East and North Hertfordshire NHS Trust

Trust Board - Public

Trust Board Part I

Boardroom, Trust Management Offices / Teams

12 January 2022 10:30 - 12 January 2022 12:30

AGENDA

#	Description	Owner	Time
1	Chair's Opening Remarks	Chair	10:30
2	Apologies for absence		
3	Declaration of Interests	All	
4	Minutes of Previous Meeting For approval Public Board Minutes 3Nov21 - Chair Approved.pdf 6	Chair	
5	Actions Log For information Public Trust Board Actions Log.pdf 20	Trust Secretary	
6	Questions from the Public At the start of each meeting the Board provides members of the public the opportunity to ask questions and/or make statements that relate to the work of the Trust. Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Trust Secretary can be contacted by email, stuart.dalton3@nhs.net, by telephone (01438 285454) or by post to: Trust Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB. Each person will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed. Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting.		
7	Chief Executive's Report For discussion CEO report to 12 Jan 22 Board.pdf 21	Chief Executive	10:45

#	Description	Owner	Time
8	Board Assurance Framework For discussion BAF to Jan 22 Board combined.pdf 24	Associate Director of Governance	11:00
9	Integrated Performance Report (including focus on Operational Pressures, Winter Initiatives, Support for our Staff) For discussion IPR combined 7 Jan for 12 Jan 22 Board.pdf 55	All Exec Directors	11:05
10	2022-23 Planning guidance For discussion National planning guidance combined.pdf 99	Deputy CEO	
11	System collaboration report To discuss System collaboration report Jan 22 Board.pdf 115	Deputy CEO	
12	Community Diagnostics Centre To discuss Community Diagnostic Hub FBC to Jan 22 Board.p... 120	Director of Improvement	
13	Learning from Deaths For discussion Learning from Deaths Summary Board Report Jan-... 173	Medical Director	
14	Nursing Establishment Review For decision Nursing Establishment Review Board 12 Jan 22 FI... 179	Chief Nurse	12:00
15	Green Plan For approval Green Plan combined Jan 22 Board final.pdf 201	Director of Estates and Facilities	

#	Description	Owner	Time
16	Reducing the governance burden during COVID For approval Reduce the burden 12 Jan Board combined.pdf 235	Trust Secretary	
17	Sub-Committee Reports		12:15
17.1	Finance, Performance and People Committee Report to Board For information FPPC Board Report 24 November 2021 final.pdf 239 FPPC Board Report 15 December 2021 Final.pdf 243	Chair of FPPC	
17.2	Quality and Safety Committee Report to Board For information QSC Board Report 23 November 2021 - Chair Appr... 247 QSC Board Report 14 December 2021 - Chair Appr... 251	Chair of QSC	
17.2.1	Complaint, PALs and Patient Experience Report For information Complaints annual report to Jan 22 Board Final.pdf 255	Chief Nurse	
17.3	Equality and Inclusion Committee Report to Board For information EIC Report 7 December 2021 - to Jan 22 Board.pdf 281	Chair of EIC	
17.4	Strategy Committee Report to Board For discussion Strategy Committee Board Report - 17 Nov 2021 -... 282	Chair of SC	
17.5	Charity Trustee Committee Report to Board For discussion CTC Board Report - 13 December 2021 - Chair Ap... 285	Chair of CTC	
17.5.1	Annual Charity Report and Accounts 14 Charity Annual Report - Cover Sheet.pdf 288	Chair of CTC	

#	Description	Owner	Time
18	Annual Cycle For information [P] 16. Board Annual Cycle 2021-22.pdf 290	Trust Secretary	
19	Data Pack For information [P] Data Pack Jan 22 Board combined.pdf 294		
20	AOB		
21	Date of next meeting 12 January 2022		12:25

East and North Hertfordshire NHS Trust

Agenda item: 4

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 3 November 2021 at 10.30am at the Lister Hospital, Stevenage & via Microsoft Teams Video Conferencing

Present:	Mrs Ellen Schroder	Non-Executive Director (Trust Chair)
	Mrs Karen McConnell	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director (via MS Teams)
	Dr David Buckle	Non-Executive Director (Associate) (via MS Teams)
	Mr Bob Niven	Non-Executive Director (via MS Teams)
	Mr Biraj Parmar	Non-Executive Director (via MS Teams)
	Mr Nick Carver	Chief Executive Officer
	Mr Martin Armstrong	Deputy Chief Executive Officer & Director of Finance
	Dr Michael Chilvers	Medical Director (via MS Teams)
	Mrs Rachael Corser	Chief Nurse (via MS Teams)
	Mrs Julie Smith	Chief Operating Officer (via MS Teams)
From the Trust:	Mr Thomas Pounds	Chief People Officer (via MS Teams)
	Mr Joseph Maggs	Trust Secretary (via MS Teams)
	Ms Jude Archer	Associate Director of Governance (via MS Teams)
	Mr Mark Stanton	Chief Information Officer (via conference call)
Also in attendance (via MS Teams):	Dr Sagen Zac-Varghese	Consultant (for item 21/103) (via MS Teams)
	Ruth Bradford	Admiral Nurse (for item 21/103) (via MS Teams)
	Sister Yam	Ward Leader, 10B (for item 21/103) (via MS Teams)
	Kerry Murphy	Pfizer Account Manager (via MS Teams)
	Derek Brunnen	Anaesthetic Registrar, UCLH (via MS Teams)
	Carlo De Laurentis	King George Manor House Surgeries (via MS Teams)
	Debbie Saunders	Clinical Scientist (ENHT) (via MS Teams)
	Catherine Boaden	Senior Operations Adviser (via MS Teams) (for item 21/107)
	Deborah Price	Local Journalist (via MS Teams)
	Linda Sheridan	HCT (via MS Teams)
	Eilidh Murray	Head of Communications (ENHT) (via MS Teams)
	Ebony Wood	Minute Taker (ENHT)

No	Sub-No	Item	Action
21/098		**CHAIR'S OPENING REMARKS**	
	21/098.1	Mrs Schroder welcomed everyone to the meeting.	
	21/098.2	Mrs Schroder advised that this was the last formal Board meeting for the Chief Executive who would be retiring at the end of the year.	

She wanted to record thanks on behalf of the Board for his 20 years of great leadership.

21/098.3 The Chief Executive arrived at the Trust in 2002 when it was one of the worst performing trusts and immediately set up a coherent long term strategy involving the community and local politicians. He had led the Trust through major improvements, including delivering the Our Changing Hospitals programme which completed in June 2015 with the opening of the new QEII hospital. The Board had appreciated the Chief Executive's strong, consistent leadership and appreciated the way they were kept up-to-date during the pandemic.

21/098.4 She noted that his legacy was to leave the Trust in such good shape not only in terms of our 'bricks and mortar', but, more importantly, in nurturing talent and the culture of our staff as well as making sure that his values and personal integrity were infused throughout the Trust.

21/098.5 Mrs Schroder further advised that it was Mr Niven's last official Board meeting after 8.5 years at the Trust. He had served on every one of the Trust's committees and his willingness and commitment as a generalist had been very much appreciated. She commended him for his focus on people and staff wellbeing which is such a vital part of a NED's role. He had a strong belief in the 'board to ward' role and was very visible within the organisation, always ready to check in on how people were. She noted that the Board and the Trust would miss Mr Niven and wished him all the best for the future.

21/098.6 Mr Niven thanked Mrs Schroder for her kind words and commented that he had enjoyed his time with the Trust. He stated that he was amazed at how hospitals functioned and how hundreds of patients benefitted every week and was pleased to have been associated in some way.

21/098.7 Mrs Schroder also noted that it was the final meeting for the Trust Secretary who had been with the Trust for six years, initially as a Corporate Governance Officer, but latterly as Trust Secretary. She noted that the Board appreciated all the work he had undertaken around board development and ensuring the board and sub-committee meetings were set up smoothly and efficiently and thanked him on behalf of the Board for all his assistance.

21/099 APOLOGIES FOR ABSENCE

21/099.1 There were no apologies for absence.

21/100 DECLARATIONS OF INTEREST

21/100.1 There were no declarations of interest.

21/101 QUESTIONS FROM THE PUBLIC

21/101.1 There were no questions submitted from members of the public.

21/102 MINUTES OF PREVIOUS MEETING

21/102.1 The minutes of the previous meeting were approved as an accurate record of the meeting.

21/103 PATIENT STORY

21/103.1 The Chief Nurse introduced Dr Zac (Consultant), Ruth Bradford (Admiral Nurse), and Sister Yam (Ward Leader from 10B) who joined the meeting to tell their story and share a video that had been commissioned highlighting the importance of communication with patients and their families/carers/loved ones, especially during limited visiting due to the pandemic. The video included a patient story and highlighted the work the team had done.

21/103.2 Dr Zac thanked the Board for the invitation to share the communication project which started in March 2020. She noted that phone calls had been received in Ward 10B from concerned relatives of patients. As part of the project, a call log was developed and calls were made every day to family members. The team presented their findings to other wards and externally. This resulted in a nomination for an excellence award.

21/103.3 Admiral Nurse Bradford commented that following the project in Ward 10B, Charity funding was received to produce two films. One was the one shown during the meeting which was a training film to show staff the importance of communication with patients and family and the second one, which was a work in progress, would be for external use.

21/103.4 Sister Yam shared how proud she was to be part of the project. She noted that in the beginning, a lot of complaints had been received but at the end there were more compliments than complaints and patients were returning to thank staff on the ward. She commented that it was also more satisfying for staff to work on the ward.

21/103.5 The Board viewed the video and highlights included:

- The importance of answering the phone on the wards and contacting family members who had requested a call.
- Asking patients what information they were happy to share with family.
- When speaking to the next of kin, to check understanding and what they already knew.
- Not using jargon.
- Listening.

21/103.6 Mrs Schroder thanked the team for the video and commented that it was clear that communication was not easy; however it was equally clear that when it was done well, it had tremendous impact.

21/103.7 Dr Carter congratulated all involved on the exceptional piece of work and felt that the narrative during the video was a good training model post-COVID. He suggested consideration be given to entering the

video for a national award.

21/104 CHIEF EXECUTIVE'S REPORT

21/104.1 The Chief Executive updated the Board on the current position in the hospital regarding COVID. He highlighted the following:

- At the last Public Trust Board meeting held on 1 September it was reported that the Trust was treating 27 COVID patients and at the time of writing the current report, 37 COVID patients were being treated.
- Many of the most seriously ill were unvaccinated by choice.
- Although there may be public perception that the pandemic was over, it was continuing despite the success of the vaccine and continued to provide a challenge to the Trust.
- Challenges also arose due to the 10% increase in patients visiting the Emergency Department and the increased acuity since the pandemic began.

21/104.2 The Board was informed that all trusts had received a letter from NHS England and NHS Improvement asking for action to be taken to address ambulance handover delays. He noted that this would be discussed later in the meeting, but emphasised that this was something the Trust had always taken extremely seriously and although he felt that the Trust was in a better position than others, he recognised there was always more that could be done individually and as a system.

21/104.3 In relation to COVID numbers, Mrs Schroder commented that she was surprised at how low the numbers were in the first wave. The Chief Executive responded that as full testing was not available at the start of the pandemic, the actual numbers may have been higher.

21/104.4 Mrs Schroder noted that the current situation felt calmer and more controlled, despite similar numbers of confirmed COVID patients. The Chief Executive commented that this could be partly due to the ability of staff to rapidly adapt to the situation. Mrs Schroder agreed that lower deaths now could be attributed in part to the vaccine and better management in the hospital with the evolving treatment available and increasing knowledge.

21/104.5 The Chief Executive thanked Mrs Schroder for her kind comments at the start of the meeting. He noted that he had spent three months of his life in board meetings and this was around his 170th board meeting. He thanked Mrs Schroder and previous chairs and past and present non-executive directors and commented that any achievements would not have been possible without the assistance of Board members. He was also grateful to system partners for the collaborative way they had worked with the Trust on so many important issues. He also wanted to thank the political representatives of Hertfordshire from all parties for the way they had

suspended short term political interest to pursue the best interests of patients.

21/104.6 He noted that the last 20 months had been a humbling time and a time of renaissance for the NHS. He was grateful for the opportunity to lead during the pandemic and wanted to thank all employees, partners and the local community for their encouragement and support.

21/105 BOARD ASSURANCE FRAMEWORK

21/105.1 The Board received the latest edition of the BAF.

21/105.2 The Associate Director of Governance informed the Board that the Committees had reviewed all their risks. There had been continued increase in activity and pressures since the last Board meeting. It was noted that COVID, operational activity, winter pressures, recovery and pressures from system partners had impacted on a number of risks, especially around performance, quality and people. These areas would be kept under review.

21/105.3 The Board was informed that the Audit Committee had received a routine deep dive review for Risk 8 Quality as part of the assurance cycle.

21/105.4 The Associate Director of Governance informed the Board that further to discussions at the Quality and Safety (QSC) and Finance, Performance and People (FPPC) committees, it had been suggested that although mitigations were in place, that operational risk be increased from 16 to 20 in order to reflect the sustained operational pressures. It was also recommended that the finance risk be reduced from 16 to 12.

21/105.5 The Chief Operating Officer noted that recognising the significant change and increase in the operational risk, she felt it would be helpful to reflect on the unprecedented challenges in terms of managing ongoing front door and higher acuity of patients, Referral to Treatment (RTT) and COVID. These areas would continue to be managed with the mitigations in place. She noted that the FPPC meeting would include deep dives in support of operational oversight and action plans and regular updates would be brought to the Board through the FPPC.

21/105.6 Mrs McConnell added that it was important to consider how effectively the actions were being implemented so that changes could be made if necessary.

21/105.7 The Board approved the changes to the BAF.

21/106 INTEGRATED PERFORMANCE REPORT

21/106.1 Mrs Schroder introduced the Month 6 Integrated Performance Report and noted that each Executive Director would comment on their relevant sections.

21/106.2 **Quality, Safety and Caring**

The Chief Nurse highlighted the following:

- Serious incidents continued to remain a focus with six cases declared in September 2021.
- The Trust welcomed colleagues from external regulatory bodies to check and challenge the infection control processes in place. It had been a positive visit with very few recommendations passed on to the team.
- A couple of COVID outbreaks had occurred, however, it was encouraging to note the lessons learnt from previous outbreaks came to the fore with prompt responses from the teams which lead to low numbers of further infection.
- The Trust continued to report recognition of deteriorating patients, sepsis and VTE. A VTE lead had been appointed who would support the operational teams in regard to risk assessments and this should lead to improvements.
- A Head of Patient and Carers Experience had been appointed who would work to improve response rates to complaints. Reducing the number of open complaints remained a focus for the team.

21/106.3 Ms Moore commented on the drop in positive recommendations around antenatal care with the report noting this trend being within the normal range. She asked if there were any reasons for the reduction in positive feedback.

21/106.4 The Chief Nurse noted that maternity was kept under review through the QSC. Unfortunately some women had remained in the antenatal ward for longer than the Trust would like. Triumvirate oversight was constantly reviewing this balance and the Trust had been open and honest with the regulators who were content with the safety audits undertaken.

21/106.5 Mrs Schroder noted that this was the month that NerveCentre was rolled out as part of the Keeping Our Patients Safe programme so would be interested in the results. The Chief Nurse confirmed that it had been rolled out in October and results should be available for the January Trust Board meeting.

21/106.6 **Effective Services**

The Medical Director noted that the crude mortality rate had decreased and the Trust remained in the best performing quartile of trusts for HSMR and in the 'lower than expected' category for SHMI.

21/106.7 The Medical Director commented that there was likely to be an effect on HSMR and SHMI once the Mt Vernon Cancer Centre transfer was complete. Information would be provided to the QSC and Board on the anticipated impact to mortality in shadow form alongside the current results until MVCC transferred from the

organisation.

21/106.8 In regard to the Trust's COVID mortality rate, the Trust has been centrally placed in comparison to the national level. In addition to routine reviews, two areas were identified for further scrutiny. These were patients who died on re-admission within 28 days and deaths in the community within 28 days of discharge. Clinical reviews had been held and of the 21 reviews, one would require further investigation and be taken to the Mortality Surveillance Committee.

21/106.9 In regard to readmission, the Medical Director commented that readmission rates had been static and on the national mean. Twenty readmissions had a clinical review undertaken with three raising some concern. Results would be reported through the QSC.

21/106.10 It was noted that over the summer months, length of stay had improved for elective surgery, with a longer length of stay for non-elective. This may be due to the case mix as ambulatory pathways rather than admission were being developed which resulted in a shorter length of stay.

21/106.11 Mrs Schroder commented that once the new Same Day Emergency Care was in place it may be worth revisiting the baseline for length of stay for non-elective treatments as it was in the interest of all to focus on patients who were sicker and had longer lengths of stay.

21/106.12 A query arose over the chart based on patients with whom their preferred place of death was discussed as to why there had been a steady decline in numbers and whether this was due to the impact of COVID. The Medical Director responded that COVID was a contributing factor but not the single factor. He noted that most patients in the last year of life were managed by primary care and there was a shared responsibility to ask the question of patients. Unfortunately despite best efforts, there were times when the patient's wishes cannot be fulfilled.

21/106.13 **Responsive Services**

The Chief Operating Officer drew the Board's attention to the following:

- The Emergency Department (ED) had deteriorated slightly against the 4-hour standard due to an increase in patient acuity and demand.
- There were zero 12-hour trolley waits reported in September.
- September had been the Trust's busiest month with an average daily patient attendance of 536 patients.
- There had been a slight improvement in the number of 30 minute ambulance breaches. All patients were assessed by ED clinical staff and patients were cohorted within the ED.
- The 4-hour standard was directly impacted by flow and discharge on the wards. The use of the discharge lounge was

positive with 627 patients in September, the highest level of activity.

- Cancer performance remained strong, achieving six out of the eight national targets in August. The Trust 62-day performance for August was 86.1% which sat the Trust at 10th overall nationally.
- RTT performance had decreased to 59% in September. The backlog continued to increase and the teams were working on detailed specialty recovery trajectories to meet this demand. A deep dive on RTT would be undertaken at a future FPPC meeting.
- In regard to stroke performance, there were continued deep dives being held and the sub-committees and Board were sighted on the action recovery plan to return to a SNNAP 'A' rating.

21/106.14 Ms Moore commented on the patient flow diagrams. She noted that there had been a number of OPEL 4 days and a Multi-Agency Discharge Event (MADE) week had been held to focus on front door initiatives. She was interested to know what the Chief Operating Officer felt were the outcomes from the MADE week and how they had helped the Trust to quickly move out of high OPEL levels.

21/106.15 The Chief Operating Officer responded that the challenges had been unprecedented and yet the staff continued to deliver great support to each other and patients. A deep dive review of the impact of MADE week had been undertaken to consider how senior leaders were used within the organisation and how the Trust worked alongside the system and community partners. She noted that nothing new came out of MADE week, but it gave people time to focus on early actions such as promoting Virtual Wards, encouraging discharges and Prevention of Admission (PoA).

21/106.16 Mr Niven commented that stroke capacity was a concern in many trusts and it was commendable that action such as deep dives were being taken. He queried whether any learning could be provided from other trusts that were in a better position in regard to stroke.

21/106.17 The Chief Operating Officer commented that this could be an option. She noted that winter funding initiatives were being considered for specialist therapies and ring fencing beds for stroke patients. The teams were redoubling their efforts with weekly oversight and visibility and quick escalation and responsiveness. The Medical Director added that there was a highly motivated Multidisciplinary Team (MDT) who were driven to improve outcomes.

21/106.18 It was noted that Mrs McConnell and Dr Buckle had arranged to meet the stroke team within the next few weeks.

21/106.19 **People Report**

The Chief People Officer drew the Board's attention to the following:

- Recruitment was just over target and there would be a continued focus on recruitment in order to manage a difficult and challenging winter.
- The Trust continued to rely on temporary staffing to manage shortfalls around sickness absence. Bank was being well utilised and agency use was being kept to a minimum.
- There was an increase in staff turnover during September with the predominant reason for leaving being people moving on to further education.
- Various initiatives had been put in place to increase the sense of belonging and value among staff including reciprocal mentoring, a series of listening sessions with staff to understand their experiences and act on issues and concerns, a programme on Free to Speak Up, and a range of recognition schemes.
- There had been an increase in sickness absence.

21/106.20 Mrs Schroder commented that both the nursing vacancy and overall vacancy rates were low and it was important to recognise that there were 131 more nurses in post than 12 months ago. Consideration could be given to where the nurses were assigned and the skill mix in order to redeploy them to other areas of need.

21/106.21 The Chief People Officer commented that it was sickness that impacted the Trust on a day to day basis. The Trust was well resourced in many areas, however there were some hotspots such as maternity and paediatrics and some areas in theatres.

21/106.22 The Chief Nurse thanked the Chief People Officer and his team for their hard work in supporting recruitment. She noted the phenomenal international recruitment of nurses and the incredibly successful Objective Structured Clinical Examination (OSCE) pass rates. She commented that a commitment to the nursing team had been made that they would only be moved to other areas if absolutely necessary. Work was being undertaken around Pathways to Excellence which had a direct correlation between excellence and retention. She noted that the Trust was in a fortunate position compared to some other colleagues and was keen to support system partners.

21/106.23 Mrs McConnell commented that alongside looking at nurse numbers at the FPPC, discussion had been held around skill mix as it had been noted there was high turnover in certain areas such as clinical support workers and healthcare assistants. The FPPC had asked for a report around how/why this turnover was taking place as it would have an impact on nursing staff as well.

21/106.24 The Chief People Officer noted that part of the Trust's success in terms of building pathways into nursing was bringing people in at entry level with a view to them becoming the Trust's future workforce. He noted that some of these moved into education and others were able to decide after six months if this was an area they

wanted to continue to work in. He noted that the Trust could not compete with other entry level positions such as retail.

21/106.25 Mr Niven agreed that the Trust's ability to respond in terms of pay was limited and asked whether this was a concern. He commented that a lot of effort had been put in to make the Trust a good place to work but wondered if other areas needed to be considered.

21/106.26 The Chief People Officer responded that other industries were offering packages at entry level roles and although the Trust could not compete with the rates, an emphasis could be given to the opportunities around joining the organisation as a longer term career path.

21/106.27 **Sustainable Services**

The Director of Finance drew the Board's attention to the following:

- The end of month 6 reporting period showed a small YTD surplus of just over £0.4m.
- A balanced budget for the second half of the year had been set following guidance on the financial framework from NHS England.

21/106.28 He commented on the ongoing development of the IPR and noted that additional sections are being developed such as dashboards for Digital, along with Estates and Facilities.

21/107 AMBULANCE HANDOVERS

21/107.1 The Chief Operating Officer informed the Board that a letter from NHS England and NHS Improvement had been sent to all Trusts and ICSs asking them to review and address delays in handing over responsibility for the care of patients from ambulances to Emergency Departments.

21/107.2 The Chief Operating Officer commented that the Trust was aware of ambulance delays and it remained an area of focus and standard item of the Trust's monthly operational performance report and a significant priority.

21/107.3 She noted that the Trust was in a positive position recognising the ED capital build which would soon provide additional capacity and would allow the ability to offload ambulance patients and cohort them with a safe level of support.

21/107.4 The Chief Operating Officer commented that the paper described the Trust's initial options appraisal and a proposed approach to reducing and stopping delays. The paper was presented as a live document and the Trust was working with partners to consider the actions.

21/107.5 It was noted that the Board and Sub-Committees would be sighted on progress and any issues would be escalated through the standard reporting mechanisms via IPR.

21/107.6 Dr Buckle commented that any ambulance delay was not something the Trust welcomed and asked if there was a level of confidence that the Trust would be able to respond appropriately, even with the advantages of increased space.

21/107.7 The Chief Operating Officer responded that the Trust was relatively confident as the capital build would offer six additional bays and the ambulance offload area to support the cohorting of patients would provide additional space. She was positive about having increased visibility and cohorting of patients and collaborations with partners but recognised the ongoing longer-term challenges around the system, winter and demands.

21/107.8 The Board noted the preferred options and supported the proposal to work up and implement these options. *Chief Operating Officer*

21/107.9 Mrs Schroder noted the Board would welcome an update once it had been discussed at FPPC and updated in the IPR.

21/108 SYSTEM COLLABORATION REPORT

21/108.1 The Director of Finance presented the System Collaboration Report which provided an update on the key strands of significant activity that the Trust was actively participating in at system, place and regional levels.

21/108.2 He noted that five task and finish groups had been set up to inform and shape the structure and nature of future system and place working arrangements as the ICS moved towards transitioning into a statutory body in April 2022. Feedback and escalations would continue to be brought to the Executive Directors Committee and Board Development sessions.

21/108.3 A System Oversight & Assurance Group had been set up with ICS colleagues to ensure oversight arrangements were in place and any escalations would be brought to the Board in subsequent months. A proposal to set up a Place Oversight & Assurance Group was also being discussed.

21/108.4 Work on pathways around Prevention of Admission, Virtual Hospital and Discharge Home to Assess had been undertaken along with other provider colleagues such as Hertfordshire Community NHS Trust (HCT). In order to provide a framework for the partners across the place system to determine the impacts of the schemes, an Enhanced Services Steering Group chaired by the Director of Improvement had been set up.

21/108.5 He noted that projects had been set up with HCT in order to set up pathways for stroke/neuro services and community paediatrics.

21/108.6 The East of England region had established two imaging networks which were already producing some good data.

21/108.7 There was a key emphasis on expanding the Community Diagnostic Centres (CDC). Mrs Schroder asked the amount of funding that was being requested and the Director of Finance responded that it was £10m capital across the five year project along with revenue funding.

21/108.8 Ms Moore commented the term provider collaborative was used but it felt like it was more partnership working. The Chief Nurse commented that maternity and mental health felt as though they sat outside and were not as visible and wondered whether more work could be done around provider collaboration.

21/108.9 The Director of Finance responded that in regard to provider collaboration the ICS had a different view on what this looked like on a place and system basis.

21/108.10 Dr Carter commented that it was an interesting paper. He noted his support for Community Diagnostic Centres as the UK had one of the lowest levels of scanners per head of population in Europe and felt that it would be helpful to understand who was making the decisions and which scanners would be used and where they would be based. The Director of Finance commented that this was an opportunity to expand the breadth of diagnostics and he would be happy to share more data around the plan.

21/109 RESPONSIBLE OFFICER ANNUAL REPORT

21/109.1 The Medical Director presented the annual report on medical appraisal and revalidation. He noted that the appraisal process had been suspended from March 2020 due to the pandemic and had now restarted. The processes had been reviewed and included peer reviews of appraisals, further appraisal training, and appraisal coaching for new doctors. There would also be a review of IT provider for the appraisal software.

21/109.2 He informed the Board that Dr Thomas Samuel had been appointed as Responsible Officer and Dr Samita Agarwal had been appointed as Lead Appraiser and the team was being restructured with the aim of improving compliance to 95%.

21/109.3 The Responsible Officer Annual Report was approved by the Board.

SUBCOMMITTEE REPORTS:

21/110 FINANCE, PERFORMANCE AND PEOPLE COMMITTEE REPORT TO BOARD

21/110.1 The Board received and noted the summary reports from the Finance, Performance and People Committee meetings held on 29 September 2021 and 27 October 2021.

21/110.2 **FPPC Annual Review and Terms Of Reference**

Mrs McConnell informed the Board that the annual review had found that the FPPC had met its duties over the period and had not identified any significant issues. There were recommendations that

had been accepted by the FPPC and suggested changes to the Terms of Reference.

21/110.3 The Board noted the findings of the annual review and approved the changes to the FPPC Terms of Reference.

21/111 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

21/111.1 The Board received and noted the summary reports from the Quality and Safety Committee meetings held on 28 September 2021 and 26 October 2021.

21/111.2 **QSC Annual Review and Terms Of Reference**

Dr Carter informed the Board that the new arrangements put in place to improve the effectiveness of the meetings, such as inviting the authors of papers to attend, were working well.

21/111.3 The Board noted the findings of the annual review and approved the changes to the QSC Terms of Reference.

21/112 AUDIT COMMITTEE REPORT TO BOARD

21/112.1 The Board received and noted the summary report of the last meeting of the Audit Committee held on 19 October 2021.

21/112.2 **Audit Committee Annual Review and Terms Of Reference**

The Board noted the findings of the annual review and approved the changes to the Audit Committee Terms of Reference.

