduced number of women having home and MLU births although rates are above minimum red flag incidence.
Spontaneous Vaginal Births	Maintain Vaginal Birth rate	≥56.4%	<53%	CMIS	52%	47%	46%	47%	49%	47%	50%	50%	44%	47%	41%	47.59 %	The vaginal birth rate continues to be impacted by caesarean section as a choice of mode of birth.
Vaginal births after previous LSCS	Percentage of VBAC of women with a previous caesarean section who had avaginal birth.	59.10%	<50%	CMIS	50%	42%	67%	50%	50%	62%	80%	71%	82%	64%	64%	57.14 %	
CLU births (including theatres)	All births occuring within the CLU	≤85.5%	>85.50%	CMIS	83%	83%	87%	87%	87%	85%	83%	83%	82%	84%	86%	83.29 %	Reflective of known increased induction of labour and caesarean section rates but within expected limits.

NHS
East and North Hertfordshire
NHS Trust

		Updated/ unchanged Goal	Updated /unchanged Red Flag	Data Source	Jun-23	Jul-23	Aug-23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Exception Reporting
Instr. Vag Del	Ventouse & Forceps	10%-15%	<8% or >16%	CMIS	9.65 %	12.07 %	12.04 %	12.05 %	8.74 %	10.80 %	10.00 %	9.06 %	11.30%	9.80 %	12.46 %	9.63 %	
C- Section	CS of Robson category 1 Nulliparous women with singleton cephalic pregnancy at term in spontaneous labour			CMIS	16%	26%	11%	21%	27%	12%	11%	9%	29%	20%	21.05 %	17.02 %	
	CS of Robson category 2 Nulliparous women with singleton cephalic pregnancy at term with induced labour or CS before labour			CMIS	52%	54%	60%	58%	53%	56%	57%	52%	56%	60%	61.80 %	63.53 %	
	CS of Robson category 5 (Multiparous women with a singleto cephalic pregnancy at term with a previous CS)			CMIS	87%	88%	90%	87%	96%	86%	77%	87%	81%	88%	86.67 %	84.31 %	
Maternity staffing	Funded midwife/birth ratio with skill mixing Against YTD births	1:29 (from March 14)	>1:33	HOM	1:24	1:24	1:24	1:27	1:24	1.23	1:24	1:24	1:24	1:24	1:24	1:23	
	Funded midwife only ratio Against YTD births	1:32	>1:33		1:24	1:24	1:24	1:26	1:24	1.23	1:23	1:23	1:24	1:23	1:23	1.23	
	Actual midwife only ratio Against activity in month	1:32	>1:33		1:26	1:24	1:26	1:27	1:25	1.25	1:22	1:23	1:24	1:21	1.22	1.21	
	1:1 care in labour excluding BBAs	100%		CMiS	100%	100%	100%	100%	100%	99.72 %	100%	100 %	100 %	99.97 %	100%	100%	
	Midwifery vacancy rate	≤5	≥5		19.52	24.78	23.03	23.44	17.0	15.55	TBA	TBA	0%	1.85 %	0.62%	2.55 %	
	Weekly hours of CLU Consultant cover	125	<125		125	125	125	125	125	125	125	125	125	125	125	125	
Morbidity	ITU Admissions in Obstetrics	<8 per annum	≥10 per annum	Datix	1	0	1	0	1	0	1	0	1	1	0	0	
	Post partum Hysterectomies	<3 per annum	3 per annum	Datix	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of cases of meconium aspiration	2 per month	>4 per month	SEND	0	0	3	1	2	2	1	1	3	0	0	1	
	Number of cases of hypoxic encephalopathy (Grades 2&3)	1 per month	>2 in 2 months	SEND	1	0	0	0	2	1	0	0	0	1	0	0	
	Term admissions to NNU	<6%	≥6%	Badger	4.60 %	5.10 %	5.60 %	4.12 %	8.45 %	6.40 %	6.02 %	7.00 %	5.84	5.50 %	6.5%	5.36 %	ATAIN rates had reduced below national average. No avoidable neonatal or obstetric cases for the month of May 2024. New TC Lead Nurse in position.
Mortality	Maternal deaths (direct)	0	≥1 a year	Datix	0	0	0	0	0	0	0	0	0	0	0	0	
	Pre-labour IUDs	14 per annum	>14 per annum	Bereavement M/W	0	0	1	0	1	2	0	1	0	1	1	0	
	Intrapartum IUDs	0	>1 a year	Bereavement M/W	0	0	0	0	0	0	0	0		0	0	0	
	Early Neonatal deaths	1 per month	>1 per month	Bereavement M/W	0	0	1	0	1	1	0	0		1	0	0	

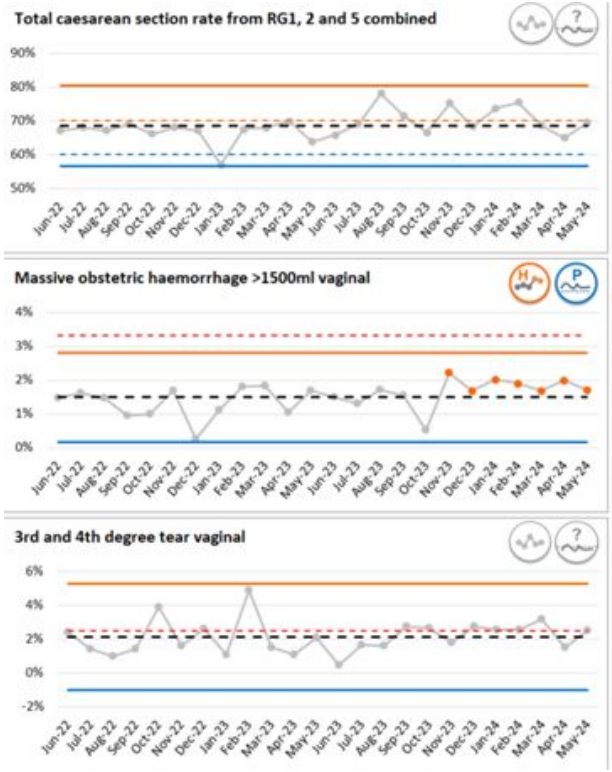
East and North Hertfordshire NHS Trust

		Updated/unchanged Goal	Updated/unchanged Red Flag	Data Source	Jun-23	Jul-23	Aug-23	Sep 23	Oct 23	Nov 23	Dec 23	Jan24	Feb 24	Mar 24	Apr 24	May 24	Exception Reporting
Risk management	Number of Sis (to include duty of candour)	≤2/2 months	>6 per annum	Risk Lead	1	0	1	0	2	1	0	0	0	0	0	0	
	Cases declared to HSIB for investigation and accepted	≤2/2 months	>6 per annum		0	0	0	0	2	0	1	0	0	1	0	0	
	Open datix that are overdue >30 days (awaiting or being reviewed)	<30	>30	Datix	63	47	72	84	64	81	135	136	15	36	57	52	Escalated to HoM for support from senior midwifery team. Data at time of report higher than current rate following closure drive. PSIRF to implement PS as daily priority. Daily Incident Triage to commence 06/24.
	Never events	0	1	Datix	0	0	0	0	0	0	0	0	0	0	0	0	
	Massive PPH ≥1500ml MOH:	≤2.9%	>3.0%	% of mothers 37 weeks and over cephalic singleton	2.23%	2.89%	2.90%	1.80%	0.28%	2.69%	2.50%	3.53%	2.16%	4.04%	2.56%	2.85%	
	MOH >2000ml	<2%	≥2.5%	% of women	1.49%	1.58%	1.46%	0.25%	0.26%	1.38%	0.83%	1.00%	0.54%	0.56%	0.57%	0.85%	
	3rd/4th degree tears	<3.5%	≥ 5%	% of all vaginal deliveries of mothers 37 weeks and over cephalic singletons	1.20%	1.80%	1.80%	1.79%	3.40%	2.00%	2.19%	2.51%	3.04%	3.12%	1.72%	3.09%	
	3rd/4th degree tears (sustained at instrumental birth and failed instrumental)	6.80%	NA	Instrumental births 37/40+ singleton, cephalic	5.30%	2.30%	2.00%	4.25%	6.70%	2.60%	8.30%	1.00%	4.87%	2.94%	2.38%	5.88%	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (NMPA) (denominator total singleton cephalic vaginal births / Instrumental births) (NMPA)
	3rd/4th degree tears (sustained at SVD)	2.80%	NA	SVD 37/40 + singleton, cephalic	0.50%	1.80%	1.70%	2.74%	1.28%	1.90%	1.39%	1.51%	2.56%	3.16%	1.51%	2.50%	% 3rd & 4th degree tear: NMPA SVD & Instrumental 3rd & 4th degree tear (NMPA) (denominator total singleton cephalic vaginal births / Instrumental births) (NMPA)
	Episiotomy rate (instrumental)	86.70%	NA	All women instrumental birth	89.70%	89.10 %	90.00 %	83.00 %	87.50 %	92.30 %	86.11 %	91.70 %	83.33%	94.29%	93.18%	94.12%	
	Episiotomy rate (SVD)	8.30%	NA	All women- SVD	5.20%	3.90%	4.80%	5.49%	7.38%	8.87%	7.73%	7.10%	8.53%	10.18%	3.42%	5.36%	OASI care bundle QI project launch and training planned October 2024.
Complaints	No. of complaints opened in month	3	5	Datix	2	3	7	6	6	4	1	TBA	3	3	4	3	2 Complaints received for May 2024 with a further 2 awaiting scope. 5 outstanding complaints (longest outstanding Feb 2024, meeting held 24th May 2024). 3 local resolution meets arranged.
Closures	Number of times the unit closed for admission	<1/month	>3/month	Risk Lead	0	0	0	1	1	0	0	0	0	0	0	0	

		Updated/unchanged Goal	Updated/unchanged Red Flag	Data Source	Jun-23	Jul-23	Aug-23	Sep 23	Oct 23	Nov 23	Dec 23	Jan24	Feb 24	Mar 24	Apr 24	May 24	Exception Reporting
Saving Babies Lives Care Bundle	Smoking at booking	≤12.5%	≥12.6%	CMIS	5%	6%	4%	5%	5%	3%	6%	6%	5%	5%	5.67%	6.23%	
	Smoking at delivery	≤6%	≥8%	CMIS	3%	3%	4%	4%	4%	3%	5%	2%	3%	4%	3.40%	5.10%	
	Births>23+6 -36+6 weeks	<6% per month/year	≥7.5% in year	CMIS	7.30%	8.29%	6.00%	8.54%	11.00 %	5.20%	6.6%	5.30%	7.43%	9.37%	9.78%	5.89%	Majority pre-term births >34/40. For May 2024 cases were in line with national target <6%. An ongoing review continues, optimisation work ongoing and Pre-term Birth Lead Midwife in post.
	Births>23+6 -26+6 weeks	TBC	TBC		0.00%	0.00%	0.00%	0.00%	0.00%	0.83%	0	0	0	0.28%	0.00%	0.00%	
	Steroid administration 2 doses < 7 days before birth	>55%	<40%	CMIS/records	25%	25%	0%	30%	50%	33%	TBA	100%	70%	6/8 75%	5/8 63%	4/4 100%	All pre-term babies had full optimisation by way of Steroid administration.
	Steroid administration 2 doses > 7 days before birth	80%	<80%	CMIS/records	25%	25%	0%	10%	0%	33%	55%	0/4 0%	1/10 10%	1/8 12.5%	1/8 13%	0	
	Magnesium Sulphate	80%	<80%	CMIS/records	0/0%	0/0%	0/0%	00%	3/3 100%	2/3 66.66 %	½ 50%	3/3 100%	3/3 100%	2/2 100%	2/2 100%	1/1 100%	All pre-term babies had full optimisation by way of Magnesium Sulphate.
	Fetal monitoring training compliance	≥90%	<80%	CG training report	95%	94%	94%	91%	92%	96%	97%	93.3 %	93%	93.3%	94%	91.33%	
	Babies with low birthweight (<10th centile)	<9%	>10%	CMIS	2.20%	1.20%	1.60%	0.75%	3.87%	1.11%	1.11%			3.4%			
	SGA detection rate <10th centile	>49.8%	<29.8	GAP (4a Antenatal detection of SGA)	37.80%			41.70 %			TBA			75.7%			
Breast feeding	Breast feeding initiated	≥72.7%	<72.7%	CMIS	79%	77%	72%	77%	76%	81%	75%	96%	77%	80%	74%	80.40%	
	Breast feeding at discharge	≥72%	<72%	CMIS	75%	78%	71%	76%	73%	79%	72%	81%	79%	72%	72%	75.07%	

Maternity Integrated Performance Report 1

East and North Hertfordshire NHS Trust



Key issues and executive response

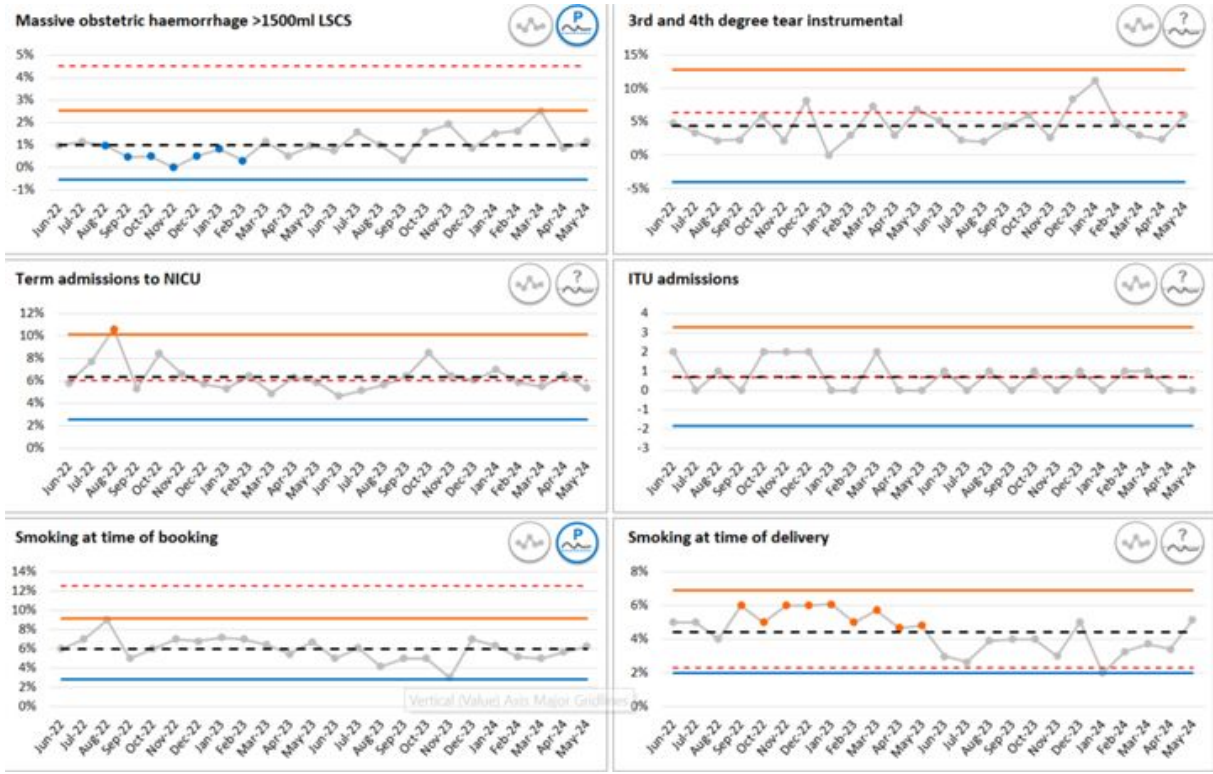
- No PSII declared between January and May 2024.
- 3rd / 4th degree tears - normal variation noted. 2023 Cases remain significantly below 2022 numbers. Monthly audit continues. Working party in place to implement the Obstetric Anal Sphincter injury (OASI) 2 care bundle in line with national recommendation. Training package produced - awaiting integration as part of MMD annual training, planned launch Autumn 2024 and during bespoke team meetings. Adaptation of existing guidance in progress to align with care bundle.
- Massive Obstetric Haemorrhage (MOH) - normal variation continues however overall rate increased. Thematic review by the Labour Ward Consultant Lead and Risk Management MDT continues on a monthly basis. Regional working party to feedback (general rise within LMNS).
- Breast Feeding initiation and discharge rates above national average.
- Term admissions to the Neonatal unit at a rate within goal limits (<6%) and below the national average. No avoidable admissions for the month of May 2024.

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 two thirds of all CS performed in most hospitals. For month 02 the combined rate is 69%.

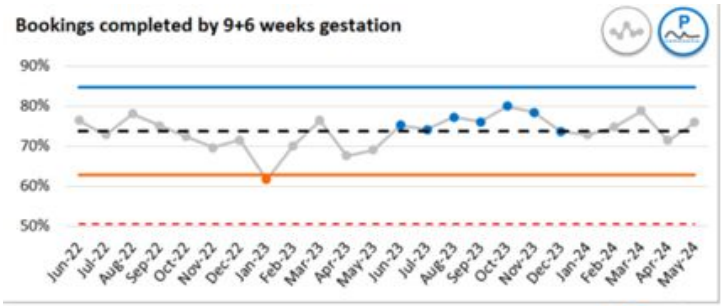
Maternity Integrated Performance Report 2

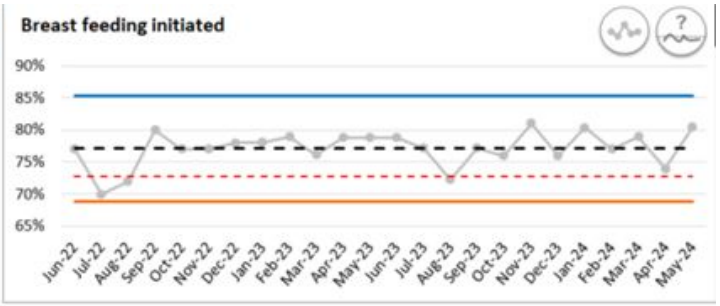
East and North Hertfordshire NHS Trust

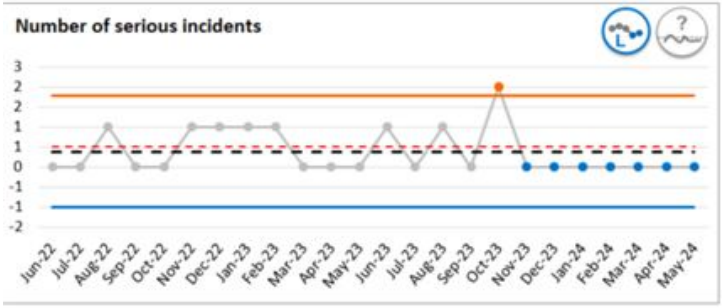


Maternity Integrated Performance Report 3

East and North Hertfordshire NHS Trust







Division – Maternity Services

Perinatal Quality Surveillance Model Tool

May 2024 data

East and North Hertfordshire NHS Trust

ProudToBeENHT

East and North Herts NHS Trust Perinatal Quality Surveillance Tool Highlight Report/Regional Perinatal Quality Oversight Group Highlight Report

Reporting Period: May 2024

KEY: CQC DOMAINS
Outstanding
Good
Requires Improvement
Inadequate

NHS England East of England

REGULATORY BODIES						
CQC DOMAINS						
Maternity unit rating: Requires Improvement (Oct 2023)						
S - Safe **E - Effective** **C - Caring** **R - Responsive** **W – Well led**	S	E	C	R	W	Action Plan Status: To commence Progressing Completed
Rating (last inspection)						

External stakeholder concerns (please give brief reason)	
NMC concerns	None
GMC concerns	None
RCM concerns	None
HEE concerns	Yes
HSIB concerns	None
CQC concerns	None
Total number of stakeholder concerns	1

CQC alerts (active alerts & year)	None
CQC warning notice (29a)	Removed (Sept 23)
Regulatory letters from coroner (28)	None
Maternity Safety Support Programme (Date of entry / stage)	January 2023

CNST MIS Safety Actions achieved (out of 10)					Ockenden investment (Total allocation)
Yr 1 (2019/20)	**Yr 2 (2020/21)**	**Yr 3 (2021/22)**	**Yr 4 (2022/23)**	**Yr 5 (2023/24)**	
10	10	10	8	10	£482, 419

CQC Maternity survey results (2023)	
CQC Maternity survey overall rating - improvement since previous year (N)	Statistically significant increase - 20 No statistical change – 29 Statistical decrease 0 **Overall rating - N**
Survey scores:	
Start of your care during pregnancy	4.0 worse than expected
Antenatal check ups	8.2 (About the same)
During your pregnancy	8.4 (About the same)
Your labour and birth	8.5 (About the same)
Staff caring for you	8.3 (About the same)
Care in ward after birth	6.9 (About the same)
Feeding your baby	8.1 (About the same)
Care at home after birth	7.9 (About the same)
Other surveys	
GMC survey results (2023) overall satisfaction	77.78%

Clinical Outcome Measures

KPI (see final slide for detail)	Measurement / Target			Trust Rate (current reporting period)
				ENHT
Massive Obstetric Haemorrhage ≥ 1500 mls (as per NMPA descriptor, slide 8)	Vaginal birth		3.3%	3.09%
	Caesarean		4.5%	2.14%
3rd & 4th degree tear (as per NMPA descriptor, slide)	SVD (unassisted)		Unassisted 2.5%	2.5%
	Instrumental (assisted)		Assisted 6.3%	5.88%
Caesarean section (%age) (see guidance document)				42.8%
(primip, singleton , ceph, over 37/40, spontaneous labour)	Robson Group 1		N/A	17.02%
[primip, singleton, over 37/40, who had labour induced (2a) or LSCS prior to labour (2b)]	Robson Group 2	**2a**	N/A	48.15%
		2b		51.85%
(Multip, at least 1 uterine scar, singleton, ceph, over 37/40)	Robson Group 5		N/A	84.31
Smoking at time of delivery			≤ 6%	5.10%
Preterm birth rate	≤36+6 weeks (over 24+0/40) for the month			5.89%
	≤6% annual rolling rate (Total PTB all babies 24-36+6))			7.44%

KPI (see final slide for detail)	Measurement / Target	Trust Rate (current reporting period)	
		x	
Term admissions to NNU Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet.	<6% (of total live term births)	5.36%	
	%age of total admissions that were avoidable	0%	
Antenatal optimisation			
Right place of birth (≤27/40, 28 /40 with multiple or EFW<800g outside a maternity unit with a L3 NICU)	Number of births = 0	100%	
Magnesium Sulphate Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth.	80% (CNST)	100%	
Antenatal steroids Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.	80% (CNST)	100%	
Percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids	ND (indicator should be as low as possible)	100%	

MBRRACE stabilised & adjusted mortality rates per 1000 births		
Stillbirth	Neonatal Death term baby < 7/7	Extended perinatal
3.04	0.99	4.02

Transformation & Incident reporting

KPI	Measurement / Target		Trust Rate (current reporting period)	% of women (booking) – Black, Asian, mixed Black & Asian / 10% most deprived decile (IMD1)*	Ethnicity data quality (%)	Post code data quality (%)	Request for Internal divert / Maternity deflect (if applicable)	Divert outside organisation
CONTINUITY OF CARER								
Percentage of women placed on CoC pathway (at 29 weeks)	% women placed on continuity of carer pathway at 29 weeks gestation		n/a					
Percentage of women on CoC pathway :Black, Asian / Mixed Black and Asian / areas of deprivation IMD1) (at 29 weeks)	Black, Asian, mixed Black and Asian	≥75% (for each element)	n/a	N/A			0	0
	Most deprived 10% (IMD1) of neighbourhoods		n/a	0				

Incident Reporting

Datix		Moderate harm and above incidents in month	Maternity Serious Incidents	Maternity Never Events
Unactioned (no / % forms received)	Open > 30 days (no/ % of all incidents)			
0	52 (oldest Feb 23)	2	0	0

LMNS confirmation of SI oversight

PMRT compliant (Ockendon IEA 1.4)	HSIB Cases (new)	Still Births			HIE cases (grade 2 or 3)	Neonatal deaths		Maternal Mortality	
		All	Term	Intrapartum		Early	Late	Direct	Indirect
Yes	None	0	0	0	0	0	0	0	0

StEIS Incidents reported 21/22 (by qtr)				
Q1	Q2	Q3	Q4	Total
1	7	5	4	17

StEIS Incidents reported 22/23 (by qtr)				
Q1	Q2	Q3	Q4	Total
1	1	3	2	7

StEIS Incidents reported 23/24 (by qtr)				
Q1	Q2	Q3	Q4	Total
1	1	0	0	2

StEIS Incidents reported 24/25 (by qtr)				
Q1	Q2	Q3	Q4	Total

Workforce / Births

Leadership and Specialist Roles

DoM in post	HoM in Post	Deputy HoM in post	Obstetric lead in post	Consultant Midwife in post	Retention Lead in Post	Lead PMA in post	MVP chair in post	Non exec director in post	Number of leadership & Specialist Roles not in place	Safety champions in place				Number of PMA's (no / WTE)
										Mat	Obs	Neo	Exec	
Yes	Yes	NA	Yes	Yes x2	Yes	Yes	Yes	Yes	None	Yes	Yes	Yes	Yes	No=13

Total births (mth / YTD)	Predicted annual births	Total bookings (mth / YTD)	LW co-ordinator supernumerary (%)	One to one care in labour (%)	BR+ completed in last 3 yrs (please give date)	Full assessment (Yes/ No)	BR+ recommended ratio	Actual ratio	Midwife no's	%age of total staff	Summary of gaps	Obs Consultant cover
357/4589	4557	475/5524	100% (see exception report)	100% (see exception report)	November 2023	Yes	n/a		225 (184.35 WTE)	175.38 WTE in post	Gaps relate to funded establishment for maternity theatres and recovery. Business Case has been submitted, escalated to NHSE as part of MSSP.	125 hours/week

Assessed compliance with CNST MIS 10 Safety Actions		Y5
1	Perinatal Mortality review tool	
2	MSDS	Impact of digital transformation on MSDS reporting requirements
3	ATAIN	
4	Clinical workforce planning	
5	Midwifery Workforce planning	
6	SBLCB V3	
7	Service user feedback / Maternity Voice Partnership	
8	Core competency framework / Multi-prof training	
9	Board level assurance	
10	HSIB /Early notification scheme	
	Repayment of CNST (since introduction) Y/N and MIS yr	

Key (current position)
Compliant with all aspects of element
On track to achieve
Working towards (MIS & SBLCB) / Partially compliant (Ockendon)
Not compliant/ At risk

Evidence of SBLCB V3 Compliance

Element		
1	Reducing smoking	
2	Risk assessment , prevention & surveillance of pregnancies at risk of fetal growth restriction	Capacity of team to perform audit –QI Manager oversight
3	Reduced Fetal Movements	
4	Effective Fetal monitoring during labour	
5	Reducing pre-term birth	
6	Diabetes	

Assessment against Ockenden Immediate and Essential Actions (IEA) – to achieve full compliance will all elements of each IEA

IEA1 : Enhanced Safety	
IEA2: Listening to Women & Families	
IEA3: Staff training & Working Together	Potential risk due to industrial action
iEA4: Managing complex pregnancy	
IEA5: Risk Assessment Throughout pregnancy	
IEA6: Monitoring Fetal wellbeing	
IEA7 Informed consent :	
• Fully compliant (self assessment)	

Training & Competency

Staff group	PROMPT	Fetal Monitoring	NBLS	ABLS	CCF
Obstetric Consultant	89	94			88
Obstetric Doctors	83	100			69
Obstetric Anaesthetic Consultants	74				
Obstetric Anaesthetic Doctors	33				
Midwives	91	80	91	91	90
Maternity Support Workers	93				
Neonatal and Obstetric Nurses			89	89	
Overall	77	91	90	90	82

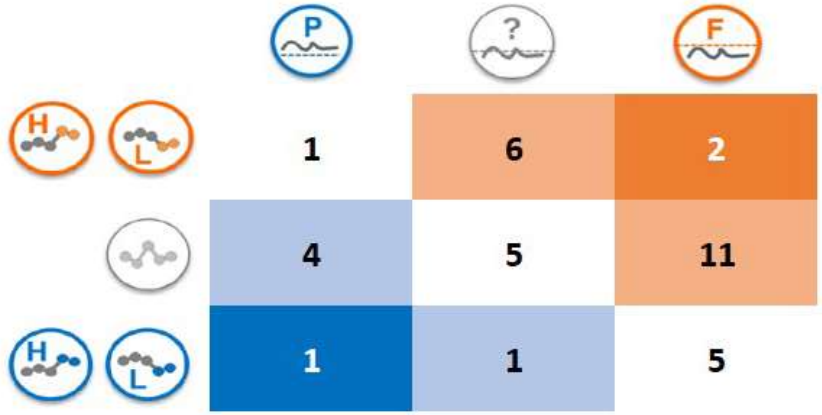
Hertfordshire and West Essex Integrated Care System

HWE ICS Performance Report

May 2024

Working together
for a healthier future

Executive Summary – KPI Risk Summary



Highest Risk	Programme
RTT 78 Week Waits	Elective
Community Waits (Children)	Community

High Risk	Programme
% of on the day GP Appointments	Primary Care
% of <14 day GP Appointments	Primary Care
ED 4 Hour Standard	UEC
% in ED > 12 Hours	UEC
NHS 111 Calls Abandoned	UEC
Ambulance Response Times	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
Community MH - Adult Waits for 2nd Appt	Mental Health
6 Week Waits	Diagnostics
62 Day Standard	Cancer
RTT 65 Week Waits	Elective
RTT 52 Week Waits	Elective
Autism Spectrum Disorder (ASD)	Community
CHC Assessments < 28 Days	Community

Lowest Risk	Programme
CHC Assessments in Acute	Community

Low Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
90% Stroke Unit	Stroke
Adult Crisis 4 Hour	Mental Health
28 Day Faster Diagnosis	Cancer
Community Waits (Adults)	Community

Variable Risk	Programme
Dementia Diagnosis	Primary Care
2 Hour UCR	UEC
No Criteria to Reside (NCTR)	UEC
Ambulance Handovers	UEC
Out of Area Bed Days	Mental Health
Adult 28 Day Standard	Mental Health
CYP Eating Disorders	Mental Health
Learning Disabilities - Time to 1st Assess.	Mental Health
31 Day Standard	Cancer
62 Day Backlog	Cancer
HPFT Early Memory Diagnosis (EMDASS)	Mental Health

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

Hertfordshire and West Essex Integrated Care System

Executive summary

URGENT CARE, Slides 8-13	**4 Hour Performance**	**Region: HWE better than average**	**National: HWE worse than average**

- Hours lost to handover improved significantly to 771 hours in March, achieving the system recovery target
- Performance against the 4-hour ED standard improved further to 74.8% in March. Whilst not achieving the 76% ambition, this was the best performance since August 21
- NHS 111 abandoned calls increased further in March to 28.3%. Latest data for April suggests significant improvement to <15%
- Category 2 ambulance response times improved to 42 minutes in March, however HWE responses remain the highest in East of England

PLANNED CARE, Slides 14-15	**18 Week RTT**	**Region: HWE better than average**	**National: HWE worse than average**

- The overall elective PTL continues to reduce and has fallen in each of the last 6 months
- All HWE acute trusts continue to report 78-week breaches beyond the March 24 target date. There were c.60 x 78 week waits in the acute trusts' end of March position, with an additional 30 cases with ISPs
- The 65 weeks backlog continues to slowly reduce. All trusts are forecasting to reach zero by end of September

DIAGNOSTICS, Slide 16	**6 Week Waits**	**Region: HWE better than average**	**National: HWE worse than average**

- 6 week wait performance improved to 68.7%. All trusts saw improvement in February

CANCER, Slides 18-19	**28 Day FDS / 31 Day / 62 Day**	**Region: HWE better than average**	**National: HWE better than average**

- 28 Day Faster Diagnosis Standard (FDS) performance continues to improve, achieving 81% in March against the 75% standard
- Patients waiting >62 days continue to reduce. The HWE final 23/24 backlog was 398 against the target of 389
- 62-day performance betters the national and regional averages at 71.4%, but has been below the historic mean for the last 14 months; 31-day cancer performance narrowly missed the national standard at 95.9%

MENTAL HEALTH, Slides 21-31	**Community MH (1st / 2nd Appts)**	**National: HWE better than average (Adult)**	**National: HWE better than average (CYP)**

- Mental Health (MH) out of area bed days increased in February, but the overall trend is one of improvement. Access to community MH services however remains challenged and high risk
- Community adult MH waits for a 2nd contact continue to increase, but better the national average

CHILDREN, Slides 27-29, 32-36	**Various**	**Community 18 Week %: HWE worse than national**	**Community MH 1st Appts: HWE better than national**

- The total number of children on community waiting lists remains very high. Longest waits increased slightly to 112 weeks, compared to 61 weeks for adults
- Pressures are predominantly in Community Paediatrics, as well as therapies and Audiology services
- Autism Spectrum Disorder (ASD) lists and waiting times remain high. Backlog funding ended in December 23. Without continuation of the backlog funding investments, ASD waiting lists will start to grow
- CAMHS caseloads have increased for the last three months, and the 28-day access standard has not been achieved since 2021
- Children's waits for a Community MH 1st appointment are better than the national average. However median waits are 110 days, compared to 84 days for a 2nd contact in adult services

COMMUNITY (Adults), Slides 37-38	**% <18 Weeks**	**National: HWE better than average**	**Adult waiting times better than CYP**

- % of adults waiting <18 weeks remains strong and betters the national average

PRIMARY CARE & CHC, Slides 43-46	**Appointments <14 Days**	**National: HWE in line with national average**

- Total number of GP appointments are variable but remain higher than pre-pandemic levels. Appointments in 2023 are highest since 2019
- The percentage of appointments seen on the same day and <14 days both have long-term decreasing trends
- CHC assessments within 28 days remains high risk, with performance particularly challenged in South & West Hertfordshire

Executive Summary – Performance Overview (1)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	Mar 24	74.8%	76.0%			68.5%	63.3%	73.7%
A&E - % spending more than 12 Hours in Dept	Mar 24	9.1%	-			10.3%	7.6%	13.0%
A&E - ED Attendances	Mar 24	49630	-			43929	37672	50185
Trolley Waits	Mar 24	182	-			178	-39	395
2 Hour Community Response	Mar 24	76.7%	70.0%			82.2%	71.3%	93.1%
14 day LOS	Mar 24	26.5%	-			25.3%	22.0%	28.5%
Ambulance - Handover >60 Mins	Mar 24	447	-			983	566	1399
EEAST: Cat 1 - Mean (<7min)	Mar 24	00:08:59	00:07:00			00:09:29	00:08:01	00:10:58
EEAST: Cat 2 - Mean (<18 Mins)	Mar 24	00:42:29	00:15:00			00:52:33	00:20:29	01:24:37
CHC - Decision within 28 days	Feb 24	57.1%	80.0%			67.6%	49.8%	85.4%
CHC - Assessments in Acute	Feb 24	0.0%	0.0%			0.1%	-0.7%	0.9%
111 - Calls received by telephony system	Mar 24	49777	-			52840	31869	73811
111 - Calls answered within 60 seconds	Mar 24	21.7%	100.0%			46.9%	15.8%	78.0%

Hertfordshire and West Essex Integrated Care System

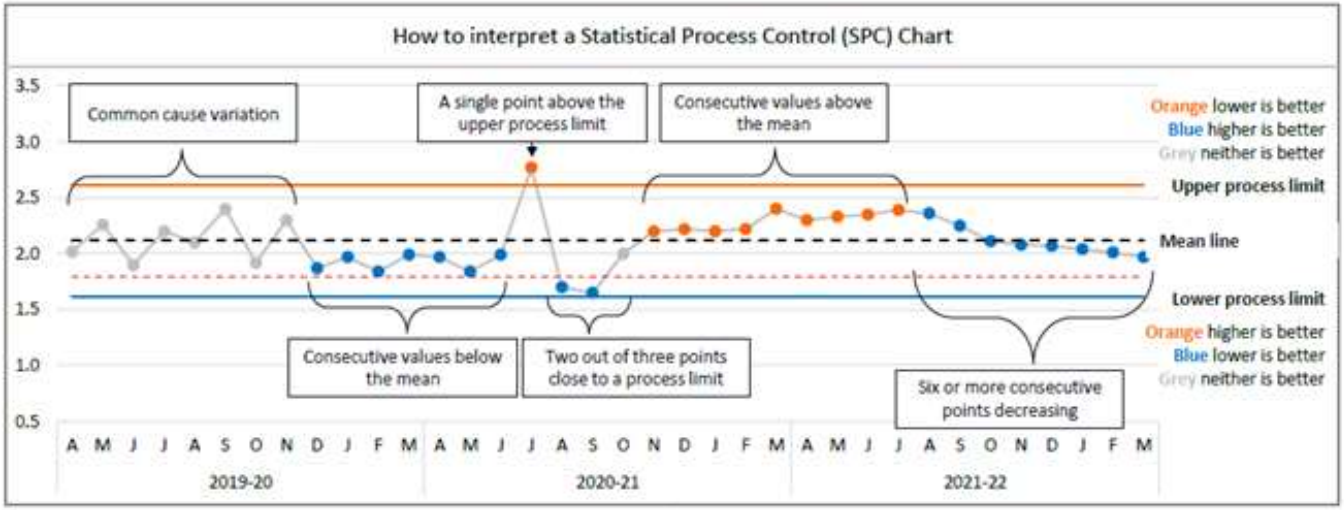
Executive Summary – Performance Overview (2)

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT - 18 Weeks	Feb 24	52.7%	92.0%			55.4%	52.5%	58.4%
RTT - 52 Week Waits	Feb 24	7288	-			8200	6655	9745
RTT - PTL Size	Feb 24	139524	-			131137	123919	138355
RTT - 78 weeks	Feb 24	124	-			922	496	1348
RTT - 65+ weeks	Feb 24	1508	-			2972	2276	3668
Cancer - 2 Week Wait Referrals	Feb 24	7327	-			7033	3358	10707
Cancer - 62 Day Standard	Feb 24	71.4%	85.0%			72.4%	63.4%	81.3%
Cancer - 62 Day Total Waiting	Mar 24	430	-			563	380	746
Cancer - 104 Day Total Waiting	Mar 24	163	-			157	108	206
Cancer - 28 Day Faster Diagnosis Standard	Feb 24	81.1%	75.0%			71.3%	61.8%	80.9%
Cancer - 31 Day Standard	Feb 24	95.9%	96.0%			95.1%	90.8%	99.4%
Diagnostics - 6 Week Wait	Feb 24	68.7%	99.0%			64.9%	57.0%	72.9%
Diagnostics - PTL Size	Feb 24	25855	-			25303	20321	30285
Primary Care - Attended Appointments	Jan 24	755633	-			658578	480546	836610
Primary Care - Routine Referrals	Feb 24	24870	-			24945	11727	38163
Primary Care - Urgent Referrals	Feb 24	5906	-			5471	2647	8296
Mental Health - Out of Area Bed Days	Feb 24	211	-			837	473	1200
Mental Health - Recorded >65s Dementia Diagnosis	Feb 24	64.4%	66.6%			62.4%	61.7%	63.1%
Mental Health - IAPT Entering Treatment	Feb 24	2586	-			2392	1310	3475
Early Intervention in Psychosis	Feb 24	90.6%	60.0%			81.6%	59.1%	104.1%

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

Hertfordshire and West Essex Integrated Care System

Statistical Process Control (SPC)



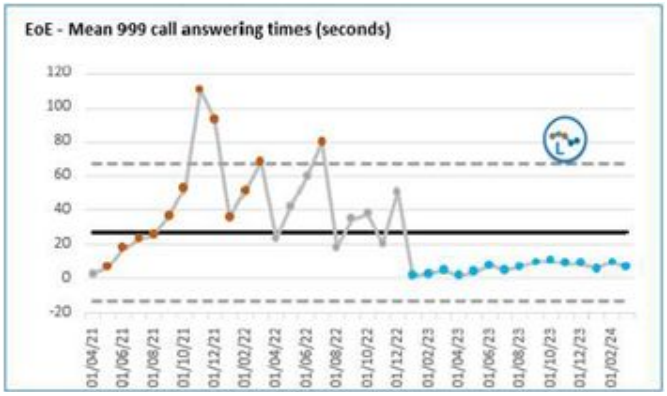
Variation	
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

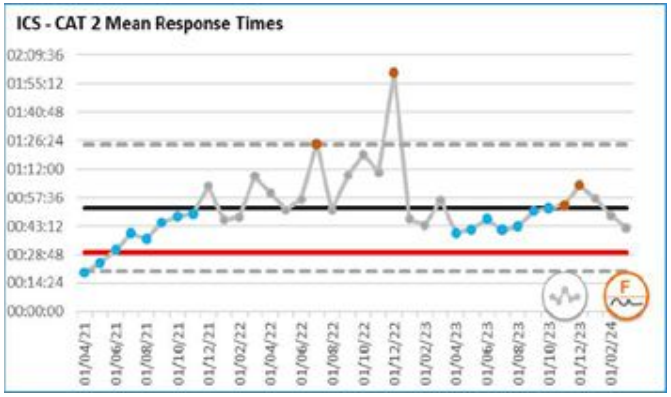
Assurance	
F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

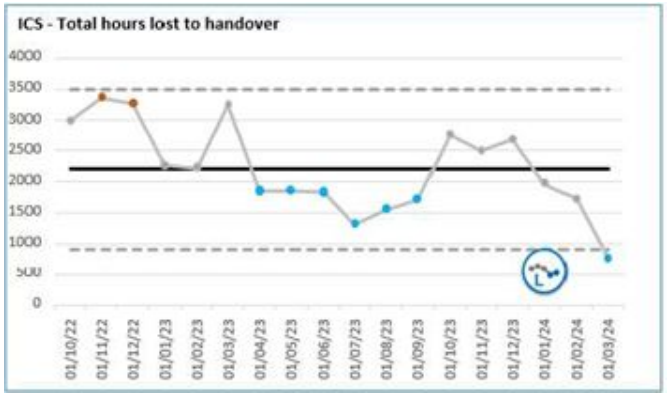
Hertfordshire and West Essex Integrated Care System

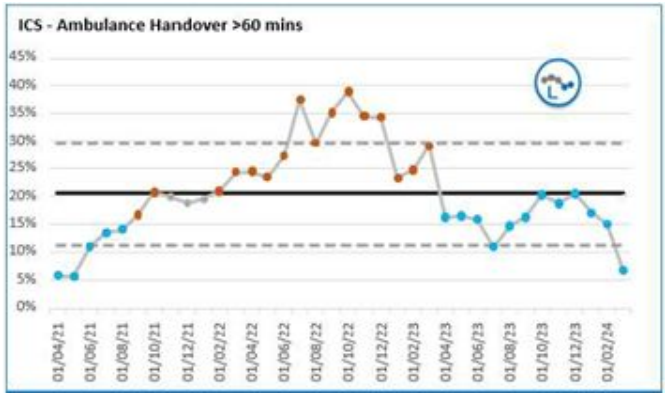
Performance by work programme

UEC - Ambulance Response and Handover



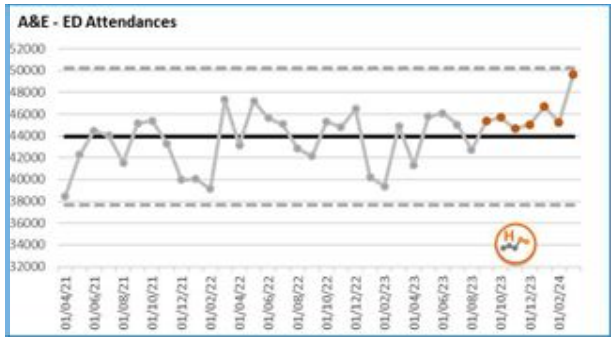


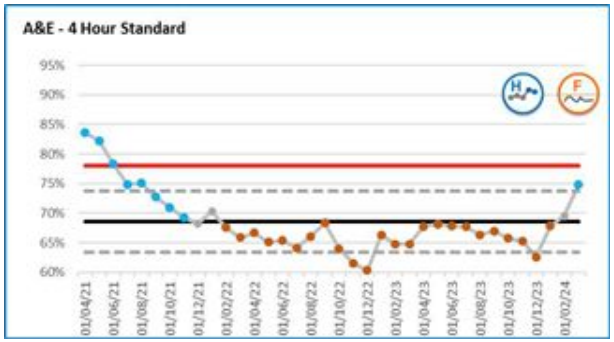


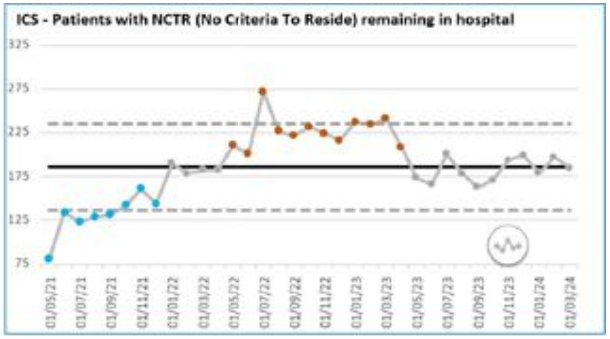


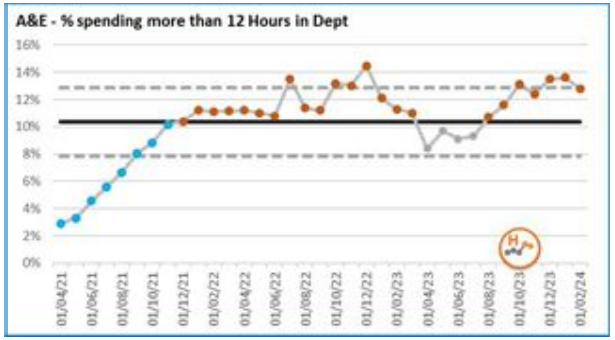
Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC)