21/112.3 **Annual Review of Standing Orders and Standing Financial Instructions**

The Director of Finance noted that the annual review and suggested changes had been considered at the Audit Committee. He commented that further work would be undertaken by the recently appointed Director of Procurement to align each partner organisation's Standing Financial Instructions and any resulting changes would be considered at a further Audit Committee meeting.

21/112.4 The Board noted and approved the proposed revisions to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

21/113 EQUALITY & INCLUSION COMMITTEE REPORT TO BOARD

21/113.1 The Board received and noted the summary report of the Equality & Inclusion Committee meeting held on 12 October 2021.

21/114 STRATEGY COMMITTEE REPORT TO BOARD

21/114.1 The Board received and noted the summary report of the Strategy Committee meeting held on 21 September 2021.

21/115 CHARITY TRUSTEE COMMITTEE REPORT TO BOARD

21/115.1 The Board received and noted the summary report of the Charity Trustee Committee meeting held on 13 September 2021.

21/115.2 It was noted that the Charity Annual Report and Accounts had been considered by a number of committees and the Board delegated to Mr Niven, Ms Moore, Dr Buckle and the Chief People Officer for final approval of the annual report and accounts.

21/116 ACTIONS LOG

21/116.1 The Board received the latest version of the Actions Log.

21/117 ANNUAL CYCLE

21/117.1 The Board received the latest version of the Annual Cycle.

21/118 DATA PACK

21/118.1 The Board received the Data Pack.

21/119 DATE OF NEXT MEETING

21/119.1 The next meeting of the Trust Board will be on 12 January 2022.

Ellen Schroder
Trust Chair
November 2021

	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 12 JANUARY 2022

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date

East and North Hertfordshire NHS
NHS Trust

Chief Executive's Report

January 2022

Christmas & New Year

Over the Christmas period and now into the New Year there has been great commitment from our staff to support our patients during a very challenging time. Our team have been committed to ensure that we provided the best and safest care to our patients and thus ensuing the safe working of our hospital.

Covid Update

On 12 December, the UK Covid-19 alert level increased from 3 to 4 meaning that transmission of cases is high and direct Covid-19 pressure on healthcare services is widespread and substantial or rising.

As a Trust we continue to monitor and review all national guidance and directives and take action as necessary. As at 4th January, the Trust had 63 Covid-19 positive patients and these numbers are increasing on a daily basis. In addition, staffing levels whilst manageable are challenging at this current time.

Staff continue to undertake Lateral Flow Testing (LFT) on a twice weekly basis and report results. These tests enable the Trust to detect asymptomatic positive staff and to mitigate further spread of Covid-19.

Arrangements have been made for gold (strategic) and silver (tactical) command meetings to take place on a daily basis as required. In addition, bronze (operational) meeting placeholders are set up to enable these meetings to take place as frequently as necessary. Our well tested Covid-19 escalation plans are being used as required. These plans relate to critical care capacity, Covid-19 ward capacity and the redeployment of staff. We are working closely with system partners to ensure a joined up response.

Nightingale Hospital

As part of ongoing NHS preparations for a potential surge in patients with Covid due to the rapid spread of the new Omicron variant, the Trust has been working closely with NHSI/E to create additional beds. This work is going on around the country, with a target of creating space for up to 4,000 beds nationally to improve NHS resilience.

In our case, this means we are now working hard with national and local stakeholders to set up a Nightingale Surge Hub in the Plaza area outside Lister's main entrance. In the coming days you will start to see dramatic changes and much activity in this space. Firstly, we will prepare the ground for the arrival of the new facility and then construction works to set up the hub itself will begin in earnest. The intention is that the Nightingale Surge Hub will be ready for use in late January, should it be required.

This Nightingale capacity is in addition to our existing detailed and comprehensive surge plans and would be based on a different clinical model being discussed and confirmed nationally. As with the Nightingale hospitals built in 2020, we hope this space never needs to be used. However, with record numbers of Covid infections, it is right that we create this additional space for beds now in case they are needed.

New QE2 Opening Hours

Opening hours at the Urgent Care Centre for minor injuries and illness, located at the New QEII Hospital, Welwyn Garden City, have changed.

Since the beginning of January, the UCC has been closing at 22:00 and reopening at 08:00. Patients already in the UCC being treated, or waiting to be treated, at 22:00 will continue to be cared for appropriately. The UCC is well-used during the day, but patient attendances overnight have been very low for a number of years, despite an increasing local population.

The decision to change the opening hours was made in July by the governing body of East and North Hertfordshire Clinical Commissioning Group, with support from East and North Hertfordshire NHS Trust.

Trust Awarded £6.88m Funding

The Trust has recently been awarded almost £7 million to invest in both increasing the number of operations carried out every day and in new technology to improve services and efficiency.

As the Trust continues to care for patients who are seriously ill with Covid-19, staff have also been working to fully restore those services which have been impacted by the pandemic. The money from the Department of Health and Social Care, announced in December last year, is part of a £700m national fund and will be invested in:

- Three new procedure rooms – at Lister Hospital, Stevenage and the New QEII Hospital in Welwyn Garden City – which will allow a greater number of simple procedures to take place during the day with no need for an overnight stay.

- Purchase of a third surgical robot, meaning that certain complex procedures can be done with minimal invasion, with far quicker and less painful recovery times. This means less time in hospital and less scarring – and often a reduced need for follow-up chemotherapy.

- A new digital scheduling system to increase the efficiency of the operating theatres at Lister Hospital, allowing for more accurate planning and scheduling, and greater monitoring to help drive improvements – and, ultimately, more operations taking place.

- A new specialist digital system for the ophthalmology (eye specialist) service, meaning greater efficiencies and less use of paper – and allowing scans and images of the eye to be more easily accessed by our clinicians. Along with the ability to better schedule appointments, this means that patients should see a faster service.

National Planning Guidance

The NHS planning guidance was published on 24 December 2021 which sets out our operational, financial and workforce priorities for 2022/23 whilst recognising that these will be kept under review.

Adam Sewell-Jones
Chief Executive

Agenda Item: 8

TRUST BOARD, JANUARY 2022
Board Assurance Framework Risks 2021/22

Purpose of report and executive summary (250 words max):
The BAF risks continue to be reviewed with each Director and Executive Team each month and at the Board and Board Committees and used to drive the agendas. The Trust's strategic risks for the Board Assurance Framework 2021/22 on one page. **Appendix a.** These with the exception of removing the reference to the short term risk of spending the capital allocation for 2020/21 (Risk 4) the scope of the risks remained unchanged for 2021/22. A formal review of the strategic risks will take place in the final stages of the development of the Trust's new Organisational Strategy. An early review of this in September has not indicated any significant changes. The Trust's strategic priorities and have been mapped to the Trust objectives for 2021/22 providing assurance on the coverage. **Appendix b.**

The BAF 2021/22 is completed with each of the lead directors, **appendix c,** using the revised template approved by the Audit Committee. The areas of high risk are covered in the Board Committee agenda items and papers. Any updates to the text from the previous month are highlighted in red text for ease.

Over the last three months the Board Committee meetings have continued to focus the agendas and discussions on the strategic risks, particularly with regards to the sustained increase in activity and pressures in specific specialities, e.g, ED, Assessment, Maternity, Paeds, Mental Health, and Critical Care. This is further compounded by the system pressures and the pandemic. This continues to impact on a number of the BAF risks including Performance, Quality, People and governance; these remain under close review through the operational and gold/silver incident command structures, and actions are in place to support the mitigation of the risks. Key updates on these areas are included on the Board Agenda.

There are not any recommended changes to the ratings from the December Board Committees.

The Board are asked to consider the BAF and further assurance required.

Action required: For discussion		
Previously considered by: Considered at each Board and Board Committee. FPPC and QSC		
Director: Chief Nurse	**Presented by: Associate Director of Governance**	**Author: Associate Director of Governance**

Trust priorities to which the issue relates:	**applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites	☒
People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways: To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term	x☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) Yes – as noted
Any other risk issues (quality, safety, financial, HR, legal, equality): As documented under each risk

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.

Level	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			

Trust risk scoring matrix and grading

Likelihood / Impact	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

BOARD ASSURANCE FRAMEWORK OVERVIEW

Risk Ref	Risk Description 2021/22	Lead Executive	Committee	Current Risk Dec	Last Month Nov	3 months ago	6 months ago	Target Score	Date added (Target dates for risk score/ changes)
001/21	Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	Chief Operating Officer	**FPPC**	**20**	**20**	16	16	**12**	01.03.18 (June 21)
002/21	There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public	Chief Nurse /Medical Director/CPO	**FPPC & Inclusion**	**16**	**16**	16	16	**12**	01.03.18 (April 21)
003/21	Risk of financial delivery due to the radical change of the NHS Financial Framework	Director of Finance	**FPPC**	**12**	**12**	16	16	**12**	01.04.19 (TBC)
004/21	There is a long term risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments (Updated May 2021)	Director of Finance	**FPPC**	**16**	**16**	**16**	**20**	**15**	01.03.18 (TBC)
005/21	There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	Chief Information Officer	**Strategy**	**12**	**12**	**12**	**12**	**12**	01.04.17 (At target)
006/21	There is a risk ICP / ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	Director of Finance	**Strategy**	**12**	12	12	12	8	01.04.20 (April 22)
007/2	There is a risk that the Trust's governance structures do not enable system leadership and pathway changes across the new ISC/ICP systems whilst maintaining Board accountability and appropriate performance monitoring and management to achieve the Board's objectives	Chief Executive / Chief Nurse	**Board**	**12**	**12**	16	16	**12**	01.03.18 (21/22)
008/21	There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	Chief Nurse /Medical Director	**QSC**	**15**	**15**	**15**	**15**	**10**	01.03.18 (TBC)
009/2	There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community	Chief People Officer	**QSC & Inclusion**	**16**	**16**	16	16	**12**	01.03.18 (March 21)
010/2	There is a risk of non-compliance with Estates and Facilities requirements due to the ageing estate and systems in place to support compliance arrangements	Director of Estates	**QSC**	**15**	**15**	**15**	**20**	**10**	22.01.19 (TBC)
011/21	There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC	Director of Finance	**Strategy**	16	16	16	12	12	01.04.20 (TBC)
012/21	Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care	COO/Chief Nurse	QSC/Board	**10**	10	15	20	10 (Met June 21)	04.03.20 (April 21)

**Changes to the risk scores discussed at the October Board Committees and approved by Board in November.*

Board Assurance Framework Heat Map –December 2021

Frequency / Likelihood	Consequence / Impact				
	1 None / Insignificant	2 Minor	3 Moderate	4 Major	5
5 Certain	low 5	moderate 10	high 15	high 20 001/21	high 25
4 Likely	low 4	moderate 8	moderate 12	high 16 004/21 004/21 009/21 002/21 005/21 007/21 011/21	high 20
3 Possible	very low 3	low 6	moderate 9	moderate 12 007/21 005/21 005/21 003/21 011/21 009/21 003/21 006/21 01/21 002/21	high 15 010/21 008/21
2 Unlikely	very low 2	Low 4	Low 6	moderate 8 007/21 006/21	moderate 10 012/21 010/21 012/21 008/21
1 Rare	very low 1	very low 2	Very low 3	Low 4	Low 5

008/21 Existing risk score

011/21 Target risk score

Movement from previous month

REVIEW OF CURRENT STRATEGIC RISKS– MAPPED TO TRUST STRATEGIC PRIORITIES AND DRAFT OBJECTIVES 2021/2022

East and North Hertfordshire NHS Trust

Our Vision

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

Our Priorities

1. Quality:	2. People:	3. Pathways:	4. Ease of Use:	5. Sustainability:
R2 Workforce	R2 Workforce R8 Quality	R1 Op Delivery	R1 Op Delivery	R1 Op Delivery
R4 Capital	R9 Culture	R5 Digital	R5 Digital	R3 Finance
R5 Digital	R12 Pandemic	R6 ICP	R6 ICP	R4 Capital
R7 Governance		R8 Quality		R6 ICP
R8 Quality		R11 Pathways		R7 Governance
R10 Estates		R12 Pandemic		R10 Estates
R11 MVCC				R11 – MVCC
R12 Pandemic				R12 Pandemic

Our Objectives 2021/22 *Board approved*

a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 (R1 Op Delivery, R2 Workforce, R3 Finance , R4 Capital ,R5 Digital, R6 ICS/ICP, R8 Quality, R10 Estates,)

b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic (R1 Op Delivery, R3 Finance , R4 Capital ,R5 Digital, R10 Estates, R12 Pandemic)

c) Embed and develop the new divisional structure and leadership model to further improve service quality (R1 Op delivery, R7 Governance, R8 Quality, R9 Culture)

d) Create a health and well-being offer that is amongst the best in the health service (R2 Workforce, R9 Culture)

e) Progress and develop our equality performance to build an inclusive culture in the workplace (R2 Workforce, R7 Governance, R9 Culture)

f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency (R3 Finance, R5 Digital, R6 ICS/ICP, R8 Quality)

g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients (R1 Op Delivery, R2 Workforce , R3 Finance , R5 Digital, R7 Governance, R8 Quality, R12 Pandemic)

h) Harness innovation, technology and digital opportunities to support new models of care (R1 Op Delivery , R4 Capital, R5 Digital , R8 Quality, R7 Governance, R9 Culture)

i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider (R1 Op Delivery, R3 Finance, R5 Digital, R11 MVCC)

Our values

We put our PATIENTS first; we strive for excellence and continuous IMPROVEMENT; we VALUE everybody; we are OPEN and honest; we work as a TEAM

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Pathways: To develop pathways across care boundaries, where this delivers best patient care Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic c) Embed and develop the new divisional structure and leadership model to further improve service quality g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients h) Harness innovation, technology and digital opportunities to support new models of care i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider**	**Source of Risk:**	Strategic Objective IPR National Directives	**BAF REF No:** 001/21
Principal Risk Decription: What could prevent the objective from being achieved? Risk to operational delivery of the core standards and clinical strategy in the context of COVID recovery	**Risk Open Date:**	01/07/2020	**Executive Lead/ Risk Owner** **Chief Operating Officer**
	Risk Review Date:	Dec-21	**Lead Committee:** **FPPC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Increases / changes to capacity and demand . ii) leadership and capacity challenges iii) conflicting priorities iv) Inconsistency in application of pathways/ processes iv) Impact of COVID 19 measures - PPE, testing, social distancing, staff and patient risk assessments, availability of workforce. v) Impact of specialist commissioning review and resultant outcome for MVCC on staff retention and recruitment, impacting on effectiveness of the cancer team. vi) Increased risk to delivery of the ERF targets. More challenging delivery targets from 1st July (95% activity against a 19/20 baseline) – if the system does not meet these targets ERF monies will not be paid. vii) The Emergency Care Data Set (ECDS) for urgent and emergency care is being revised and Trusts will be expected to report against three new metrics from 1 November 2021 ('time to initial assessment', '12 hours in the department' and 'clinical ready to proceed') - viii) Impact of winter could impact on overall capacity within the hospital	i) Limited ability to respond to changes in capacity and demand impacting on service delivery - changes to referal patterns following COVID. Patients presenting later to GP's ii) Adverse impact on sustaining delivery of core standards iii) impact on patient safety, experience and outcomes iv) increased regulatory scrutiny v) reputation - Public confidence vi) Financial Impact if the Trust does not meet the ERF targets - ERF monies will not be paid. vii) Reputational risk if performance standards are not achieved viii) Risk of winter demand/ illnesses on overall capacity within the hospital	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	5	20	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Risk stratification of patients is ongoing, overseen by the Clinical Advisory Group. The group is chaired by a consultant. The Trust continues to have oversight of performance through three Delivery & Oversight Groups which meet monthly and focus on (1) Quality and Safety, (2) Performance and Transformation and (3) Finance and Workforce. In addition, a range of groups meet regularly to focus on specific aspects of performance and recovery. These groups take a targeted approached to review performance, identify risks and determine corrective action. These groups include a system-wide Cancer Board chaired by Trust's Chief Operating Officer, a weekly Gastroenterology Surveillance group and the weekly Executive Committee. A weekly access meeting takes place. Recovery plans are in place for all specialities and progress is reviewed on a weekly basis. A series of deep dives are planned for 2021/22. winter initiatives have been agreed to enable the Trust to respond to the pressures of the winter period; there is a risk that the additional staff required may not be available.	We have a set of 'flat pack' Covid escalation plans ready for use if required and we have developed Covid policies and procedures. We have developed a recovery dashboard which is divisional and specialty based. FPPC receives and reviews our IPR, performance reports and deep dives at its meetings. It also reviews ED performance and configuration, progress in relation to the endoscopy review and demand and capacity modelling. In addition we have divisional delivery operational groups, divisional Board meetings and a fortnightly clinical transformation group. Performance Deep Dives - Stroke, July 2021, Sept 21 Performance relating to ambulance handovers will be monitored through usual governance processes including the IPR. Theatre and Outpatients deep dives to FPPC, December 21.	Recovery of our performance continues to be good and we are exceeding our plans. Performance against RTT and diagnostics is improving. -RTT and DMO1 deep dive to FPPC June 21. The number of patients waiting over 18 weeks is decreasing.		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1 Complexity of operation recovery in the context of COVID C2 National changes to guidance and policy requiring local response at short notice C3 Phase 3 capacity modeling to deliver national targets within financial model	A1 Define metrics to support monitoring of recovery A2 Capacity to support increased demand post COVID - endoscopy and other specialities - delivery against plans A3 Effectiveness of winter planning initiatives/ transformation with community A4 Optimisation and effective discharge	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

			Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps (Action plan under review with Lead Direcotr and Managing Directors's)

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Deliver Operation Recovery Programme inline with national guidance and with risk stratification	C1, C2, C3	COO, MD's (Planned and Unplanned Care)		Monitored weekly and monthly. Access Manager now in post.	
ii) Continue to engage with our ICS and ICPs. Develop system recovery plan with ICP, PCN's, Community and Social Care services (e.g. further development of Ambulatory care to create ED capacity; discharge to assess)	C1, C2, C3, A1, A3, A2	COO, MD's (Planned and Unplanned Care)		Workstreams in place. Winter planning paper to FPPC in October 21 . Winter initiaitves approved - task and finish groups to monitor implementation	
iii) Delivery of the ED reconfiguation programme and SDEC	A1, A3	Unplannned Care Managing Director		ED capital plan and action plan report to FPPC , Sept 21.	in progress
iv) Delivery of discharge improvement programme	A4	COO		Discharge improvement update on October agenda for FPPC	in progress
v) Delivery of bed reconfiguration programme	A2., A3	COO/ Director of Estates			
iv) Review delivery performance metrics in line with standards	A1,	COO		Review of new national ED standards. Measures running in shadow form; paper to FPPC in Feb 21. Exploring the use of predictive analyitics (FPPC in June 2021)	
iv) Delivery of elimination of ambulance handover waits	A1,	COO		Action in place including earlier escalation to surge plans	
Summary Narrative:					

July 2021: New guidance has been issued requiring performance to be at 95% against 19/20 activity levels. This will be challenging to achieve, particularly with increasing Covid numbers and a predicted 4th Covid wave. If the system as a whole does not achieve the targets ERF monies will not be paid. Sept 21: Although challenging the Trust has so far performed well against these new standards. As we approach winter, competing pressures and an increase in Covid numbers and a potential decrease in available workforce could make this position harder to sustain'.
October 2021: Risk level reviewed at QSC and FPPC and recommended increasing the risk from 16 to 20; recognising the impact of the current operational performance/ challenges and continued challenges of activity, winter pressures, competing priorities, impact of staff sickness. FPPC recieved a deep dive and assurance on the Discharge Improvement Programme and Winter Planning - including internal and system wide actions/initiatives to support mitigation of the risk. Noting next months deep dive will focus on RTT recovery.
November 2021: The Board considered the requirement to eliminate ambulance handovers and approved the proposed actions. Monitoring will take place through the usual governance processes including the IPR.
December 2021: Impact of the level 4 incident on performance and operational delivery is under close review.Response developed in line with the national guidance.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability, Quality, PeopleWe provide a portfolio of services that is financially and clinically sustainable in the long term . We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030** **d) Create a health and well-being offer that is amongst the best in the health service** **e) Progress and develop our equality performance to build an inclusive culture in the workplace g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients**	**Source of Risk:**	strategic objectives	**BAF REF No:** 002/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the workforce model does not fully support the delivery of sustainable services impacting on health care needs of the public.	**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner** Chief People Officer
	Risk Review Date:	Dec-21	**Lead Committee:** FPPC and QSC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Failure to develop effective workforce plan/workforce model for each service that takes account of new/different ways of working. ii) Failure to maximise staffing options through the use of flexible working initiatives. iii)Failure to work collaboratively across the Integrated Care System. iv)Failure to develop staff to be able to work more flexibly in terms of role design. v) Impact of the pandemic and self isolation guidance on the availability of staff	i) Current staffing models may not be cost-effective. ii) There may be an adverse impact on service quality and safety. Iii) Recruitment costs may be higher than necessary. iv) Staff may not have the required skill set to support innovative role design and ways of working.	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	4	16	⟺
		Target Risk: (TBC)	4	3	12	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
i) A process by which articulation of clinical strategy is linked to organisational redesign and workforce modelling. ii)Workforce transformation approach to service development. iii)Demand and Capacity Modelling. iv) People Strategy action planning v) Finance and People Divisional Board / Divisional Oversight Group. Established Workforce triggers and redeployment processes	i) Care Quality Commission service inspections / TRA's ii) Staffing costs /staff turnover costs iii) Monthly safer staffing reports to QSC Nursing establishment review, Dec 21 Workforce Assurance Framework for winter, Dec 21(N&M)	Erostering Internal Audit - 'reasonable' assurance 2020.		yes
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received.	**Reasonable Assurance Rating: G, A, R**		
C1. Inadequate links between service planning and workforce planning. C2. Lack of horizon scanning to allow early recognition of potential skills gaps. C3. National shortages of clinical professionals and failure to engage clinicians in the	A1 the variation between current staffing arrangements and optimum workforce model is not yet quantified.	Green	Effective control is in place and Board satisfied that appropriate assurances are available	

C3. National shortages of clinical professionals and failure to engage clinicians in the workforce planning process. C4. COVID/ Post covid challenge to existing workforce model - ability to maximise using staff flexibly	workforce model is not yet quantified. A2 ability readily monitor capability, specialist skills and risk assessments to maximise using staff flexibly	Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action: (Actions under review with CPO)	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Ongoing implementation of the People Strategy to support staff recruitment and retention, in particular through the development of a strategic forum to link future organisational design requirements with job design and provision of necessary educational support.	C1, A1	Chief People Officer		Staff experience Group in place to consider exit interview data / undertaking workforce planning with services via the integrated business planning process will identify new ways of working and roles to support development / education board considers other development and training mechanisms to support R&R	
ii) Enhance areas of staff supply	C2	Chief People Officer		Continue to work with NHS Professionals on bank recruitment to support staffing shortfalls, plans have been agreed for 21-22 with clear targets in place throughout all staff-groups. / International recruitment continues to identify and recuit additional staff as needed	
iii) Work with divisional leadership on demand and capacity modelling, and establish workforce architecture/modelling approach and capability	C1, C2, A1	Chief People Officer		Workforce Planning gap identified in current establishment, has been addressed in the revised people team structure. Some work has been undertaken with the planning team around demand and capacity modelling but in it's infancy.	
iv) Improve the offer to staff around flexible working.	C4, A2	Chief People Officer		flexible working review being undertake in conjunction with establishment review to assess winter and summer plans and options appraisals.	
v) delivery of a Education and a capability strategy for the organisation	C1, C2, C3, C4	Chief People Officer		The People Stategy launched in 2019, bringing education, training and Leadership under capability. A number of senior personnel changes and covid has led to a slow and steady implementation of this plan. In June 2021 the Capability strategy was launched, this has been presented to QSC. To deliver against the strategy structural changes remain to be implemented, which are planned for Q4. Currently the service is reliant on a high number of seconded staff to meet demands and there are a small number of staff absent due to long term sickness causing a significant impact on service delivery, particularly in Medical Education. These are hard to fill with bank and senior leaders are having to directly support services. A deep dive into the LDA and education finances is required to ensure in future that activity and payment are met, ensuring quality and value for money	
Summary Narrative:					

December 2021: Impact of the pandemic and self isolation guidance on the availability of staff. Staff Risk assessments in place in line with national guidance. Workforce triggers and redeployment processes reviewed and ready to stand up when required.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider**	**Source of Risk:**	Operating Plan- Use of Resources - Financial Framework 2021/22	**BAF REF No:** 003/21
Principal Risk Decription: What could prevent the objective from being achieved? Risk of financial delivery due to the radical change of the NHS Financial Framework associated with the current COVID pandemic	**Risk Open Date:**	01/04/2018	**Executive Lead/ Risk Owner** Director of Finance
	Risk Review Date:	Dec-21	**Lead Committee:** FPPC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
• Change in the national funding framework during COVID • Mid Year change in funding framework• Good financial management and governance not maintained • Allocation of resources via system mechanisms rather than based on activity volumes• Impact of revised operational targets (eg. P3 recovery / Winter & COVID Resilience) • Dilution of financial understanding and knowledge within divisional teams• New operational structures weakening traditional arrangements for strong financial control	• Significant increase in costs above funding levels • Financial balance not maintained • Failure to track expenditure causation • Unable to invest in service development • Challenge in tracking spend for regulatory and audit purposes • System funds allocated on differential basis• Spend committed recurrently in response to non recurrent circumstances• Breakdown of regular financial / business performance meetings• Weakening of traditional balance between - Finance / Performance & Quality	**Inherent Risk** (Without controls):	4	5	**20**	⟺
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Regular Monthly financial reporting arrangements in place• COVID expenditure tracking and approval processes in place• Recruitment approval mechanisms in place• Financial appraisal and pre-emptive agreement of winter pressure and P3 programmes • Attendance at regular national, regional and ICS DOF briefing and engagement sessions • Suite of weekly internal Finance SMT meeting to track financial delivery and governance issues • Mth 1-6 and M7-12, internal budget frameworks in place • Strong framework of BI financial reporting tools deployed to track and monitor delivery • Weekly Demand & Capacity meetings to track P3 delivery achievement and associated PAM meetings to support accurate and comprehensive activity capture • MVCC Due Diligence meeting, plus Critical Infrastructure meeting • Implementation of Divisional Finance Boards to promote strong financial governance - Financial Planning 2021/22 & including ICS developments to FPPC in January 21.	Monthly Finance Reports to FPC, Board and Divisions (L1) • Monthly cash reporting to FPC / Trust Board and NHSI(L2) • COVID governance and reporting briefing to FPPC • COVID financial planning updates to monthly FPPC and Exec Committee• Monthly Accountability Framework ARMs including Finance (L1) • Bi- Monthly Financial Assurance Meetings & PRM with NHSE (L1) • Regular Data quality and Clinical Coding updates to PAM and AC (L2) • Weekly D&C activity tracking meetings • Forecast activity and winter planningbed model in place linked to M7-12 financial plan • Internal Audit review programme - Costing Assurance Audit and action plan to FPPC in June 2021			I&E delivery against financial plan Cash balances maintained within prescribed limits • Capital spend to be maintained within approved levels • Temporary staffing spend to be maintained within agreed threshold

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1 nconsistent delivery of routine budget management meetings across divisions C2 Impact from the system funding distribution under the new finance framework C3 Variable capture and escalation of winter and in year cost pressures C4. Weak temporary staffing control environment in respect of medical and nursing staffing C5 Ongoing COVID ineffiencies	A1. Impact future funding frameworks on Trust financial sustainability strategy A2. Embedding of core financial and business competencies within divisional teams A3 Clarity in respect of NHS contract and business arrangements for 21/22 A4 Impact of the Implementation of 'ENHT Way' as a means of delivering future financial savings A5 Assurance in respect of the delivery of the 21/22 summer and winter bed plans within agreed parameters, with the associated risk of additional unplanned costs	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps (Actions under review by Lead Director)					
Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Launch and development of Finance Academy for all Budget holders	C1, A2	Director of Finance		Launched in May 2021	In progress
ii) Development of Finance Sustainablity Strategy in line with the NHS Financial Framework and monitoring delivery	C2, C5, A1, A3,	Director of Finance		H2 planning guidance and budgets , FPPC Sept / October 21	
iii) Continue to develop BI and support divisions / directorates using effectively	C1, C4	Director of Finance			
iv) Engagement with Divisions/ Directrates on delivery on financial savings from month 6	C5, A4, A5	Director of Finance / Direcotr of Improvement / MD's (Planned ad Unplanned)		H2 CIP Delivery plan to Sept / October 21 FPPC	
Summary Narrative:					
October 2021: Risk level reviewed at FPPC and recommended reducing from 16 to 12, taking in to account the current and forecast position including the reports on the H2 Planning Guidance and budget and H2 CIP delivery.					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Quality: To deliver high-quality, compassionate services, consistently across all our sites. Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic h) Harness innovation, technology and digital opportunities to support new models of care**	**Source of Risk:**	Business Plan, Clinical Stra	**BAF REF No:** 004/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk of the availability of capital resources to address all high/medium estates backlog maintenance, investment medical equipment and service developments.	**Risk Open Date:**	01.03.18	**Executive Lead/ Risk Owner** Director of Finance
	Risk Review Date:	01/122021	**Lead Committee:** FPPC