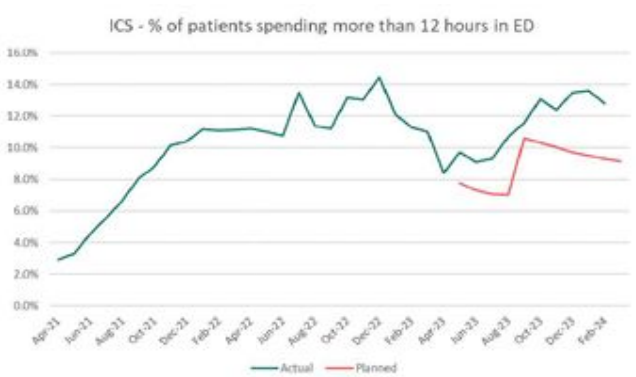


Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC) Improvement Trajectories

4 Hour Standard

% of Patients Spending > 12 Hours in ED



Ambulance Category 2 Mean Response Times

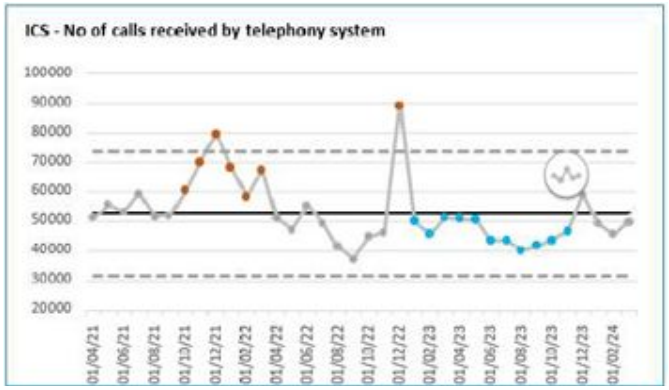
Hours Lost to Handover

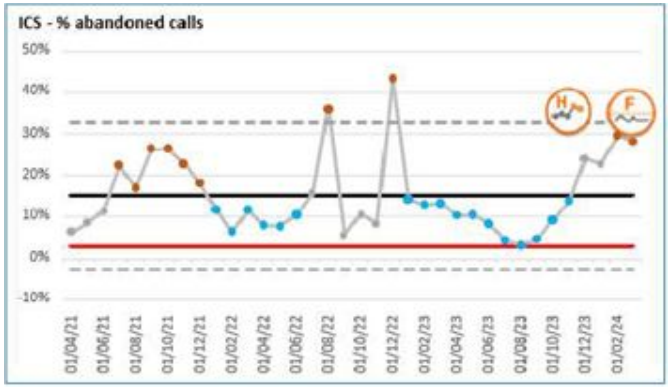
Hertfordshire and West Essex Integrated Care System

Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Performance against the 4-hour ED standard improved to 74.8% in March, which is the best performance since Aug-21. • This was achieved in-spite of Mar-24 having more ED attendances than any previous month in Hertfordshire and West Essex • There remains variation at a place level for performance against the 4-hour standard. However, the gaps have reduced: – SWH = 78.2% – ENH = 76.2% – WE = 67.9% • All three HWE acute trusts were in the top 20 trusts nationally for the improvement in 4-hour performance between Dec-23 and Mar-24 • 999 call answering times have remained low with an average of 7 seconds in March • The mean Category 2 ambulance response time was 42 mins in March. This is a considerable improvement compared to Dec-23 (63 mins), but remains adrift of the national 30-minute standard, and is consistently longer than other systems in the region • Hours lost to handover reduced to 771 hours in March; this is the best performance since Oct-22 and better than the target of 1351 hours for Mar-24 • Average patients per day with NCTR remaining in hospital improved to 185. This is slightly behind the March target of 178 hours	• Continued high demand and high acuity of patients requiring UEC services. ED attendances and ambulance conveyances across the health system in Q4 were 14% higher than they were in Q4 22/23. Mar-24 had the highest number of ED attendances ever in the HWE system • Increase in 111 call volumes during the winter months. However, 111 call volumes in Q4 were lower than during Q4 22/23. 111 call abandonment rates were higher in Q4 than they were in Q4 22/23 • Mental Health presentations at ED remain high, coupled with a shortage of beds / assessment space. Analysis suggests that mental health patients are more likely to wait >12 hours in ED • Hospital flow remains very challenging with high occupancy rates, especially at PAH where average bed occupancy in March was 97%	**System** • At the end of Dec-23, a series of protocols were introduced to help reduce handover times. These had a significant impact on reducing the hours lost to handover between December and March • Increased number of double staffed ambulances on evening / overnight shifts • C2 revalidation pilot has taken place and 37% of cases were stepped down from C2 **East and North Herts** • Interventions such as the new Lister UTC, expansion of SDEC and new ED nursing rotas, and launch of the MH UTC had a significant impact on ED performance during Q4 of 23/24 • Further upcoming interventions include: - Implement trusted assessor model to reduce 20 patient per day gap in medicine - August Junior Doctors roster implementation to give additional capacity in evenings - Extending hours of SDEC / UTC and opening of a Paediatric UTC - Robust and consistent use of plus one and reverse boarding in medicine (min of 5 per morning) **West Essex** • Falls car - working with EPUT to extend to end of 24/25 • Work continues with EPUT and ICB on MHRV for MH patients. Business case in discussion. WE vehicle expected live in September • Multi Agency Discharge Event (MADE) on w/c 25th March • EEAST / GP direct access to SDEC pathways - timeframe to be agreed • New IUATC phase 2 is now live • Additional senior decision maker in ED between 10pm and midnight • Golden patient SOP being finalised for April launch **South and West Herts** • Access-to-stack acceptance rates have been maintained since November workshop • Implementation of 45-minute rapid release supported by corridor care and application of the boarding policy (16 April 2023) • Additional assessment trolleys created in majors 2 • Workforce Business Cases going to TMC to support flow and time to initial assessment for nursing workforce, medical workforce, performance co-ordinators

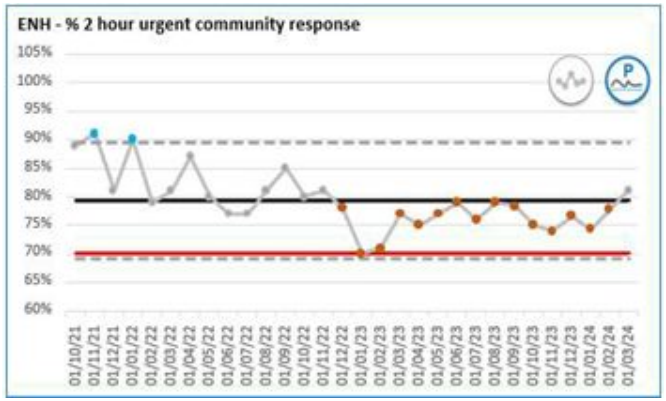
NHS 111

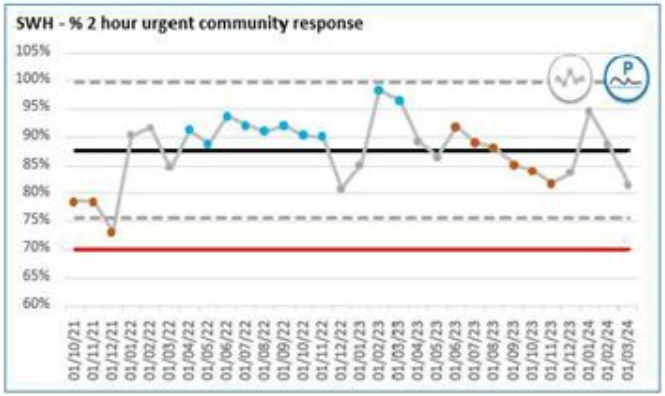


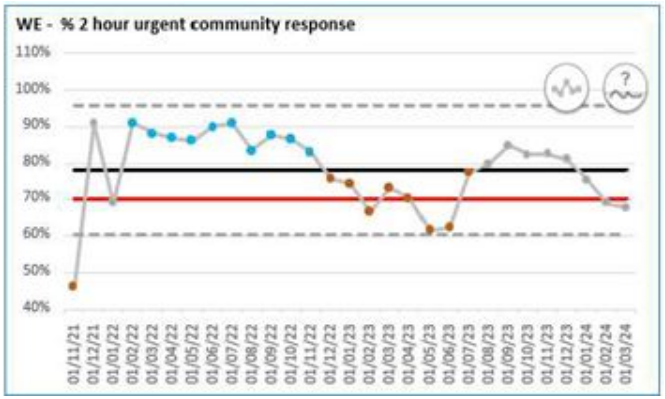


ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have been consistently trending below the historic mean for the last year, other than a spike in December when more than 10,000 additional calls were received • Abandoned calls reached a yearly high of 29.5% in February • March showed a small improvement to 28.3% • Indicative data for April suggests considerable improvement to <15%	• Health Advisors need to hold calls until clinical advice has been given, leading to c.5% increase in call time • Recruitment issues; 21 WTE vacancies across HWE for Health Advisors • 25% of Health Advisors on probation requiring additional support • High number of early leavers, not finishing the training course • Activity levels higher than planned	• Abandonment rates under review with the ICB & NHSE. Ongoing investigation • Full week of recruitment assessment centres in February. 19 FTEs appointed across the next 3 months. Training courses to be live by May • NHSE National Resilience agreed for part of 24/25 - dedicated workforce to pick up an agreed % of HUC calls. NHSE employed remote staff • Continued staff support with MH and wellbeing • Calibre of new staff reviewed through assessments, separate to the interview process • Internal Action Plans in place to work through concerns and scrutinise performance • Clinical Navigator in place to support clinical staff • Cross-site working and pooling resources across HUC-Footprint (HAs and CAS)

UEC - Urgent 2 Hour Community Response (UCR)







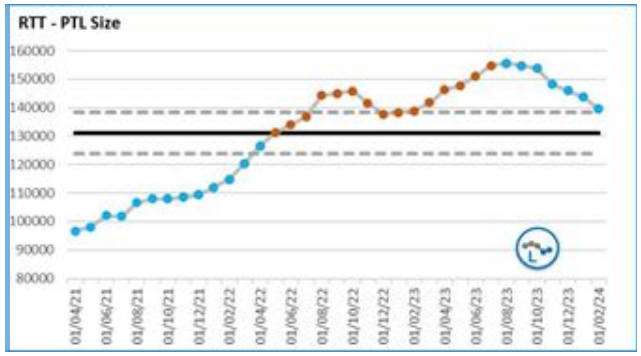
Activity	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
West Essex	466	376	348	472	430	489	375	413	464	357	374	497	455
East & North Herts	471	454	545	545	641	649	693	643	631	650	709	568	707
South & West Herts	136	203	222	196	232	159	175	180	158	157	213	212	209

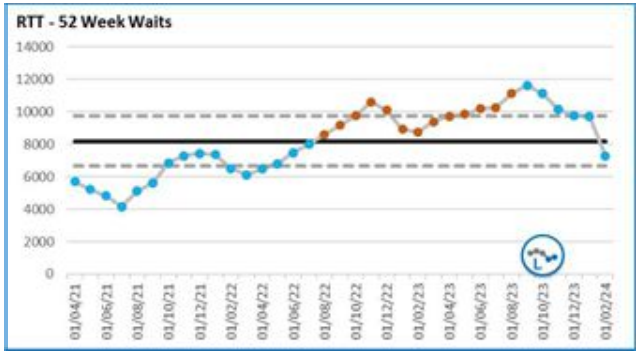
ICB Issues, escalation and next steps

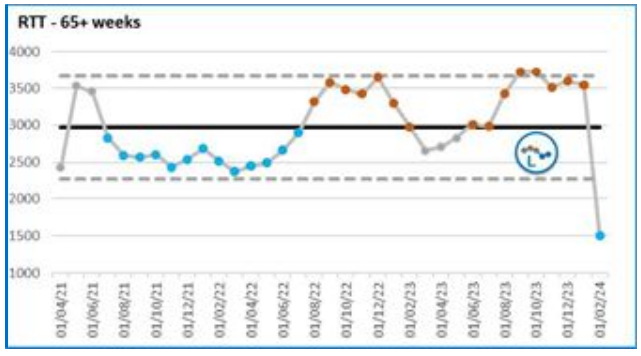
- West Essex performance dipped slightly below the 70% standard in February & March. This resulted from a lack of capacity within the EEAST RIS car in the Harlow and Epping localities
- Work continues in SWH to ensure recording practices are correct and to improve referrals to the service. CLCH Business Team have developed bespoke training material and guidelines to be rolled out in line with national guidance
- The system is working with the regional team to ensure consistency of reporting and capture of all UCR activity. We expect additional UCR activity for all Places in the next report

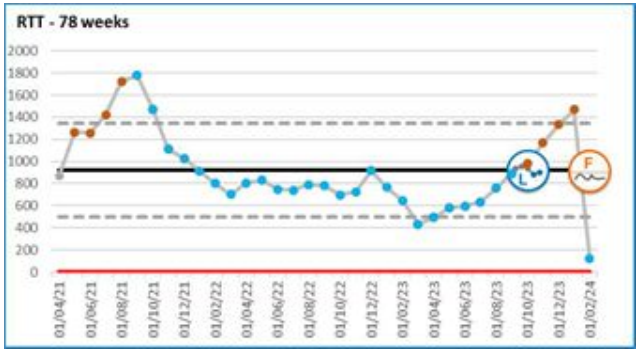
Hertfordshire and West Essex Integrated Care System

Planned Care – PTL Size and Long Waits







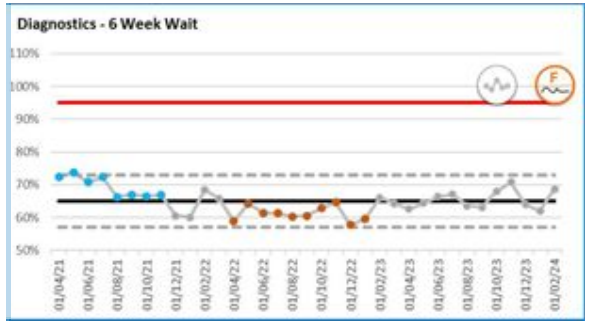


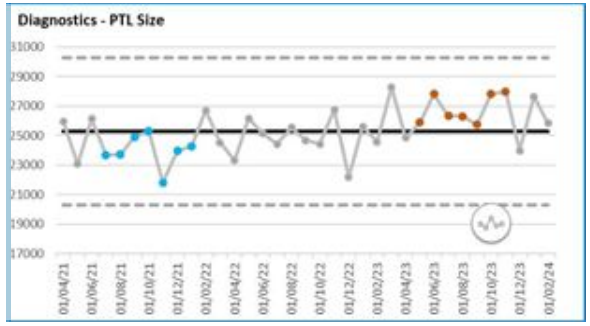
Community Paediatrics patients have been excluded from RTT reporting from February 2024 in line with national guidance
Waiting lists therefore show significant reductions

Planned Care – PTL Size and Long Waits

ICB Area	What the charts tell us	Issues	Actions
HWE	• Due to the change in national guidance, Community Paediatrics patients have been excluded from RTT reporting from February 2024. Waiting lists therefore show significant reductions in the latest data. These waits are included within the Community section of this report – see slide 35 • The overall PTL size remains high, although showing a decreasing trend over the last seven months • Excluding Community Paediatrics, February saw a slight increase in the number of patients waiting >78 weeks. This was mainly driven by PAH • Excluding Community Paediatrics, the number of patients waiting >65 weeks is beginning to reduce and has seen steady improvement over the last two months • Excluding Community Paediatrics, the number of patients waiting >52 weeks has decreased over the last three months, but remains an area of concern	• Trauma and Orthopaedics (T&O) remains the main specialty under pressure • Staffing remains a challenge, particularly in Anaesthetics • Latest data shows that PAH 78-week waits have reduced, although the ISP has taken 56 long waiting patients to their lists from PAH • There were 93 x 78-week breaches in the system's 2 end of year position (March data) • The latest 78ww April forecast (as of 21/4) is 91 for the system (ENHT 26 / WHTH 2 / PAH 22 / ISP 41)	• Princess Alexandra Hospital will be in Tier 2 of the national oversight and support infrastructure for Elective (including Diagnostics) recovery from the week commencing 29 April 2024. Fortnightly tiering meetings with the NHSE EOE regional team commence on 9th May **Management of waiting lists** • System focus on reducing number of patients waiting >78 weeks and >65 weeks, with regional and national oversight • Demand, capacity & recovery plans are in place to monitor 78 & 65 weeks • Weekly KLOEs in place with NHSE to track 104/78/65-week positions • Fortnightly performance meetings with each of the three acute Trusts are in place with NHSE support • Validation and robust PTL management in place • The 65ww target to zero breaches has been extended to September 2024 with each of the three trusts submitting plans to meet that target **Increasing capacity and improving productivity** • Pro-active identification of pressured specialties with mutual aid sought via local, regional & national processes • Outpatients has a full programme of work to increase productivity including PIFU (patient initiated follow up), reducing follow ups including discharging where appropriate, and increasing take up of advice & guidance • Maximising use of ISP capacity and WLIs where possible • Theatre Utilisation Programmes in place including an ICB wide programme • Anaesthetist recruitment

Planned Care – Diagnostics





ICB Area	What the charts tell us	Issues	Actions

HWEICB	• 6-week wait performance across the ICS improved by 6.7% in February
	• PAH saw improvement of 9.9%; 6.1% at ENHT; 5.7% at WHTH
	• The overall PTL continues to fluctuate within expected common cause variation limits
		• Workforce remains the key area of concern across the ICS
		• Significant variation in Trust performance:
		  • ENHT – 55.3%
		  • WHTH – 90.9%
		  • PAH – 75.2%
		ENHT
		• Imaging remains the most significant risk to delivering 6-week wait performance
		• The number of people waiting over 6 weeks for imaging is 7,995 (MRI 2,764, CT 1,132, DEXA 1,296, US 2,803). This compares to 1,528 at PAH, and 85 at WHTH
		PAH
		• Non-Obstetric Ultrasound (NOUS), Echocardiography, Cystoscopy and Audiology are the key challenges at PAH
		WHTH
		• Audiology presents the greatest risk to 6 week wait performance
		• There has been a substantial improvement in all other modalities
			• Workforce lead for diagnostics in post and working with providers on the various projects
			• Recovery trajectories in place and overseen at Trust performance meetings and diagnostic programme
			ENHT
			• Seeking to outsource imaging to the independent sector and will look at mutual aid / levelling up
			• DEXA capacity will increase significantly over 24/25 after a robust demand & capacity exercise
			• New Cardiac CT Consultant capacity coming online
			PAH
			• PAH CDC is live for MRI, X-ray and Ultrasound Extended Access using insourcing and existing facilities
			• Audiology insourcing in place – significant improvement in > 6-week backlog
			• NOUS – Insourcing live from May
			• Discussions progressing for ISP Cystoscopy support
			• Echocardiography – new General Manager in post
			WHTH
			• Continued focus on DEXA – now showing an improving position
			• Plan to share learning on Echocardiography improvement across the ICS
			• Working on CDC and Endoscopy Unit mobilisation

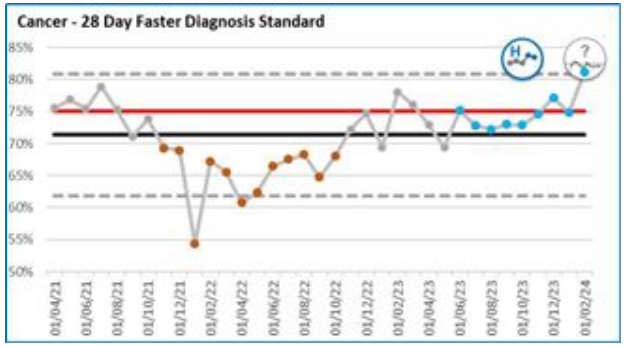
Planned Care – Theatre Utilisation

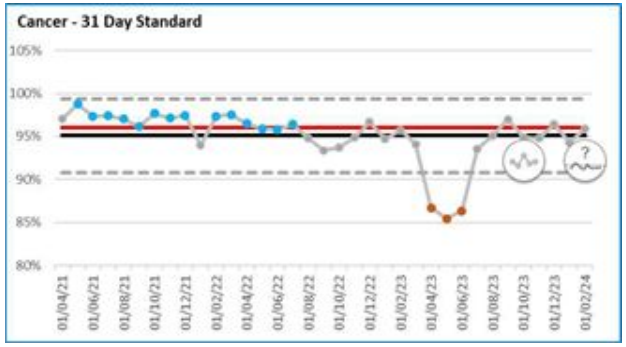
Theatre Utilisation (w/e 7/04/24 unless otherwise stated)	ENHT	WHTH	PAH	ICB Total	Peer Average
Number of theatres	18	12	9	39	40
Number of cases*	336	231	129	696	603
Average cases per 4 hour session*	2.8	2.5	2	2.5	2.4
Utilisation - Capped	81.2%	74.9%	72.9%	77.2%	77.4%
Average late starts (Minutes)**	21	32	36	28	28
Average inter case downtime (Minutes)	15	14	16	15	16
Average early finish (Minutes)**	75	70	69	67	69
Average unplanned extensions (Minutes)**	29	75	62	55	47
% of emergency surgery conducted within elective lists*	1.5%	0.9%	0%	1.0%	1.0%
BADS day case (October-December 2023)	86.5%	77.2%	77.0%	81.4%	80.1%
Conversion from day case to inpatient (October-December 2023)	6%	11%	18%	10%	11%
* no national target					
** lists started late/finished early/extended time					

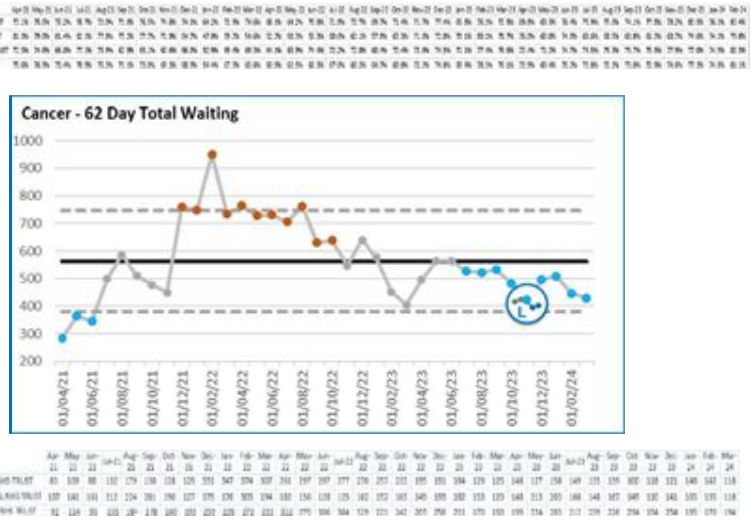
ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Comparable performance v. peers for all aspects, excluding number of cases, and average unplanned extensions • Average cases per session for the ICB is slightly higher than peer average, although PAH are below average • Average early finishes are on a par with peer average, although much higher than the expected 15-30 minutes • BADS rate is lower than the 85% target	• Overall productivity has improved in March / April across all three providers. The main driver is average cases per 4-hour session • ENHT – although overall good performance, capped utilisation has yet to achieve the national target of 85% • PAH – consistently high conversion from day case to inpatient rate, alongside a low day case rate • WHTH - Capped utilisation rates and average cases per session have maintained improvement over the last 6 months	• Improvement programmes are discussed at the Theatre Utilisation Network Group • A series of reviews have taken place with Trusts through the GIRFT theatre programme team and improvements are underway as can be seen through the improved numbers • Active theatre improvement programmes at each of the acute providers • There will be a further GIRFT review visit in June 2024

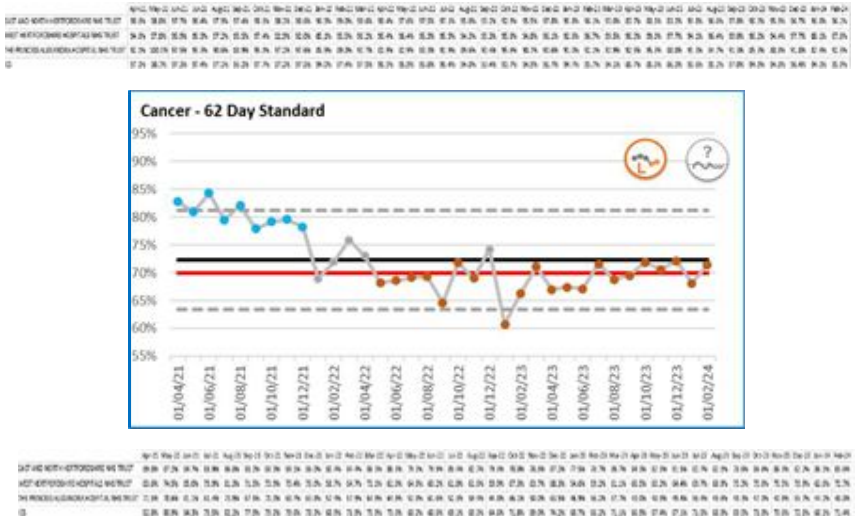
Hertfordshire and West Essex Integrated Care System

Cancer







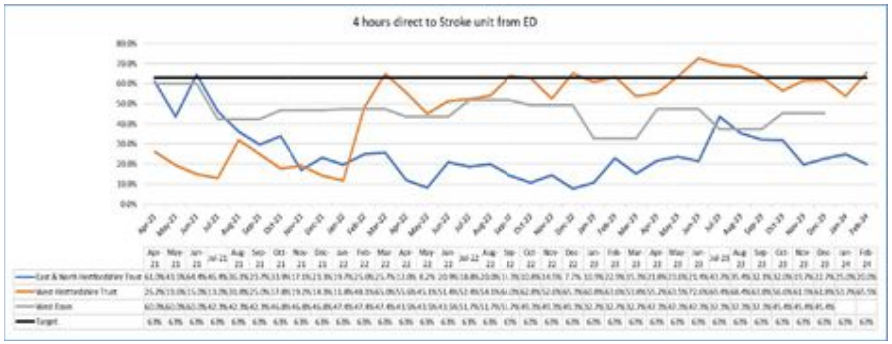


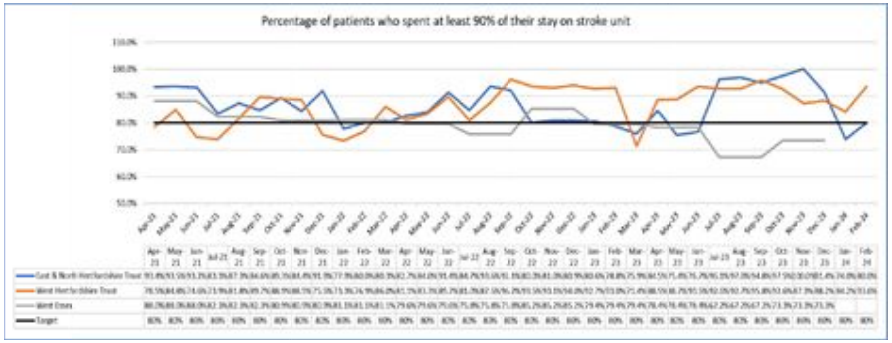
Hertfordshire and West Essex Integrated Care System

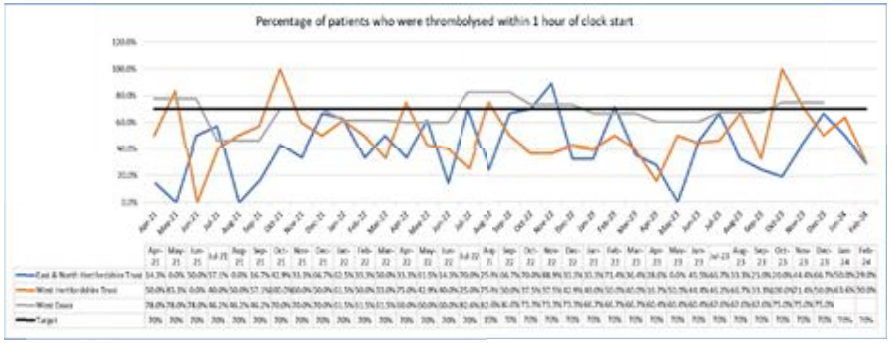
Cancer

ICB Area	What the charts tell us	Issues	Actions
ICB	• 28-day Faster Diagnosis Standard (FDS) performance has improved significantly over the last two months and is now at 81% • Each of the Trusts have surpassed the 75% FDS standard for the first time since prior to April 2021 • The 31-day 95% target was met collectively, although PAH was slightly below target at 92% • Performance against the 62-day standard remains below the national target, but is achieving the 70% standard expected in the 24/25 National Planning Guidance • The 62-day backlog decreased over the last two months, predominantly at WHTH and PAH	• There are no 62-day backlog targets for 24/25 • Oversight is focussed on achievement of the national FDS, 31 & 62-day standards **ENHT** • At the end of March, the 62-day backlog reached 194 patients vs a target of 134 patients • This is primarily due to late transfers (61 compared to an original plan of 25) • In addition, there have been patient choice delays on Skin and Urology pathways; PET CT delays; delays in negative results over Easter **WHTH** • 62-day backlog: At month end there were 118 (6.7%) pathways over 62 days, with a total PTL of 2,331 patients. The NHSE objective to have a backlog of no more than 6.4% • Increased referrals noted, but no subsequent increase in numbers of cancers diagnosed • Gynaecology and Urology account for 50% of the 62-day referral to first treatment breaches, both affected by capacity shortfalls, case complexity and patient availability **PAH** • 23/24 target for 62-day backlog clearance missed by 6 patients. Urology and Skin are the key services driving overall PTL and backlog pressures • Number of services referred on to tertiary providers, and delays in transfer times • Urology staffing, Cystoscopy capacity, and increase in prostate referrals • Urology is particularly challenged in both FDS and 62-day % performance	**ENHT** • Two-stop pathway for Urology service to be introduced from April with an MRI scan first • Head & Neck to increase one-stop service to eight slots per week • Haematology introducing triaging system to reduce blood test delays • Community breast pain clinic is reliant on continued funding • Continued Colonoscopy outsourcing to Pinehill **WHTH** • Review of Urgent Suspected Cancer referral forms; Gynae and Urology forms close to completion, however, launch delayed due to the complexity of changes required. All forms to be mandated going forward, which is expected to improve referral quality • Additional Gynaecology capacity is now in place and improvement is expected imminently • Additional photography clinics and triaging for Skin referrals - outsourcing in place for 6 months • Pilot project for radiology diagnostic post within LGI pathway – Endoscopy / surgery pathway. • Work to implement one stop diagnostic for Urology continues – operationalising planning and review of job plans (radiology) as key enablers • Breast pain pathway evaluation underway • Submission of transformation bids for the coming year to support continuation of current pilots and new projects • 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. Escalated as necessary using new escalation process. Any patient found to have cancer will be subject to a clinical harm review after treatment **PAH** • Princess Alexandra Hospital will be in Tier 2 of the national oversight and support infrastructure for Cancer recovery from the week commencing 29 April 2024. Fortnightly tiering meetings with the NHSE EOE regional team commence on 9th May • Cancer Improvement Plans refreshed and agreed at tumour site level • Focussed work to drive more timely transfers to tertiary providers • Prostate CNS now in post. Return of consultant on restricted practice delayed • Discussions progressing for ISP Cystoscopy support • Additional weekend theatre sessions for Breast planned, subject to radioactive isotope support • Ongoing participation in the national GIRFT programme, with a particular focus on Urology • Participation in FDS Lower GI programme • System support and oversight in place, with Cancer Alliance & NHSE attendance

Stroke







ICB Issues and actions

West Essex

Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for WE patients, reported quarterly via SSNAP. The Trust's overall 23/24 Q3 SSNAP performance rating improved from D to C.

- Continued high demand for bed occupancy, with larger complex strokes requiring longer treatment plans
- TIA – Continued improvement following escalation of pathway delay issues. 26 days response now reduced to 8 days. Some ongoing issues due to shift fill and short notice cancellations
- EPUT - Staffing concerns due to 2 x WTE staff members leaving the service and 1 requesting to be re-deployed. Meeting being organised to review
- Catalyst Project – Vocational rehab, working age population affected by stroke to be provided with support
- SQUIRE ICSS – May LTC board to discuss supporting delivery of the ICSS. NHSE target of 75% of people who have a stroke will have access to the comprehensive care by 2027/28
- Local WE comms campaign to be initiated to notify the population that Princess Alexandra Hospital (PAH) does not have a HASU / ASU service, and that this will delay care if stroke patients present at PAH

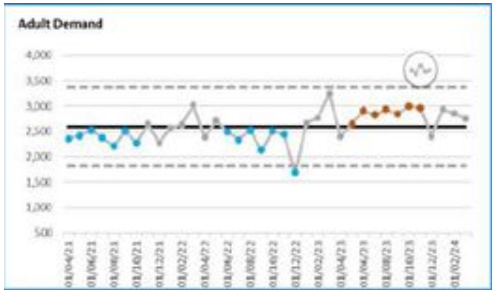
ENH

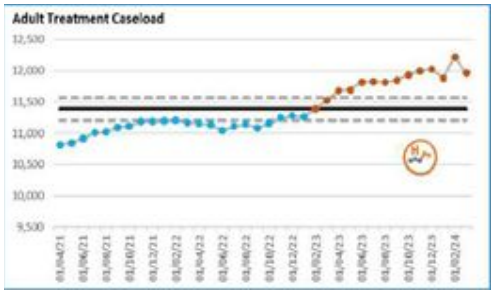
- The ENHT SSNAP performance rating for Q3 23/24 remained as a B rating. There is a risk to maintaining a B rating going forward due to therapies establishment and alignment with the new clinical guidelines
- The % of reaching a stroke unit within 4 hours increased to 36% in Mar-24. This is still notably below the target of 63%, but it is the best performance since Jul-23. The most significant delays tend to be for out-of-hours patients
- The % of patients spending >90% of their stay on a stroke unit dipped during January and February. However, in March, this figure was back up to 89%, meeting the target. Four ring-fenced stroke beds remain in place
- The % of patients thrombolysed within 1 hour of arrival met the target of 70%, but this standard is not consistently met
- Thrombolysis in Acute Stroke Collaborative (TASC) project underway to support improvement in Thrombolysis performance rate to 14%. Improved thrombolysis rates will support overall flow within the stroke wards, due to positive impact on simple discharges

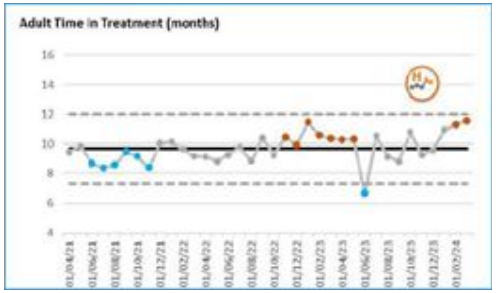
S&W Herts

- WHTHT overall Q3 SSNAP rating has been maintained at an A rating
- Performance remains below the national standard (90%) for 4 hours direct to stroke unit from ED at 65%. This is similar to March 23 performance at 63.6%, and consistent with national performance. Wider system pressures such as late referrals, bed capacity constraints and patients admitted to another ward before the Stroke unit due to an unclear diagnosis are all issues which delay provision. Ring-fenced beds on HASU and a side room for thrombolysis have been maintained, and patients receive stroke consultant input for their care while waiting for admission to the stroke unit
- 94% of Stroke patients spent 90% of their time on stroke unit which is above the national target of 90%
- The % thrombolysed within 1 hour of clock start decreased to 30% (local standard 50%). WHTH are taking part in the EOE Ambulance Video Triage pilot (started Dec. 23). It is hoped that this will have a positive impact on patients' movement through ED and time to thrombolysis, but this is not as yet seen in the February data
- The rehab gym is no longer being utilised as a bed capacity surge area and assurance of maintaining going forward
- ESD, NETT and Community Stroke Service: ESD patients are now being seen within 1-2 weeks of referral. Additional resource has been allocated, aimed at reducing NETT and ESD waiting times

Mental Health – Adult Services

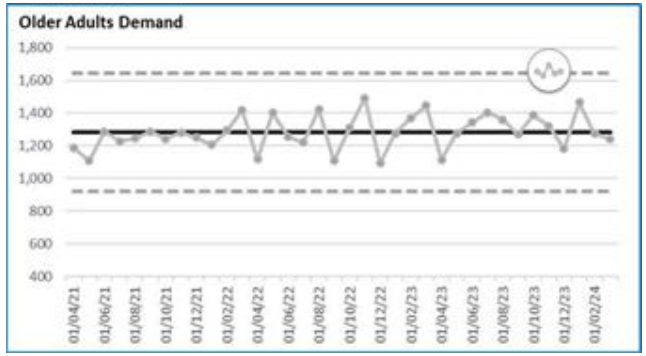


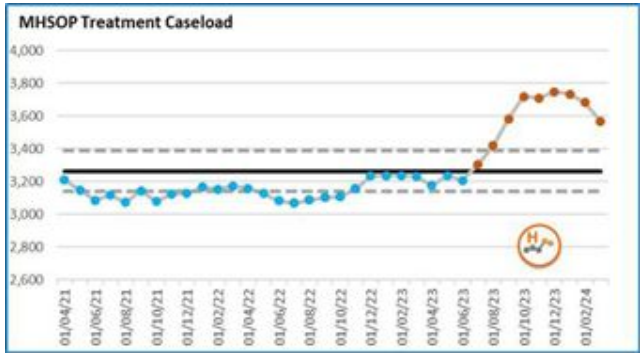


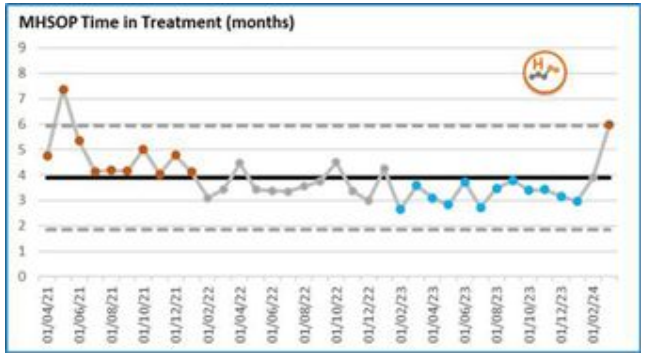


ICB Area	What the charts tell us	Issues	Actions
Adult Community Mental Health Services Herts & West Essex Herts data includes ADHD patients with the exception of the KPI. ADHD is excluded from the WE data	• Overall referral demand is stable, but remains high across the ICS • Demand in Herts fell slightly in February and March • Adult ADHD referrals have fallen by c.14% in February (compared to January) since letter to GPs requesting a hold on inappropriate new referrals • Community caseload increased slightly in February in Hertfordshire and stabilised in March. West Essex caseload was static • Initial assessments within 28 days of referral showed significant improvement as part of the Hertfordshire recovery work. The 95% target has been achieved in March • EPUT continue to meet the 28-day referral standard in West Essex • Overall time spent on treatment pathways has risen in February and March	• Hertfordshire recovered the 28-day target of 95% in March, in line with their recovery trajectory • Ongoing work with HPFT to split ADHD and SMI referrals. Separate service for West Essex as ADHD is not mental health • Working with HPFT to bring Voluntary Community, Faith and Social Enterprise (VCSFE) activity into the transformed community offer	• Additional assessments including out of hours clinics • Continued use of agency to improve capacity across Hertfordshire • Recruitment deep dive into areas most challenged with access • Additional admin. support to community MH teams • Hertfordshire demand and capacity review as part of the community transformation programme. ADHD review ongoing with commissioners to propose plan to address increased demand • Continued focus on triage to increase numbers signposted to more appropriate services from SPA, rather than post-assessment • Ongoing review of Care Coordination Centre (CCC) use in West Essex to enable access to right service first time and reduce delays in waits • Robust waiting list management and risk management protocols in place with daily and weekly reviews

Mental Health – Older Adults Services





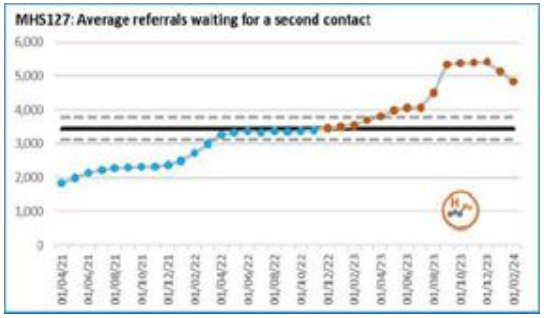


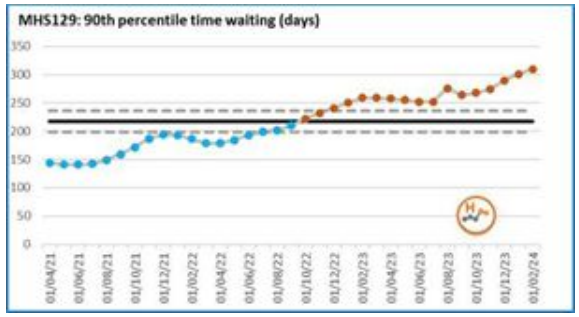
ICB Area	What the charts tell us	Issues	Actions
Older Adult Community Mental Health Services Herts & West Essex	• Demand is variable but remains within expected common cause variation limits • Rising caseload has stabilised, and is now reducing due to reductions in the EPUT WE caseload • March saw a sharp rise in time in treatment in Hertfordshire, but related to low numbers of patients discharged	• Recruitment continues to be an issue across the ICS • New waiting times from NHSE come into full effect at the end of Q4. This is expected to present an initial challenge for older adult services in Hertfordshire to meet the 28 days to intervention standard, as currently they are working to an 18 week wait to treatment standard • West Essex adult services are all age (18 plus) and currently achieving 28 days for older adults • Potential discrepancy between Hertfordshire & West Essex relative caseloads under investigation	• Robust workforce mobilisation plan in place for West Essex, including a positive recruitment pipeline projection. Currently working with the University of Essex • A joint deep dive into Hertfordshire older people services as part of the SDIP will be reviewing current service delivery and ensuring transformation is in line with adult community transformation plans • CQI project underway in Hertfordshire to prepare for introduction of full waiting time measures • Risk review and prioritisation for longest waiting service users • Reviewing older adults with SMI have a primary and community care offer

Hertfordshire and West Essex Integrated Care System

Mental Health – Community Waits

Adults and Older Adults – time still waiting for second contact



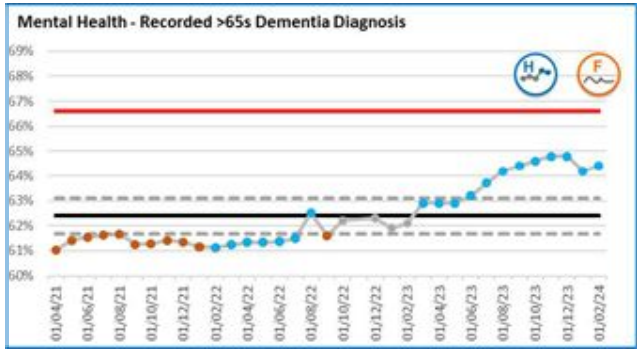


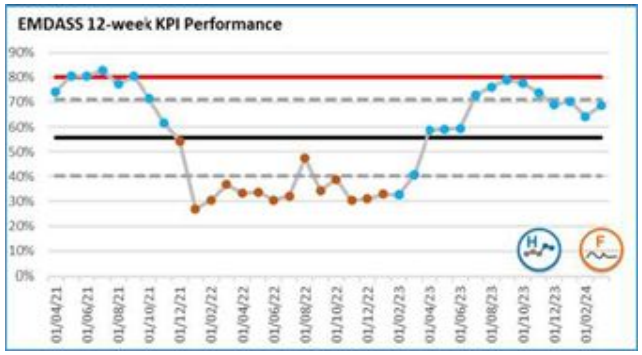
ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times for a 2nd appointment increased further to 84 days
	• 84 days benchmarks well against the national average of 114 days, however there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 53 & 101 days:
	  • East & North Herts 53 days
	  • South & West Herts 101 days
	  • West Essex 78 days
	• 90th percentile waits increased further to 310 days
	• 310 days benchmarks well against the national average of 714 days, however again there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 237 & 382 days:
	  • East & North Herts 237 days
	  • South & West Herts 339 days
	  • West Essex 382 days
		• Datasets are not currently complete, and work is ongoing with ICBs and NHSE to finalise collections and reporting
		• The data flow from Primary care and VCSFE providers to MHSDS or the GP equivalent has not been worked through either locally, regionally or nationally
		• This relates to the transformed PCN areas that have ARRS workers and Enhanced Primary Care
		• The data collection from these new services is recorded locally on System one or EMIS
			• NHSE working with all ICBs to finalise the data
			• In Hertfordshire, a CQI project has been initiated to take forward the new waiting times and ensure that they are reflected in the design and processes of services. Awaiting the publication of SQL scripts to replicate this reporting internally
			• We are also working with NHSE and Voluntary Community, Faith and Social Enterprise (VCFSE) providers to look at the data flow from them to MHSDS, to include as part of the second contact information