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
Lack of available capital resources to enable investment • Weakness in internal prioritisation processes • Weak in year delivery mechanisms to ensure commitment of resources • Weak assessment of the long term capital resources to meet strategic objectives • Requirement to repay capital loan debts • Volume of leased equipment not generating capital funding resources • COVID capital funding arrangements impact BAU capital requirements • Weak internal understanding of NHS capital funding arrangements • Poor internal business case development skills	• Aged equipments and assets - at our beyond lifespans • Increased associated risks to continuity and reliability of service delivery eg. Radiotherapy • Limited ability to invest in IMT, equipment and services developments • Limited innovation and associated limitations on ability to deliver efficiencies • Negative Impact on the potential to deliver the overarching Trust strategy • Annualised and sub optimal process of competitive short term bidding • Difficulty in expressing a coherent capital profile to external stakeholders eg. ICS / Region / DH	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Six Facet survey undertaken in 17/18• Capital Review Group meets monthly to review and manage programme spend • CRG Prioritising areas for limited capital spend through capital plan • Fire policy and risk assessments in place • Asset Register Maintained by the Finance Department • Mandatory training• Equipment Maintenance contracts • Monitoring of risks and incidents • ICS capital monitoring processes across the system • Directors of Finance and E&F meet weekly with teams to track and facilitate capital spend • Equipment review process to support covid 19 pandemic requirements • Implementation of the new Capital and Cash Framework • Detailed Qlikview Capital Monitoring Application in place • Bi weekly MVCC Critical Infrastructure group with stakeholders	• Annual AE report on Fire Safety to H&S Committee (L2) - Monthly Fire Safety Committee • Monthly Capital Review Group (CRG meetings) feeding into FPC and Exec Committee (L1) • Report on Fire and Backlog maintenance to RAQC(L2) • Reports to Health and Safety Committee (L2) • Capital plan report to FPPC (L2) • Annual Fire report (L3) • PLACE reviews (L3) • Reports to Quality and Safety Committee • Steering Groups in place to oversee strategic programme delivery eg. Vascular, Renal, Ward Reconfiguration & ED • Capital programme report, FPPC May 21. - Risk Register reports to CRG	• External Audit process reviews the appropriate accounting and treatment of capital assets. • DH / NHSE review and approval of strategic business case schemes requiring funding		
Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**		
C1. Not fully compliant with all Fire regulations and design C2. No effective arrangements presently in place to monitor and control space utilisation across the Trust C3. No formalised equipment replacement plan or long term capital requirement linked through to LTFM and Trust Strategy C4. Weaknesses in Estates and facilities monitoring structures and reporting C5. Absence of Overarching site Development Control Plan	A1. Availability of capital through either internal or national funding sources A2. Implementation of the new capital and Cash Framework A3.Transparent mechanisms to access Section 106 funding A4. Long Term Capital Investment Plan to regulate investment	Green	Effective control is in place and Board satisfied that appropriate assurances are available	
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient	
		Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Estates strategy to support the trust clinical strategy	C1, C5, A4	Director of Estates and Facilities	TBC	Development to be reported Strategy Committee	Not yet started
ii) Develop capital equipment replacement plan	C3, A4	Deputy Director of Finance	Ongoing	Capital Planning for 2021/22 paper to FPPC in March 21, based on new planning guidance.	In progress
iii) Develop programme for Charity to support with fundraising	A1	Deputy Director of Finance / Head of Charities	Ongoing		In progress
iv) Agree capital investment for 2021/22 and monitor delivery	C4, A2	Executive	May-22	Report to May FPPC. For 6 monthly review. Report on ED capital plan to FPPC in Sep 21. Up date on ED project and Captial spend against plan to FPPC in November 2021	In progress
v) Review other sources of funding / opportunities for investment	A1, A3	Director of Finance / Project leads	Ongoing		In progress
vI) Undertake detailed space utilisation survey, implement revised strategy and then monitor	C2	Director of Estates and Facilities / Improvement Director	TBC		In progress
Summary Narrative:					

June 2021 ,following review, including structures and monitoring in place, further actions and oversight of the risks, and the FPP Committee discussions in May 21, the rating has reduced to 16. October 2021: FPPC discussed the risk rating and confirmed it remains a 16; taking into account the longer term position of access to capital .

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Trust Strategic Aims:
services,consistently across all our sites **Quality: To deliver high-quality,compassionate**
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff **Pathways: To develop pathways across care boundaries, where this delivers best patient care**
services that is financially and clinically sustainable in the long term **Sustainability: To provide a portfolio of**

Strategic Objective: **Trust** **Objective:** **a)Develop a new strategic direction** **for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030** **b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic** **f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency** **g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients** **h) Harness innovation, technology and digital opportunities to support new models of care** **i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider** **Digital Objective: The design and delivery of a Digital programme to support the Trust clinical strategy**	**Source of Risk:**	Digital Programme/ Strategy	**BAF REF No:** 005/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the digital programme is delayed or fails to deliver the benefits, impacting on the delivery of the Clinical Strategy	**Risk Open Date:**	Jun-20	**Executive Lead/ Risk Owner** **Chief Information Officer (CIO)**
	Risk Review Date:	Dec-21	**Lead Committee:** **Strategy Committee**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Staff Engagement / Adoption Lack of Clinical/Nursing/Operational engagement in system design - reduces likelihood of system adoption Lack of Clinical/Nursing/Operational adoption of digital healthcare creates innefective process which can introduce clinical risk ii) Financial / Resource AvailabilityFailure to resource its delivery within timescalesTrusts may not be in a position to finance the investment (including Lorenzo renewal 2022) iii) Business RiskIT resources may get diverted onto other competing Divsional projects iv) Knowledge & ExperienceDelivery team does	i) Unable to deliver the Clinical strategy ii) Unable to deliver target levels of patient activity iii) Unable to meet contractual digital objectives (local, national, licience) iv) adverse impact on performance reporting	**Inherent Risk** (Without controls):	4	5	**20**	
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Staff Engagement Risk:Digital steering group(Consultant led design focus) and IT steering Group (Project Led delivery led) are in place for project Governance, prioritisation and to support clinical engagementBusiness Risk:CIO is member of the executive team and CIO/CCIO have an agenda item on at the Private board to ensure board members are apprised of progress and risks.Financial / Resource Availability Risk:Finance and PMO to be involved throughout the Business case processFinancial / Resource Availability Risk:Business case identifies resourcing from the Divisions and makes provisions for back-fill where appropriateKnowledge & Experience Risk:Key roles (Programme Director, Procurement consultant, Architect etc.) are identified and recruited at and early stage an retained.New Performance Delivery Framework Clinically led workstreams feeding into the Digital Steering Group (model from EPMA) Digital roadmap to 2022, with 2020/21 priorities (July 2020)	• Reports to Executive Committee,Strategy Committee and Board (L2)• Weekly Executive monitoring(Where appropraite) aligned with clinical strategy- staff engagement acorss all sites, at all levels during COVID 19 adopting new many technologies for communication and service delivery Transformation DOG - Strategy for "Evolving our technology" , including including road map to 2022 presented to Strategy Committee, Feb 2021.	Disaster recovery - IA - Limited (action plan in place) Cyber Maturity - IA - green except - network security and secure configuration		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Poor attendance from stakeholders at the Digital steering group C2. Availability of capital to deliver priorities C3. No long term digital plan beyond 2022 (Contractual end date for Lorenzo) C4 Integration into Divisional planning for resource management delivery of tachical solutions to delivery the five priorities rather than the digital road map NHS I/ D/ X expection that we implement with little time and enable of - systems / timeface to enable local scruitinty	A1. Delivery of the roadmap and measures of progress A2. DSO and IGM capacity to support the DPIA processes for increase pathway changes (action to be confirmed with CIO) A3 Clinical engagement and leadership to support developing and embedding the changes	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps					
Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i)Engagement and delivery of the digital roadmap against plan	C1, A1	CIO		Sept 21 update - Delivery in progress. Roadmap has been updated on all workstreams and was presented to the Trust in July 2021. October : KOPS (Keeping our patients safe) launched in October 2021. November 2021: Update on digital strategy presented to Strategy Comm.	In progress
ii) Seek investment through ICS where available	C2	CIO		Sept 21 update - Creation of a business Case to support Digital Aspirant/Unified Technology Digital funding is underway. ICS and regional stakeholders engaged. Other funding oppertunities being actively pursued as they become available.	In progress
iii) Long term Lorenzo strategy/commercials to be finalised	C3	CIO		Sept 21 update- Lorenzo strategy under consideration within the scope of above business case.	In progress
iv) Implementation of a Business partner process (Post Silver)	C4	CIO		Sept 21 update - No update but in progress	In progress
v) Relaunch of EMPA roll out	A1	Deputy Medical Director, Chief Pharmacist and CIO		Sept 21 update - Rollout planning has now commenced. EPMA full rollout delayed.	In progress
vi) recruitment into Chief Nurse Information Officer Role	A3	Chief Nurse	Jan-22	Recruitment commenced August 21 interviews scheduled for end September. October 21: Appointed and due to commence in January 2021.	In progress
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Pathways: To develop pathways across care boundaries, where this delivers best patient care Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 f)** **Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency**	**Source of Risk:**	National directives	**BAF REF No:** Risk 006/21
Principal Risk Decription: What could prevent the objective from being achieved? ICP/ICS partners are unable to work and act collaboratively to drive and support system and pathway integration and sustainability	**Risk Open Date:**	01-Apr-20	**Executive Lead/ Risk Owner** Director of Finance (From August 21)
	Risk Review Date:	Dec-21	**Lead Committee:** Strategy

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of effective collaborative system leadership ii) Executive, clinical and operational leadership and capacity iii) Ability of the ICP to effectively engage primary care iv) Lack of synergies between organisational, ICS and ICP strategic development and priorities v) Lack of risk and benefit sharing across the ICP vi) Complex ICP governance arrangements	i) Failure to progress. Lack of strategic direction and modelling of collaborative leadership ii) Slow pace of ICP development and transformation of pathways. Perpetuautes inefficient pathways. iii) Primary care is not effectviely engaged in the development of the ICP impacting the scope and benefits of integration iv) Unwillingness or inability of organisations to adopt new pathways / services because of contractual, financial or other risks v) Impedes the pace and benefits of transformation	**Inherent Risk** (Without controls):	4	4	**16**	⇔
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	2	8	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
• ICP Partnership Board Building on the successful system working in response to the pandemic • ICS CEO bi-weekly meeting ICS Chairs' meeting • Joint projects such as Vascular Hub project with West Herts and PAH; ICS pathology procurement; Imaging Networks • ENH improvement methodology - 'here to improve' • Integrated discharge team • OD support for ICP development • ICP Development Director based at ENHT one day/week to support developing relationships - ENH ICP Directors' Group	Reports to Board and FPC Reports to ICS CEOs' Reports to Partnership Board Reports to ICP CPex and TDG Collaboration Report to Strategy Committee and Board Pathology Procurement report, Vascular Services report and monitoring via Stategy Committee and Board Population health data presented to FPPC in May 21			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance:Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
C1. Partnership Board Scope for accelerated development of ICP and governance arrangements that support collaborative transformation at pace C2 Need to identify and release clinical leadership capacity to drive greater pan system understanding of population health and priorities for ICP improvement work C3. Need to influence and understand future Trust and ICP representation with ICS from Apr 22 - Identification of dedicated capacity to support provider collaboration C4 Maximising the implementation of an improvement model to build capability and capacity	A1. Availability of population health data to inform shared priorities for transformation and improvement A2. ICS PHM learning set commenced March 21 Trust COO representaton at the ICP Transformation and development group to enable integrated pathway redesign. A3. Assurance that ENHT voice fully represented by ICS in key discussions e.g. satellite radiotherapy. To be discussed at CEO level	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps (action plan under reivew with Lead Director)

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
i) Continue to review and evolve the ICP and ISC governance structures in line with national guidance	C1, A3	Chief Executive (with Associate Director of Governance & Trust Secretary)		MoU recommended for approval by statutory Boards. New ICS design guidance published June 2021 - ICP governance under development by Impact Group.	in progress

ii) Agree and deliver approach ICP priorities through collaboration - developing risk and benefit sharing	C3, A2	COO/ Director of Finance		ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Bi-lateral work undertaken with HCT on potential models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission at Lister.	in progress
iii) To consider with the ICS/ICP a joint improvement model to collaborate on to facilitate cross organisational working and building capability and capacity. E.g 'here to improve'	C4	Director of Improvement		The ICP Virtual Transforamtion Model has now been established and sucessfully working since January 2021. Agreement was reached this month for all Providers toa dopt the same PM3 project software solution. Discussions regarding our CI model are ongoing as there is not yet a shared vision.	
iv) continue to identify clinical leadership capacity to support the development of collaborative, ICP integrated pathways	C2, C4	Medical Director/Director of Nursing			
v) To share the ENHT population health data with the wider ICS and ICP to facilitate discussion and agreement of priorities	C3, A2, A1	Director of Finance		Population health data under development. ICP commenced a health inequalities sub-group to enhance and advice CPEx on health inequalities.	in progress
vi) To review the Trust representation at the revised ICS workstreams for 2021/22	A3	Director of Improvement with COO/ Director of Finance		On hold pending ICS confirmation of 21/22 transformation programmes. Director of Strategy attends ICS Design & Delivery Group to maintain connection with ICS programmes pending confirmation.	Not yet started
Summary Narrative:					

Sep 21 - DDoS contributing to development of ICP Strategy; ongoing work on Strategy Refresh, including areas identified for PHM projects; transformation team part of shared project resource on key collaborative ICP projects
Aug 21 - confirmation received of funding for year 1 of CDH; business case for year 2 approved in principle by Execs; work on IBP continues
July 21 - ICP bid submitted for Community Diagnostic Hub at QEII, with pilot in community; helping to build joint working with system partners
June 21 - MoU recommended for approval by statutory Boards. ICP developing refreshed strategy and developing plans for April 22 in conjunction with ICS development and transformation. Work underway to test alternatve models of collaboration. Agreed joint transformation project to develop enhanced services in the community to support reduction of acute LoS and alternatives to admission.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Quality: To deliver high-quality, compassionate services, consistently across all our sites Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term

Strategic Objective: **new divisional structure and leadership model to further improve service quality** **an inclusive culture in the workplace** **c) Embed and develop the** **e) Progress and develop our equality performance to build** **g) Working with system partners, progress development and delivery of integrated and**	**Source of Risk:**	Strategic Objectives External reviews	**BAF REF No:** 007/21
Principal Risk Decription: What could prevent the objective from being achieved? Quality: To deliver high-quality, compassionate services, consistently across all our sites Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term	**Risk Open Date:**	01.04.2020	**Executive Lead/ Risk Owner** Chief Executive
	Risk Review Date:	Oct-21	**Lead Committee:** Board

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) In effective governance structures and systems - ward to board ii) Ineffective performance management iii) ineffective staff engagement iv) Impact of covid 19 pandemic outbreak	i) risk to delivery of performance, finance and quailty standards ii) risk of non compliance against regulations iii) risk to patient safety and experience and outcomes iv) reputational risk	**Inherent Risk** (Without controls):	4	5	**20**	⇕
		Residual/ Current Risk:	4	3	12	
		Target Risk:	4	2	8	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
• Monthly Board meeting/Board Development Session/ Board Committees • Annual Internal Audit Programme/ LCFS service and annual plan • Standing Financial Instructions and Standing Financial Orders • Each NED linked to a Division • Commissioned external reviewsReview of external benchmarks including model hospital , CQC Insight– reports to FPC and RAQC (QSC) • Board Assurance Framework and monthly review • Performance Management Framework/Accountability Review meetings monthly • Integrated Performance Report reviewed month at Trust Board, FPC and QSC - Board committees with Annual Cycles included scheduled deep dives. - Incident gold/silver command structure in place from mid March 2020 and reviewed/ flexed to ensure meets organisaitonal needs Delivery oversight framework in place. Partnership Board and ICP Board and groups established and link to divisional structures Board development programme	• Commissioned external reviews – PwC Governance Review September 2017 NHSI review of Board and its committees 2019 • Visibility of Corporate risks and BAF as Board Committees and Board (L2)• Internal Audits delivered against plan, outcomes report to Audit Committee • Annual review of SFI/SFOs (L3) Annual review of board committee effectiveness and terms of reference (May-July) (L3) • PwC Governance review and action plan closed (included well led assessment) (L3) • Annual governance statement (L3) • Counter fraud annual assessment and plan (L3) • Annual self-assessment on licence conditions FT4 (L3) • CQC Inspection report July 2018 –(overall requires improvement) and actions plan to address required improvements and recommendations (L3 -/+) • Internal Audit Reports - Major incident structure and documentaion - log books, action logs, minutes RIDDOR reporting	Internal Audits 2020/21 reasonable or substancial assurance on Serious incidents, clinical audit, risk management, BAF, compliance framework, health and safety, DSPT, Financial audits CQC - Positive TRA's - Medicine, Surgery, MVCC Medicine, IPC , ED and medicinces management and well led in 2020/21 NHSI/E - positive vists to ED and Assessment and ICP visit (September / October)		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Effectiveness of governance structures at ward to Divisional level C2 Implementation of Internal Audit Recommendations C3 HSE Improvement notices received on V&A, MSD and sharps in October 2019 (awaiting formal closure with HSE) C4 The Trusts existing clinical strategy is no longer appropriate to manage emerging risks and system changes C5 Changes to Board members/ organisational leadership	A1 Embedded risk management and risk appetite - CRR and BAF A2 Embedding effective use of the Integrated performance report / BAF in discussions A3 Evidence of timely implementation of audit actions A4 Consistency in the effectiveness of the governance structure's at all levels A5 Capacity to ensure proactive approach to compliance and assurance A6 Ensuring compliance with other external reviews and follow up	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps					
Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Implementation against plan of the revised Compliance and Risk Framework	C2, C3, A1, A3, A6 , A5	Associate Director of Governance	on going	Compliance and Risk framework combined and priorities drafted. Discussed divisional oversight group in May 21. Sept: Progress report to QSC and reivew of priorites scheduled for October 2021 inline with the new regulation regimes	In progress
ii) Review of the Board and Divisional Governance structure to ensure effective and reduce duplication (including links to ICS/ICP)	C1, A2, A4	Associate Director of Governance	Q2, ongoing	Board and Board committee review in progress. Review of the new divisional structure against the orginal objectives is in progress for completion at the end of Dec .	In progress
iii) Recruitment of new CEO	C5	CPO/Chair	Dec-21	completed - commenced in January 2022. Induction scheduled	completed
iv) Implementation of the Strategic Planning Framework and Integrated Business Plan Structure	C4	Deputy CEO/ Director of Strategy		Implementation of the Strategic Planning Framework and Integrated Business Plan Structure presented to Strategy Committee in February 2021; recommended to Board for approval. Strategy Sessions commenced. Monitored by IBP steering group and Strategy Committee. September 21: Progress reviewed by Strategy Committee and discussion on system collaboration refered for full Board	In progress
v) review of external regulatory actions - CQC and HSE to support closure at next review.	C1, C3, A6	Associate Director of Governance		CQC inspectiion action plan - scheduled for closure in June 2021; testing compliance. Testing HSE actions; training elements recommenced. . Sept 21: CQC action plans reviewed and closed with divsional boards. On going review of the fundimental standards in place and programme of testing. On going testing in place	In progress
vi) Scope / consider independant well led review in line with the national guiidance	C1	Associate Director of Governance / Deputy CEO		To review with new CEO, and Head of Corporate Services in January	
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Quality: To deliver high-quality,compassionate services,consistently across all our sites People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce Pathways: To develop pathways across care boundaries, where this delivers best patient care

Strategic Objective: **a)Develop a new strategic direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030** **c) Embed and develop the new divisional structure and leadership model to further improve service quality** **f) Using a population health management approach to plan and focus improvements, reduce health inequalities, and improve patient outcomes, experience and efficiency** **g) Working with system partners, progress development and delivery of integrated and collaborative services, making them easier to use for patients** **h) Harness innovation, technology and digital opportunities to support new models of care**	**Source of Risk:**	Objectives Quailty Assurance data / CQC Inspection	**BAF REF No:**	008/21	
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is not always able to consistently embed a safety and learning culture and evidence of continuous quality improvement and patient experience	**Risk Open Date:**	01/03/2018	**Executive Lead/ Risk Owner**	**Chief Nurse/ Medical Director**	
	Risk Review Date:	Dec-21	**Lead Committee:**	**QSC**	

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of consistent approach to quality improvement. ii) Need to embed culture of improvement and learning iii) Inconsistent ward to board governance structures and systems iv) Workforce skill mix, capability and capacity v) increase in activity on some specialities (ED, Assessment, Maternity, Paeds, CCU, Mental Health) post covid vi) Increase in complaints and SIs related to post covid activity and delays in pathways. vii) Fatigued workforce	1) Limited learning opportunites from current and future continuous quality activities 2) Poorer patient and staff experience 3)Limited leadership development of all staff 4) impact on reputation 5 increased regulatory scrutiny	**Inherent Risk** (Without controls):	5	4	**20**	
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Quality and Safety Governace Structure - reporting into Patient Safety Forum, Patient and Carer Experience, Clinical Audit and Effectiveness, ICP, Safeguarding, Health and Safety Reports to QSC as per annual cycle including deep dives. Pathways to excellence framework and programme 'Here to improve' programme Training and development programmes including Leadership pathway and QI Harm free care and deteriorating patient collaborative Patient and Carer Experience Programme Patient safety specialists / leads Mental Health Srategy Group Complex discharge Improvement group Quailty and Safety Dash boards Oversight of 'hot spots' with clear leads and committee structure, May 21 (QSC and Q&C DOG) Learning events - IPC, safety huddles Clincal Harm Review process and panel Divisional quailty structures GIRFT Board Health Inequalities Committee	ToR, Minutes and papers for the Quailty and Safety Committee Structures Report and deep dives to QSC Internal Audit Programme CQC TRAs and gap analysis Quailty and Safety visits and audit programme Action plans from Mental Health Strategy Group / Discharge Group Maternity surge plan and fortnightly Maternity focus with commissioners, regulators and region LMS - mins and actions	Positive CQC TRA reviews for Medicine (lister and MVCC) and Surgery Core Pathways (with supporting gap analysis and evidence on KLOE) and well led. EoI, OPD Internal Audits 2020/21 reasonable or substancial assurance on Serious incidents, clinical audit, risk management, BAF, compliance framework, health and safety, DSPT, Routine Deep dive review at Audit Committee October 2021. Ockenden response October 2021. Pathways to excellence - ward accreditations Quailty Assurance visits (CCG and Trust) NHSI IPC visit 22.10.21		

Gaps in Controls	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
•C1 National guidance and GIRFT Gap analysis identifies areas for improvement C2 Consistency with engagement with clinicians C3 Patient safety team and complaints team capacity (impact of COVID) C4 Complex discharge pathway (core action and oversight listed in Risk 1) C5 3 Never events were reported in 20/21 C6 Increased number of Mental Health Patients presenting at the Trust - Adults and CYP	A1 Consistency in following care bundles A2 Implementation and tracking of action plans related to GAPS associted with National Audit & NICE guidance, GIRFT recommendaions, NatSSIP Audit compliance A3 Embedding of learniing from SIs/Learning from Deaths/ never events A4 Delivery against CQC improvement plan A5 Delivery of harm review process following COVID impact on 52wk waits , follow	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

C7 VTE compliance C8: Environmental Agency review	up and survieliance A6 Effectivness of Pathway for safe discharging of complex patients - complaints and referals A7 Assurance on Ockenden Report recommendations and PFD (Maternity) A8 Implementation of End of Life Strategy A9 Ward to Board visibility of key Q& S metrics A10 Consistancy of meeting the food hygiene standards and routine assurance	Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) i) Delivery of the Quality Strategy Priotrities	C1-7, A1-9	Chief Nurse / Medical Director	ongoing	2021/22 priorities under review . Chief Nurse and Medical Director strategy session scheduled. Priorities under review including strenghtening the divisional governance structures	In progress
ii) Delivery and monitoring of CQC improvement plans and preparedness for future inspections	A4, C2,	Associate Director of Governance		Quailty visit programme recommenced. Compliance and risk framework reviewed. Monthly review of fundimental standards recommenced. Review of divisional action place in progress and governance, compliance, cqc communcation plan in place with supporting materials	in progress
iii) Implemention of patient safety strategy priorities	A2, A3, A5, A7	Patient Safety Specialists		Quailty and safety digital update to QSC Sept 21. Annual cycle of deep dives to the committee reviewed.	in progress
iv) Implementaiton of End of Life strategy and priorities	A8	Medical Director			In progress
v) Develop and implement Mental Health Stategy for Acute Care and work in collboration with the system to support patients required to stay longer in acute care whilst awaitng speciaist beds	C6	Chief Nurse		Mental health strategy in development. System working to develop local solutions to support acute patinets awaiting inpatient beds.	In progress
vi) Implementaion of pathways to excellence	A3, A5	Chief Nurse		Programme recommenced.	In progress
vii) Review harm review, hospital onset COVID reviews and mortality review processes due to increased demand following COVID	C3, C2	Medical Director and Chief Nurse		Progress under currently review to support the increased volum due to Covid.	In progress
iv) Review complaints process and oversight in line with PHSO guidance and increases following COVID	C3	Chief Nurse		Responding to complaints remains a focus. Interium addiitional resources in place to support recovery plan. Recruitment of new Head of Patient Experience in progress; interviews Sept.	In progress
vii) Complete Gap analysis on GIRFT reports and develop and monitor action plans	C1	Medical Director		Report to QC sept 21	in progress
viii) Review the quailty and safety metrix ward to board with BI	A9	Associate Chief Nurse		work in progress and compliance team also reviewing compliance and assurance data sets	In progress
ix) Implementation of Datix Icloud	A9	Associate Director of Governance	Q2/Q3	Project plan and workstreams in place. Awaiting IT to complete the required technical solution due in July 2021. Will then progress to commence inplementaion across Q2/Q3 . Sept 21: Technical solution completed at end August to enable Datix to complete confirguations. User testing to commence in Oct. Review of programm timetime commenced and to be agreed in October. October 2021: claims module went live in October. Anticipate programme to deliver the rest of the modules in Q4.	In progress
x) Implementation of new cleaning contract and active monitoring of the standards		Direcotr of Estates		Supporting implementation of the new cleaning contract and cleaning standards. Contract monitoing, training, early escalation in plan. Further challenged by the increased levels of activity. October 21: Internal IPC / environmental supportive audits in place.	In progress

Summary Narrative:					
October 21: Routine deep dive review at Audit Committee October 2021, Discussion on the impact of the backlog of activity , current activity pressures and changes to pathways in the context of quailty and safety. Assurance given on the actions being taken. Also discussed Medical Director and Chief Nurse holding joint strategic session for their senior teams. This will include review of quality and safety priorities, maximising working together and supporting the divisions effectively and streamlining meeting structure where possible.					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability, Quality, People **We provide a portfolio of services that is financially and clinically sustainable in the long term. We deliver high quality, compassionate services consistently across all our sites. We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**