Hertfordshire and West Essex Integrated Care System

Mental Health – Dementia Diagnosis in Primary Care & Herts EMDASS Service

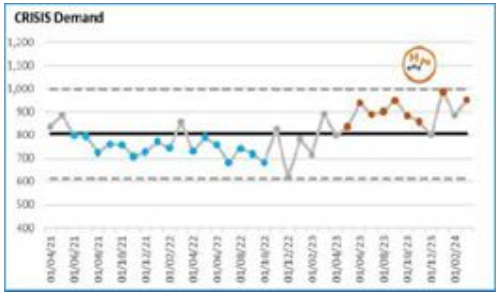


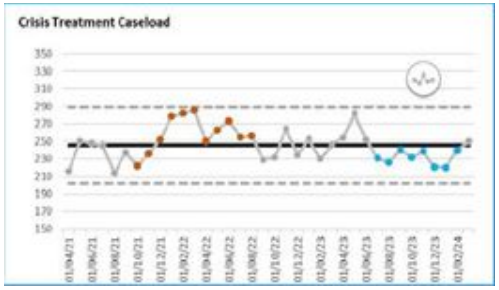


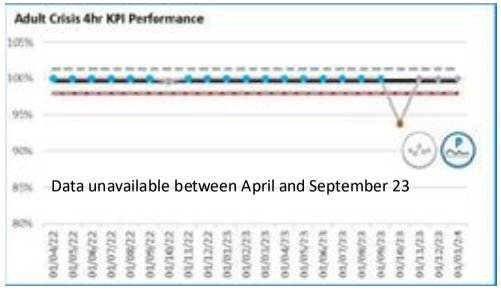
ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care Herts EMDASS Service	• Dementia diagnosis rate across the ICB achieved 64.4% for February, below the national target of 66.7% • West Essex met the standard with 71.2% achieved • East and North Herts achieved 62.8% • South & West Herts achieved 62.1% • EMDASS service (Herts only) – the 80% target is not currently being met. Significant recovery programme has been underway, but demand for memory assessment remains very high • In 23/24 the EMDASS service saw c.230 patients per month, with c.160 of those patients seen in less than 12 weeks	• Estimated prevalence rate of people with dementia rises month on month. Constant growth and increasing demand, particularly in Hertfordshire • In Hertfordshire there is a significant waiting list for dementia diagnosis • Current EMDASS model of service may not be able to keep up with demand in future years re ageing population	• Diagnosis is a key focus of the Herts dementia strategy, with a subgroup progressing actions to improve diagnosis • Twice monthly meetings continue to monitor progress. Weekly performance report is produced • HPFT has tweaked its EMDASS pathway, bringing a Primary Care Nurse in house to increase capacity • Plan to increase number of assessments provided in Hertfordshire

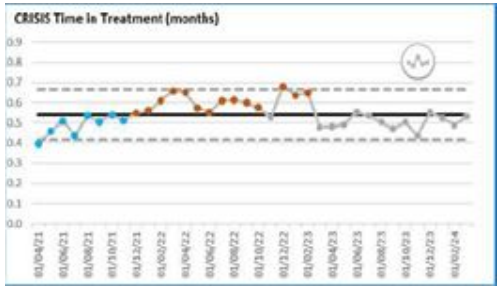
Hertfordshire and West Essex Integrated Care System

Mental Health – Adult Crisis Services



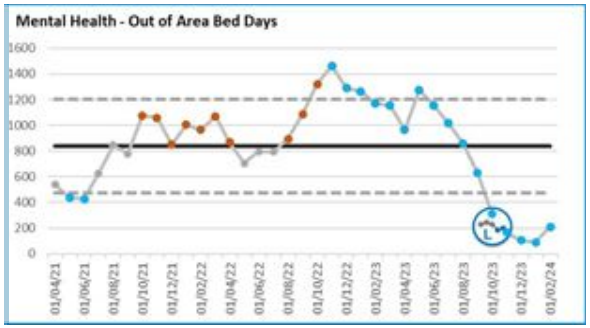






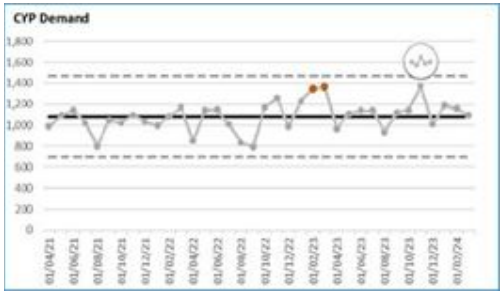
ICB Area	What the charts tell us	Issues	Actions
• Crisis Services – Adults and Older Adults • West Essex data is not included in the caseload chart as the service does not hold a caseload	• Crisis demand remains high. Referral numbers in all but one month in 23/24 have been above the historic mean • Caseload is variable but within expected common cause variation limits • Hertfordshire has re-modelled the way they record waiting times in line with the latest UEC guidance • 100% of people requiring a very urgent assessment were seen within 4 hours in February and March • The average time in treatment remains stable	• There is increased demand into the crisis service through supporting acutes with early discharges to manage bed pressures and flow issues • Recruitment to vacancies continues to be a significant issue across the ICS	• Ongoing focus on recruitment to vacancies and retention of existing staff • Review of community mental health caseloads to improve flow • ICB wide communications to be developed to promote 24/7 crisis lines (through NHS 111 for public and dedicated professionals' lines) • Wider communications re. crisis directory have been prepared as part of the winter planning and will be shared with system partners • ICB ongoing programme of engagement with ambulance and urgent care partners • Continue to identify delayed transfers of care on crisis caseload • Ongoing monitoring and MDT discussion to identify treatment pathway and discharge plans

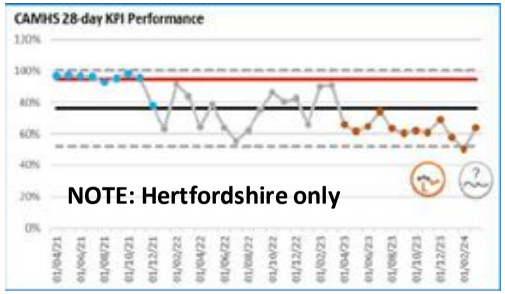
Mental Health – Out of Area (OOA) Bed Days

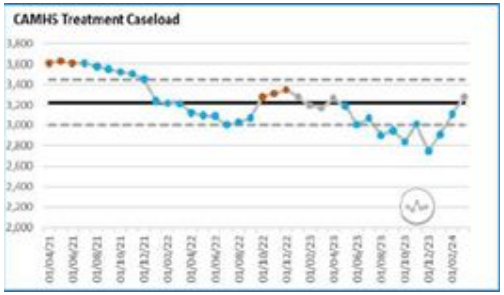


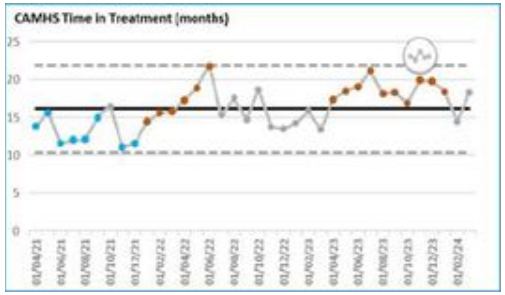
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Continued improvement in the number of Out of Area Bed Days • The 39 bed days February position was the lowest since July 22	• A national shortage of MH beds and increased pressures on service use of inappropriate OOA beds is very likely to continue	• Review of Essex bed stock and Essex wide risk share contract continues • Review of West Essex Community Rehab has seen an increase in discharges at place to support repatriation • Weekly system Delayed Transfer of Care (DTOC) calls and ongoing focus on 'time to care and purposeful admissions' • OOAP Elimination & Sustainability Impact System Group (Essex wide) to monitor the impact of the NHSE OOAP Action Plan • Continued engagement with national Getting It Right First Time (GIRFT) programme to identify areas of improvement
Herts	• Following a sustained period of improvement, Out of Area Bed Days rose from 36 to 172 days in February due to bed pressures	• Hertfordshire low number of beds per population – now supported by provision of additional block beds • A national shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Challenges finding suitable placements for service users with complex needs who are clinically ready for discharge • Inpatient and Community recruitment • The closure of Aston Ward (with 20 beds) due to 'Water Safety Incident' has impacted the pressure on demands and recued the capacity	• Daily OOAP reviews / dedicated clinical ownership • Gatekeeping process and on call gatekeeping consultant • Consultant-led bed management meetings 3 per day, 5 days per week • COO sign-off for all out of area placements remains in place • Introduction of Enhanced Discharge Team, dedicated to supporting discharge • Review DTOCs and plan discharges with ongoing MADE type events • 10 additional block beds in place – a total of 42 remain in place • Enhanced community offers for rehab and assertive outreach • Introducing further alternatives to admission – Crisis House • Wider Executive led work at system level to support placement of longer term DTOCs • Bed management system being deployed in Hertfordshire and new arrangements in place to monitor demand and capacity • East Regional Mental Health, LD & Autism Inpatient Quality Transformation Group in place. Initial meeting Jan 24 to identify local priorities and actions

Mental Health – CAMHS Services





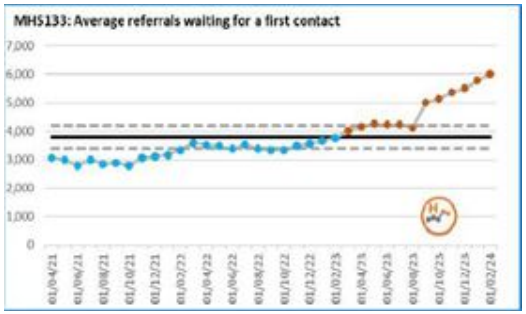


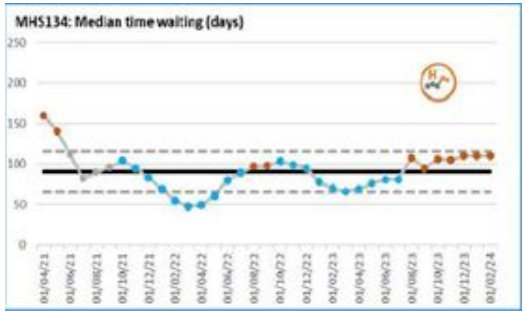


ICB Area	What the charts tell us	Issues	Actions
CAMHS Herts and West Essex. The CAMHS 28-day KPI Performance target relates to Herts only	**West Essex** • West Essex does not have a formal KPI for 28 days, but this is monitored at monthly provider meetings • Demand at SPA remains high, with seasonal downturn showing in December • CAMHS caseload remains on an improving trend through 23/24 **Herts** • Demand into the service remains stable • Caseloads have seen a steady increase since December • 28 days from referral to initial assessment remains below standard. 56% was achieved in March 24 • Time in treatment is variable but close to the historic mean	• Essex SPA and Eating Disorders (ED) services are undergoing changes to site location and management • Active issue regarding recruitment to vacancies across Herts and West Essex impacting on capacity and performance. Acquiring highly skilled CAMHS clinicians remains difficult. Non health support roles being used to bolster teams	• In Herts Community Quadrant teams an action plan is in place with weekly recovery meetings focusing on recruitment & review of resources across all teams • In Hertfordshire, the primary issues are in the West and East Teams. Both teams are being supported by the wider leadership team • NELFT Kent ED team providing support and supervision to Essex ED service • Ongoing focus on recruitment and retention in both HPFT & NELFT, including recruitment incentives in NELFT, and more recently exploring international recruitment • Successful recruitment to senior clinical posts in West Essex CAMHS • WE - New SPA team manager recruited and rolling advertisement for ED clinical lead • SPA Triage Tool improved to meet 5 day pass on to teams target in Hertfordshire • The Hertfordshire service had forecast recovery of the the 28-day KPI by end of Q4. However continuing vacancies have meant that the recovery prediction has moved to Q2/3 24/25. A revised recovery trajectory is in place

Mental Health – Community Waits

Children – time still waiting for a first contact

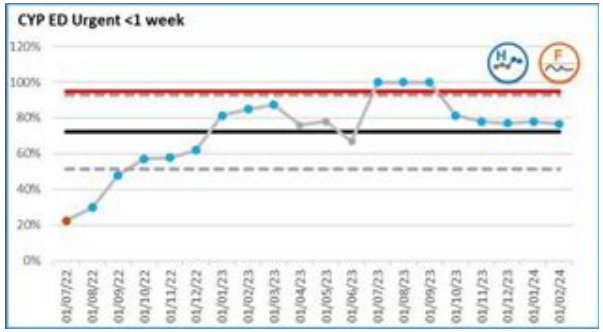


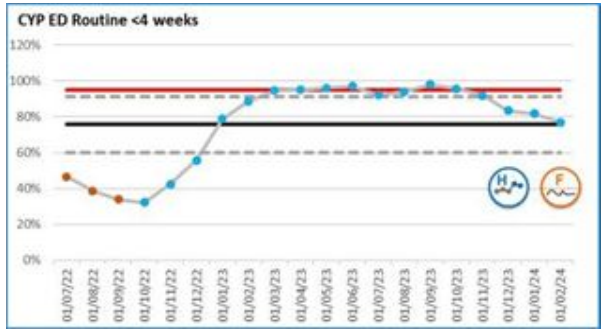


ICB Area	What the charts tell us	Issues	Actions

Hertfordshire & West Essex	• Median waiting times remain at 110 days and have been trending above the historic mean since August 23
	• 110 days benchmarks well against the national average of 198 days
	• Within the system there is variation of between 32 and 136 days:
	  • East & North Herts 32 days
	  • South & West Herts 136 days
	  • West Essex 52 days
	• 90th percentile waiting times are broadly unchanged at 428 days, and on a long-term trend of improvement
	• 428 days benchmarks well against the national average of 732 days
	• Within the system there is variation of between 312 & 428 days:
	  • East & North Herts 312 days
	  • South & West Herts 428 days
	  • West Essex 295 days
		The Hertfordshire data reflects the historically longer waiting times in the South and West of the County.
		
		The biggest impact on the Hertfordshire waiting list (long waiters) is Autism & ADHD backlogs / waiting lists for diagnostic pathways. NHSE to confirm if this will be included or excluded in the long-term. Currently it is included, which is masking the waiting times for core MH services.
			In Hertfordshire a CQI project has been initiated to take forward the new waiting times and ensure that they are reflected in the design and processes of services. Awaiting the publication of SQL scripts to replicate this reporting internally.
			
			GIRFT project to present some waiting times / flow data as part of CYPMHS, which excludes ASD/ADHD might provide a more accurate position on core MH waiting times and whether it has changed over the last few years.
			
			A local waiting time for each service is reported via provider dashboards, as well as the number of CYP waiting for assessment & treatment, and the average number of days waited to be seen per month. Where there are waiting lists, a recovery action plan is in place and closely monitored by commissioners.
			
			Commissioners, HPFT and now a HCT representative are linked into EOE waiting times standards group.
			
			HPFT have undertaken an initial cleansing exercise to remove any long waiters that are not true long waiters.

Mental Health – CYP Eating Disorders

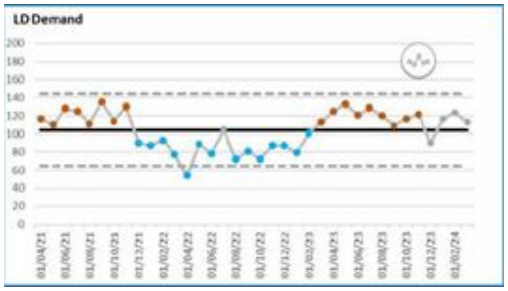


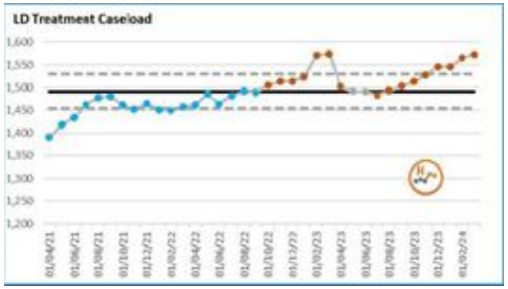


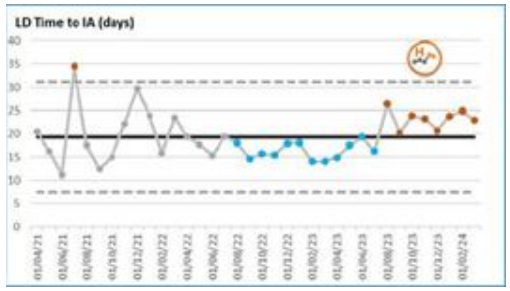
Description	Target		Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
CYP ED Urgent <1 week	95%	Herts	12%	20%	43%	53%	54%	58%	80%	83%	86%	76%	78%	67%	100%	100%	100%	80%	77%	76%	77%	75%
		West Essex	92%	92%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CYP ED Routine <4 weeks	95%	Herts	37%	30%	26%	25%	36%	49%	75%	86%	94%	95%	96%	97%	92%	94%	98%	96%	92%	83%	81%	76%
		West Essex	97%	97%	97%	96%	96%	96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	90%	90%	100%	100%

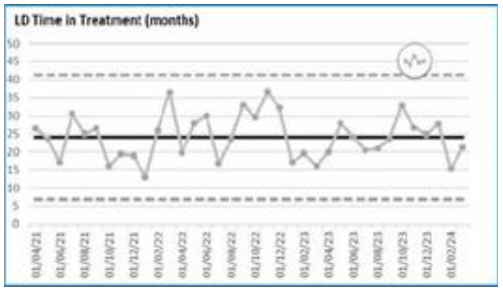
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Urgent 1 week standard consistently achieved in West Essex • Performance dropped to 90% in Q3 for routine referrals, but has returned to 100% compliance	• West Essex data from NELFT not currently flowing through MHSDS	• Commissioners working with NELFT and NHSE to secure more current data, as well as to flow data through the MHMDS
Herts	• The Eating Disorders Team had been performing consistently until a spike in referrals in Oct-Dec, coupled with an increase in vacancies • There are small numbers of urgent referrals, so each breach significantly impacts % achievement • Local reporting for March shows 100% for both standards	• The increase in referrals Oct-Dec is a seasonal and mirrors previous years • Overall annual referrals are broadly similar to 22/23 • Review of the ED service is currently in progress. Acuity and complexity tool shows CYP remain in service for a considerable amount of time and require input from a number of clinical resources. We have no baseline for acuity & complexity so cannot demonstrate the increase, but clinicians are flagging this as an issue	• The following actions are in place to improve access to the service: o Recruitment in progress and at pace o Strict adherence to inclusion criteria and service specification with non-ED diagnostic cases being signposted to relevant services o ED Consultation to referrers in place to support other services o Caseload and RAG rating review and equitable redistribution of caseload across workforce o Agreement for First Steps ED Service to manage a cohort of stabilised children and young people from the caseload o Work underway in Herts to ensure MHSDS reporting reflects local reporting.

Mental Health – Learning Disabilities Services









ICB Area	What the charts tell us	Issues	Actions
• Learning Disabilities Service • LD services are 18+ years and includes those with a learning disability who may have a diagnosis of Autism	• Overall referrals remain stable • Caseload continues to rise and has been consistently above the historic mean for the last 18 months • Time in treatment is subject to common cause variation • Within the services there is a wide range of treatment types with timeframes ranging from a few days to many years	• Lack of social care placement and housing in West Essex impacts on in-patient Length of Stay • Physical Health needs has a very clear area of focus for all MHLDA	• Service user and carer engagement and involvement programme continues aimed at improving care planning, service delivery and outcomes for LD service users across Herts and Essex • Ongoing review of Essex services with system partners across all ages to identify the wider impact for WE place • Work commenced on further development of the Adults Dynamic Support Register to increase support and access to services • Continuing work with commissioners to ensure that GPs are aware of and know how to refer directly into LD services • Inpatient flow is better, with some discharges in recent months and a reduction in length of stay • Opportunities for capturing feedback - ongoing partnership working • Continue progress on LD AHCs • Action plan approved for the new LeDeR three-year Essex plan • Overall LeDeR in Essex is performing better than both regional and national averages

Mental Health – Learning Disability (LD) Health Checks

LD Health Checks February 2024	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to February 2023
NHS Hertfordshire and West Essex ICB	**7,591**	**5,397**	**163**	**2,031**	**71.1%**	**67.8%**
East & North Hertfordshire	3,112	2,145	76	891	**68.9%**	**66.0%**
South & West Hertfordshire	3,342	2,501	53	788	**74.8%**	**71.3%**
West Essex	1,137	751	34	352	**66.1%**	**58.2%**

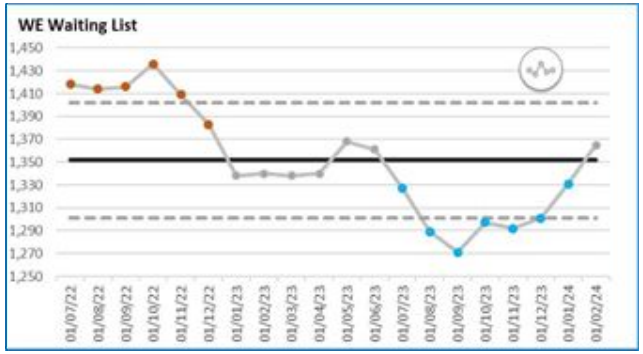
*** 75% Year End Target**

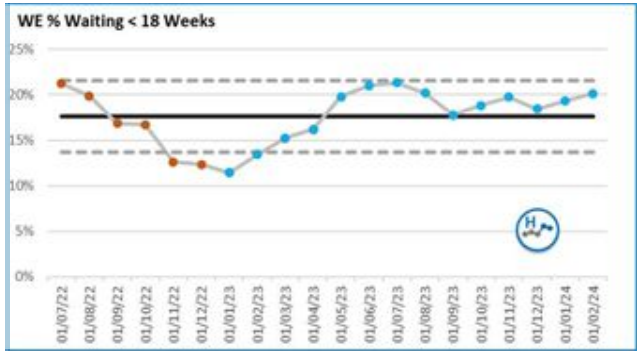
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• As of February 2024, the ICB is 3.3% ahead of its equivalent 2023 position. This is an improvement from a 1.2% lead in January • All three Places are also ahead of their equivalent 2023 positions	• It is challenging to forecast 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 • The System is optimistic of once again achieving the 75% national standard	• Ongoing work between HWE Team and NHSE to cross check local data against national systems

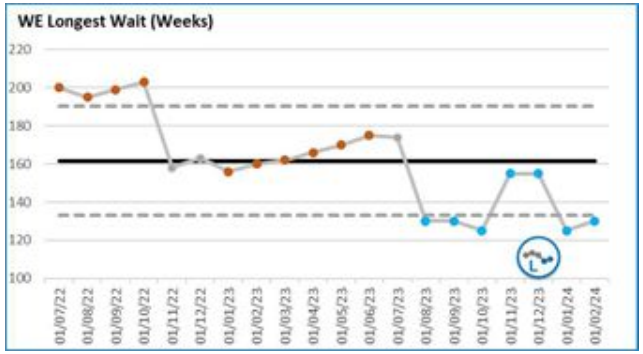
Hertfordshire and West Essex Integrated Care System

Autism Spectrum Disorder (ASD) – West Essex

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	1331	1365	↑	19.31%	20.15%	↑	125	130	↑	February





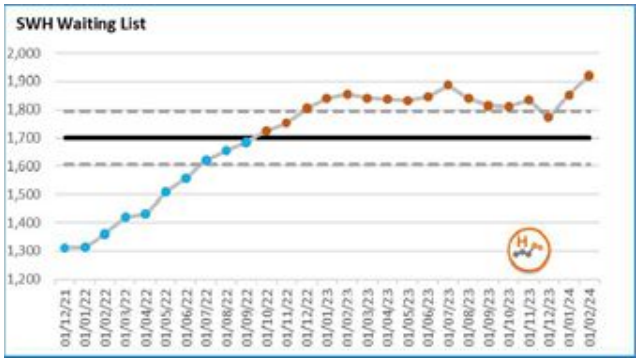


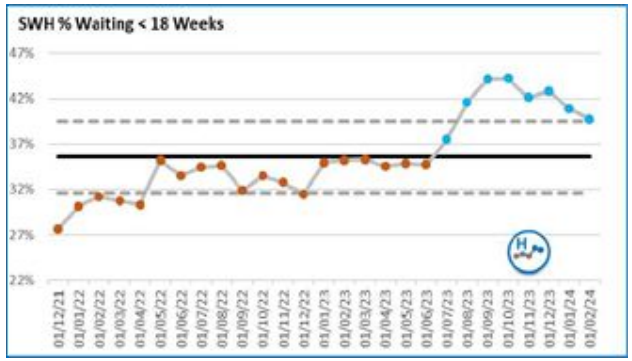
ICB Area	What the charts tell us	Issues	Actions
West Essex	• The ASD waiting list has increased for the last 3 months and is now exceeding the historic mean • The % of ASD waiters <18 weeks continues to fluctuate between 18-20% • The longest wait increased slightly to 130 weeks. There are 3 patients >125 weeks • 216 of the 1365 total waiting list are >104 weeks	• Average monthly referral rate for Q4 increased to 73, against commissioned capacity of 40 assessments per month • Demand and capacity analysis forecasts continued waiting list growth • Imminent CQC / Ofsted SEND Inspection for Essex. ASD waiting times and progress with improvement since last inspections in 2019 and 2022 expected to be highlighted • Inconsistencies in ICS and Essex datasets resulting in additional data collection and analysis for provider and commissioner	• Business case submitted to increase core capacity for sustainable delivery and address prescribing gap not supported due to available funding • 24/25 plans in discussion. Available funding will leave a capacity gap • 'Waiting well' workstream continues with local partners at place, led by HCRG, also linking in with Essex wide joint commissioning initiatives • Working with Hertfordshire partners on application of Neurodiversity Segmentation Model. This is similar to the West Essex JADES model already in place and requiring additional investment. Therefore, likely limited impact for West Essex

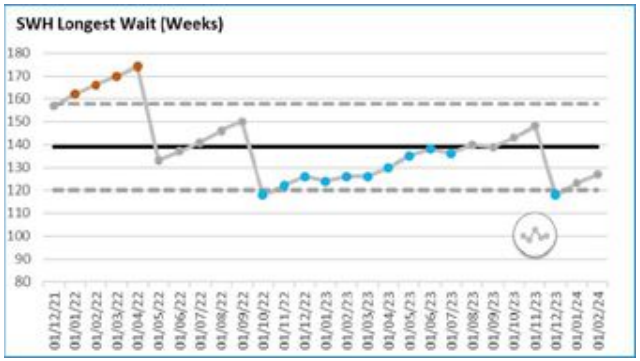
Hertfordshire and West Essex Integrated Care System

Autism Spectrum Disorder (ASD) – South & West Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	Children	1852	1920	↑	40.87%	39.74%	↓	123	127	↑	February

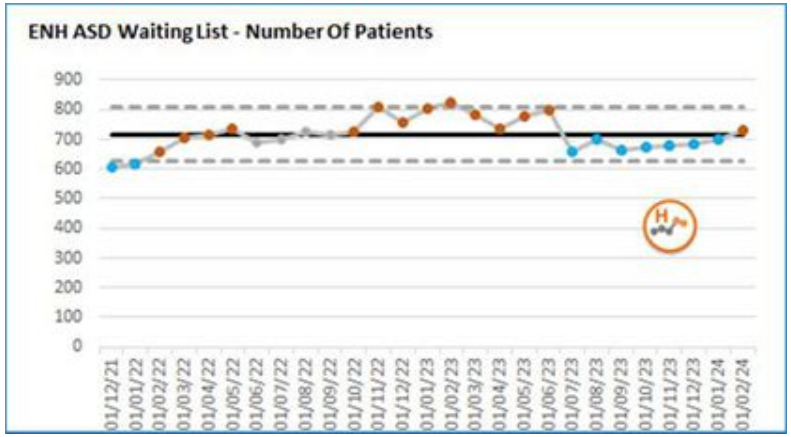






ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The overall waiting list remains consistently above the historic mean and increased to its highest level in February • The % of ASD waiters < 18 weeks remains above the historic mean, but has fallen by c.5% since October • The longest wait is now 127 weeks, up slightly in each of the last 2 months	• Capacity in existing services does not meet demand • Further increases in demand predicted • Funding for outsourcing additional diagnostic assessments to reduce the waiting list ended in December 2023. HCT continue to review the potential of extending this work, but it is dependent on funding	• Procurement process is progressing to outsource assessments for autism, ready to proceed subject to agreement of funding • Additional internal capacity and processes have been improved significantly • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through HCT clinical governance and agreed by operational teams to inform the business case. Nearing completion to take though ICB and provider governance processes. The business case is scheduled to go to the ICB Strategic Finance and Commissioning Committee in July • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in August / September 24 • Expression of interest submitted for Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB was successful. Planning for implementation is now in progress

Autism Spectrum Disorder (ASD) – East & North Hertfordshire

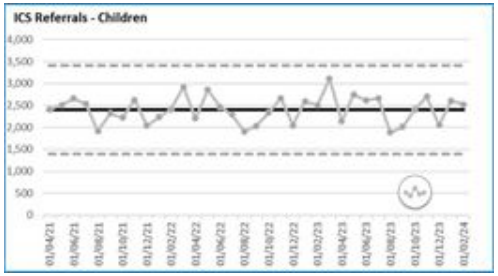


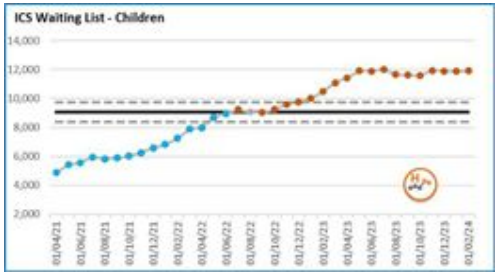
- In ENH patients have a first appointment with Community Paediatrics. If the clinician then considers that the patient requires an ASD assessment then they are added to the ASD waiting list
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments once a patient has been added to the ASD assessment waiting list. However, data is not available for both pathways combined
- The chart opposite shows the trend in the number of patients waiting for an ASD assessment once they have been referred by a community paediatrician
- The table below summarises how long patients on the ASD waiting list have been waiting (as of Dec-23):

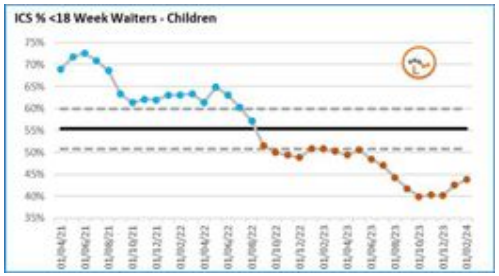
Waiting list bucket	Number of patients (Dec-23)	Number of patients (Feb-24)
<18 weeks	103	125
18 – 65 weeks	443	406
66 – 78 weeks	88	95
>78 weeks	86	103

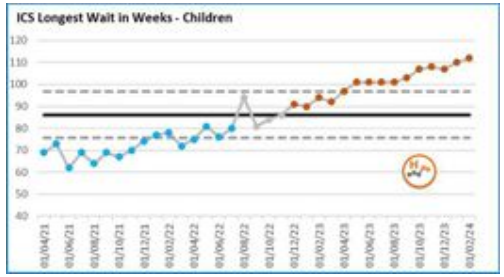
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting list continues to fluctuate within the normal range of 600-800 patients • However, there have now been five months in a row where the overall waiting list has increased • The number of patients waiting >65 weeks has increased from 174 in December to 198 in February • The waiting list shown above does not include patients waiting for their first community paediatrics appointment, even if they have been referred by their GP as query ASD. It only shows patients who have been assessed by a community paediatrician and referred for a detailed ASD assessment	• Data not currently reportable on the same basis as the other two ICB Places • ENHT is currently subject to Tier 2 Oversight and Scrutiny meetings for Community Paediatrics with NHSE every 6 weeks because of increasing > 78-week waiters • Backlog funding ended December 2023. Without continuation of the backlog funding investments, ASD waiting lists will start to grow • Further increases in demand predicted	• Procurement process is progressing to outsource assessments for autism, ready to proceed subject to agreement of funding • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through HCT clinical governance and agreed by operational teams to inform the business case. Nearing completion to take though ICB and provider governance processes. The business case is scheduled to go to the ICB Strategic Finance and Commissioning Committee in July • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in August / September 24 • Expression of interest submitted for Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB was successful. Planning for implementation is now in progress

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	2604	2524	↓	11870	11919	↑	42.51%	43.82%	↑	110	112	↑	February

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	351	374	↑	1014	1015	↑	75.74%	82.07%	↑	50	51	↑	February
ENH	AJM/Millbrook	22	15	↓	125	118	↓	71.20%	72.03%	↑	34	36	↑	February
ENH	ENHT Community Paeds.	318	294	↓	5168	5295	↑	17.92%	17.58%	↓	110	112	↑	February
ENH	**All**	**691**	**683**	↓	**6307**	**6428**	↑	**28.27%**	**28.76%**	↑	**110**	**112**	↑	**February**

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	1342	1313	↓	4573	4464	↓	51.52%	54.75%	↑	82	73	↓	February
SWH	AJM/Millbrook	18	18	→	108	108	→	72.22%	71.30%	↓	31	35	↑	February
SWH	**All**	**1360**	**1331**	↓	**4681**	**4572**	↓	**52.00%**	**55.14%**	↑	**82**	**73**	↓	**February**

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	23	15	↓	27	25	↓	100.00%	100.00%	→	16	17	↑	February
WE	HCRG / Virgin	530	495	↓	855	894	↑	93.80%	92.62%	↓	26	26	→	February
WE	**All**	**553**	**510**	↓	**882**	**919**	↑	**93.99%**	**92.82%**	↓	**26**	**26**	→	**February**

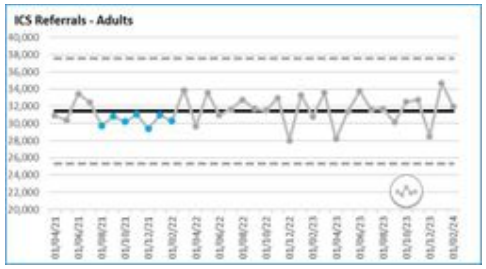
Hertfordshire and West Essex Integrated Care System

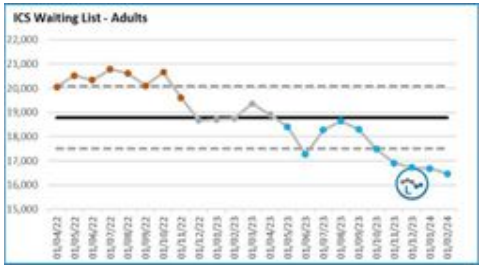
Community Waiting Times (Children)

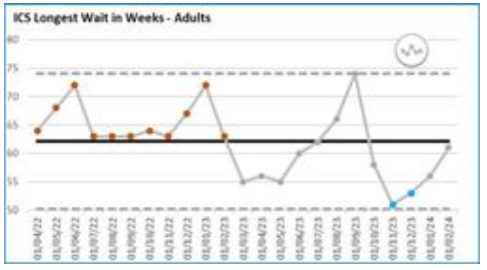
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services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

ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals continue to fluctuate within expected common cause variation limits • The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks remains of concern at c.44%, but has improved in each of the last 2 months. The national average is 51.8%, which is a deteriorating position • The longest waits are within the ENHT Community Paediatrics Service at 112 weeks. There are also long waits of up to 73 weeks within HCT services in South & West Hertfordshire • Consultant led 18-week RTT performance: SWH Community Paediatrics – 46.9% SWH Children's Audiology – 38.3% ENH Community Paediatrics – 17.6% WE Community Paediatrics – 98.6%	**Hertfordshire** • Referrals to HCT children's specialist services increased by 35% in 23/24, compared to 19/20, with most services seeing a marked increase in demand • Waiting times in the SWH HCT Community Paediatrics service are improving, with a decreasing number of long waiters. Service productivity shows clear improvement since 19/20, but referrals have increased by c.32% • There are continued waiting time pressures in Paediatric Audiology in SWH, but there has been improvement with a 31% decrease in total waiters since a high point in June. The service is also currently supporting ENHT newborn hearing pathways • Waiting times across Hertfordshire for children's therapies (OT, Speech & Language and Physiotherapy) remain under pressure **West Essex (WE)** • 18 week % is comparatively strong at 92.8%, but this is the 2nd lowest month recorded • The volumes on the Community Paediatrics waiting list continue to increase • Waits for first appointments have increased – ongoing demand and capacity challenge • Business case for additional funding remains unresolved	**Hertfordshire** • For HCT services the number of over 52-week waits has reduced from 605 in July, to 323 in March, and continues to improve in the most recent data • Focus on reducing DNA/NBI rates for children living in relatively more deprived neighbourhoods • Outsourcing in place in several services • Community Paediatrics in SWH is receiving non-recurrent additional investment to increase workforce capacity and introduce new specialist nursing posts. Recruitment remains a risk • Community Paediatrics also working with NHSE Elect to optimise waiting list management • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow ups, and signposting to interim advice whilst awaiting assessment. Demand and capacity analysis now completed to identify required staffing model to reduce the waiting list • Children's Therapies – increasing capacity through successful recruitment, waiting list initiatives and outsourcing. Pilot for self-booking in one locality has reduced NBI by over 50% • EHCP dashboard developed to improve waiting list management **Community paediatrics ENHT** • New clinical model agreed by all providers: HPFT, HCT and ENHT • Capacity model being populated with input parameters from the providers to support development of the business case. Target date for the business case is end Apr-24 • Single referral form expected to be in place by Sep-24 (but potentially earlier for some providers) • Target implementation date for the new model is Jan-25 • Providers have forecast investment levels to continue with outsourcing / backlog work in 24/25. Neurodiversity Directors Group to review / agree • ICB / HCC has agreed to expand the Neurodiversity Support Centre across Hertfordshire (staffed by experts by experience). Diagnosis not required to access the support • HCC local offer to be updated with consolidated support and patient signposting **West Essex (WE)** • Community Paediatrics Business Case: 23/24 requested investment has been rolled into year 2 of the 3-year investment plan. Process for 24/25 in year pressures remains unresolved • Admin exercise to review / discharge long waiters complete. Regular caseload review now BAU • Procurement planning initiated. Gap in current funding envelope. Investment will be required in order to procure a sustainable service going forward

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	34696	31992	↓	16686	16466	↓	93.31%	92.83%	↓	56	61	↑	February

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	9312	7882	↓	7432	7585	↑	91.04%	90.34%	↓	56	61	↑	February
ENH	AJM/Millbrook	132	82	↓	484	456	↓	73.55%	66.23%	↓	32	37	↑	February
ENH	**All**	**9444**	**7964**	↓	**7916**	**8041**	↑	**89.97%**	**88.97%**	↓	**56**	**61**	↑	**February**

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	7738	7350	↓	1853	1621	↓	95.84%	97.47%	↑	38	42	↑	February
SWH	Connect	3652	3481	↓	3172	3135	↓	99.75%	99.74%	↓	34	34	→	February
SWH	HCT	989	977	↓	1036	1035	↓	89.77%	90.14%	↑	41	44	↑	February
SWH	AJM/Millbrook	123	120	↓	492	495	↑	76.22%	72.93%	↓	36	40	↑	February
SWH	**All**	**12502**	**11928**	↓	**6553**	**6286**	↓	**95.30%**	**95.47%**	↑	**41**	**44**	↑	**February**

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	12650	11986	↓	2126	2037	↓	99.39%	99.61%	↑	25	23	↓	February
WE	EPUT - Wheelchairs	100	114	↑	91	102	↑	98.90%	100.00%	↑	21	17	↓	February
WE	**All**	**12750**	**12100**	↓	**2217**	**2139**	↓	**99.37%**	**99.63%**	↑	**25**	**23**	↓	**February**

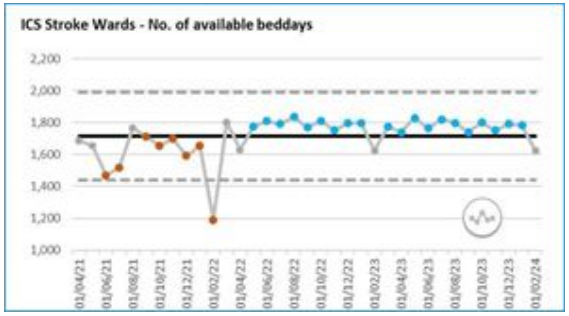
Hertfordshire and West Essex Integrated Care System

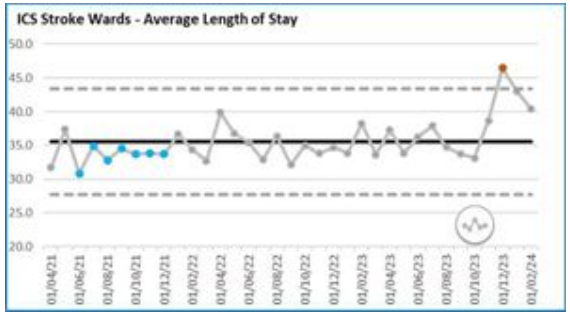
Community Waiting Times (Adults)

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

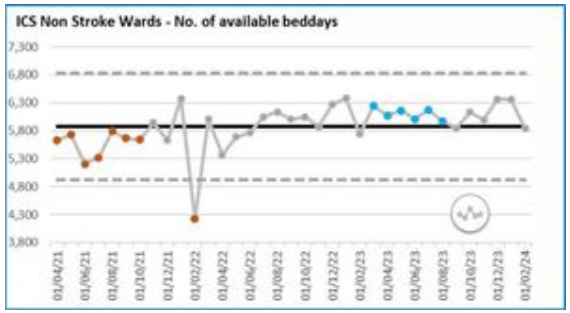
ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals continue to fluctuate within expected common cause variation limits • The % of patients waiting less than 18 weeks continues to fluctuate at c.93%, compared to the national average of 83.5% • The total number of adults waiting on waiting lists decreased for the 6th consecutive month • Longest waits are within HCT services in East & North Hertfordshire – up for the 4th month to 61 weeks • Consultant led 18-week RTT performance: ENH Skin Health – 87.9% SWH Respiratory – 97.3% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Referrals have increased by 15% compared to 19/20 and are also up compared to last year. Overall 'waiting within target' performance continues to be more favourable when compared to the pre-pandemic baseline **South & West Hertfordshire (SWH)** • MSK services previously delivered by Connect have been reprocured with Circle. There may be some interruption to data flows during mobilisation • Slight decrease in referrals at CLCH. The number of patients waiting continues to reduce, as does the number of patients waiting above 18 weeks. Respiratory service is now achieving 97% • Longest waiter remains within the Neuro Rehab service (ABI patient waiting for psychology input) • Now recruited to ABI Psychology post – start TBC • Lymphedema and Bladder and Bowel services now within agreed waiting times target **West Essex (WE)** • Pulmonary Rehab recruitment partially successful. Band 6 post remains unfilled • Small number of breaches in Leg Ulcer and Bladder & Bowel services	**East & North Hertfordshire (ENH)** • All waits are closely monitored and subject to robust internal governance • Service productivity analysis continues • Forecasting suggests a stable trend over the next 12 months, and that overall current waiting time performance will be maintained or slightly improved • MSK performance and overall waiting within target performance remains strong and now more favourable than pre-pandemic **South & West Hertfordshire (SWH)** • External provider continuing to support with PD and MS Nursing and ABI caseloads • External provider now also supporting with planned care therapy and NETT waits • Agree start date for substantive ABI Psychology starter • Recruit to PD post – funding secured • Divisional weekly waiting times group remains in place which also feeds into Trust group • Division specific recruitment plan underway, including developing videos to compliment adverts and targeting social media channels. A number of recruitment fairs held, with more being planned • Trajectories now in place for all services of concern. These are reviewed and monitored weekly **West Essex (WE)** • Pulmonary Rehab recovery trajectory agreed. Compliance with 8-week standard expected from June • Bladder & Bowel – temporary staffing in place to cover maternity leave. Recovery expected in May

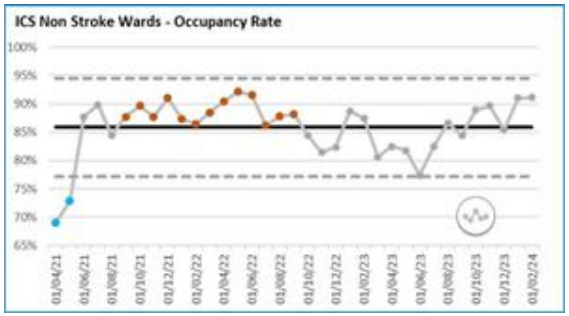
Community Beds (Stroke & Non-Stroke)

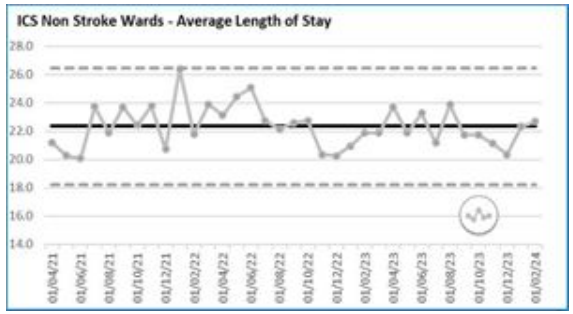




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	744	672		95.97%	91.37%		39.6	32.4		February
SWH	CLCH	605	561		98.84%	100.00%		48.4	33.5		February
WE	EPUT	434	392		97.09%	91.37%		41.0	63.0		February
ICS	**All**	**1783**	**1625**		**97.20%**	**96.31%**		**43.0**	**40.4**		**February**







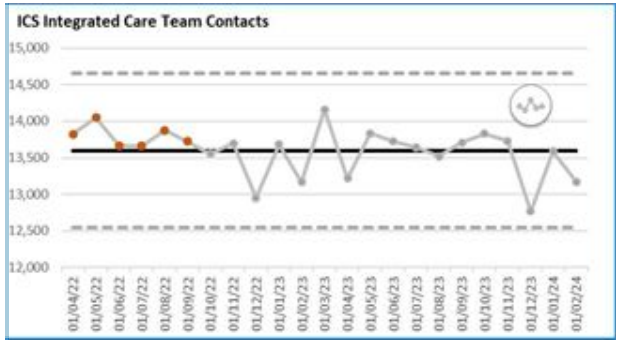
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1767	1640		87.83%	87.20%		27.7	26.9		February
SWH	CLCH	2330	2159		89.18%	93.47%		26.4	26.0		February
WE	EPUT	2263	2044		95.45%	91.93%		14.5	15.9		February
ICS	**All**	**6360**	**5843**		**91.04%**	**91.17%**		**22.3**	**22.7**		**February**