Strategic Objective: **divisional structure and leadership model to further improve service quality best in the health service workplace** **c) Embed and develop the new** **d) Create a health and well-being offer that is amongst the** **e) Progress and develop our equality performance to build an inclusive culture in the**	**Source of Risk:**	strategic objectives/ Staff Survey	**BAF REF No:**	009/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that our staff do not feel fully engaged and supported which prevents the organisation from maximising their effort to deliver quality and compassionate care to the community.	**Risk Open Date:**	Sep-20	**Executive Lead/ Risk Owner**	**Chief People Officer**
	Risk Review Date:	Dec-21	**Lead Committee:**	**QSC, FPPC, Inclusion**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Staff not sufficiently involved in changes that affect or impact them. ii) Organisational failure to invest in line manager skillset/capability. iii)Management style/actions may not enable staff engagement or empowerment. iv)Organisational failure to drive inclusivity, so some groups feel they cannot make their voice heard. v)Staff may not be able to access the support or training they need to develop in their role.	i) Quality and Safety Improvement Culture is not fully achieved ii) Opportunities for improving patient care are missed iii) Staff leave the Trust, resulting in higher recruitment costs, loss of skills, talent, organisational memory, and increased focus on induction rather than on staff development.	**Inherent Risk** (Without controls):	4	5	**20**	⇔
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
i)Trust People Strategy designed to offer mitigations to this risk. ii) All staff are expected to embody PIVOT values. iii)Trust policies such as Dignity and Respect Policy and Raising Concerns Policy provide route for staff to voice concerns. iv) Freedom to Speak up Guardian can support staff to make their concerns known, so that the organisation can respond to those concerns. v)Staff Experience Group and Divisional Forums provide space for constructive dialogue with staff to impove staff engagement/experience. vi) Education Board provides means to drive forward new approaches to education and development for all staff. New role of Head of Culture to commence in June 2021 Equality and Inclusion Committee from May 21	i) Staff surveys, including quarterly Pulse survey ii) Monitoring of trends via reports to Trust Board and accountability through scrutiny at Trust Board. iii)Monitoring of level of challenge through application of staff policies, for example from under-represented groups.			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. failure to review and update some staffing policies C2. Need to develop education approach to supporting staff in under-represented groups C3. Need senior leadership development programmes to support the service improvement and transformation agenda. C4. Maximising the support networks abilty to influence service and culture change C5. Maximining staff access to wellbeing offers	A1. Failure to achieve Integrated Performance Review targets is an indication of negative assurance where the targets are relevant to this risk. A2. Capacity of F2SUG and static reporting	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) Embed compassionate leadership approach to organisational management.	C1,	**Chief People Officer**	Jul-21	leadership rhythms and compassionate leadership conversations being rolled out across the orgnaisation. 150 targetted to attend ICS sessions 145 confirmed. Additional programmes being identified as part of culture strategy for FPPC consideration in July 2021	in progress

ii) Develop improved education and training offer for all staff groups.	C2	Chief People Officer	Oct-21	Capability strategy developed to support all staff groups across the organisation. Now developing further the delivery of the roadmap	in progress
iii) Improve staff engagement through promotion of the EDI agenda, including support for staff networks.	C4	Chief People Officer	Aug-21	Head of culture in post from 4.6.2021 identifying new ways of working to relaunch culture strategy / staff network chairs backpay agreed via Exec in June 2021 / EIC to include feedback from staff networks / reciprocal mentoring planned for September 2021 / listening events planned in August to hear what is working and what improvements could be made. Head of People Culture in post from 1.6.2021 working on a culture plan aligned to the Trust People Strategy. Allocation of time agreed by the Board for Staff Network Chairs, job purpose and descriptions being finalised for existing chairs. A Staff Network Chair's Away Day was held on 12.7.2021 where the group worked on objectives and outcomes over the next 12 months.	in progress
Support and develop staff wellbeing services, in line with NHS People Plan and Trust People Strategy.	C5	Chief People Officer	Oct-21	wellbeing pyramid in place for all staff / regular communication of how to access and feedback given on effectiveness / review of interventions to be iundertaken in Autumn 2021	in progress
Provide effective channel for staff communication through Staff Experience Group and Divisional Forums	A1	Chief People Officer	Sep-21	Staff voice and staff experience group ongoing with regular reports to SEG and FPPC. Next report in September 2021	in progress
Roll out talent management approach and support career conversations across whole Trust.	A1, C2, C3	Chief People Officer	Oct-21	Grow together launch on ENH academy taken place in May 2021, managers and staff to discuss long term plans plus CPD. Review in Autumn 2021	in progress
Review of Freedom to Speak Up approach and implement development plan	A2	Chief People Officer/ Chief Nurse	Oct-21	FTSU guardian identified and project plan being developed. Detailed plan to be delivered to FPPC Autumn 2021. Business case approved by Executive committee to support new structure October 21: Fulltime FTSUG appointed and should commence in the new year. Our Trust has been chosen to take part in a pilot project on Inclusive Freedom to Speak up; workshops in place for October/November.	in progress
Summary Narrative:					

July 21: All interventions in place are highlighting particular areas of concern across the organisation, and interventions are being streamlined around these areas to maximise impact. A multi-disciplinary task and finish group is being set up including senior staff from the departments affected to implement the work.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: 1. Quality: 5. Sustainability:

Strategic Objective: **direction for the Trust, incorporating an Integrated Business Plan which triangulates finance, workforce and operational needs to 2030 clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic** **a)Develop a new strategic b)Safely restore capacity, and operational and**		**Source of Risk:**	Strategic Objectives/ AE reports	**BAF REF No:**	010/21
Principal Risk Decription: What could prevent the objective from being achieved?		**Risk Open Date:**	21.01.19	**Executive Lead/ Risk Owner**	**Director of Estates and Facilities**
		Risk Review Date:	Nov-21	**Lead Committee:**	**QSC**

Causes	**Effects:**	**Risk Rating**	**Impact**	**Likelihood**	**Total Score:**	**Risk Movement**
i) Lack of robust data regarding current compliance ii)Lack of available resources to enable investment ii) Ineffective governance processes iii) Reactive not responsive estates maintainance iv) skill mix, expertise and capacity	i) lack of information to inform risk mitigation and decisions ii) Lack of assurance that routine maintainance is completed ii) risk of regulatory intervention iii) poor patient experience iv) potiental staff and patient safety risks	**Inherent Risk** (Without controls):	5	5	**25**	
		Residual/ Current Risk:	5	3	15	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Revised leadership and governance structure within Estates & Facilities, Premises assurance framework/data base Specialist Authorised engineers in place as per statutory requirements, annual reports to H&S Health and Safety Group reports into QSC. Meets 6 weekly. Health and Safety Strategy 2020 Fire Policy and Procedures Capital funding prioritiesed Other statutiry groups and supportive workstreams Audit programme including - Weekly environmental audits Water safety group and action plan Ventilation group Links to corporate meeting includign COVID speciatist advisory group.	Assurance reports under statutory requriements - June QSC 21. E&F risk register reviewed and updated. - Risk clinics / workshops held in 2021 Authorised engineer reports Fire safety annual report			

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1. Ineffective estates and facilities governance structures C2. Estate strategy due for renewal C3. Lack of capital funding to bring the Lister and other sites to compliance C4. Implementation of actions from the AE reports C5 Limited visibility on the compliance status for the Trusts satellites locations. C6 Confirmation of level of compliance with Premisis Assurance Model (PAM) to inform gap analysis and work programme. C7. Optimal Space utilisation and decision making process for changes	A1. Limited assurance from other sites trust operates from A2. Actions to adress limited assuranceassessment for H&S, Medical Gases, Ventilation and decontamination A.3 PAM GAP analysis and action plan to inform decision making	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete

i) Substantive recuitment into leadership structure and other vacancies	C1, A1	Director of Estates and Facilities	Aug-21	Recruitment of E&F Compliance and Deputy Director of E&F underway	COMPLETED
ii) Development of Estates Strategy in line with the Organisational strategy	C3, C2	Director of Estates and Facilities	TBC	Progress report to Strategy Committee in September 21.	In progress
iii) Space Utilisation review and implement governance of decision making	C7	Director of Estates and Facilities	Dec-21	Systems for the management of space being investigated and compared. Investment required to implement	In progress
iv) Ensure actions plans and monitoring in place to raise the areas of 'limited assurance' to 'reasonable assurance' - for H&S, Medical Gases, Ventilation and decontamination . Including HSE notices.	C3, C2	Director of Estates and Facilities		Head of Compliance now in post, developing / implementing guideline for governance, control requirements and responsibiliies for all critical systems and functions. Feeding into the Premises Assureance Model (PAM). Estates Compliance monthly meeting in process of being established.	In progress
v) Complete the PAM gap analysis	A3, C2, C6	Director of Estates and Facilities	Dec-21	Compliance manager recruited and will prioritise this audit. PAM gap analysis is underway, supported by TIAA external PAM Audit.	In progress
vi) Review mechanisms of oversight of complaince across all sites to ensure effective	C1, C3, C5, A1	Director of Estates and Facilities		Estates Compliance monthly meeting in process of being established. To inlcude over-sight of all E&N Herts sites.	In progress
vi)					
Summary Narrative:					

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim: Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term; Quality: To deliver high quality, compassionate services, consistently across all our sites; Pathways: To develop pathways across care boundaries, where this delivers best patient care

Strategic Objective: i) Develop a future, local vision for the Trust's cancer services, and support work with partners to safely transfer MVCC to a tertiary provider	**Source of Risk:**	Specialist Commissioning Review	**BAF REF No:** 011/21
Principal Risk Decription: What could prevent the objective from being achieved? There is a risk that the Trust is not able to transfer the MVCC to a new tertiary cancer provider, as recommended by the NHSE Specialist Commissioner Review of the MVCC.	**Risk Open Date:**	Apr-20	**Executive Lead/ Risk Owner** Director of Finance
	Risk Review Date:	Nov-21	**Lead Committee:** Strategy

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Lack of continued commitment of the preferred provider to progress service transfer ii) Failure to make decision on long term service model following public consultation iii) Inability of NHSE to reach agreement with providers, including investment required, and execute the transaction iv) Failure of service sustainability in the pre transition phase due to failture to address critical infrastructure priorities	i) Increase in uncertainty over future of MVCC and adverse impact on recruitment, retention, morale and research. ii) Potential detrimental impact on care pathways at Trust sites. Protracted strategic uncertainty impacting the abilty to deliver a sustainable service model for future services provided by MVCC iii) Protracted strategic uncertainty and increased financial pressures on the Trust iv) Potential impact on quality, safety and ability to sustain safe service	**Inherent Risk** (Without controls):	4	5	**20**	⇔
		Residual/ Current Risk:	4	4	16	
		Target Risk:	4	3	12	

Controls/ Risk Treatment: (Preventive, Corrective, Directive or Detective)	Assurances on Control (+ve or -ve): Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	Positive Assurance (Internal or External) Evidence that controls are effective.	Positive Assurance Review Date	Key Performance Metrix aligned to IPR
- Programme Board governance in place for Strategic Review of the MVCC - Weekly ENHT, UCLH and NHSE Director level call in place and monthly Tripartite meeting in place to monitor delivery of the Strategic Review against plan - Fortnightly Due Diligence governance meeting in place (NHSE, UCLH, ENHT, HHT) - UCLH Transition Team in place at MVCC - ENHT MVCC Transfer Programme leadership (Programme Director) and governance (Steering Committee and Task & Finish) in place - Escalation reporting to Strategy Committee and Board - Clinical policies - Monthly ENHT, UCLH, NHSE Critical Infrastructure Review in place underpinned by action plans & risk register - MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG, HHT and UCLH) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility	- Regular reports to Strategy Committee and the Board - Status reporting through ENHT Steering Committee - July 21 - Audit Committee Deep Dive	- Strategic review and recommendations from clinical advisory panel re MVCC, July 2019 - Positive Risk Review with Specialist Commissioners, December 2019 - Jan 20 NHSE approved the recommendation that UCLH is the preferred tertiary provider for MVCC (Jan 2020) subject to due diligence outcome. - NHSI/E Risk Review - significant assurance provided and decision to step down to BAU assurance monitoring. - Dec 2020 MVCC Review Programme Board - supported recommendation for full replacement and enhancement of current MVCC services on an acute site; shortlisted Watford (meets all essential criteria) and supported full options appraisal on the Watford site. - May 2021 Submission of Due Diligence reports from UCLH to NHSE. - June 2021 - East of England Clinical Senate review of proposals; informal feedback from review team has been positive - Sept 2021 - UCLH Expression of Interest submitted to DHSC, with support from ENH Trust Board, seeking route to capital as part of new hospitals programme		

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	Gaps in Assurance: Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	Reasonable Assurance Rating: G, A, R	
	A1) Confirmation by NHSE of route to access capital for reprovision by UCH, and outcome of public consultation as required by UCH Board A2) Mitigation of financial impact of transfer on our Trust A3) Confirmation of UCH operational and corporate capacity to conclude DD to outcome and implement transition A4) Confirmation of ENHT operational and corporate capacity to implement transition	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient
		Red	Effective controls may not be in place and assurances are not available to the Board.

Action Plan to Address Gaps

Action:	Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)	Lead:	Due date	Progress Update	Status: Not yet Started/In Progress/ Complete
ii) Provide input and support as relevant to NHSE activities to access capital	A1	Director of Finance	Ongoing	- Input provided to capital paper shared with NHSE Finance colleagues - Input and support provided for UCLH Expression of Interest in capital as part of DHSC new hospitals programme	In progress
iii) Chief Executive briefing of regional team to support activities in relation to access capital	A1	CEO	Ongoing	- Briefing of Ann Radmore	In progress
iv) Support public consultation process through effective development and execution of ENHT communications and engagement plan	A1	Director of Finance	TBC	- Planning to start once timing of Public Consultation is clearer, dependent on capital assurance	Not yet started
v) Finalise assessment of ENHT stranded costs	A2	Director of Finance	May-21	- Initial Financial Impact Assessment of MVCC Transfer on ENHT has been developed; detailed analysis completed. To be refreshed as required over time	Complete
vi) Negotiate settlement with NHSE to address ENHT stranded costs	A2	Director of Finance	Jul-21	- Review of stranded costs agreed with NHSE mid June 2021	Complete
vii) Lead definition and execution of plans to reshape corporate departments to deliver target reductions in corporate overheads	A2	Director of Finance	Mar-22	- Meetings held in May at which Corporate Directors shared their plans	In progress
viii) Seek assurance from UCH of commitment to resourcing and plans at programme governance forums	A3	Programme Director – MVCC Transfer	May-21 Ongoing - dates to be realigned with earliest possible transfer of October 22	- Assurance sought from UCH re resourcing and commitment to delivery Due Diligence activities to revised plan - Initital discussions underway between ENHT and UCLH to discuss transition planning principles, approach and governance	Complete In progress
ix) Lead the programme-level development of transition and decoupling plans to identify corporate and divisional resources required to implement transition	A4	Programme Director – MVCC Transfer	Ongoing - dates to be realigned with earliest possible transfer of October 22	- Prior to confirmation from NHSE supporting work at risk, initial transfer and transition/de-coupling activities underway	In progress
Summary Narrative:					

May 21 - Due Diligence is due to complete at the end of May. Overall Strategic Review Programme milestones are under review, to be presented at May Programme Board, with an expected commitment to continue to target an April 22 transfer date.

June 21 - Strategic Review Programme Board in May presented a 'Plan A' timeline with Transfer date of April 22 and 'Plan B' timeline which would move the transfer date to July 22. Both dates are at risk due to critical dependency on route to capital, which remains unclear. UCLH Due Diligence reports with revenue and capital requests were submitted at end May 21 to NHSE for assurance process.
June 21 - Strategy Board - discussed MVCC Programme transfer update and noted the completion of the UCLH due diligence. Due to the level risk of a delay to the programme increasing the Committee increase the current risk score from 12 to 16. Work being undertaken to mitigate the risk was noted.

July 21 - Strategic Review Programme Board: Confirmation that due to continued uncertainty regarding route to capital, earliest feasible transfer date is now October 2022. In light of the delays, an MVCC Service Sustainability Forum (NHSE, ENHT, ENH CCG and HHT) established to oversee monitoring of a monthly integrated sustainability dashboard to enable early identification of increasing service fragility. ENHT refresh of scenario analysis in light of the delays, for discussion at July Audit Committee. Government announcement w/c 12th July regarding DHSE competition to fund 8 new hospitals, with Expressions of Interest due early September.

Sept 21 - Expression of Interest in capital for re-provision of MVCC Services was submitted by UCLH to DHSC on 08/09. ENH Trust Board supported the submission (discussed at 01/09 Private Board).
The first MVCC Service Sustainability Group meeting took place 06/09, comprising NHSE, ENHT, UCLH, THH and ENH CCG, to review the sustainability dashboard which will be produced monthly. The Group will next meet in November unless there is an urgent requirement to meet sooner.

EAST AND NORTH HERTFORDSHIRE NHS Trust Board Assurance Framework 2021-22

Strategic Aim:
compassionate services, consistently across all our sites **Quality: To deliver high quality,**
best patient care **Pathways: To develop pathways across care boundaries, where this delivers**
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term **People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce**

Strategic Objective: **b)Safely restore capacity, and operational and clinical performance affected by the COVID-19 pandemic, working across the system to maximise patient benefits pandemic progress development and delivery of integrated and collaborative services, making them easier to use for patients** **g) Working with system partners,**	**Source of Risk:**	External/ Civil Contingencies Act	**BAF REF No:** 012/21
Principal Risk Decription: What could prevent the objective from being achieved?**Risk of pandemic outbreak impacting on the operational capacity to deliver services and quality of care**	**Risk Open Date:**	04-Mar-20	**Executive Lead/ Risk Owner** Chief Operating Officer/ Chief Nurse
	Risk Review Date:	Dec-21	**Lead Committee:** QSC/ Board

Causes	Effects:	Risk Rating	Impact	Likelihood	Total Score:	Risk Movement
i) Covid 19 outbreak/pandemic - impact of varients nationally and world wide - increasing testing, self isolation, school closures, sickness. ii) Potential increased need of respiratory and critical care beds iii) Potential increase from containment to 'social distancing' iv) Enactment of the Civil Contingency Act v) Insufficent capacity for the increased demand - including ED and assessment and side room capacity vi) Likelihood of future surges / increase in covid numbers resulting in an increase in Covid numbers and hospitalisations, ventilated patients and a decrease in available workforce. vii)Future Covid surges combined with a decrease in available workforce could have a negative impact on staff resilience viii) Impact of winter could impact on overall capacity within the hospital	i) Risk of staff unable to attend work - due to self isolation or covid 19 positive. ii) Risk to patient safety as unable to provide safe staffing iii) There is a risk to the Trust's reputation if an outbreak was to occur/or criticism of our procedures. iii) Risk that some services are suspended for a period e.g. non urgent elective surgery, training iv) Risk of not meeting regulatory requirements v) Risk of financial impact if regulatory requirements are not achieved vi) Risk of winter demand/ illnesses on overall capacity within the hospital	**Inherent Risk** (Without controls):	5	4	**20**	
		Residual/ Current Risk:	5	3	10	
		Target Risk:	5	2	10	

Controls/ Risk Treatment**: (Preventive, Corrective, Directive or Detective)**	**Assurances on Control (+ve or -ve):** Where we can gain evidence that our controls/systems, on which we are placing reliance, are effective?	**Positive Assurance (Internal or External)** Evidence that controls are effective.	**Positive Assurance Review Date**	**Key Performance Metrix aligned to IPR**
Major incident Plan and Business continuity plans in place. Major Incident Command structure - Strategic, Tactical and Operational (Gold , silver, bronze) Command structures reviewed/adapted to ensure continued support to organisation / major incident Communication plan - internal and external Linked into and represented at Local and National resilience fourms/ communications/ conference calls Emergency Preparedness, Resilience and Response Committee - Chaired by Managing Director for Unplanned Care COVID Specialist Advisory Group with task and finish group structure reporting to it On call rotas - various Staff training programme - MI, loggist, Fit testing, skills refresh. Mortuary Capacity Plans IPC Policies and BAF Review and monitoring of O2 and ventialation Staff well being programme and deployment / reassignment processes - flexible (workforce triggers in place) Monitoring, review and recording of all national guidance and directives recieved re pandemic People and placed based risk assessments re COVID Social Distancing strategy Regional and Trust Local Indicators to suport decision making Flat packed pathways e.g. Ability to step up capacity esp in respiratory and critcal care pathways LFT testing and fast tracked PCR testing available for all staff Staff vaccine hub and vaccination programme Visitors Policies - including agreed triggers if changes required. winter initiatives have been agreed to enable the Trust to respond to the pressures of the winter period;	COVID dashboard Weekly Audits on environmental, IPC, H&S and social distancing Action Log/ Minutes from Strategic (GOLD), Tactical (Silver) and COVID SAG Trust Communications	Compliant with Emergency Planning Core standards 2021/22.	Report to QSC, June 2021 and December 202	

Gaps in control: Where are we failing to put controls/systems in place. Where are we failing in making them effective (List at C1, C2, C3, C4 etc and cross reference to actions)	**Gaps in Assurance:**Where effectiveness of control is yet to be ascertained or negative assurance on control received. (List at A1, A2, A3, A4 etc and cross reference to actions)	**Reasonable Assurance Rating: G, A, R**	
C1.Possibility of insufficient staff available on all shifts who have passed their FFP3 Fit testing C2. Possibility of staff being exposed to Covid-19 postive people especially with the rise in asymptomatic cases. C3. Possibility of visitors being exposed to Covid-19 postive people especially with the rise in asymptomatic cases. C4.There is a risk that patients are not screened on admission as per questions based on UK Health	A1 BCP's for high risk areas / small specialitist services/ On going resilience to sustain responsiveness to national guidance which is updated daily (esp in small teams / single posts) A2 Continuity of supplies as position changes - responding to national guidance and alerts A3 Adequacy of Ventilation in clinical areas	Green	Effective control is in place and Board satisfied that appropriate assurances are available
		Amber	Effective control thought to be in place but assurances are uncertain and/or insufficient

Security Agency (UKHSA) guidance about recent travel. C5.There is a risk that Trust and agency/bank staff may be confused by various external sources of information about WN-CoV and IPC precautions to take C6. There is a risk people in the community with symptoms are directed to ED, when they should stay at home - due to unclear community guidance C7. Business continuity plans may need to include WN-CoV. C8. Updates to national advice daily as the position changes C9. Demand for assessment and beds exceeds sideroom and bed capacity Requested regent to enable patient and staff testing internally / capacity of CUH to support increased testing Impact of COVID surges on capacity and staffing C10 – Overall hospital capacity limited by winter pressures. Winter initiatives agreed to provide additional capacity.	A4 Implementaion of winter initiatves	Red	Effective controls may not be in place and assurances are not available to the Board.	

Action Plan to Address Gaps

Action:	**Cross reference to gaps in controls and assurances (C1, C2…../ A1, A2 etc)**	**Lead:**	**Due date**	**Progress Update**	**Status:** Not yet Started/In Progress/ Complete
i) COVID Specialist Advisory Group oversight and leading policy, guidance and expertise - PPE, logistics, testing, social distancing, IPC issues	A2, C1, C2, C3, C4, C5,	Chief Nurse, Medical Director	Ongoing	Currently meets fortnightly. IPC Summer BAF inder review. Ongoing audit programme. 21 July 2021: meeting weekly meetings reestablished- reporting to SILVER and GOLD. New treatment pathway under development. Test and trace self isolation risk assessment and guidance for staff undeway. Continues to meet weekly / fortnightly dependant on need.	Ongoing
ii) Review of ventilation in clinical areas and develop proposal for improvement	A3	Director of Estates and Facilities/ Ventilation AE	Q1-Q2	Engaged with external company to review the adequacy of the ventilation in the clinical areas and developing a proposal for improvement. This is being monitored through Covid SAG and Health and Safety Committee.	In progress
iii) Prepare for any future National COVID Vaccination Programme in line with National Guidance	C2, C5,	DoF/ CPO / Emergency Planning		July 2021: Awaiting national guidance Sept 21: Covid boosterand flu vaccination programme in place ready to commence in October 21. Vaccination Programmes commenced. November 21: review of mandatory vaccination programme	In progress
iv) Monitoring of triggers to enable responsivness and 'unflat packing' of COVID response if/when required.	C9	COO / Emergency Planning	On going	July 2021: Command and Control structures reviewed - GOLDnow meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. Specialty working groups include - Critical care surge (adults/children), Paeds, Respiratory, Renal, Maternity. October 21: review of the triggers commenced to ensure they remain fit for purpose. Command structure ready to increase freqency if/when required. December 2021: Surge plans and triggers under review	In progress
iv) Implementaion of lessons learnt from previous COVID surges (internal and system)	C7, A1	COO / Emergency Planning	on going	July 2021: Command and Control structures reviewed -Workstreams, task and finish groups and surge plans - reviewed and stood up. Reviewing and preparing taskteam / deployment in readiness to respond.	In progress
v) Annual review programme and testing of the emergency planning standards	A1, C7	COO / Emergency Planning	on going	2020/21 assessment - compliant with the EPRR standards - Report to QSC June 2021. Assessment for the 2021 standards completed and compliant.	completed
vi) Monitoring implemention of winter initiatives (links to risk 1, operational delivery)	C10, A4	COO		see risk 1 performance .	
Summary Narrative:					

June 2021, the Committee considered the assurances received including confirmation of maintaining compliance with the EPRR standards 2020/21 and supported reduce this risk from a 15 to 10. Noted triggers and action in place to 'unflat pack' surge plans and plan in place/underdevelopment for potential increase in children young people attendances/ admissions. July 2021: Command and C|ontrol structures reviewed - GOLD now meeting twice a week and reinstated SILVER from 21 July 2021. Workstreams, task and finish groups and surge plans - reviewed and stood up. October 2021: Review of operational triggers and strucutre to support escalation commenced (taking into account the winter pressures) . December 2021 : Frequency of Gold/ Silver incident meetings reviewed and increased in frequency. Review of task and finish groups to support level 4 incident response locally and in line with national requirements. Risk assessment process introduce to support staff return to work in line with National Guidance

East and North Hertfordshire NHS Trust

Agenda Item: 9

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022
Integrated Performance Report

Purpose of report and executive summary (250 words max): The purpose of the report is to present the Integrated Performance Report up to the end of November to the Trust Board. Key challenges and mitigations under each domain are identified within the report.		
Action required: For discussion		
Previously considered by: N/A		
Director: All Directors	**Presented by:** All Directors	**Author:** All Directors / Head of Information and Business Intelligence

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

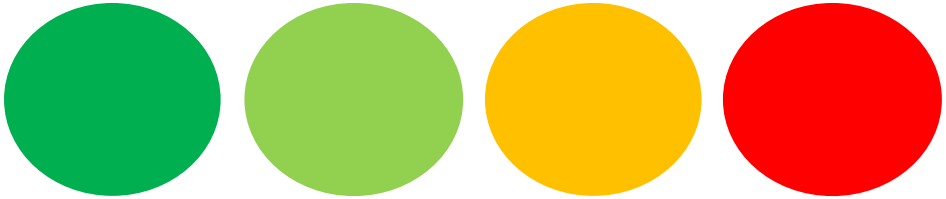
Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality): Key challenges and mitigations under each domain are identified within the report.