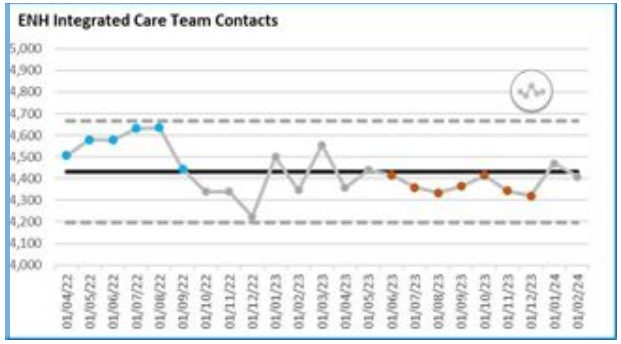
Community Beds (Stroke & Non-Stroke)

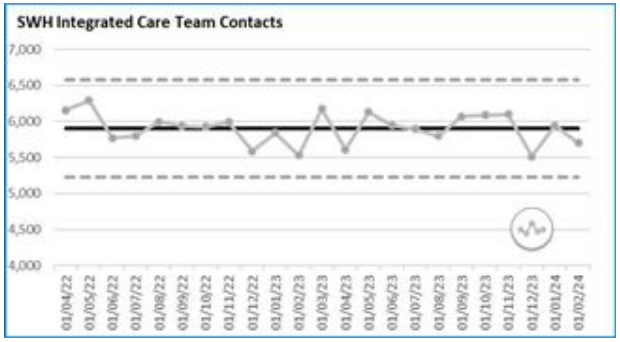
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds Days** • Available stroke bed days remain consistent. February numbers dipped due to the reduced number of days in the month • Overall stroke bed occupancy rates continue to trend above the historic mean, but have reduced in each of the last 2 months • Overall length of stay has reduced from the high seen in December, but continues to be impacted by a complex long stay patient at EPUT in West Essex **Non-Stroke Beds Days** • Available stroke bed days remain consistent. February numbers dipped due to the reduced number of days in the month • Overall occupancy rates across the system have been increasing through 23/24 but remain within common cause variation limits • Overall length of stay remains within common cause variation limits	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 92% in 23/24. Herts & Essex and QVM have an average occupancy of 81% and 83% respectively • Average length of stay in 22/23 for Herts & Essex averaged 22 days, and 23 days at QVM. At Danesbury, there is now normal variation with an average of 32 days. Admissions into community hospitals show no significant change in trend at Herts and Essex and QVM • Danesbury has the least admissions with an average of 17 a month, with QVM averaging 19, and Herts & Essex averaging 31 **South & West Hertfordshire (SWH)** • Continued high occupancy rates across all beds due to supporting system flow and admitting higher acuity patients. Slight reduction in general rehab. beds • Slight reduction in average length of stay due to better management of No Criteria to Reside (NCTR) patients **West Essex (WE)** • Extended length of stay on stroke ward due to a complex patient. Extension to stay has been agreed with ICB commissioners	**East & North Hertfordshire (ENH)** • Comprehensive health inequalities metrics in place. Health inequalities analytics has allowed the Trust to compare waiting times and DNA rates for those living in relative deprivation versus those that do not, and critically to set targets to address discrepancies • New process regarding criteria to reside in place to support discharge **South & West Hertfordshire (SWH)** • Daily assurance calls remain in place with HCC with clear escalation process • In collaboration with system partners, action plan agreed to support flow and winter plan also drafted • In collaboration with system partners, SPOC review completed, and action plan agreed which is currently being worked through (most actions completed) • In partnership with social care colleagues, currently reviewing escalation plan **West Essex (WE)** • Daily escalation calls in place to support all delayed discharges • All extended stays are agreed with ICB commissioners

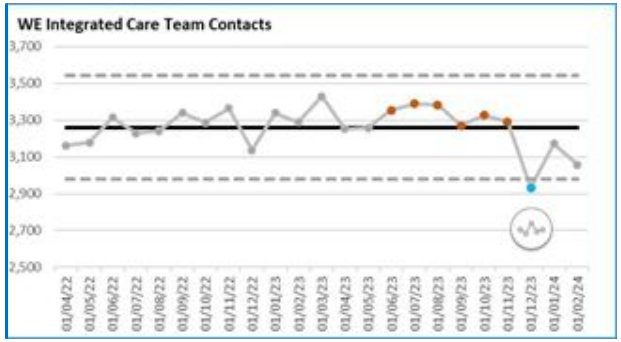
Hertfordshire and West Essex Integrated Care System

Integrated Care Teams (ICT)









			Contacts (unique patients)			Contacts (unique patients) per 1000 population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	4470	4409		7.1	7.0		February
SWH	CLCH	All	5944	5705		8.7	8.3		February
WE	EPUT	All	3172	3058		9.6	9.2		February
ICS	**All**	**All**	**13586**	**13172**		**8.3**	**8.0**		**February**

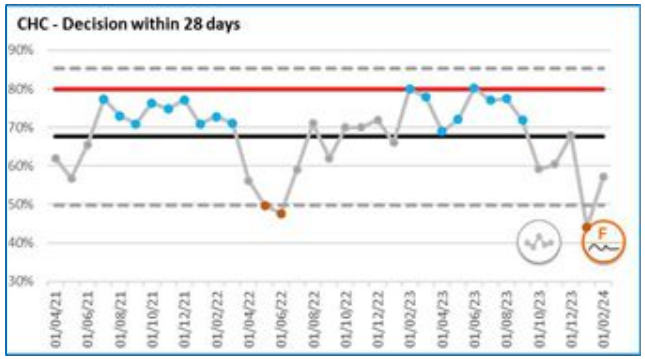
Hertfordshire and West Essex Integrated Care System

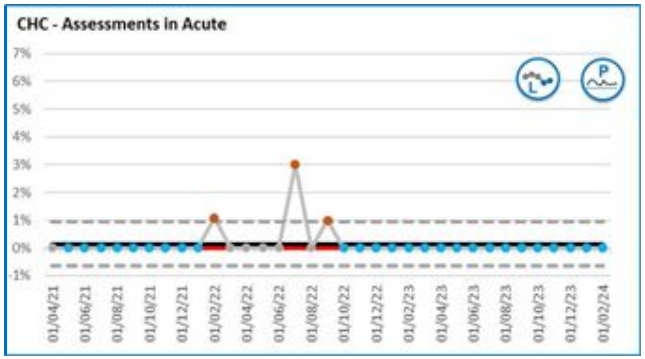
Integrated Care Teams (ICT)

ICB Area	What the charts tell us	Issues	Actions
ICB	• This section of the report has changed from this month to report on the number of unique patients in contact with the three HWE ICT Teams. Using this method removes the previous discrepancies seen due to provider internal recording and coding differences • Unique contacts in each place and at HWE System level are within expected common cause variation limits	**East & North Hertfordshire (ENH)** • Overall, referrals show a small increase compared to pre-pandemic, although the pattern differs at Locality level • Increasing patient complexity has driven an increase in caseload and first to follow up ratios • Service and staff are under growing pressure • Focus on increased deferral rates **South & West Hertfordshire (SWH)** • Slight reduction in referrals number in month. However, caseload numbers are largely unchanged **West Essex (WE)** • Since April 2021 ICTs have seen a reduction in referrals. Contacts per patient however have increased from 7.5% to 9.7% (c.30% increase), suggesting an increase in acuity of patients receiving care in the community	• Community services review underway across HWE to reduce variation and shift to reporting outcomes and impact, to compliment the activity driven data that exists **East & North Hertfordshire (ENH)** • Steering group in place chaired by HCT Chief Operating Officer • Various recruitment initiatives underway • A comprehensive support programme in place focused on workforce, wound care and diabetes management with the ICT • Additional activity support with locality cross team working to reduce deferrals **West Essex (WE)** • ICTs are focussing on proactive working within the Integrated Neighbourhood Teams, aligned to the 6 West Essex PCNs

Hertfordshire and West Essex Integrated Care System

Continuing Health Care (CHC)





	What the charts tell us	Issues	Actions

HWEICB	• The 28-day standard continues to present a significant challenge, most notably in South & West Hertfordshire
	• The 80% target was achieved in West Essex and East & North Herts in February; however, all Places will miss the target in March:
	  • Overall ICB – 43%
	  • West Essex – 76%
	  • ENH – 67%
	  • SWH – 24%
	• The assessments in an acute setting <15% standard continues to be routinely achieved
		• Workforce - new starters do not have CHC experience and require robust training and development
		• Recovery of the 28-day standard is forecast to take at least 6 months and has been agreed with NHSE
			• Weekly meetings are in place across all areas to monitor performance. Additional assurance meetings are being held with NHSE
			• A further comprehensive layer of management control and support has been implemented across the SWH service to significantly improve work allocation, daily analysis of completed work, case status and risk identification
			• The same process for all areas will be implemented moving forwards

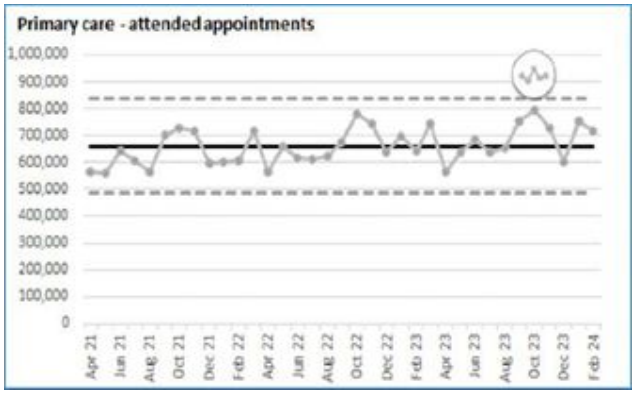
Hertfordshire and West Essex Integrated Care System

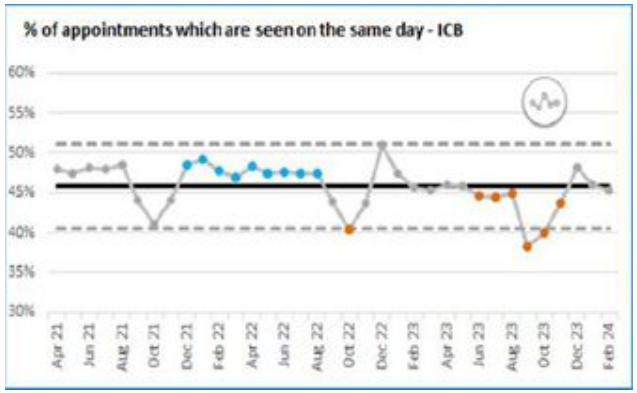
Primary Care – performance summary

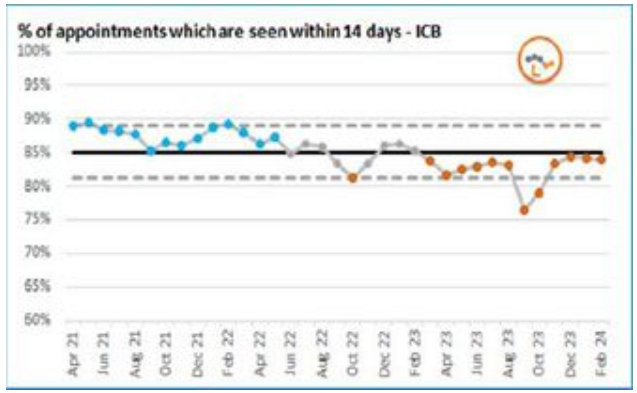
Current Performance Period vs Prior Period								ICB	ENH	SWH	WE
Area	Indicator	Type	Prior Mth	Current	Change	Movement	Period	Rank (out of 42 ICBs)	Rank (out of 106 ICBs)		
Primary Care	S001a: Number of general practice appointments per 10,000 un-weighted patients	Monthly	4,468	4,227	(241)	↓	Feb-24				
	% of appointments which are seen on the same day	Monthly	46.0%	45.3%	(0.7%)	↓	Feb-24				
	% of appointments which are seen within 14 days	Monthly	84.2%	83.9%	(0.3%)	↓	Feb-24	23	92	33	35
	S074a: FTE doctors in General Practice per 10,000 weighted patients	Monthly	6.22	6.13	(0.09)	↓	May-23				
	S075a: Direct patient care staff in GP Practices and PCNs per 10,000 weighted patients	Quarterly	6.29	6.67	0.38	↑	Q4 23-24	35			
	S037a: Percentage of patients describing their overall experience of making a GP appointment as good	Annual	54.5%	52.4%	(2.1%)	↓	2023	32			
	S085a: Proportion of people with severe mental illness receiving a full annual physical health check and follow up interventions	Quarterly	68.7%	74.9%	6.2%	↑	Q1 23-24				
	S030a: Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check ICB	Monthly	42.6%	41.2%	(1.4%)	↓	Dec-23	38			
	S055a: Number of referrals to NHS digital weight management services per 100k head of population	Quarterly	24.7	37.9	13.2	↑	Q4 22-23				
	S050a: Cervical screening coverage - % females aged 25 - 64 attending screening within the target period	Quarterly	73.6%	73.8%	0.2%	↑	Q2 23/24	7	28	43	20
	S047a: Proportion of people over 65 receiving a seasonal flu vaccination	Seasonal	80.3%	80.7%	0.4%	↑	Feb-23	26	47	51	82
	S109a: Units of Dental Activity delivered as a proportion of all Units of Dental Activity contracted	Annual	67.1%	72.5%	5.4%	↑	2022-23				
	S044a: Antibiotic items prescribed in primary care per STAR-PU (specific age-sex related prescribing unit)	Monthly	1.034	1.029	(0.005)	↓	Nov-23	28	56	19	76
	S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	Monthly	8.54%	8.56%	0.02%	↑	Nov-23	34	83	84	70

Hertfordshire and West Essex Integrated Care System

Primary Care – key indicator trends







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

What the charts tell us

- GP appointments remain within expected common cause variation limits
- The % of appointments which were seen on the same day returned to common cause variation following the dips seen in Sep-23 and Oct-23. Historically, those months are low due to flu vaccinations, which are not same day appointments
- The % of appointments which were seen within 14 days has been consistently below the mean for the last 12 months

Hertfordshire and West Essex Integrated Care System

Primary Care – narrative

ICB Area	Issues	Actions
ICB	• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • 23/24 contractual requirement for an offer of assessment, an appointment, or signposting to occur when the patient contacts the practice • National contract for 24/25 imposed without agreement from profession, with Industrial Action in Primary Care a possibility and added to the risk register	**Engagement with the National Access Recovery Plan** • All 34 PCNs have an agreed Access Improvement Plan (AIP) as outlined in the Primary Care Access Recovery Plan • Comms. to all practices noting AIP requirements by year end to be eligible for payment- assessment of achievement end of April • Some practices transitioning to Modern General Practice through demand / capacity analysis, use of cloud base telephony, enacting the National GP Improvement Programme (19 practices and 4 PCNs), roll out NHS app, online GP registration, development of GP and PCN websites and testing triage models • Transformation support funding - Indicative £13.5k per qualifying practice available for 23/24, and the same for 24/25. Place teams reviewed and approved submissions from practices • 28 sites identified for cloud base telephony. Delays in national procurement hub implementation may result in practices unable to deliver improvement in telephone access for 2023/24. Escalated to the regional team • Good progress on online access to GP records. Targeted work with practices to enable access by opting into (EMIS) or following self-enablement process (TPP) – proactive follow up of practices with low take up or high exclusion rates • Partnership working to increase self-referrals in high volume services: Physio, IAPT, Podiatry etc. • Support Level Framework (SLF) - Self assessment tool to support practice teams in understanding what they do well, what they might wish to do better, and where they might benefit from development support. Aim for all practices to have had a facilitated discussion using the SLF during the year • Comms. to support ICB and practice websites, media statements and patient comms re the Delivery Plan • Attendance at NHSE regional weekly drop-in sessions to escalate any issues or questions for clarification • GP contract for 24/25 - continued focus on access and reducing bureaucracy with light touch approach to Access Improvement Funding • Development of PC Dashboard to include further metrics to allow triangulation / narrative in the absence of plan / reporting requirement in national contract **Other** • Enhanced Commissioning Framework (ECF) reviewed and streamlined for 23/24, review for 24/25 to focus on outcomes and reducing bureaucracy • Trend analysis to identify practices with poor access via complaints and patient contacts • PCCC and Primary Care Board oversight of GPPS results. Action plan developed through the Access MDT Group • Initiatives for Primary Care Workforce to support recruitment and retention, supported by the HSE ICB Training Hub • 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 • Oversight of all Access plans as submitted and sharing of best practice across the ICB • Pharmacy First now live, work with Community Pharmacy leads and practices to promote service

Performance v. 23/24 Operational Plans

		M11 Only					Year To Date				
POD	Description	Plan	Actual	Actual vs Plan %	Change	Performance	Plan	Actual	Actual vs Plan %	Change	Performance
EM13	Number of attendances at all type A&E departments	35,329	42,101	19.17%	6,772	↑	438,326	456,170	4.07%	17,844	↑
EM11a	Number of specific acute non-elective spells in the period with a length of stay of zero days	3,091	3,480	12.58%	389	↑	37,839	33,329	-11.92%	-4,510	↓
EM11b	Number of specific acute non-elective spells in the period with a length of stay of one or more days	6,026	6,457	7.15%	431	↑	67,993	73,851	8.62%	5,858	↑
EM10a	Elective day case spells	10,039	10,236	1.96%	197	↑	100,488	108,431	7.90%	7,943	↑
EM10b	Elective ordinary spells	1,247	886	-28.95%	-361	↓	12,800	9,830	-23.20%	-2,970	↓
EM32g	Outpatient attendances (all TFC; consultant and non consultant led) - First attendance	43,694	41,911	-4.08%	-1,783	↓	474,957	462,403	-2.64%	-12,554	↓
EM32h	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance	50,942	65,996	29.55%	15,054	↑	575,380	716,226	24.48%	140,846	↑
EB20	The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	1,775	1,508	-15.04%	-267	↓	25,887	34,575	33.56%	8,688	↑
	Operational planning modalities (provider)	36,393	33,735	-7.30%	-2,658	↓	393,765	380,199	-3.45%	-13,566	↓

ICB Issues and escalations

- YTD attendances, and non-elective spells with a length of stay of one of more days, are both higher than plan
- Non-elective spells with a zero-day length of stay are slightly below plan
- Elective inpatient activity is below plan. Elective activity in all areas has been impacted by Industrial Action
- The number of 65-week waits is above plan, however the target for zero 65ww breaches has been extended to end of September 2024

Appendix A – Performance Dashboard

February 2024

Area	Activity	Target	Herts & West Essex ICB (Commissioner) Latest published data	Data published	Trend *1	Variation	Assurance	NATIONAL position (ICB vs National)	REGIONAL position (ICB vs EoE Region)	ICB Ranking	Provider ICB Aggregate Provider	Trend *1	ENHT	Trend *1	WHTHT	Trend *1	PAH	Trend *1
111	Calls answered < 60 seconds	95%	21.9%	February 24	-61.64%			58.61% (Worse)	47.23% (Worse)	3rd lowest	21.9%	-61.64%						
	Calls abandoned after 30 seconds	5%	29.5%	February 24	22.37%			9.31% (Worse)	15.78% (Worse)	1st lowest	29.50%	22.37%						
A&E	% Seen within 4 hours	76%	74.8%	March 24	7.086%			74.21% (Better)	75.52% (Worse)	20th highest	74.80%	7.09%	76.20%	4.59%	78.20%	9.46%	67.90%	7.22%
	12 Hour Breaches	0	182	March 24	-71.98%			42,181 (0.43%)	2,913 (6.25%)	5th highest	182	-71.98%	37	-191.89%	44	13.64%	101	-65.35%
Cancer	31 days	96%	94.1%	February 24	5.94%			91.11% (Better)	91.16% (Better)	14th highest	95.90%	1.67%	96.10%	-0.73%	97.60%	9.73%	92.30%	5.31%
	62 days	85%	70.4%	February 24	6.29%			63.94% (Better)	63.17% (Better)	8th highest	71.40%	4.62%	83.60%	-2.99%	72.70%	13.89%	48.80%	9.43%
	28 days Faster Diagnosis	75%	78.9%	February 24	6.81%			78.12% (Better)	75.21% (Better)	20th highest	81.10%	7.77%	83.40%	8.75%	79.80%	7.14%	80.30%	7.22%
RTT	Incomplete Pathways <18 weeks	92%	55.7%	February 24	2.87%			57.55% (Worse)	53.83% (Better)	14th lowest	52.70%	4.74%	54.20%	7.93%	51.40%	2.72%	52.70%	3.04%
	52+ weeks	0	9,225	February 24	-26.08%			305,050 (3.02%)	50,086 (18.42%)	9th lowest	7,288	-33.07%	2,909	-83.91%	2,420	0.54%	1,959	0.92%
	65+ weeks	0	2,058	February 24	-96.02%			75,004 (2.74%)	14,302 (14.39%)	13th lowest	1,508	-135.08%	500	-385.00%	353	-13.88%	655	-9.62%
	78+ weeks	0	124	February 24	-4.84%			9,969 (1.24%)	2,110 (5.88%)	14th lowest	124	-1085.48%	30	-4423.33%	10	-40.00%	84	-17.86%
Diagnostics	6 week wait	5%	26.4%	February 24	-21.59%			20.78% (Worse)	27.43% (Better)	9th lowest	31.30%	-21.41%	44.70%	-13.65%	9.10%	-62.64%	24.80%	-39.92%

Area	Metric	Target	Herts & West Essex ICB (Commissioner) Latest published data	Data published	Trend *1	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking	Sub-ICB ICS Aggregate Provider	Trend	East & North Herts	Trend *1	South & West Herts	Trend *1	West Essex	Trend *1
111	Calls answered < 60 seconds	95%	21.9%	February 24	-61.64%			58.61% (Worse)	47.23% (Worse)	3rd lowest	N/A		22.33%	-59.89%			20.00%	-69.50%
	Calls abandoned after 30 seconds	5%	29.5%	February 24	22.37%			9.31% (Worse)	15.78% (Worse)	1st lowest			29.76%	21.70%			28.20%	24.82%
Mental Health	Dementia Diagnosis rate	66.6%	64.4%	February 24	0.20%			64.50% (Worse)	62.90% (Better)	22nd (middle)			62.85%	0.29%	62.12%	0.27%	71.20%	-0.01%
	OOA placements	0	211	February 24	57.35%			n/a	n/a	n/a			172	79.07%			39	-38.46%
CHC	% of eligibility decisions made within 28 days	80%	57.1%	February 24	22.94%			76.45% (Worse) *2	79.06% (Worse) *2	10th lowest *2			80.40%	37.81%	35.40%	1.41%	84.60%	9.57%
	% of assessments carried out in acute	15%	0.0%	February 24	0.00%			0.32% (Better) *2	0.29% (Better) *2	12th lowest *2			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

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	
Report title	Audit and Risk Committee 18 June 2024 highlight report			**Meeting Date**	10 July 2024
Chair	Jonathan Silver – Committee Chair and Non-Executive Director				
Author	Debbie Okutubo – Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Internal Audit summary internal controls assurance (SICA) report
- Internal Audit recommendation tracker
- NHS Provider accounts 2023-24
- External Audit Completion report
- External Auditor's Annual report
- Annual report and Annual Governance Statement.

Alert:

- The Committee approved the NHS Provider accounts 2023/2024
- The Committee reviewed the Annual Report and Accounts and were satisfied with them subject to clarifications and minor amendments with delegated authority to approve the amendments delegated to the Chair, Jonathan Silver, Karen McConnell, Deputy Trust Chair & Non-Executive Director and Martin Armstrong, Deputy CEO and Director of Finance to enable submission on time to NHS England without the need to convene a full Audit and Risk Committee.
- Subject to the completion of fieldwork, the external auditor is anticipating issuing an unqualified opinion on the Trust's financial statements on or soon after 27 June 2024.

Advise:

- N/A

Assurance:

- To ensure a seamless handover from the outgoing internal auditors and the incoming team, final reports concluding all internal audit recommendations will be presented at the 9 July committee meeting.

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

- The Committee requested that an exception/assurance report be provided on:
  - theatre stock roll-forward and
  - logging batch job failures.

Items referred to the Board or a committee for a decision/action:

- None

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**	17a
Report title	Finance Performance and Planning Committee – Highlight report May 2024	**Meeting Date**	1 May 2024
Chair	Karen McConnell - Committee Chair and Non-Executive Director		
Author	Chloe Milton – Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Action Log - Radiology Timeline
- Performance and flow spotlight – Urgent Treatment Center and UEC
- Productivity Spotlight – Ophthalmology
- Productivity and ERF report
- Front Entrance Development update
- Divisional CIP Plans
- Finance Month 1
- Performance Report
- IT/Digital update
- Board Assurance Framework

Alert:

- There was a reduction in 4-hour performance in April, from 73.4% in March to 68% in April with some recovery in May. Whilst the success of the UTC was welcomed, and future actions noted a timeline was requested for the achievement of consistent performance against the 78% waiting target for the Emergency Department
- Community Paediatric waits remain of concern. The number of patients waiting is growing and improvement in performance relies upon a long-term plan for system re-design. Text messages had been sent to all patients on the community paediatrics waiting list to determine if they still required the service.
- Following the spotlight on radiology last month, a summary of the recovery trajectories and action plans to deliver DM01 compliance by March 2025. This

	showed a shortfall in MRI capacity. Recovery action requires support and cooperation from an external provider to achieve compliance. This is being put in place. There remains a risk to delivery should there be an unexpected increase in demand and/or high intensity of high priority work.
Advise:	
	- The Trust submitted a final 24/25 plan in May of break-even. This plan assumed delivery of a £33.8m (5%) cost improvement plan (CIP) - At month 1 there was a planned deficit of £0.6m and actual position of £1.4m deficit. Elective activity was the most significant variance from plan. The adverse pay position was offset by reserves. - £33.4m of the £33.8m CIP target has been identified. The Trust delivered £1.3m savings against a £2.2m target. £0.7m of the adverse variance related to CIP schemes. It has been a challenging start to the year and all divisions are reviewing their CIP delivery and slippage go identify further mitigations. - Cancer: sustained the faster diagnostic standard and cancer performance (minus late referrals). Action is being taken to improve 62 day cancer performance specifically relating to colonoscopy capacity and haematology. - Progress continues with plans to develop the front entrance with further meetings planned in July. - The EPR upgrade programme is on track with the governance framework being put in place, risk log being developed, workshops taking place and active clinical engagement.
Assurance:	
	- The first productivity review was concluded and provided a useful template for the future. The Ophthalmology service has engaged very positively with the process and had identified some areas and developed plans to improve productivity. It had been invited to a GIRFT meeting as an example of a department performing well.
Important Items to come back to committee:	- MRI - Community Paediatrics - 4-hour performance in ED
Items referred to the Board or a Committee for decision or action:	

Recommendation	N/A

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	17b
Report title	Finance Performance and Planning Committee – Highlight report June 2024	**Meeting Date**	10 July 2024
Chair	Karen McConnell - Committee Chair and Non-Executive Director		
Author	Chloe Milton – Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Performance and flow spotlight – Discharge
- Productivity Spotlight –Surgical Pathway
- Finance Month 2
- Final System Financial Plan 2024/25
- Procurement update
- Productivity and ERF report
- Performance Report
- IT/Digital update
- Board Assurance Framework

Alert:

- to The Trust reported a £1.1m deficit in line with the plan at the end of month 2. However, ERF remains significantly behind plan and staff recruitment to support ERF had been slow. More proactive management of budgets is required by divisions to ensure the Trusts financial duties are met.
-
- The System has moved from a deficit position of £44.9m at the beginning of May to a final agreed submission of a deficit of £20m. The impact of the triple lock and the significant savings that need to be made are challenging for all parties.
- ED performance remains of concern. FPPC has requested a timeline over which improvement in performance can be achieved.
-

- MRI capacity remains of concern. Arrangements are being made to outsource scans, but we do not yet have confirmation that the private provider can meet all the anticipated demand. -
Advise:
- A series of actions are being taken by the discharge improvement group to improve discharge performance and patient flow. Work is wide ranging and includes identifying barriers, enhancing clinical leadership, engaging with all key stakeholders, and building an evidence base for improvement. Progress is good and FPPC has requested an action plan and future updates on progress against it. - The productivity spotlight on surgical pathways identified some helpful improvements and actions that could be taken to improve average cases per list and touch time utilisation. Particular focus was on Trauma and Orthopaedics and Ophthalmology. Discussion revealed some further opportunities including around preoperative assessments. - The ICS procurement service update included agreed budgets for the ICS and ENHT together with the agreed savings target. Steps are being taken to improve engagement between the procurement team and operational teams. - Elective 78-week and 65-week recovery trajectories are on track apart from Trauma and Orthopaedics. Attention is being focussed on both T&O and pain performance (osteotomy pathway, foot and ankle) - EPR upgrade programme is on track and is in the discovery/ current state phase until the end of July. -
Assurance:
- - Cancer sustained the faster diagnostic standard - Stroke performance sustained at category B

Important Items to come back to committee:	
Items referred to the Board or a Committee for decision or action:	- Finance position - System financial position - ED - UEC - MRI

Recommendation	N/A

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	Quality and Safety Committee 22 May 2024 - highlight report			**Meeting Date**	10 July 2024
Chair	David Buckle				
Author	Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Safe, Care, Effective report
- Maternity Assurance report
- Combined Compliance, Clinical Audit and Effectiveness report
- Nursing and Midwifery fundamentals of care strategic update
- Integrated compliance report- incident, compliance and risk report
- Incident and Complaints triangulation report
- Consent to Treatment policy
- Patient Safety escalation report.

Alert:

- The Director of Midwifery has informed the committee that initially the division was looking to exit the maternity improvement programme in the summer, but this would now be postponed and they would be keeping in touch with NHSE.
- Q4 monthly NICE notifications:- Trust response rate was low, but a plan is in place to reverse this.
- Duty of Candour compliance rate is averaging below 50% and the Trust is responding to this. QSC will continue to monitor performance.

Advise:

N/A

Assurance:

- A member commented on the 21 adults with learning disability who died during 2022/23 and asked if any of the deaths were avoidable. In response it was explained that a review was done on every learning disability patient who died, and all the deaths were reported externally. Members were assured that the Trust was not an outlier.
- HSMR and SHMI continue to be better than the national standard.
- Safe staffing (nurses) levels are well maintained.

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

- On clinical audit and effectiveness, there is ongoing work on ENHance which would lead to improved triangulation on quality governance which would be brought back to QSC.
- IV antibiotics (for sepsis) is below target and will be reviewed.

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**	18a
Report title	Quality and Safety Committee 26 June 2024 - highlight report	**Meeting Date**	10 July 2024
Chair	Peter Carter – Deputy Committee Chair and Non-Executive Director		
Author	Debbie Okutubo – Deputy Company Secretary		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- Safe, Care, Effective report
- Maternity Assurance report
- Ophthalmology update
- Quality Account
- Integrated compliance report- incident, compliance and risk report
- Board Assurance Framework
- Learning from death report
- Health and Safety Annual report
- Research and development annual report
- Quality Governance Operational structure
- Clinical effectiveness committee escalation report
- Patient Safety forum
- Patient and Carer Experience Group.

Alert:

- In ED, the number of logged issues has increased. QSC has requested that staff assaults be monitored to avoid it becoming normalised.
- The Ophthalmology department has experienced a cluster of serious harms relating to ophthalmology patients with delayed follow-up. This Is being monitored by QSC.

Advise:

N/A

Assurance:

- There has been a decrease in the number of C difficile cases this month compared to the previous month by 36%. This remains on the radar of the QSC.
- On the cultural issues in the Maternity division, the external maternity assessment has been finalised and there is a recommendation for leadership development for the senior midwifery team which will take place over the next 6 to 9 months.
- No Ophthalmology equipment on the risk register which is good news.

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

- Continuity of Carer Service.

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**	19
Report title	People Committee – Highlight report 14 May 2024	**Meeting Date**	10 July 2024
Chair	Val Moore		
Author	Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- People Report
- Men's network
- Admin Community
- People Strategy progress report
- Staff survey triangulation report
- Model Employer/inclusive recruitment
- Freedom to Speak up annual report
- Workforce plan
- Guardian of safe working hours
- Resourcing

Alert:

- Due to system finances a triple lock had been introduced. For interim staffing a cut off of 3.2% of workforce budget had been introduced. The latest agency spend was being measured as a percentage of the PAY bill which was currently at 3.3% and therefore needed to reduce.
- A number of vacancies the Mount Vernon Cancer Centre were specialist, hard to fill, roles. The people team were working with MVCC to offer support to help fill those roles.

Advise:

- The Trust's current five-year strategy was coming to its end and the draft new People Strategy would be presented at November's committee meeting.
- The Trusts vacancy rate was currently at 8.3%. These figures along with the Trust's explanation on how they intended to reduce the vacancy rate further and accomplish the workforce plan were presented to the ICB. The Committee requested analysis reports comne back to the committee for both exit interviews and relationship scores between staff and their managers from GROW (appraisal) reviews.
- The Freedom to Speak up report outlined that the number of staff who had spoken up had increased to 270. But the committee requested comparative data with previous years on the number of speak up cases where the member of staff had raised the matter with their line manager and it had not been resolved.
- The Resourcing team rapid improvement workshop had now been completed which had identified the need to improve ID badge and IT set up for new starters.

- A decline in recruitment of staff from BAME backgrounds was highlighted. Recruitment for all band 8A and above roles would now have an inclusion ambassador as a mandatory requirement, rather than a best practice requirement. - The Chief People Officer was the lead across the ICB for a cross-partner tender process for a temporary staffing management service which was intended to achieve quality and financial improvements.	
Assurance:	
- There were now Freedom to Speak Up Guardians across all sites. - The Grow Together management competency framework had been launched. - New Men's Network and the Administrator Community networks had been set up and had started to meet and were embedding well. The Adminstrators network already had 105 active members showing the level of interest in a support community for administrators.	
Important Items to come back to committee:	N/A
Items referred to the Board or a Committee for decision or action:	- People and Culture Committee Terms of Reference included for approval following the committees change of name.

Recommendation	The Board is asked to **NOTE** the People Committee report and **APPROVE** the terms of reference.

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East and North Hertfordshire NHS Trust

EAST AND NORTH HERTFORDSHIRE NHS TRUST
PEOPLE AND CULTURE COMMITTEE
TERMS OF REFERENCE

1. Authority

1.1 The People and Culture Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

1.2 The People and Culture Committee is directly accountable to the Trust Board and is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee or contractor of the Trust and all employees and contractors are directed to cooperate with any request made by the Committee.

2 Purpose

2.1 The People and Culture Committee will provide assurance to the Trust Board on all aspects of the development and delivery of the Trust's People strategy and plans to ensure and deliver a sustainable workforce that is engaged, motivated and well supported.

2.2 The People and Culture Committee will ensure the Trust's strategic ambitions in relation to the workforce are delivered in an affordable manner and any corporate risks identified and managed.

2.3 To provide assurance to the Trust Board on all aspects of workforce, capability and OD supporting the provision of safe, high quality, patient-centred care;

3 Membership

3.1 The members of the People and Culture Committee shall be appointed by the Trust Board and comprise:

Members

- Three Non-Executive Directors
- Chief People Officer (named as the lead Executive Director)
- Chief Nurse
- Medical Director
- Director of Estates and Facilities
- Deputy Chief People Officer
- Deputy Director of Finance
- Chief Operating Officer

Attendees

- Equality, Diversity and inclusion Lead
- Executive Network sponsors
- Staff Network Chairs
- Trades Unions
- FTSU lead role

- Associate Directors of People Function as required
- Assistant Director – Communications and Engagement
- Divisional Directors

3.2 One Non-Executive Director will be appointed as the Chair of the People and Culture Committee by the Trust Board. In the absence of the Committee Chair a deputy will be appointed to Chair.

3.3 Only members of the People and Culture Committee have the right to attend Committee meetings. However, other post-holders and external advisors may be invited to attend all or part of any meeting, as and when required.

3.4 Each member of the People and Culture Committee shall disclose to the Committee:

- Any conflict of interest
- Any personal financial interest in any matter to be decided by the Committee

Any such member shall refrain from discussions concerning such matter and, if requested by the Committee Chair, will leave the meeting for the duration of the discussion.

4. Quorum

4.1 A quorum shall be three members comprising two Non-Executive Directors and one Executive Director.

5. Attendance

5.1 Members should make every effort to attend all meetings of the People and Culture Committee and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year. If a member fails to attend more than three meetings in a financial year, the Chair of the Committee will consider with the Chair of the Trust the appropriate action to be taken. The Committee Secretary will monitor attendance by members and report this to the Chair of the Committee on a regular basis.

5.2 Other Executive Directors and other Trust staff will be invited to attend for specific agenda items with the agreement of the Chair of the Committee.

6. Frequency of Meetings

6.1 Meetings will be held six times a year.

6.2 The Chair of the People and Culture Committee may convene additional meetings if required to consider specific business that requires urgent attention.

7. Duties

STRATEGY

7.1 Shape and drive the Trust's People and Organisational Development Strategy and its implementation to ensure appropriate impact;

CULTURE & ORGANISATIONAL DEVELOPMENT

7.2 Shape, approve and drive improvements arising from the triangulation of feedback from staff surveys, exit interviews, Freedom to Speak Up Guardians and other sources of intelligence; to continually develop and shape the workforce to deliver service needs

7.3 Oversee the development of an inclusive culture where people feel safe and able to raise concerns and that concerns raised are suitably and consistently addressed;

7.4 Monitor the Trust's activities designed to enable colleagues to feel supported in their work, and consistently experience civil and respectful behaviours;

7.5 Oversee the Trust's approach to enhancing the health and wellbeing of staff and integrating health and well-being consideration into organisational decision-making.

EQUALITY, DIVERSITY & INCLUSION

7.5 Oversee the development and delivery of the Trust's inclusion, equality and diversity strategy for our people, particularly ensuring a representative and supported workforce with inclusive leadership;

7.6 Oversee the development of effective data collection and KPIs to enable effective scrutiny of delivery against the equality, diversity and inclusion priorities;

7.7 Receive a regular report on inclusion, equality and diversity in the Trust and specifically review the inclusion, equality and diversity strategy;

WORKFORCE PLANNING & REPORTING

7.9 Review the development and delivery of the Trust's workforce planning with a focus on:

- Strategic workforce information and planning
- Recruitment and retention
- Education, learning and organisation and leadership development
- Inclusion, equality and diversity
- Staff experience and engagement, reward, recognition, health and wellbeing
- Staff benefits, recognition and rewards

7.10 Receive a report at each meeting from the Executive lead for the People and Culture Committee covering issues escalated from relevant executive groups and compliance with statutory and regulatory workforce standards, workforce performance indicators and provide assurance that any necessary corrective plans and actions are in place. Provide assurance that legal and regulatory requirements relating to the workforce are met;

7.11 Advise the Board on remuneration proposals changes for Trust employees (excluding senior staff covered by the Remuneration Committee);

7.12 Consider any proposed significant changes in the terms of employment of Trust employees, including national directives requirements;

7.13 Receive annual workforce planning briefs of proposed and major workforce changes taking place in the following year

STAFF ENGAGEMENT

7.13 Oversee the development of the Trust's staff engagement and communications strategies and related programmes of work, and review the effectiveness of internal communications and engagement;

7.14 Ensure engagement and consultation processes with staff reflect the ambition and values of the Trust and also meet statutory requirements;

AUDIT & RISK

7.15 Receive and review at each meeting those entries on the Board Assurance Framework (BAF) which are to be overseen by the People and Culture Committee and ensure they are appropriately reflected on the Committee's work programme to

enable the Committee to gain assurance on the effective controls in place and address gaps in controls and assurance.

7.16 Review the proposed Internal Audit Plan and make recommendations to the Audit Committee on the internal Audit work programme as relevant to the remit of the People and Culture Committee.

7.17 Review on behalf of the Audit Committee the findings of Internal and External Audit reports covering matters within the remit of the People and Culture Committee, seeking assurance that appropriate actions are identified and implements in response to recommendations and that learning is shared across the organisation.

7.18 Receive and review reports of significant concern or adverse findings highlighted by Regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the People and Culture Committee. Seek assurance that appropriate action is being taken to address these.

7.19 Review any People issues referred to the committee by the Trust Board.

COMMITTEE EFFECTIVENESS

7.20 Develop an annual work programme agreed by the People and Culture Committee to discharge duties as set out above.

7.21 Undertake an annual review of the effectiveness of the Committee to inform the Committee's annual report to the Trust Board and the following year's work programme.

8. Reporting Arrangements

8.1 The People and Culture Committee will identify and report the key issues requiring Board consideration to the Trust Board after each meeting. It will make recommendations to the Board and Executive Team to take appropriate action.

8.2 The People and Culture Committee will work closely with other Trust Board sub-committees as required.

9. Committee Review

9.1 The People and Culture Committee will monitor and review its performance and compliance through the following:

- The Committee's report to Trust Board
- An annual evaluation of the People and Culture Committee
- An annual review of the People and Culture Committee Terms of Reference

10. Support

10.1 Administrative support will be provided by the Trust Secretariat alongside advice to the People and Culture Committee on pertinent areas.

Updated ~~18.04.23~~ 26 June 2024

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	20
Report title	Charity Trustee Committee – June 2024	**Meeting Date**	10 July 2024
Chair	David Buckle – Committee Chair and Non-Executive Director		
Author	Chloe Milton – Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Major Projects update
- Charity Finance Report
- Investment Portfolio Report
- Approvals in Excess of £5,000
- Charity Highlight Report

Alert:

- NONE

Advise:

Total yearly income was £1,361k . This included an increase in fundraising income of £197k when compared with the previous year.

- The following requests for funding were agreed:-

Cancer – MVCC	Funding for a skilled practitioner to lead on a collaborative inquiry in the form of Action Research to Identify service requirements for the information and support services at MVCC.This is to ensure that the structure and function of the team are suitably aligned with current and future cancer services.	£47,724	Paula Statham	Cancer Research Fund
Cancer	Deep Oscilation personal Pro Machine	(£4,650 inc VAT)	Sue Barber	Grant request made

	(£4,650 inc VAT) and a lymphscanner (£4,250 inc VAT)	(£4,250 inc VAT)		specifically cancer.
Women's and Children's	Portable ultrasound machine (Sonosite PX) for use in a clinic that sees womens with a past history of miscarriage.	£40,142	Douglas Salvesen	To fundraise for

Assurance:	
- Rainbow run in June had a record number of 508 runners.	
Important Items to come back to committee:	N/A
Items referred to the Board or a Committee for decision or action:	N/A

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

To be trusted to provide consistently outstanding care and exemplary service

Board Annual Cycle 2023-24

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Standing Items													
Chief Executive's Report	X		X		X		X		X		X		X
Integrated Performance Report	X		X		X		X		X		X		X
Board Assurance Framework	X				X				X				
Corporate Risk Register	X				X				X				X
Patient/Staff Story (Part 1 where possible)	X		X		X		X		X		X		X
Employee relations (Part 2)	X		X		X		X		X		X		X
Board Committee Summary Reports													
Audit Committee Report	X		X		X		X		X		X		
Charity Trustee Committee Report			X		X				X		X		X
Finance, Performance and Planning Committee Report	X		X		X		X		X		X		X
Quality and Safety Committee Report	X		X		X		X		X		X		X
People Committee	X		X		X		X		X		X		X
Strategic reports													
Planning guidance											X		
EPR implementation to Lorenzo	X		X		X						X		X
Trust Strategy refresh and annual objectives	X												X
Strategy delivery report					X						X		

Board Annual Cycle 2023-24

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Strategic transformation & digital update	X				X				X				X
Integrated Business Plan									X				
Annual budget/financial plan	X												X
System Working & Provider Collaboration (ICS and HCP) Updates	X		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)											X		
Estates and Green Plan													
Workforce Race Equality Standard											X		
Workforce Disability Equality Standard											X		
People Strategy											X		
Enabling Strategies													
Estates and Facilities Strategy							X						
Green Strategy									X				
Clinical and Quality Strategy											X		
Equality, Diversity and Inclusion Strategy	X												X
Digital Strategy			X										
Engagement Strategy					X								
Other Items													
Audit Committee													
Audit Committee TOR and Annual Report (if required)													

Board Annual Cycle 2023-24

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Review of Trust Standing Orders and Standing Financial Instructions (if required)													
Charity Trustee Committee													
Charity Annual Accounts and Report									X				
Charity Trust TOR and Annual Committee Review	X												
Finance, Performance and Planning Committee													
Finance Update (IPR)	**X**		**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)													
Staff Survey Results	**X**		**X**										**X**
Learning from Deaths			X				X		X		X		
Nursing Establishment Review											X		
Patient Safety and Incident Report (Part 2)			X						X				
Teaching Status Report			***X***										
QSC TOR and Annual Review (if required)			X										
People Committee & Culture													

Board Annual Cycle 2023-24

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Workforce Plan													
Trust Values refresh					X								
Freedom to Speak Up Annual Report							X						
Staff Survey Results			**X**										
Equality and Diversity Annual Report and WRES							**X**						
Gender Pay Gap Report			**X**										
People Committee TOR and Annual Report (if required)			**x**										
Shareholder / Formal Contracts													
ENH Pharma (Part 2) shareholder report to Board					**X**								