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

East and North Hertfordshire NHS Trust

Integrated Performance Report

Month 08 | 2021-22

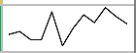
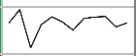
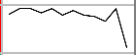
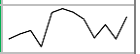
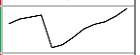
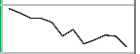


Data correct as at 07/01/2022

NHS Oversight Framework

East and North Hertfordshire NHS Trust

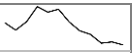
Quality of care

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Overall	CQC rating	-	Dec-19	-	-	Requires improve-ment	
Caring	Written complaints - rate	Monthly	Oct-21	Local	1.9	0.9	
Caring	Staff Friends and Family Test % recommended - care	Quarterly	Q2 2019-20	National	81.3%	78.9%	
Safe	Occurrence of any Never Event	Monthly (six-month rolling)	Jun-21 - Nov-21	National	0	3	
Safe	Patient Safety Alerts not completed by deadline	Monthly	Dec-21	National	0	0	
Caring	Mixed-sex accommodation breaches	Monthly	Nov-21	National	0	0	
Caring	Inpatient scores from Friends and Family Test - % positive	Monthly	Nov-21	Local	95.0%	96.6%	
Caring	A&E scores from Friends and Family Test - % positive	Monthly	Nov-21	Local	90.0%	80.2%	
Caring	Maternity scores from Friends and Family Test - % positive - antenatal care	Monthly	Nov-21	Local	93.0%	0.0%	
Caring	Maternity scores from Friends and Family Test - % positive - birth	Monthly	Nov-21	Local	93.0%	98.1%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal ward	Monthly	Nov-21	Local	93.0%	97.1%	
Caring	Maternity scores from Friends and Family Test - % positive - postnatal community	Monthly	Nov-21	Local	93.0%	100.0%	
Safe	Emergency c-section rate	Monthly	Oct-21	Local	15%	18%	
Organisational health	CQC inpatient survey	Annual	2019	National	8.0	7.8	
Safe	Venous thromboembolism (VTE) risk assessment	Quarterly	Q3 2019-20	National	95%	88.1%	
Safe	Clostridium difficile (C. difficile) plan: C.difficile actual variance from plan (actual number v plan number)	Monthly (YTD)	Nov-21	NHSI	52	47	
Safe	Clostridium difficile – infection rate	Monthly (12-month rolling)	Dec-20 - Nov-21	National	21.86	32.38	
Safe	Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Monthly (12-month rolling)	Dec-20 - Nov-21	National	0.92	0.54	
Safe	Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias infection rate	Monthly (12-month rolling)	Dec-20 - Nov-21	National	12.57	11.87	
Safe	Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	Monthly (12-month rolling)	Dec-20 - Nov-21	National	27.72	26.45	
Effective	Hospital Standardised Mortality Ratio	Monthly (12-month rolling)	Nov-20 - Oct-21	National	100	82.4	
Effective	Summary Hospital-level Mortality Indicator	Monthly (12-month rolling)	Aug-20 - Jul-21	National	100	85.7	
Safe	Potential under-reporting of patient safety incidents	Monthly (six-month rolling)	May-21 - Oct-21	National	6.06%	4.84%	

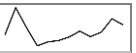
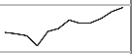
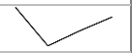
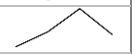
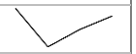
Finance

Domain	Measure	Frequency	Period	Target	Target	Score	Trend
Financial sustainability	Capital service capacity	Monthly	Oct-21	National	1	n/a	
Financial sustainability	Liquidity (days)	Monthly	Oct-21	National	1	n/a	
Financial efficiency	Income and expenditure (I&E) margin	Monthly	Oct-21	National	1	n/a	
Financial controls	Distance from financial plan	Monthly	Oct-21	National	1	n/a	
Financial controls	Agency spend	Monthly	Oct-21	National	1	n/a	

Operational performance

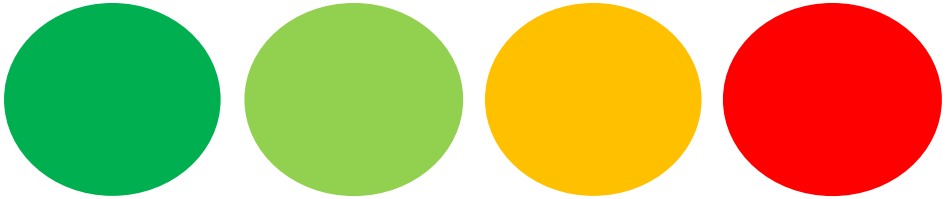
A&E	A&E maximum waiting time of four hours from arrival to admission/transfer/discharge	Monthly	Nov-21	National	95%	68.82%	
RTT 18 weeks	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	Nov-21	National	92%	55.07%	
Cancer Waiting Times	62-day wait for first treatment from urgent GP referral for suspected cancer	Monthly	Oct-21	National	85%	86.09%	
Cancer Waiting Times	62-day wait for first treatment from NHS cancer screening service referrals	Monthly	Oct-21	National	90%	87.50%	
Diagnostics Waiting Times	Maximum 6-week wait for diagnostic procedures	Monthly	Nov-21	National	1%	39.04%	
The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours who:							
Dementia assessment and referral	a. have a diagnosis of dementia or delirium or to whom case finding is applied	Monthly	-	National	95%	-	
	b. who, if identified as potentially having dementia or delirium, are appropriately assessed	Monthly	-	National	95%	-	
	c. where the outcome was positive or inconclusive, are referred on to specialist services	Monthly	-	National	95%	-	

Leadership and workforce

Organisational health	Staff sickness	Monthly	Nov-21	Local	3.8%	5.41%	
Organisational health	Staff turnover	Monthly	Nov-21	Local	12.0%	13.3%	
Organisational health	Proportion of temporary staff	Monthly	Nov-21	Local	-	12.1%	
Organisational health	NHS Staff Survey Recommend as a place to work	Annual	2019	National	63.3%	58.1%	
Organisational health	NHS Staff Survey Support and compassion	Annual	2019	National	20.9%	22.5%	
Organisational health	NHS Staff Survey Teamwork	Annual	2019	National	65.5%	66.2%	
Organisational health	NHS Staff Survey Inclusion	Annual	2019	National	87.8%	86.7%	
Organisational health	BME leadership ambition (WRES) re executive appointments	Annual	2019	National	7.4%	0.0%	

Quality & Safety

Month 08 | 2021-22



Quality and Safety

Summary

East and North Hertfordshire NHS Trust

Key Issues

Incidents and Serious Incidents (SIs)

- 1,224 patient safety incidents were reported in November.
- 23 cases were declared as serious incidents in November 2021. This is an outlier from our normal average variation of serious incidents reported., due to increased presentation of Hospital Onset COVID cases.
- SI cases were related to:
  - Infection Control incidents (HOCI) (11)
  - Care related incidents (4)
  - Accidents related incidents (1)
  - Child Protection incidents (1)
  - Falls (1)
  - Medication incidents (1)
  - Obstetric incidents (1)
  - Operation/Theatre related incidents (1)
  - Pathology incidents (1)
  - Resuscitation Related incidents (1)
- SI Round table discussions are now imbedded as initial learning review events post serious incidents
- The joint quality review meeting with CCG and NHSE/I there is a real recognition of the hard work in tackling the backlogs but ongoing plans for HOCI cases and trajectory for the overdue serious incident report publications. The number of overdue serious incidents are on trajectory of improvement.

Infection Control

- MRSA - 0
- C.diff. - 7
- E.coli - 5
- MSSA - 4
- Klebsiella - 3
- Pseudomonas aerudinosa - 1
- CPOs - 0
- Hand Hygiene - 92.3%

Deteriorating Patients

- Cardiac arrest rates were reported as 0.7 per 1000 admissions in November, continued sustained improvement below the national average.
- Doctors' digital escalations alerts have now susses fully gone live.
- Hospital at Night project remains progress.
- Reliability of observations were captured at 4hrly 71% and 1hrly 44% on Nerve Centre e-Obs.

Sepsis Screening

- 101 patients were audited across ED & Inpatient were captured in November.
- Inpatient 6/6 sepsis bundle compliance increased from 16% in October to 34% in November.
- ED sepsis bundle has increased from 31% in October to 54% in November.

Venous Thrombo-embolism

- VTE risk assessment stage has improved from 74% in September to 93% in November.
- VTE risk assessment for stage 2, 3 has improved form 44% in September to 51% in November.
- TED stockings were correctly prescribed and documentation; and fitted improved form 52% in September to 60% reliability in November.
- The trust has reliably sustained >95% in correctly prescribing and documenting low molecular weight heparin.
- 6 cases of hospital acquired thrombosis were noted to be potentially preventable in November.

Complaints

- There were 55 complaints received in November.
- 100% of complaints were acknowledged within 3 working days. The Trust target is 75%.
- The final response to complaints in November was 85%. This is above the Trust target of 80%.
- 86 Complaints were also closed in November.

Executive Response

Incidents and Serious Incidents (SIs)

- 1,191 (97%) of all incidents reported were low or no harm, which teams a recognised and celebrated for demonstrating a healthy reporting culture
- 77 incidents were presented to SIRP in November, 15 serious incidents were appropriate for thematic cluster learning reviews
- Ongoing re-design processes are in progress to drive improvements related with the Divisional report and action plan sign off.
- Ongoing review of round table processes, SI template and other quality issues are planned for December
- Weekly escalations of delays to report continue with corporate and divisional leads
- Review of all outstanding HOCI cases coming to panel has been completed with final list sent to the divisions. The final report is now in draft version, with some final amendments underway. The national Patient Incident Response Framework (PSIRF) workshop is planned for Dec 2021 and feedback from the early adopter sites which will inform and help finalise our patient incident response policy.

Infection Control

- The numbers of community admissions for COVID-19 has increased in line with the regional rates in November 2021.
- There were five COVID-19 outbreaks reported in November 2021. Planned Care wards: 5A; Unplanned Care wards: 6A North and South, 8A North, and 9B South.
- The COVID-19 outbreak wards closed in November were: 7B South, 7A, and 6A South.
- We had an amazing 150 plus attendees join us on the Stronger Together IPC webinar on Thursday 11th November 2021. We were grateful to everyone who shared their knowledge and enthusiasm with us to help take our infection, prevention and control standards even higher across the health care system. We had speakers from UWL, NHSE/I, Bangor University, WHHT, PAH, and ENHT, and support from Ecolab, Gama, and the East and North Hertfordshire Hospitals' Charity.
- Peer review continued with a visit to Watford General Hospital to review C.difficile cases.
- IPC team supported the Trust antimicrobial week
- IPC team was happy to support the phenomenal International Nurses Day
- Supported with Christmas planning to ensure staff could enjoy Christmas in the safest way possible, after such a challenging two years.

Deteriorating Patients

- The resuscitation team and palliative care team are collaborating to support the design and implementation of better recognition and management of end-of-life care through RESPECT documentation framework.
- Through the digital Keeping Our Patients Safe programme and clinical leadership fluid balance monitoring module has been designed and is now ready for testing within Nerve Centre, plan to move trust wide in Dec 2021.
- Ongoing discussions with the integration with Nerve centre re: tags / prompts on NC on adding Sepsis e-assessment, hypercapnia, airway, prompts for GCS/FB/BMs.
- Improving reliability of observations and competency-based education programme by CCOT for ward nurses to improve identification and escalation of patient deterioration is in progress.

Sepsis

- With the increased attendances in ED the sepsis team and CCOT continue to support the ED teams with the timely recognition of sepsis and training needs.
- Sepsis Team will continue to be clinically visible to advice/support IP staff with Sepsis 6 completion with plans to offer Venepuncture/IV Cannulation/ Administration training including newly qualified and overseas staff.
- Deep dive scheduled to be present at the December Patient Safety Forum

Venous Thrombo-embolism

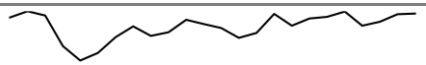
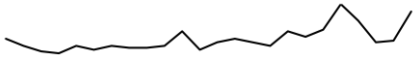
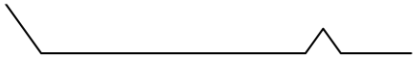
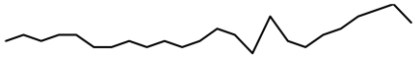
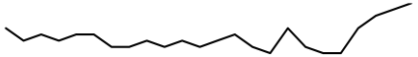
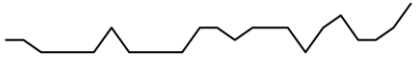
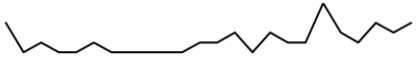
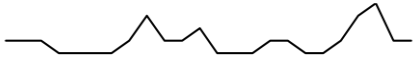
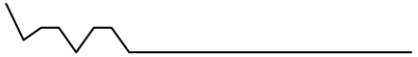
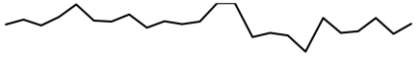
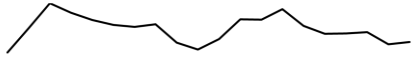
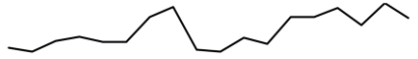
- VTE pharmacist lead has been appointed with the recruitment process ongoing for a lead VTE/HAT consultant.
- Specific wards have seen excellent results through targeted improvement plans for VTE risk assessment through the Nursing & Midwifery Excellence Accreditation programme
- E-learning for VTE is now on ENH Academy as essential training for doctors and pharmacists and VTE has been added as a standard in the ward accreditation programme.
- Learning from VTE incidents that have been discussed at SIRP have been included in the corporate RHD learning points document.
- All potentially preventable thrombosis cases are presented and discussed in SIRP and reviewed through the trust Thrombosis Action Group.

Complaints

- A review of the themes arising from complaints has indicated communication as a leading with further analysis that may highlight specific areas for quality improvement.
- 80% of complaints in November related to Quality of care or communication
- Ongoing review of triage of all concerns / complaints is forwarded to the most appropriate team.
- Priority is given o longest outstanding responses
- The highest proportion of PALS concerns relate to delays in treatment and communication.

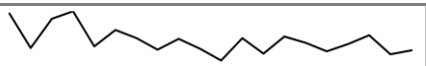
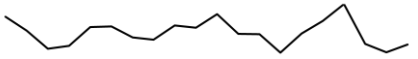
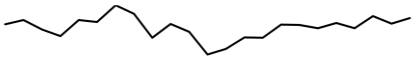
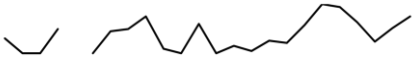
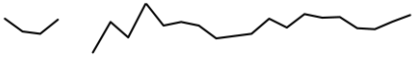
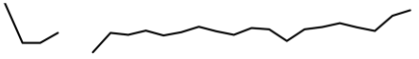
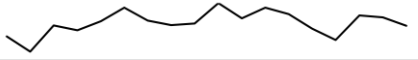
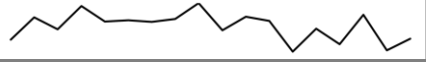
Key

▲	normal variation but trending up	◀▶	normal variation with no trend	▼	normal variation but trending down
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Incidents	Total incidents reported	Nov-21	n/a	1,224	▲		Special cause variation (9 points above the mean)
	Serious incidents	Nov-21	5	23	▲		Special cause variation (1 point above upper control limit)
COVID	Number of deaths from COVID-19	Nov-21	n/a	17	n/a		
	Number of deaths from hospital-acquired COVID-19	Nov-21	n/a	4	n/a		
Infection Prevention and Control	Hospital-acquired MRSA	Nov-21	0	0	◀▶		Zero hospital-acquired MRSA since Jun-21
	Hospital-acquired c.difficile	Nov-21	n/a	5	◀▶		Normal variation
	Hospital-acquired e.coli	Nov-21	n/a	8	◀▶		Normal variation
	Hospital-acquired MSSA	Nov-21	n/a	4	▲		Special cause variation (1 point above upper control limit)
	Hospital-acquired klebsiella	Nov-21	n/a	3	◀▶		Normal variation
	Hospital-acquired pseudomonas aerudinosa	Nov-21	n/a	1	◀▶		Normal variation
	Hospital-acquired Carbapenemase Producing Organisms (CPOs)	Nov-21	n/a	0	▼		Zero hospital-acquired CPOs since Jun-20
	Hand hygiene audit score	Nov-21	80%	92.3%	◀▶		Normal variation
Safer Staffing	Overall fill rate	Nov-21	n/a	69.8%	◀▶		Normal variation
	Staff shortage incidents	Nov-21	n/a	44	◀▶		Normal variation

Key

▲	normal variation but trending up	◀▶	normal variation with no trend	▼	normal variation but trending down
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Cardiac Arrests	Number of Cardiac Arrest calls per 1,000 admissions	Nov-21	n/a	0.66	◀▶		Normal variation
	Number of Deteriorting Patient calls per 1,000 admissions	Nov-21	n/a	0.53	◀▶		Normal variation
Deteriorating Patients	Reliability of observations (4-hour)	Nov-21	n/a	71.4%	◀▶		Normal variation
	Reliability of observations (1-hour)	Nov-21	n/a	43.6%	◀▶		Normal variation
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Nov-21	95%	60.0%	▲		Special cause variation (9 points above the mean)
	Inpatients Sepsis Six bundle compliance	Nov-21	95%	50.0%	◀▶		Normal variation
	ED attendances receiving IVABs within 1-hour of red flag	Nov-21	95%	81.8%	◀▶		Normal variation
	ED attendance Sepsis Six bundle compliance	Nov-21	95%	62.2%	▲		Special cause variation (1 point above upper control limit)
VTE	VTE risk assessment stage 1 completed	Nov-21	95%	74.2%	◀▶		Normal variation
	VTE risk assessment for stage 2, 3 and / or 4	Nov-21	95%	43.7%	◀▶		Normal variation
	Correct low molecular weight heparin prescribed and documented administration	Nov-21	95%	96.6%	◀▶		Normal variation
	TED stockings correctly prescribed and documentation of fitted	Nov-21	95%	52.3%	◀▶		Normal variation

Key

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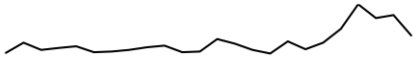
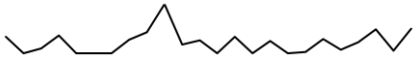
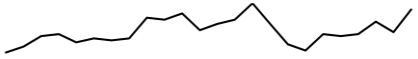
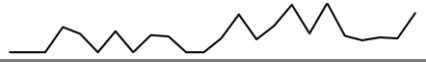
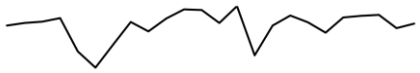
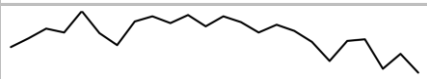
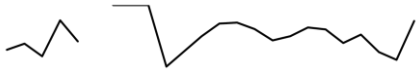
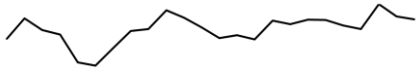
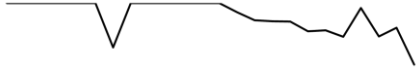
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
HATs	Number of HAT RCAs in progress (rolling 24 mths)	Nov-21	n/a	34	◀▶		Normal variation
	Number of HAT RCAs completed	Nov-21	n/a	36	◀▶		Normal variation
	HATs confirmed potentially preventable	Nov-21	n/a	6	▲		Special cause variation (1 point above upper control limit)
PU	Pressure ulcers All category ≥2	Nov-21	n/a	26	◀▶		Normal variation
Patient Falls	Rate of patient falls per 1,000 overnight stays	Nov-21	n/a	tbc	tbc		
	Proportion of patient falls resulting in serious harm	Nov-21	n/a	4.4%	◀▶		Normal variation

East and North Hertfordshire NHS Trust

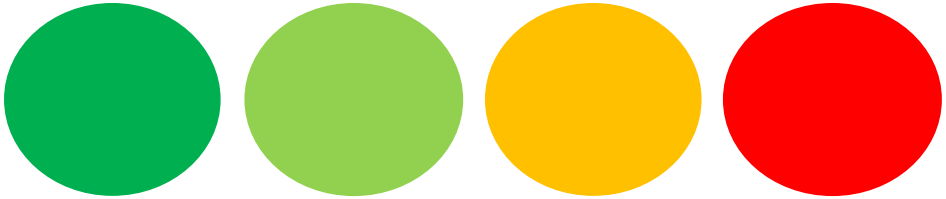
Summary

▲	normal variation but trending up	◀▶	normal variation with no trend	▼	normal variation but trending down
▼▲	statistically significant positive outlier	▼▲	statistically significant negative outlier		

Sub-Domain	Metric	Month	Target	Actual	Change	Long-term Trend	Comment
Friends and Family Test	Inpatient FFT Positive recommendations	Nov-21	93%	96.6%	◀▶		Normal variation
	A&E FFT Positive recommendations	Nov-21	93%	80.2%	▼		Special cause variation (1 point below lower control limit)
	Maternity FFT - Antenatal Positive recommendations	Nov-21	93%	0.0%	▼		Special cause variation (1 point below lower control limit)
	Maternity FFT - Birth Positive recommendations	Nov-21	93%	98.1%	◀▶		Normal variation
	Maternity FFT - Postnatal Positive recommendations	Nov-21	93%	97.1%	◀▶		Normal variation
	Maternity FFT - Community Positive recommendations	Nov-21	93%	100.0%	◀▶		Normal variation
	Outpatients FFT Positive recommendations	Nov-21	95%	95.2%	◀▶		Normal variation
PALS	Number of PALS referrals	Nov-21	n/a	317	▲		Special cause variation (9 points above the mean)
Complaints	Number of written complaints received in month	Nov-21	n/a	55	◀▶		Normal variation
	Proportion of complaints acknowledged within 3 working days	Nov-21	75%	75%	▼		Special cause variation (1 point below lower control limit)
	Proportion of complaints responded to within agreed timeframe	Nov-21	80%	85%	◀▶		Normal variation

Effective Services

Month 08 | 2021-22



Key Issues

Crude Mortality
- The in-month crude mortality rate decreased from 12.21 deaths per 1,000 admissions in October, to 10.41 in November.
- The rolling 12-months crude mortality rate was 14.25 deaths per 1,000 admissions in the 12 months to November and is lower than the most recently available national rate of 14.99 deaths per 1,000 admissions (Nov-20 to Oct-21).

Hospital-Standardised Mortality Ratio
- The in-month HSMR has increased from 80.28 in September to 82.64 in October.
- The rolling 12-months HSMR has increased from to 82.09 to 82.38 in the 12 months to October.
- The Trust remains within the best performing quartile of Trusts for HSMR.
- HSMR is usually available 1-2 months in arrears.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest SHMI release for the 12 months to July has decreased to 85.74, from 86.67 in June.
- This Trust remains in the 'lower than expected, Band 3' category.

Re-admissions
- The re-admission rate for 12 months to October has increased from 7.16% to 7.53%.

COVID-19
- To date CHKS analysis of our COVID-19 mortality has shown the Trust to be centrally placed in comparison to national and our PMO peer group.
- Probable/definite hospital acquired COVID-19 cases which sadly resulted in a death where COVID-19 was on part I of the death certificate have now been reviewed and passed to the SI Panel for consideration. To date over half have been discussed by Panel and declared SIs.

Learning from Deaths
- Where mortality reviews give rise to significant concern regarding the quality of care or the avoidability of the death, the case is subject to further scrutiny and discussion at the relevant specialty clinical governance forum. The outcomes of these reviews are then considered by the Mortality Surveillance Committee.
- A number of reforms are underway regarding the Trust's learning from deaths framework. These include the adoption of a Structured Judgement Review format based on the RCP model; the incorporation of this review onto the incoming Datix DCIQ platform, together with changes to the composition of, and management of, the pool of Trust mortality reviewers.

Executive Response

Crude Mortality
- This measure is available the day after the month end. It is the factor with the most significant impact on HSMR.
- The general improvements in mortality have been as a result of a combination of corporate level initiatives such as the mortality review process and more directed areas of improvement such as the identification and early treatment of patients with Sepsis, Stroke, etc. together with a continued drive to improve the quality of our coding.
- Our crude mortality has steadily improved over recent years. In the second half of 2019 our rolling 12month crude mortality rate was consistently better than the national average. 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.

Hospital Standardised Mortality Ratio (HSMR)
- Our current HSMR of 82.38 (rolling 12 months to October 2021) positions us in the best performing quartile of Trusts nationally (19/123 trusts). We remain focussed on driving further improvement.
- The NHFD advised that we are a 3SD outlier for #NOF mortality for the Jan-Dec 2020 year. A detailed review together with remedial action plan has been approved and submitted to the Q&S Committee. Progress continues to be monitored by the Mortality Surveillance Committee with regular updates provided to the Executive.
- The significant changes in overall admissions and the change in case mix during the pandemic have made interpretation of this data challenging but the Trust's position will continue to be monitored.

Summary Hospital-level Mortality Indicator (SHMI)
- The latest figure of 85.74 (12 months to July 2021) sees the Trust positioned within the 'lower than expected' band 3 category. Our position relative to our national peers currently stands at 11th out of all acute non-specialist trusts (123).
- COVID-19 activity continues to be excluded from the SHMI by NHS Digital.
- The fact that SHMI includes deaths within 30 days of discharge, and the Trust has remained well placed in comparison to the national picture, provides some assurance that our response to COVID-19 has not generally resulted in a disproportionate increase in deaths within 30 days of discharge.

Re-admissions
- The Trust's re-admission rate has generally been consistent with the national performance. Significant dips in readmissions were seen in March and October 2020 while July to September saw the Trust's rate rise slightly above the national picture. Recent months have seen performance improve and stabilise, with the Trust tracking below the national average.

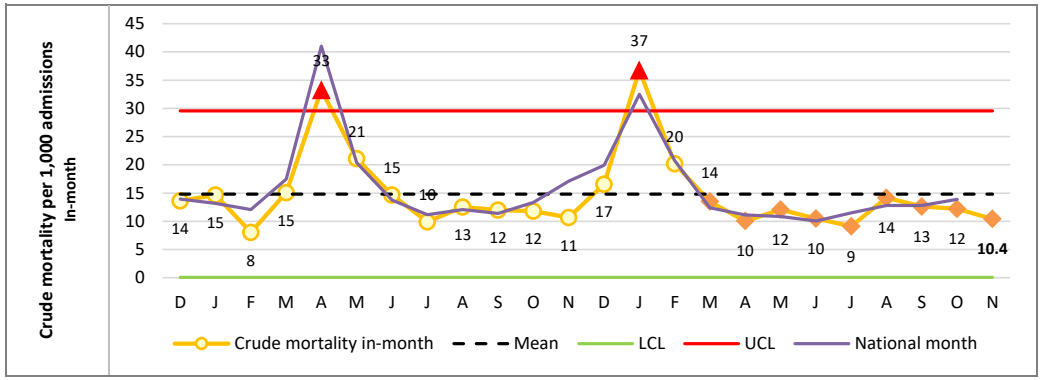
Learning from Deaths
- In addition to the outcomes of cases escalated to specialties being considered by the Mortality Surveillance Committee, the quarterly Learning from Deaths report includes a summary of key themes emerging from these cases. This detail is shared with all Trust Specialties and with interested working groups such as Deteriorating Patient, End of Life and Seven Day Services Steering Group and is scrutinised by both the Quality & Safety Committee and Trust Board.
- In tandem with the proposed move to Datix iCloud and full rollout of the Medical Examiner function a general review of our mortality review and learning from deaths processes is taking place.

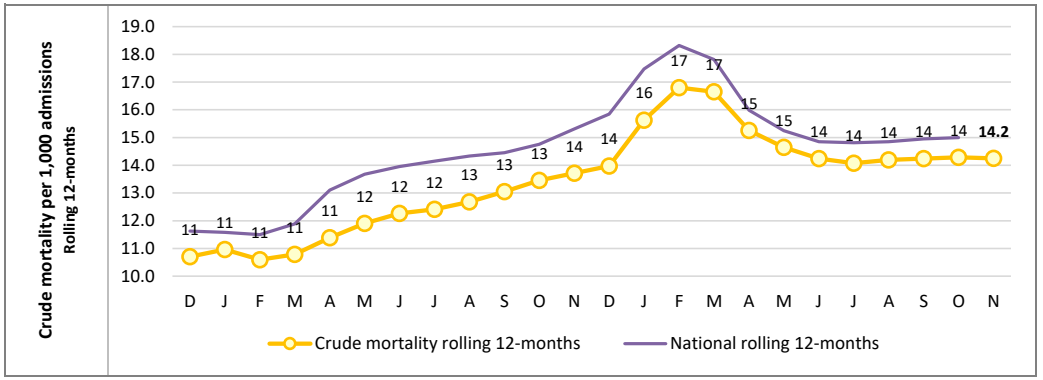
Mount Vernon
- The secession of MVCC as part of the Trust, will affect both our HSMR and SHMI. In addition to reporting the current situation, in preparation for the split we will shortly begin to report these metrics showing the anticipated effect of the loss of MVCC.

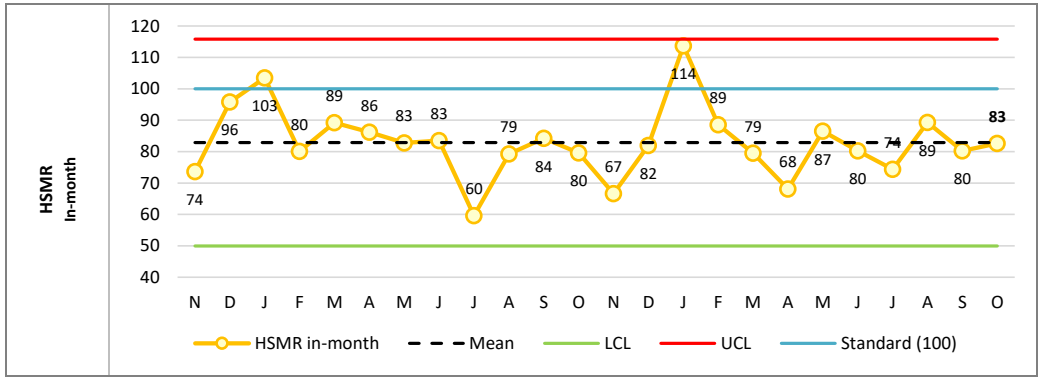
Specialist Palliative Care
- This data refers solely to patients under the care/review of the Palliative Care Team (PCT). Other data is available for deaths that are not known to the PCT. However, it resides in an access database and we are currently working through some data quality issues. The data provided in this report only relates to information recorded on Infoflex (currently only the Cancer service uses this system) and does not reflect the Trust-wide position
- We know that nationally, Specialist Palliative Care will only see in the region of 20% of hospital palliative care patients. Our Trust-wide figure sits at 55.6% from manual ICP data collection.

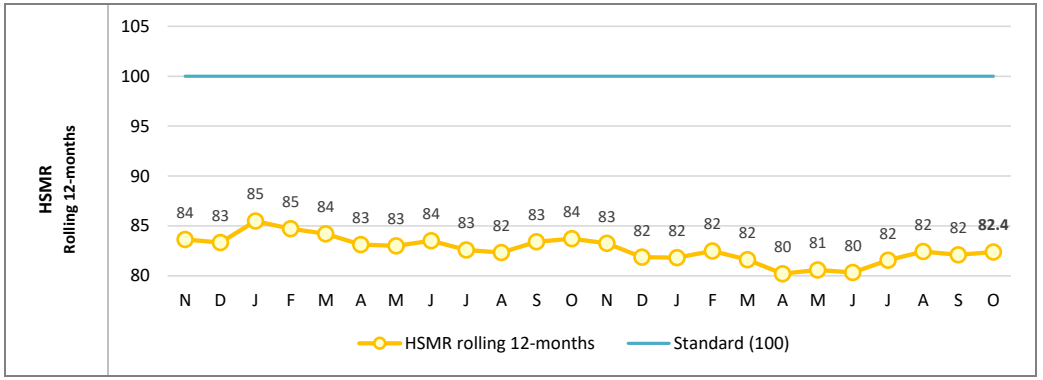
Effective Services

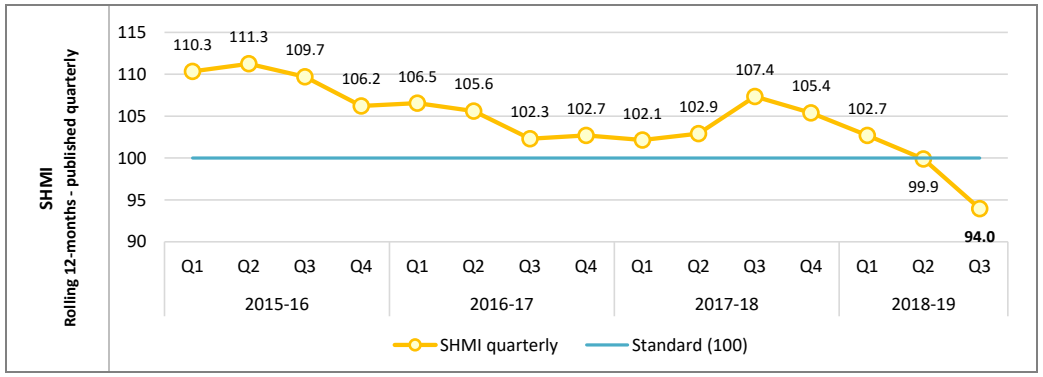
East and North Hertfordshire NHS Trust

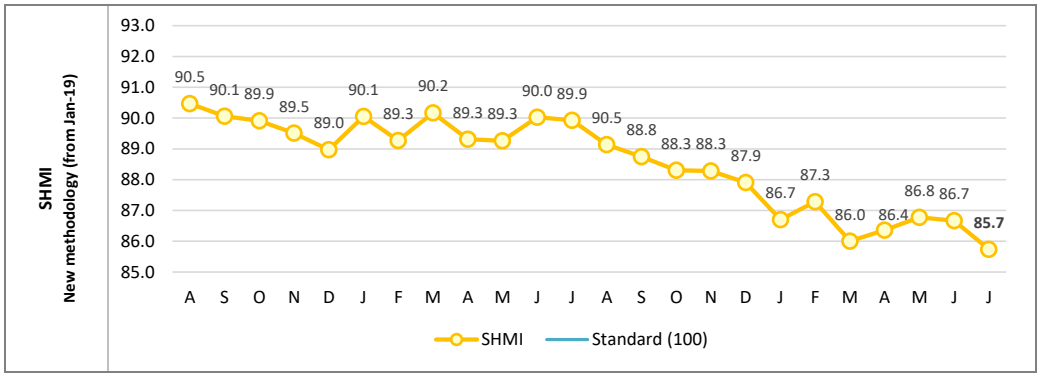






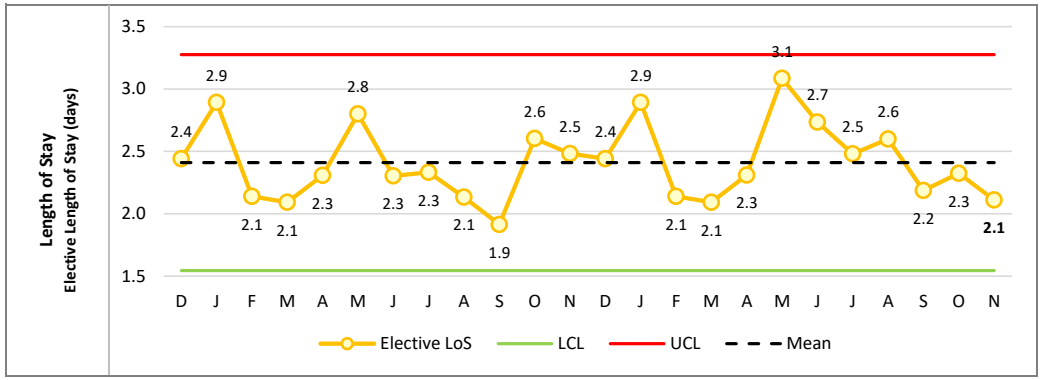


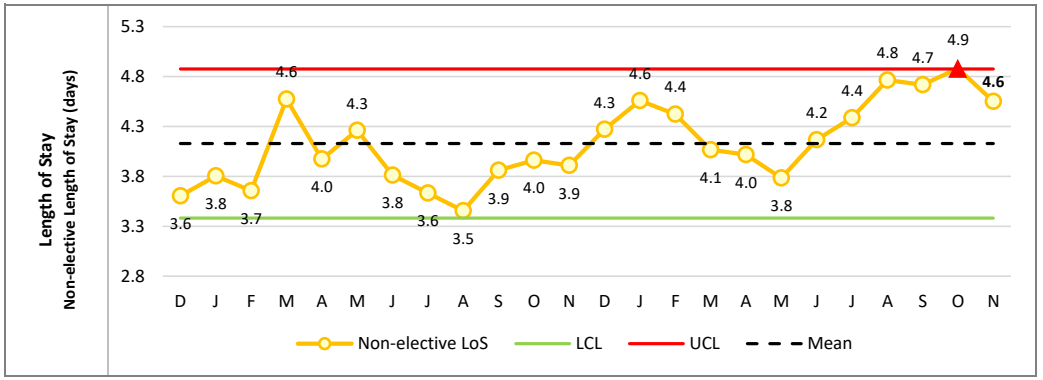


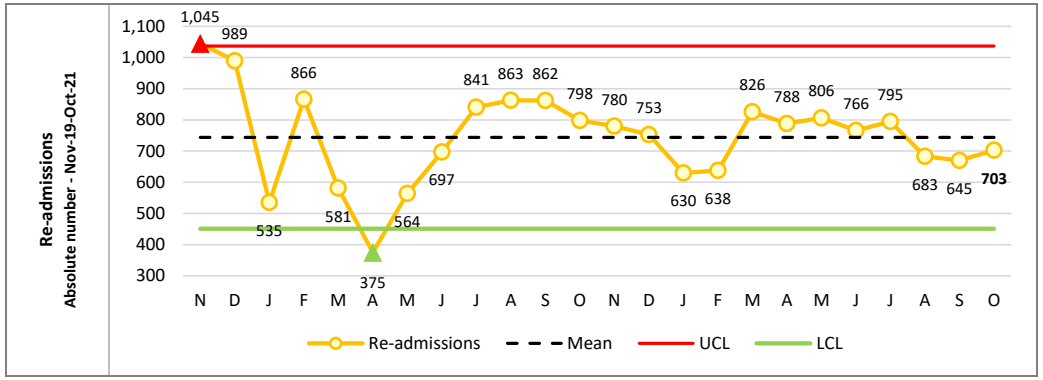


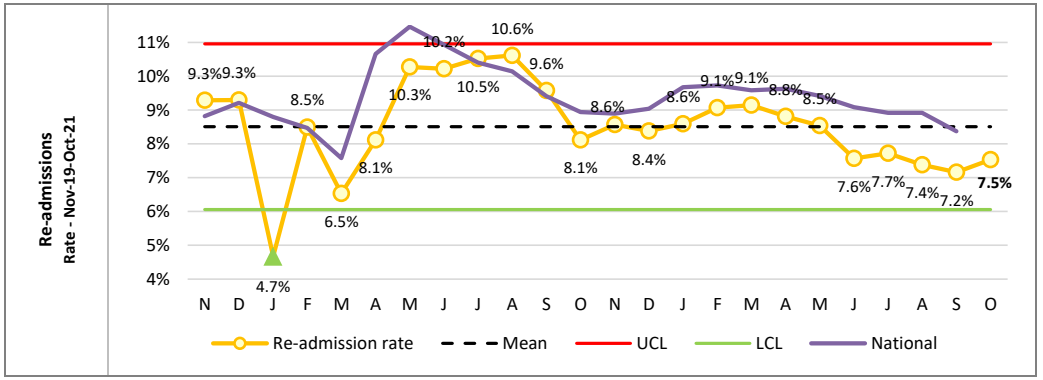
Effective Services

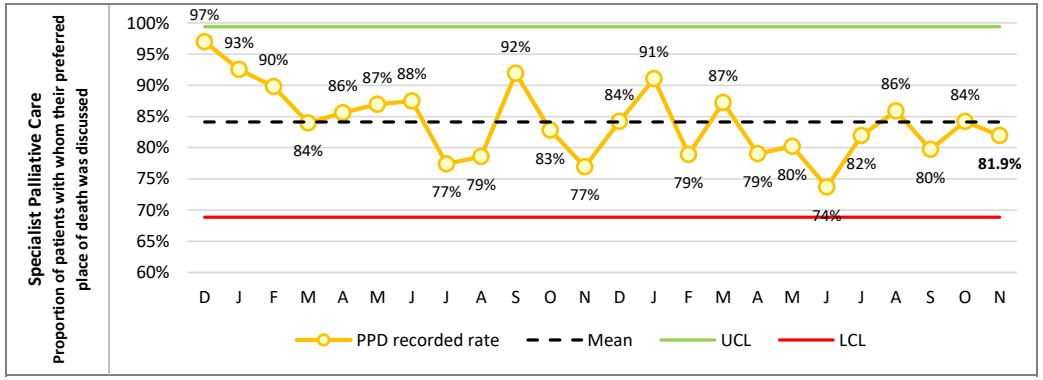
East and North Hertfordshire NHS Trust

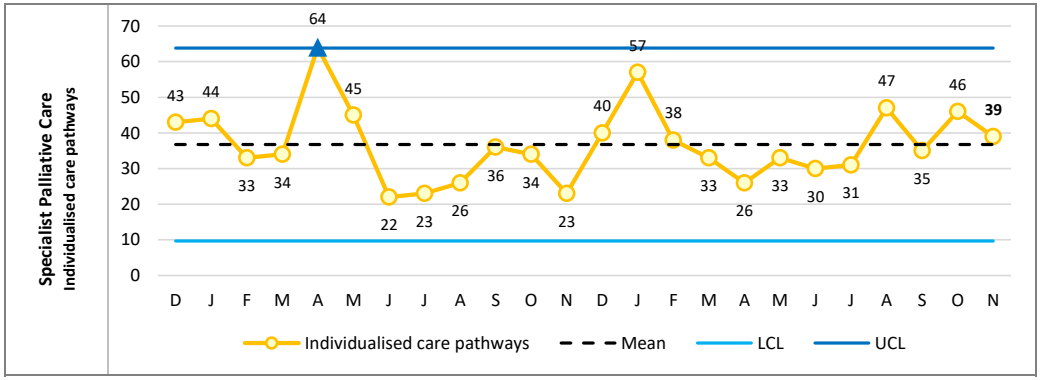






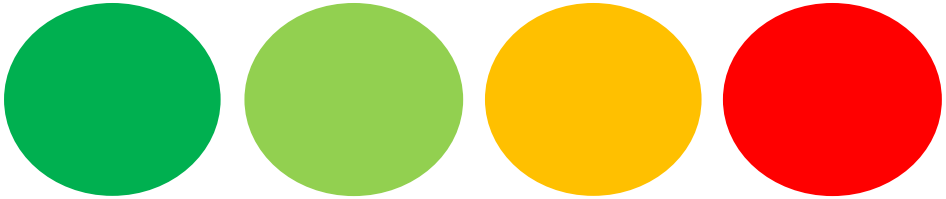






Responsive Services

Month 08 | 2021-22



Key Issues

A&E
- Performance for the month of November was 68.82%.
- There was one 12-hour trolley waits reported in November.

Cancer Waiting Times
- The Trust achieved 6 out of the 8 national targets for Cancer performance in October.
- The Trust 62-day performance for October was 86.1%.
- There were 5.0 pathways over 104 days for the 62-day standard and zero pathways over 104 days for 62-day screening. Longest wait is 6.5 days for 62-day standard.
- Good progress continues on the specialty cancer action plans, all plans being reviewed and updated weekly.
- Robust weekly cancer PTL management is in place.

RTT
- Incomplete performance for November was 55.07%. This is a decrease from the 56.84% reported in October.
- The November backlog was 23,960, an increase of 569 from 23,391 in October.
- There were 4,102 52-week breaches reported in the November incomplete position, an increase of 284 from the 3,818 reported in October.
- There were 76 patients waiting over 104 weeks in November. The longest week wait currently is at 165 weeks.

Diagnostics
- DM01 performance for November was 39.04%, against the national standard of 1% and the October position of 39.63%.
- Latest available National performance (October) was 24.98%.

Stroke
- 4hr Stroke performance for November is 17.1% - reason for high number of breaches (64) - main areas of impact on breaches - 42% of overall breaches due to impact on demand within ED. 38% of overall breaches due to Bed capacity issues - due to pressures on the Trust capacity within Opel status, impacting on Stroke bed capacity and therefore flow for admissions.
- Thrombolysis performance is at 7.7% in November
- Door-to-needle declined to 33.3% for November
- CT 1-hour to scanning 50%.

Executive Response

A&E
- November proved to be another challenging month. Total ED occupancy remained a significant concern with continued risk of failu re to social distance as well as the need for regular use of surge capacity, which in turn reduces visibility and increases the ris k of clinical incidents.
- Positively non-admitted performance has demonstrated a stable position for last 3 months, which is due to the ongoing training a nd development for staff around redirection to alternative settings such as primary care and SDEC. It is recognised that due to the capital project and temporary relocation of paediatric ED into the purpose built SDEC unit, that ability to stream away is reduced du e to capacity. Increased SDEC capacity is expected in early March. In the meantime, other pilots are due to take place during MADE week in mid-December which include increased access to out of hours GP, increased access to the patient's own GP appointments and increas ed clinical navigator support to enable faster turnaround of patients requiring social input to support discharge. It is hoped if successful these pilots may evolve into winter resilience schemes.
- Admitted performance continued to deteriorate with the average length of time admitted patients remaining in the emergency de partment increasing from by approximately 40 minutes compared to previous month. This is explained by a loss of beds due to IPC issues, continued exit blocks for patients with complex needs and continued staffing pressures restricting the ability to open escalation areas . In mid-December, the new winter resilience operational structure commenced providing increased senior operational support to wards t o support improved escalations and early identification and planning of discharges. This structure will also support the work of the disc harge improvement team.
- Ambulance handover has maintained its performance, without further deterioration over the last 3 months. However, the trust recognises that significant improvements are needed to bring our performance in line with the expected standard. In late November, the trust opened a new cohort area providing space for 7 patients. The area is collocated to the main ED, utilising a section of our new build. In Late December, this area will be converted to a ringfenced handover area, as per the intended use of the area in line with the capital proje ct. Therefore, it is expected that improvement against the handover standard will be improved and sustained.

Executive Response (continued)

Cancer Performance (October)
- In October 2021, the Trust achieved 6 of the 8 national targets and 2 out of 3 28 -day FDS standards for Cancer performance: 2ww GP Referrals, 2ww Breast Symptoms, 31-day Subsequent for Radiotherapy, surgery and Chemotherapy, and 62-day urgent referral to treatment.
- The Trust has always previously delivered against the 2ww national standard which requires 93% of patients referred on a two -week pathway by their GP to have attended the 1st Outpatient appointment within 14 days. For October 2021 the Trust performance was 97.2%.
- In October 2021, the Trust wide average days wait for first appointment is at 10 days and the majority of patients were seen between 8 and 12 days.
- The Trust has consistently delivered against the Breast Symptomatic national standard which requires 93% of patients referred to have attended the 1st Outpatient appointment within 14 days. For October 2021, the Trust performance was 100%.
- The Trust has consistently delivered the 31-day second or subsequent treatment for Radiotherapy and Chemotherapy but not for the subsequent Surgery. For October 2021 the Trust Chemotherapy performance was 100%, the Trust Radiotherapy performance was 99.7% and the Trust subsequent Surgery performance was 96.8%.
- The Trust performance for 31-day to first definitive treatment was 94.3%. The standard requires 96% of patients to receive treat ment within 31 days of diagnosis.
- In October 2021, the Trust performance for the Faster Diagnosis is 77.0% for the 2ww patients, 86.6% for Breast Symptomatic a nd 34.1% for screening patients.
- Reported 62-day performance for September 2021 was pre-sharing 80.1% and post-sharing 86.1%.
- Cancer performance is available one month in arrears.

RTT
- The Trust continued to see more patients in clinic in November, 48,519 compared to 42,370 in 2019 -20, with a significant increase in OP procedures.
- Patient Tracking list:
  - Overall number of patients waiting decreased in November.
  - The number of patients over 52 weeks has increased.
  - The number of patients waiting over 104 weeks has remained stable in November with a slight increase at the end of the month.
- PTL management continues, reviewing and managing patients on our treatment lists with a focus on plans for each patient.
- Investment in validation team to complete focussed work on removing DQ issues on incomplete PTL by March 2022.
- Treatment priority given to patients classified under the Royal College of Surgeons Guidelines (P1 – P6), then long waiters taking into consideration of patient's needs, such as Learning Disabilities. 97.7% of admitted patients are risk stratified against the Royal College guid elines.

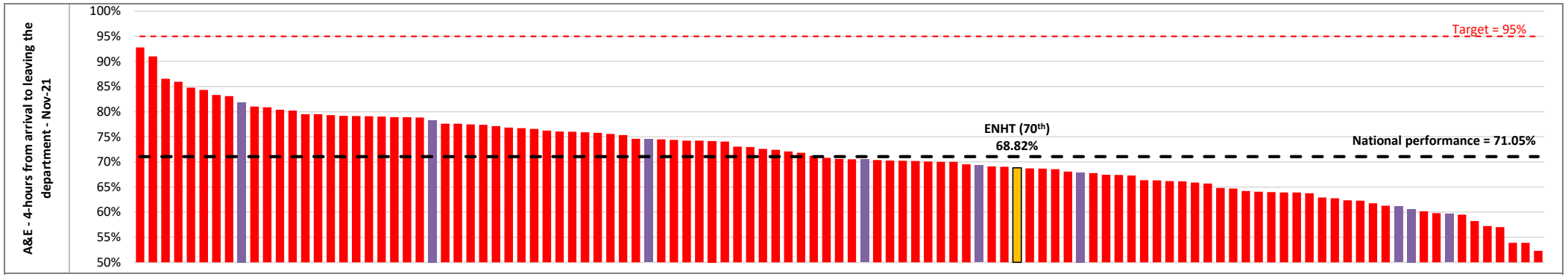
Diagnostics
- Imaging has delivered steady improvements from request to exam turnaround for all modalities however backlog clearance still a significant issue and DMO1 compliance is not achieved.
- Imaging demand continues to increase, including cancer referrals and imaging that is more complex and therefore more time con suming. Additional capacity is being added for USS and CT, staffing permitting.
- Additional Endoscopy capacity in place to support driving down 6 and 13 week waits.
- In November Cystoscopy, Neurophysiology and sleep studies are reporting no patients waiting above 13 weeks.
- Reduction in the number of Colonoscopy patients waiting above 13 weeks.

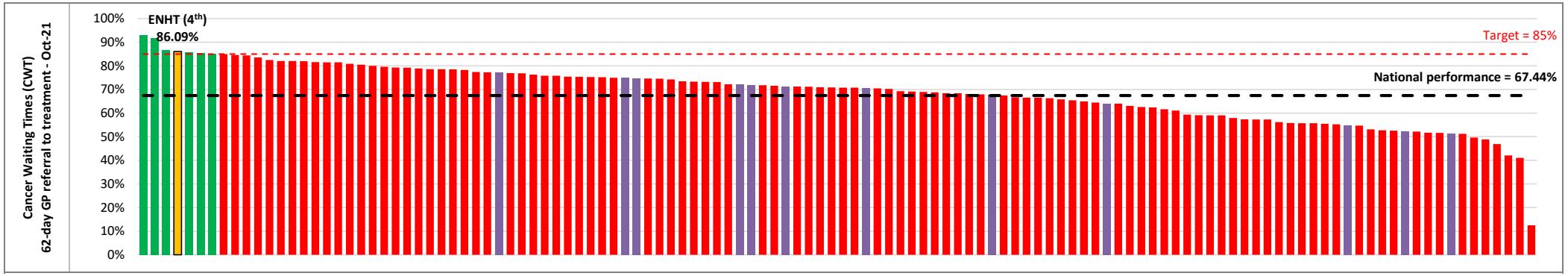
Stroke
- 4-hour performance, against the 63% target, for November was 17.1% - 64 Breaches
- Breakdown of breaches within working establishment. In -hour breaches: 39% / Out of Hour 61% - Out of hours is only provided by Stroke CNS with no Stroke specialism medical workforce and only Tele -Medicine providing support for Thrombolysis/Thrombectomy pathways.
- Concerns are ongoing with the requirements of Stroke beds needing to be used for Medical patients to support Trust position a nd to ensure all patient's safety. This reduces the available capacity for Stroke treatment and adherence to 4hr performance, due to the impa ct of available bed capacity and side rooms to support management of IPC requirement (while awaiting Swab results), which resulted in 38% of the overall breach reasons.
- Concerns with relation to the overall ED demand within the Month. This resulted in an impact of 18 Pathways/9 Late referrals (42%) of overall breaches due to late referrals to the Stroke services - this is linked with the overall demand within ED and Ambulance offload delays. Within the pathway breaches this includes the delays with Medical clerking out of hours as this is managed by ED or Medical on call team to complete the clerking,
- SNNAP rating performance reduction. Main contributing factors are 4hr performance and OT/PT non -compliance of establishment in-line with National Specification. Business case has been provided for approval to support levels to be compliant and therefore provide the necessary delivery of care in accordance with the SNNAP requirement.
- Door to Needle performance within 1hr is 33.3%. Ongoing issues due to delays within the pathway due to impact on demand with in ED and ambulance offload delays to get Stroke patients into Resus for Thrombolysis.
- 2 patients transferred to Charing Cross as per Thrombectomy pathway, with delays to being on a Stroke unit within 4hrs from E NHT arrival and arrival to Charing Cross within 4 hrs, due to travel time and delays within Ambulances to support transfers.

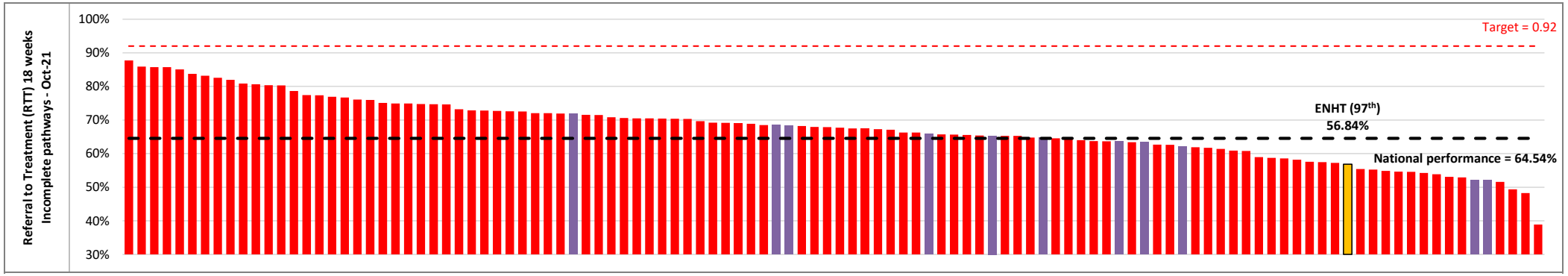
Responsive Services

Trust performance against all Trusts nationally

East and North Hertfordshire NHS Trust



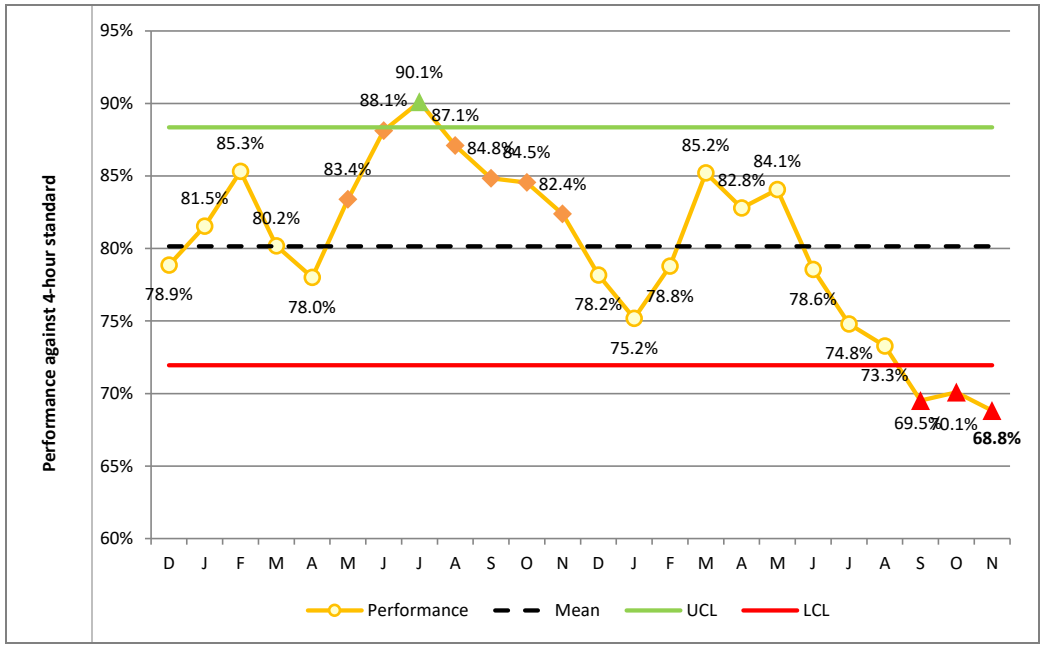




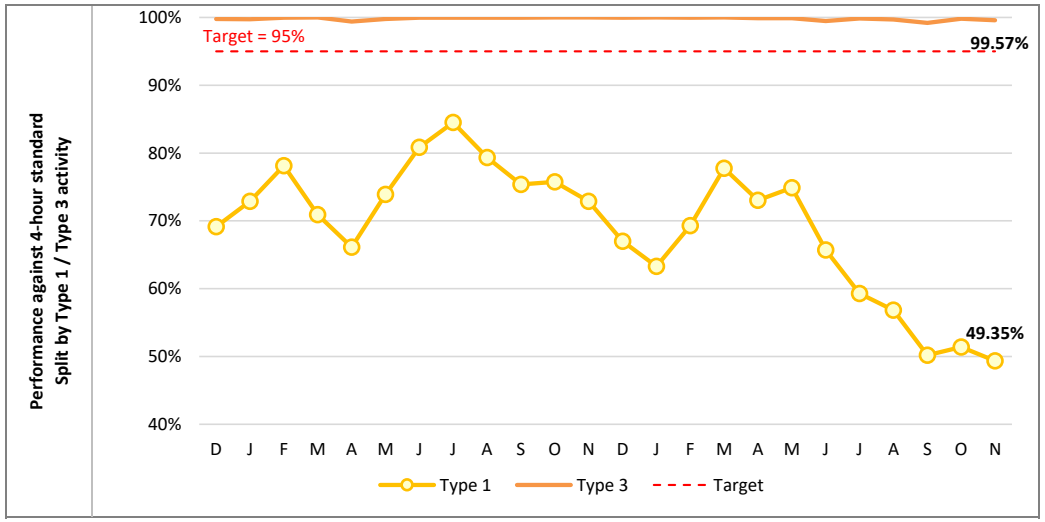
Responsive Services

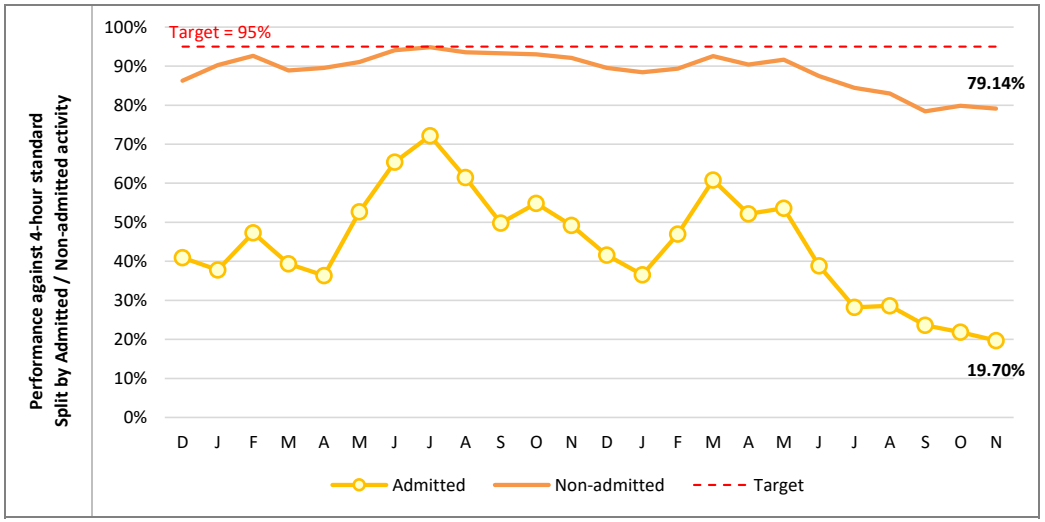
Emergency Department Performance

East and North Hertfordshire NHS Trust

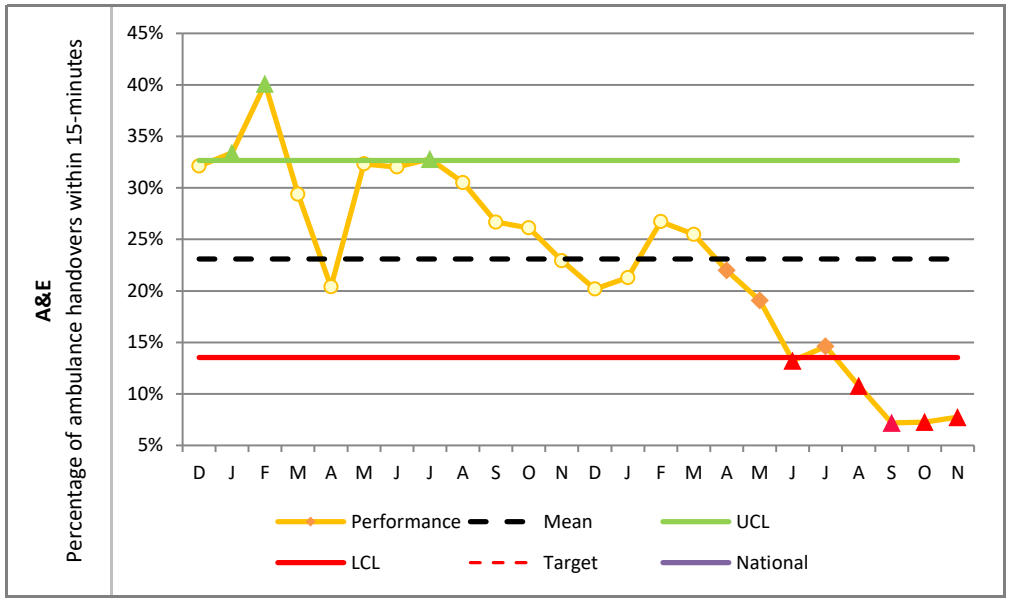


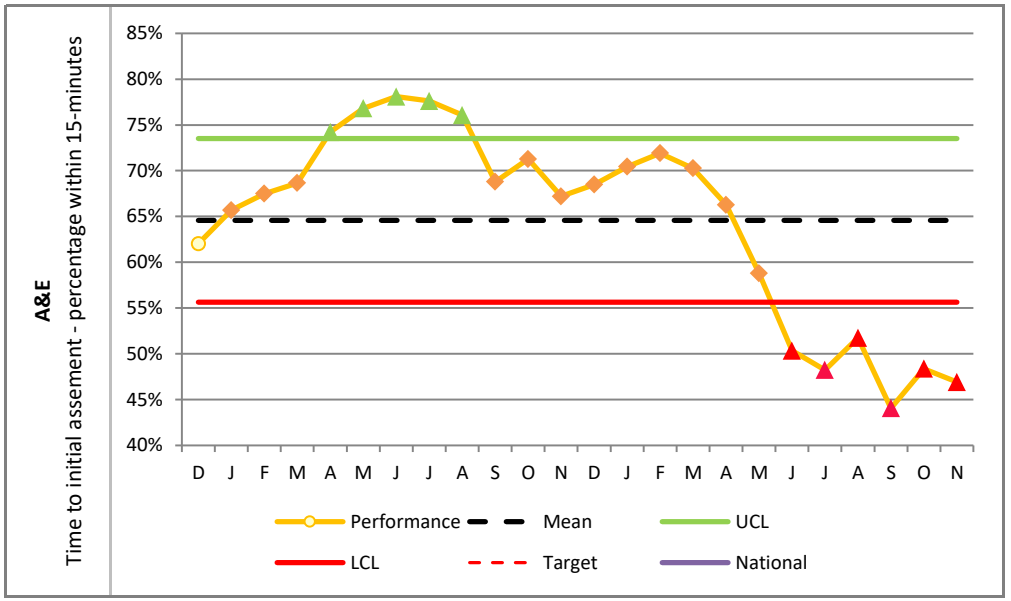
Domain	Metric	Target	Oct-21	Nov-21	Change	Trend
Other Emergency Department measures	Ambulance handovers (Arrival to Handover) Proportion within 15 minutes	-	7.3%	7.7%	▲	
	Ambulance handover breaches 30 minutes	334	932	tbc	◀▶	
	Ambulance handover breaches 60-minutes	73	441	tbc	◀▶	
	Attendance to admission conversion rate	-	26.8%	29.0%	▲	
	Time to initial assessment Percentage within 15 minutes	-	48.4%	46.9%	▼	
	Average (mean) time in department Non-admitted patients	-	185	186	▲	
	Average (mean) time in department Admitted patients	-	568	582	▲	
	Left department before being seen for treatment	5%	2.91%	2.63%	▼	
	Unplanned re-attendance rate	5%	5.99%	5.69%	▼	

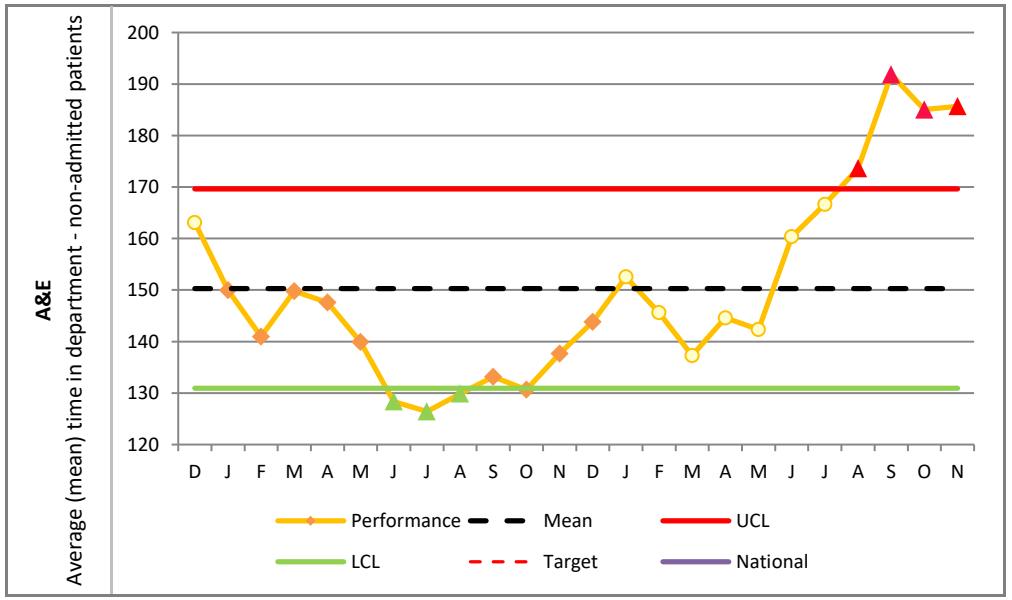


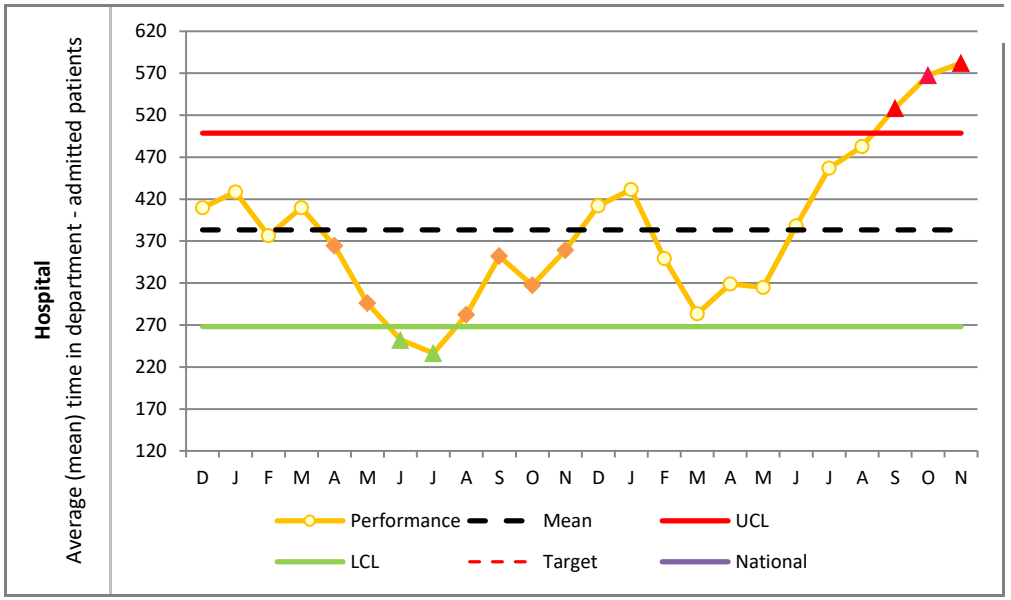


New Emergency Department Standards









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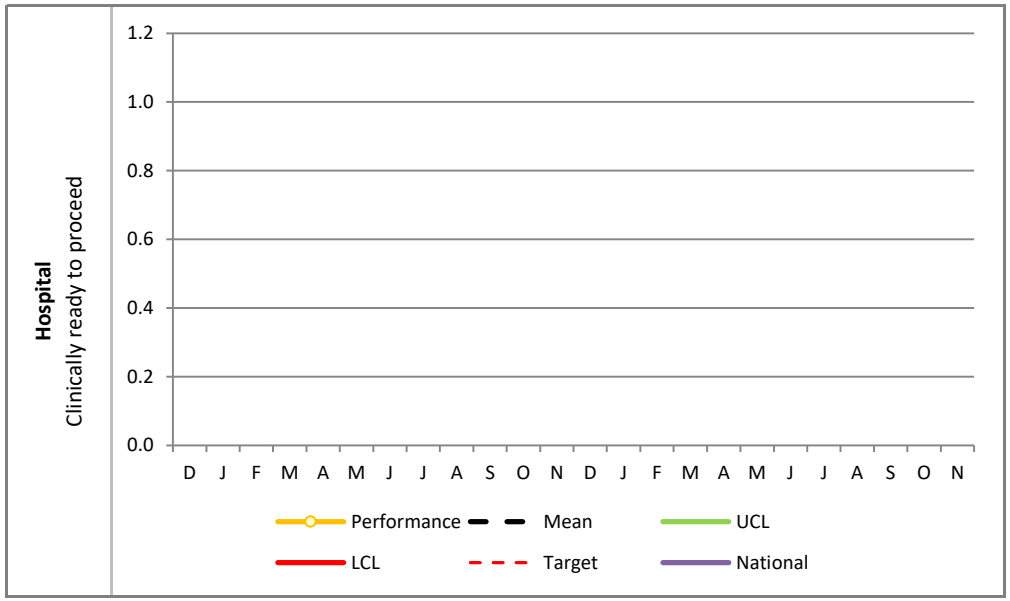
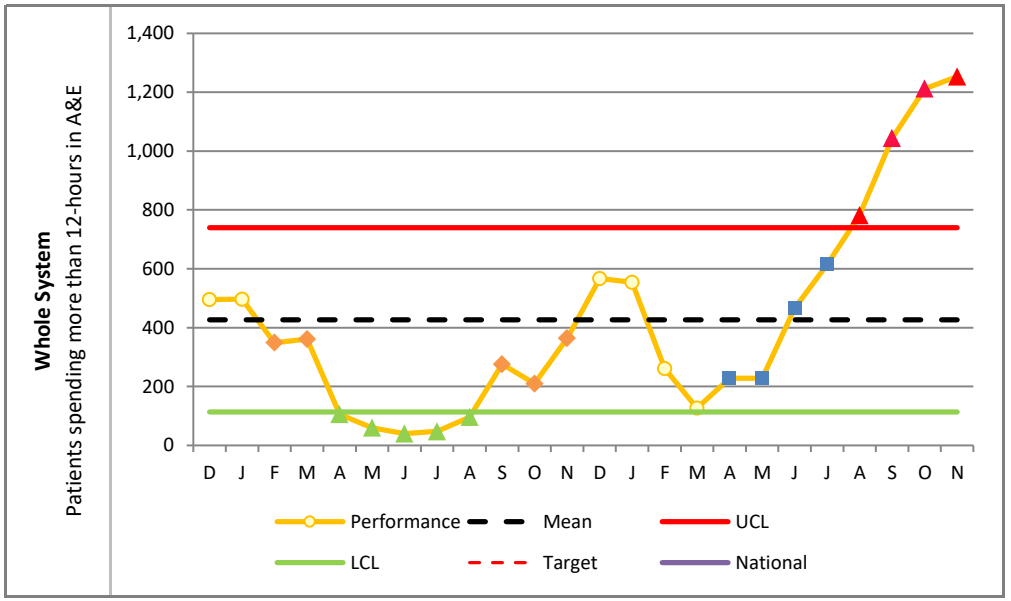
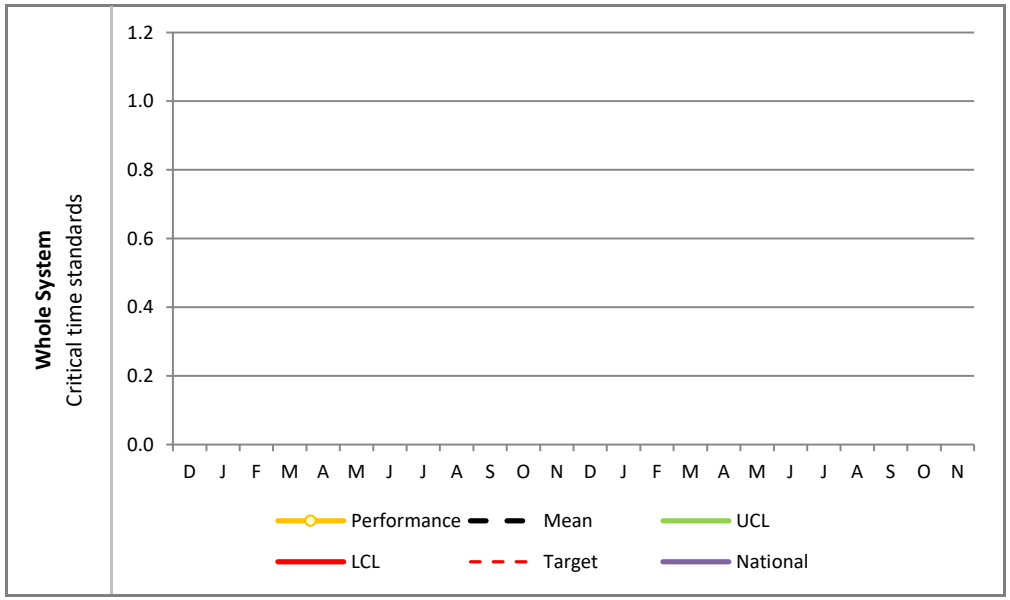






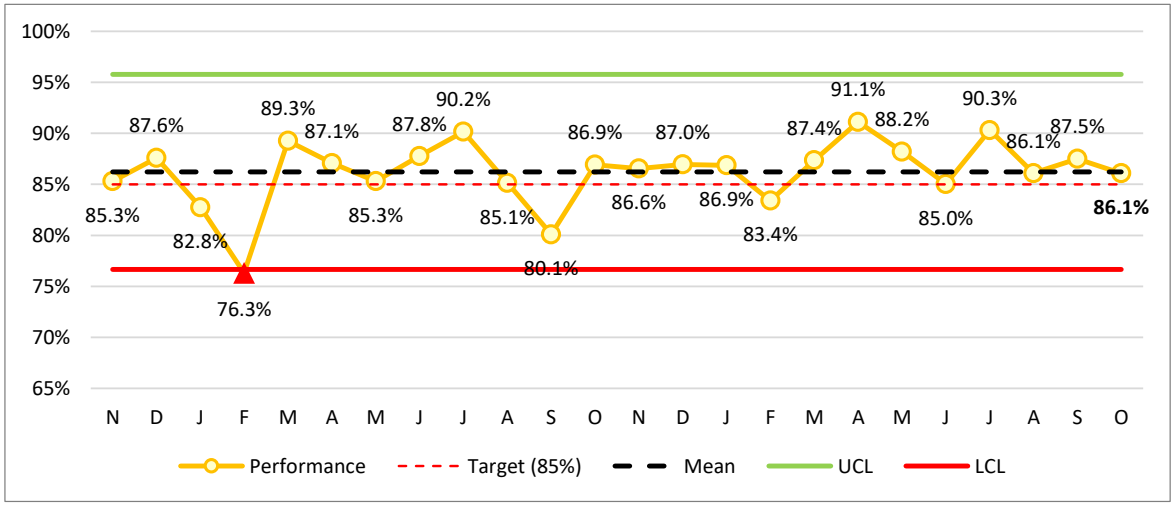
Responsive Services

Cancer Waiting Times

East and North Hertfordshire NHS Trust

12-months' performance - all standards	Standard	Target	2020-21						2021-22							
			Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	YTD
	Two week waits Suspected cancer	93%	97.36%	98.12%	96.17%	98.00%	99.13%	97.26%	96.84%	97.86%	98.60%	97.62%	97.21%	97.49%	97.21%	97.56%
	Two week waits Breast symptomatic	93%	97.64%	93.33%	93.40%	100.00%	100.00%	97.08%	95.10%	95.24%	96.36%	100.00%	97.83%	100.00%	100.00%	97.82%
	31-day First definitive treatment	96%	98.68%	99.57%	99.05%	97.84%	96.97%	98.11%	99.51%	99.51%	96.69%	97.12%	96.93%	96.94%	94.35%	97.22%
	31-day subsequent treatment Anti-cancer drugs	98%	100.00%	100.00%	100.00%	99.42%	100.00%	99.86%	100.00%	100.00%	99.10%	99.48%	99.48%	100.00%	100.00%	99.70%
	31-day subsequent treatment Radiotherapy	94%	98.90%	99.63%	98.76%	98.51%	99.35%	98.87%	99.29%	98.63%	98.50%	98.94%	98.72%	99.37%	99.65%	99.00%
	31-day subsequent treatment Surgery	94%	95.45%	100.00%	75.00%	92.11%	87.76%	92.68%	84.44%	92.50%	88.89%	97.14%	86.67%	78.43%	96.77%	88.43%
	62-day GP referral to treatment	85%	86.55%	86.96%	86.87%	83.41%	87.36%	86.13%	91.12%	88.21%	85.04%	90.32%	86.10%	87.50%	86.09%	87.72%
	62-day Specialist screening service	90%	100.00%	84.62%	80.00%	75.00%	64.29%	69.34%	81.48%	76.47%	75.00%	77.78%	85.00%	88.89%	87.50%	80.61%

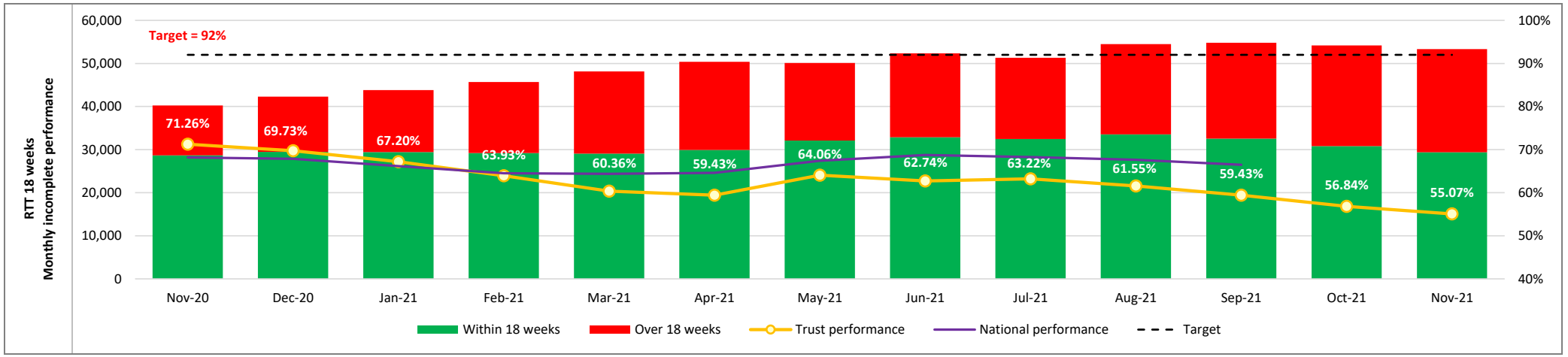
62-day GP referral to treatment Oct-21	Tumour Site	OK	Breach	Total	Perf.	104+ day waits
	Breast	18.0	3.0	21.0	85.71%	2.0
	Gynaecology	3.0	1.0	4.0	75.00%	0.0
	Haematology	5.0	1.0	6.0	83.33%	0.0
	Head and Neck	4.5	0.0	4.5	100.00%	0.0
	Lower GI	7.5	5.0	12.5	60.00%	1.0
	Lung	3.0	1.5	4.5	66.67%	0.5
	Other	2.0	0.0	2.0	100.00%	0.0
	Skin	16.0	3.0	19.0	84.21%	1.0
	Testicular	2.0	0.0	2.0	100.00%	0.0
	Upper GI	1.5	0.5	2.0	75.00%	0.5
	Urology	36.5	1.0	37.5	97.33%	0.0
	Total	**99.0**	**16.0**	**115.0**	86.09%	5.0



Responsive Services

RTT 18 weeks

East and North Hertfordshire NHS Trust



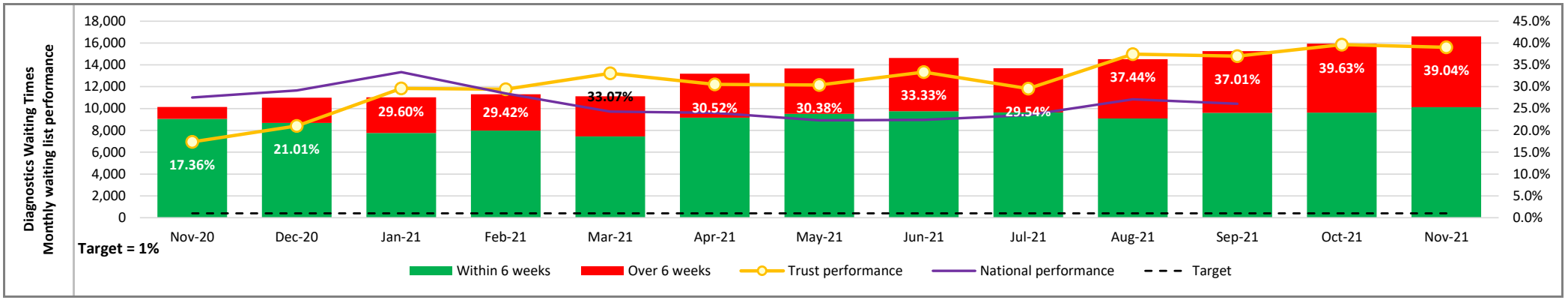
RTT 18 weeks
In-month performance by Specialty - Nov-21

Specialty	Clock Stops - Admitted			Clock Stops - Non-admitted			Incomplete pathways						Clock Starts
	Total	Performance	Over 52 weeks	Total	Performance	Over 52 weeks	Within 18 weeks	Over 18 weeks	Total	Performance	Over 52 weeks	Over 104 weeks	
General Surgery	285	52.98%	**39**	538	36.43%	9	1,445	1,622	3,067	**47.11%**	**264**	**0**	666
Urology	141	64.54%	**28**	768	38.28%	57	1,281	784	2,065	**62.03%**	**169**	**7**	530
Trauma & Orthopaedics	97	15.46%	**44**	972	30.04%	56	1,435	2,471	3,906	**36.74%**	**850**	**39**	414
Ear, Nose & Throat (ENT)	103	65.05%	**13**	1,642	21.92%	37	2,418	1,385	3,803	**63.58%**	**120**	**1**	982
Ophthalmology	121	22.31%	**17**	1,472	32.20%	92	3,361	3,968	7,329	**45.86%**	**575**	**0**	1,230
Oral Surgery	65	20.00%	**38**	622	21.06%	53	1,191	1,691	2,882	**41.33%**	**496**	**8**	240
Plastic Surgery	89	69.66%	**4**	600	47.17%	0	1,282	237	1,519	**84.40%**	**13**	**0**	683
Cardiothoracic Surgery	1	100.00%	**0**	10	30.00%	1	18	2	20	**90.00%**	**0**	**0**	16
General Medicine	0	-	**0**	32	50.00%	0	120	5	125	**96.00%**	**0**	**0**	58
Gastroenterology	227	56.39%	**48**	774	20.41%	127	2,338	3,454	5,792	**40.37%**	**812**	**0**	949
Cardiology	37	78.38%	**0**	1,140	37.02%	2	2,085	521	2,606	**80.01%**	**3**	**0**	880
Dermatology	2	50.00%	**1**	604	30.13%	4	1,015	931	1,946	**52.16%**	**1**	**0**	360
Thoracic Medicine	24	95.83%	**0**	456	34.43%	0	824	205	1,029	**80.08%**	**5**	**0**	322
Neurology	0	-	**0**	398	45.73%	1	500	33	533	**93.81%**	**0**	**0**	240
Rheumatology	1	100.00%	**0**	194	18.56%	1	569	322	891	**63.86%**	**5**	**0**	163
Geriatric Medicine	0	-	**0**	92	38.04%	1	167	26	193	**86.53%**	**0**	**0**	63
Gynaecology	88	27.27%	**25**	672	23.96%	11	1,968	1,131	3,099	**63.50%**	**51**	**0**	664
Other	160	49.38%	**34**	2,506	76.94%	111	7,354	5,172	12,526	**58.71%**	**738**	**21**	3,611
Total	**1,441**	**49.41%**	**291**	**7,999**	**66.38%**	**563**	**29,371**	**23,960**	**53,331**	**55.07%**	**4,102**	**76**	**12,071**

Responsive Services

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust



Diagnostics Waiting Times
In-month performance by Modality - Nov-21

Category	Modality	Patients still waiting at month end					Number of tests / procedures carried out during the month			
		Within 6 weeks	Over 6 weeks	Total	Performance	13+ weeks	Waiting List	Planned	Unscheduled	Total
Imaging	Magnetic Resonance Imaging	1,603	1,600	3,203	49.95%	307	1,753	150	1	**1,904**
	Computed Tomography	1,566	1,631	3,197	51.02%	475	3,064	750	1,638	**5,452**
	Non-obstetric ultrasound	4,483	1,904	6,387	29.81%	12	5,624	542	66	**6,232**
	DEXA Scan	541	828	1,369	60.48%	259	267	12	0	**279**
Physiological Measurement	Audiology - audiology assessments	61	6	67	8.96%	2	42	0	0	**42**
	Cardiology - echocardiography	942	241	1,183	20.37%	2	961	0	0	**961**
	Neurophysiology - peripheral neurophysiology	70	1	71	1.41%	0	84	0	0	**84**
	Respiratory physiology - sleep studies	117	0	117	0.00%	0	81	0	0	**81**
	Urodynamics - pressures & flows	57	99	156	63.46%	37	19	0	0	**19**
Endoscopy	Colonoscopy	311	110	421	26.13%	50	413	0	0	**413**
	Flexi sigmoidoscopy	131	37	168	22.02%	17	116	0	0	**116**
	Cystoscopy	15	0	15	0.00%	0	44	0	0	**44**
	Gastroscopy	227	27	254	10.63%	9	318	0	0	**318**
Total		**10,124**	**6,484**	**16,608**	**39.04%**	**1,170**	**12,786**	**1,454**	**1,705**	**15,945**

Responsive Services

Stroke Performance

East and North Hertfordshire NHS Trust

Domain	Metric	2021-22 Target	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend
Stroke	Trust SSNAP grade	A	C	C	C	C	C	C	C	C	tbc	tbc	tbc	tbc	
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	80%	71.4%	100.0%	100.0%	85.7%	88.9%	87.5%	66.7%	100.0%	85.7%	100.0%	91.7%	100.0%	
	4-hours direct to Stroke unit from ED Actual	63%	52.0%	48.3%	28.1%	49.3%	61.0%	43.5%	64.4%	46.4%	36.1%	29.7%	33.9%	17.1%	
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	63%	52.1%	50.9%	29.5%	48.5%	66.7%	45.0%	65.5%	47.5%	34.8%	29.5%	34.0%	17.3%	
	Number of confirmed Strokes in-month on SSNAP	-	83	64	66	70	63	62	59	85	72	65	57	78	
	If applicable at least 90% of patients' stay is spent on a stroke unit	80%	87.7%	88.5%	92.3%	97.1%	93.4%	93.5%	93.2%	83.3%	87.3%	84.6%	89.3%	84.4%	
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	50%	55.4%	57.8%	47.0%	52.9%	55.6%	58.1%	49.2%	45.9%	56.9%	49.2%	50.9%	50.0%	
	Scanned within 12-hours - all Strokes	100%	100.0%	98.3%	97.0%	95.7%	98.2%	91.9%	96.6%	94.1%	97.2%	93.8%	96.5%	98.7%	
	% of all stroke patients who receive thrombolysis	11%	11.0%	11.3%	10.6%	5.7%	11.3%	3.2%	3.4%	8.2%	4.2%	9.2%	12.5%	7.7%	
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	70%	77.8%	71.4%	85.7%	25.0%	14.3%	0.0%	50.0%	57.1%	0.0%	16.7%	42.9%	33.3%	
	Discharged with JCP	80%	92.6%	94.7%	85.0%	91.3%	75.8%	91.9%	87.0%	52.6%	72.3%	81.6%	86.8%	90.7%	
	Discharged with ESD	40%	69.2%	76.7%	80.0%	62.5%	56.8%	73.0%	73.9%	60.7%	70.2%	71.7%	65.8%	60.4%	

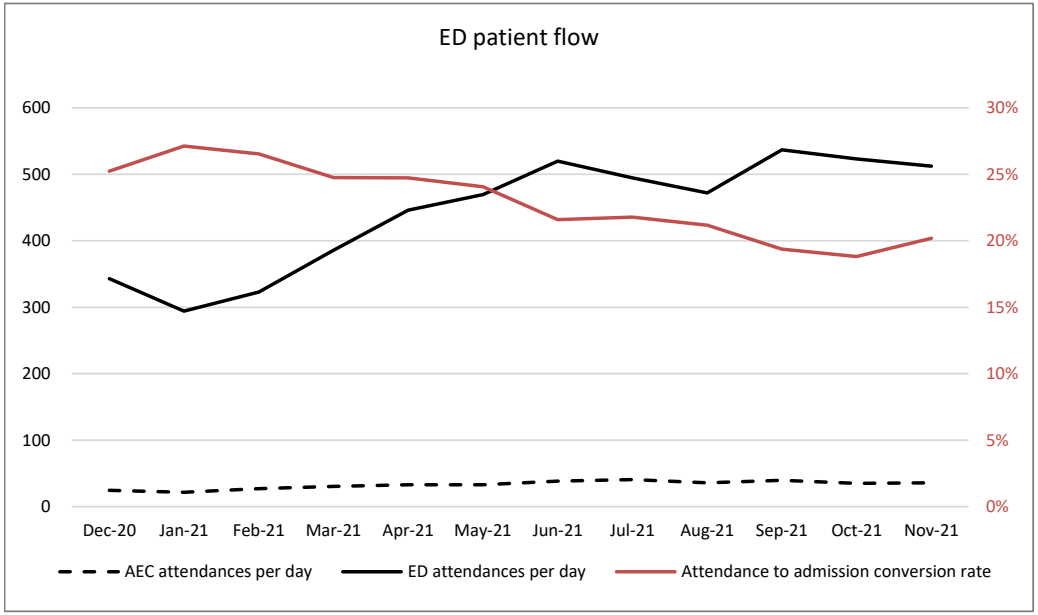
Breaches Nov-21	Breach reasons:			Breach Reasons: In Hours: 25 Out of Hours: 39
		• Challenging Diagnosis/Complex Patients = 2 • Late referral = 9 • Share Care Transfers = 2 • Pathway (ED delays) = 18	• Bed Capacity = 19 • Inpatient Stroke = 1 • Patient Related = 8 • COVID POC = 5 • Other = 0	

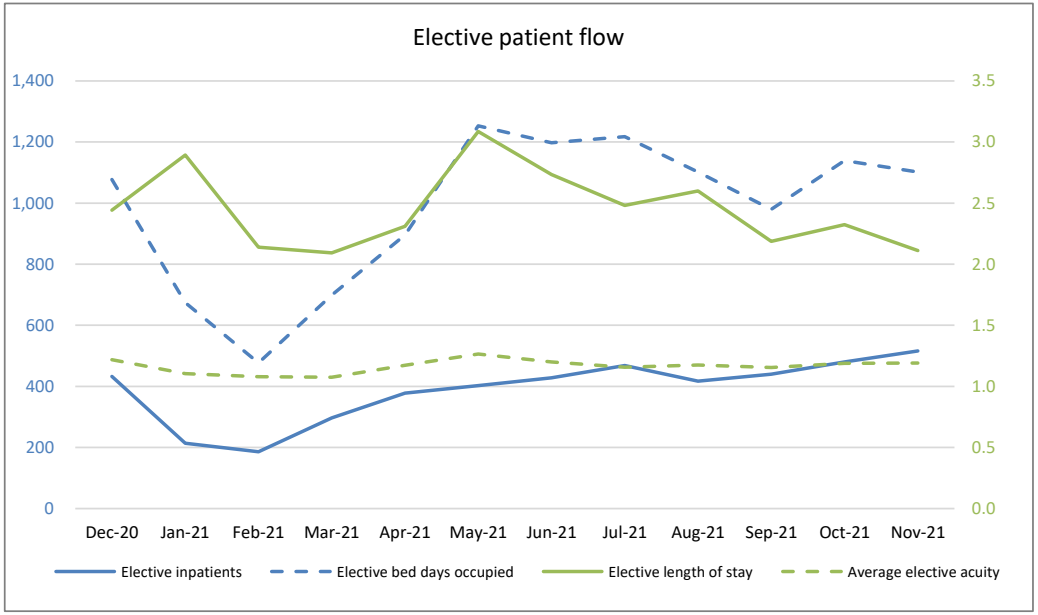
Responsive Services

Patient Flow

East and North Hertfordshire NHS Trust

Domain	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend
Emergency Department Flow Indicators	A&E & UCC attendances	10,639	9,119	9,044	11,955	13,380	14,556	15,595	15,337	14,627	16,105	16,215	15,372	
	Attendance to admission conversion rate	25.2%	27.1%	26.5%	24.8%	24.7%	24.1%	21.6%	21.8%	21.2%	19.4%	18.8%	20.2%	
	ED attendances per day	343	294	323	386	446	470	520	495	472	537	523	512	
	AEC attendances per day	24	22	27	31	33	33	39	41	36	40	35	36	
	4-hour target performance %	78.2%	75.2%	78.8%	85.2%	82.8%	84.1%	78.6%	74.8%	73.3%	69.5%	70.1%	68.8%	
	Time to initial assessment Percentage within 15 minutes	68.5%	70.4%	71.9%	70.3%	66.3%	58.8%	50.4%	48.2%	51.7%	44.1%	48.4%	46.9%	
	Ambulance handover breaches 30-minutes	634	467	327	274	380	341	586	548	812	783	932	tbc	

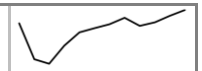
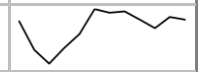
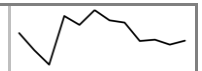
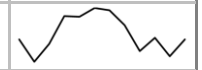
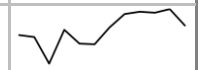
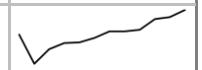
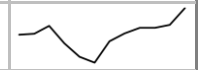




Responsive Services

Patient Flow

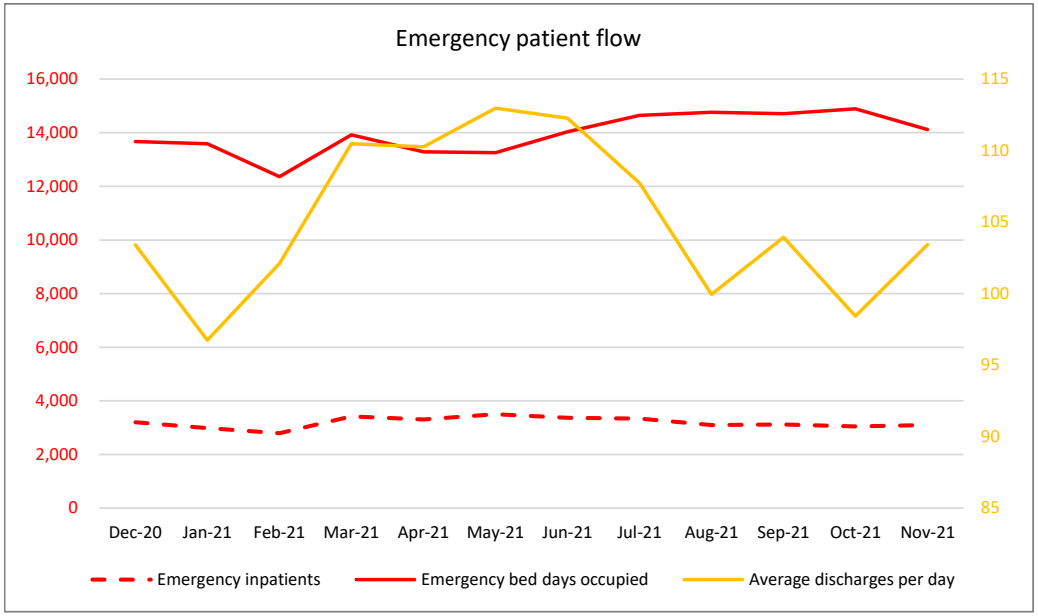
East and North Hertfordshire NHS Trust

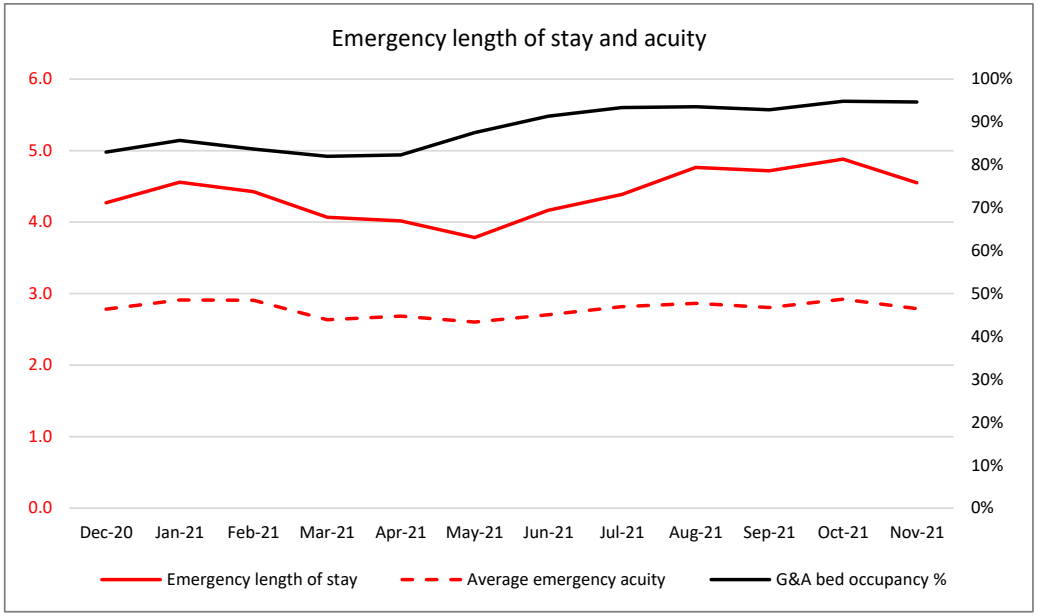
Domain	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend
Elective Inpatient Flow Indicators	Elective inpatients	433	214	186	297	378	403	428	468	417	440	480	516	
	Elective bed days occupied	1,077	674	477	699	896	1,253	1,198	1,218	1,102	980	1,139	1,102	
	Elective length of stay	2.4	2.9	2.1	2.1	2.3	3.1	2.7	2.5	2.6	2.2	2.3	2.1	
	Daycase rate %	87.0%	89.2%	89.6%	89.1%	87.9%	89.0%	89.8%	89.1%	88.7%	88.3%	87.3%	87.1%	
	Average elective acuity	1.22	1.11	1.08	1.07	1.17	1.26	1.20	1.16	1.18	1.15	1.19	1.19	
Emergency Flow Indicators	Emergency inpatients	3,202	2,981	2,794	3,425	3,308	3,502	3,368	3,340	3,098	3,118	3,051	3,103	
	Average discharges per day	103	97	102	110	110	113	112	108	100	104	98	103	
	Emergency bed days occupied	13,676	13,588	12,361	13,926	13,290	13,253	14,033	14,650	14,758	14,714	14,892	14,119	
	Emergency length of stay	4.3	4.6	4.4	4.1	4.0	3.8	4.2	4.4	4.8	4.7	4.9	4.6	
	Average emergency acuity	2.8	2.9	2.9	2.6	2.7	2.6	2.7	2.8	2.9	2.8	2.9	2.8	
	G&A bed occupancy %	83%	86%	84%	82%	82%	88%	91%	93%	94%	93%	95%	95%	
	Patients discharged via Discharge Lounge	465	234	348	398	404	438	489	491	502	588	602	661	
	Discharges before midday	12.6%	13.1%	13.8%	12.8%	14.7%	14.6%	14.2%	13.3%	14.1%	15.7%	14.2%	14.7%	
	Weekend discharges	13.3%	17.3%	13.2%	13.9%	14.6%	19.0%	14.5%	16.3%	15.1%	14.6%	16.8%	13.7%	
	Proportion of beds occupied by patients with length of stay over 14 days	19.3%	19.4%	20.4%	18.2%	16.6%	15.9%	18.5%	19.4%	20.1%	20.1%	20.5%	22.5%	
	Proportion of beds occupied by patients with length of stay over 21 days	9.5%	9.4%	10.8%	9.1%	8.9%	8.1%	9.6%	9.9%	11.0%	9.8%	10.2%	12.8%	

Responsive Services

East and North Hertfordshire NHS Trust

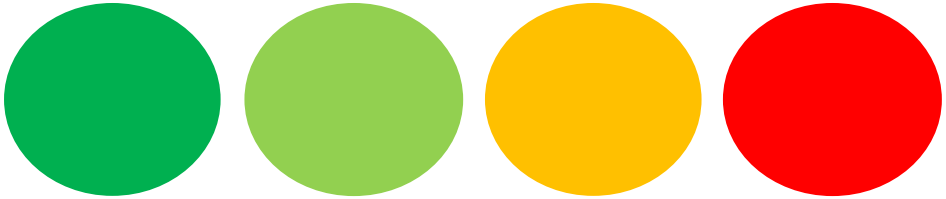
Patient Flow





People Report

Month 08 | 2021-22



Key Issues

Work

- Vacancy rate overall has decreased to 6.1% (380 vacancies). There are 30 more staff in post this month compared to last month and 152 more nurses in post than 12 months ago. There were 119 starters and 76 leavers in month, giving a +42.
- Nursing vacancy rate has decreased from 3.2% to 2.8% (52 vacancies). There were 37 new nursing and midwifery starters in month and 9 leavers, giving a +27 for this staff group.
- Agency spend decreased by £225k, this was consistent with the reduction of 3% in agency worked hours. Healthcare Scientists saw the largest increase in agency usage (11%) in month, all other staff groups utilised less agency hours against M6.
- Overall temporary staffing worked hours reduced by 4% which is consistent with substantive unavailability improving by 2% to 72.8%
- 2,615 hours were requested through the roster to special patients in M6, this equates to 24% of additional duty hours.

Grow

- Statutory training compliance is now at 88%. The number of staff with 100% compliance is at 60%.
- The recorded appraisal rate is static at 56%. Digital version of Grow together (Appraisal) launched on ENH Academy. Some ongoing technical reporting issue means appraisals are not showing in data set.
- Significant ongoing input into the Integrated Strategic Business Planning that will require additional education and development across the organisation.
- CPD funding for all staff groups allocated with the training needs analysis process to start next month estimated £20k underspend.
- Deeper understanding of LDA and new contracts needed.

Thrive

- Staff survey is currently open with a response rate at 39%, with 1 weeks remaining.
- Staff turnover has increased from 12.8% to 13.1%. One of the highest reasons for leaving was due to promotion followed by work/life balance and relocation.
- Duration of suspensions has increased to 140 days due to closure of some shorter suspension cases. Disciplinary and grievance case averages have both reduced in month due to closures.

Care

- Sickness absence rate has increased by 1% which is the highest it has been since the peak in January.
- Over 3,000 staff have received their Covid booster and flu vaccines.

Executive Response

Work

- Key actions are underway to mobilise a Winter Staffing support unit - focusing on additional flexible staff requirements, facilitate workforce requests supporting sickness mitigation and redeployment, the MDT consisting of resourcing, clinical lead, temporary staffing and NHSP have instigated a winter resilience T&F to ensure the programme is effective, agile, and responsive to operational needs around winter planning. Key roles for support include housekeepers, care support workers and team support workers, of which there have been 33 applications made in the week since launching.
- There are 131 people in the pipeline, 34 of these are international nurses and 33 are newly registered nurses. There are 47 doctors in the pipeline, of which 7 are consultants.
- International Nurse recruitment continues to be a focus with an aim to recruit 53 nurses in the coming months, we will be making an ICS wide bid to NHSE/I for funding to support the international nurses programme for 2022.
- Candidate experience rating remains high at 4.5 out of 5 for the past 6 months and time to hire remains on target (10 weeks). Inclusion Ambassador Programme continues to gain momentum with plans to include an IA on all 8a and above posts by December 2021. Resourcing hotspots are currently midwifery and radiography, a collaborative approach to midwifery international recruitment with the ICS, we expect to recruit 9 international midwives in 2022.
- Clinical Support Worker vacancies are rising again, and an ongoing recruitment campaign is addressing this.

Executive Response

Work (cont'd)

- Medical establishment has improved with a new lower vacancy rate of 3.9% (37 vacancies) and targeted campaigns are underway on the hard to recruit to posts alongside divisional leadership support.
- The Trust is now 84% compliant against NHSE/I clinical levels of attainment with a rostering system (6% off target), in addition 92% of junior doctors and 46% of consultants are live on eRoster with the remaining implementation of new areas progressing well against the action plan. Procurement for new Medical Rostering software will be concluded in November 2021 with any implementation/data migration occurring alongside the current Allocate contract until May 2022.
- The Temporary Staffing Division on behalf of ICS trusts is underway against a clear work plan focusing on 4 key objectives for 21-22. These focus on Pay Alignment, Demand Management, Shared Locum Bank and Grow Your Own Bank which focuses on increasing the pool of available bank staff - a progress paper was shared with FPPC in October.

Grow

- CPD policy refresh to start involving divisions and corporate teams, further work to start on CPD portal due to start in December.
- Reorganisation of the team and recruiting into vacant posts will ensure capacity and capability across the teams. Recruitment plans for some key roles in place, Q4 will see move from reliance on secondments to permanent posts.
- Work commenced on a deep dive into the LDA to ensure all commissioned education activity and finances align.

Thrive

- Changing culture through conversations launches in November with the start of staff listening events and reciprocal mentoring programme.
- The trust has developed a range of recognition schemes due to be launched in November including a recognition award which will feed into staff awards, a 'pay it forward' scheme to offer thanks to colleagues going above and beyond and recognition of length of service.
- Work continues with the service lines to review a range of cultural indicators including staff survey results as part of the development of the new integrated strategic business plan. Themes for focus include Equality, Diversity, and Inclusion; Safe Environment; and Health and Wellbeing.
- The integrated business planning process continues with this work transitioning to the new people business partner model of delivery.
- The average duration of suspensions has increased due to the closure of three cases with one long standing case expected to be closed next month.
- Work continues to take place within the ERAS team to improve service delivery and ensure managers are able to access training, coaching and support.
- The national staff survey remains open. A comprehensive communication strategy is in place to ensure the maximum number of staff are encouraged to complete the survey. Managers are regularly reminded to enable their teams to take time to complete the survey.

Care

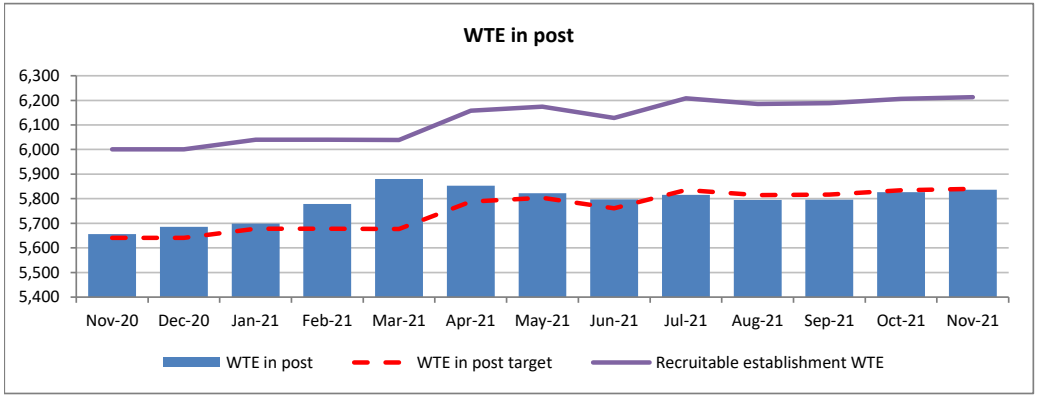
- Hug in a Mug launched and has been well received.
- Days lost due to sickness related to stress and mental health issues has increased in October, although days lost due to musculoskeletal health issues is 10% lower than the previous year.
- Hot spot areas are receiving targeted support including leadership coaching, support for wellbeing champions and drop-in support sessions.
- Ward based group and individual sessions from 'Here for You' to support staff unable to leave the clinical area to attend reflective spaces and Schwartz rounds are being planned and undertaken.
- Health at Work and 'Here for You' are attending Trust sites to promote the range of support available. A package of staff support webinars from 'Here for You' are also being promoted.
- Work continues to promote regular asymptomatic COVID testing.
- COVID booster uptake is 56%, flu vaccine uptake 54.7%, both are gradually increasing. Booked appointments continue to be offered in addition to drop-in sessions. Mobile clinics are being held across Lister and other sites to increase vaccine accessibility.
- The availability of COVID 1st and 2nd doses is being promoted in addition to boosters. Plans are being developed to support increased vaccine uptake ahead of COVID vaccination being a condition of employment.
- Work is underway to launch a monthly individual star and team star of month, built around the values and nominations online via charity pages for ease of access - launch due Jan 22.

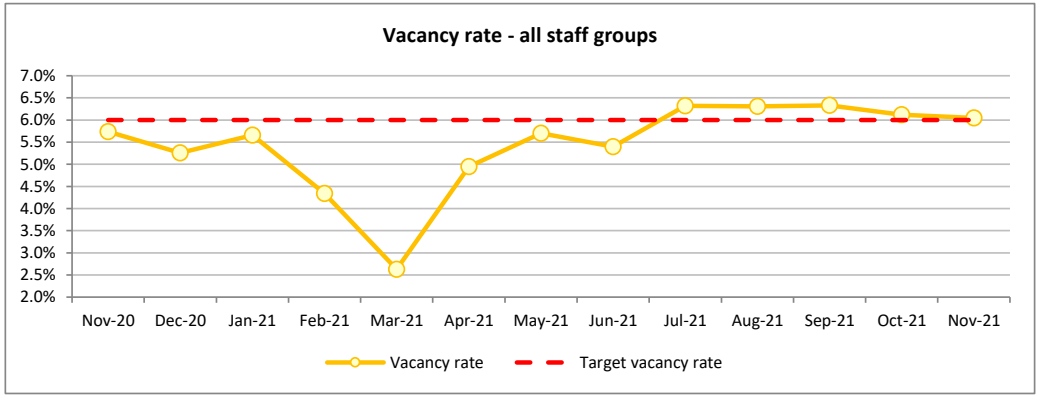
People Report

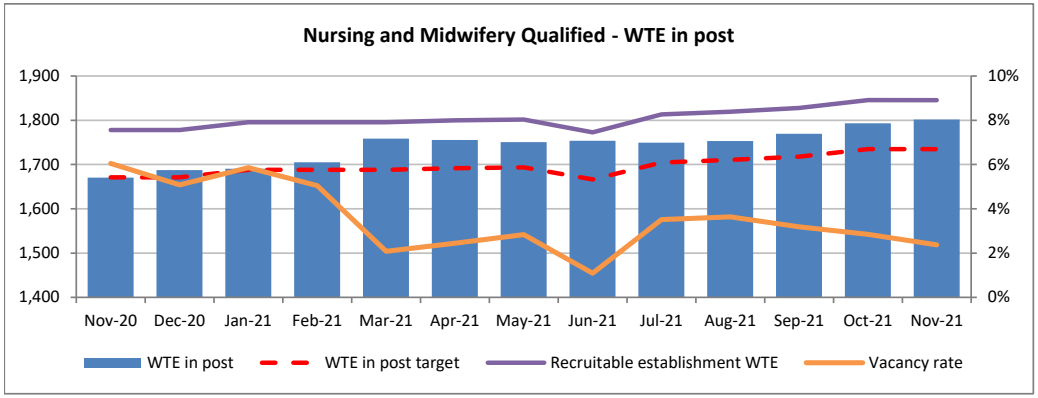
Work Together

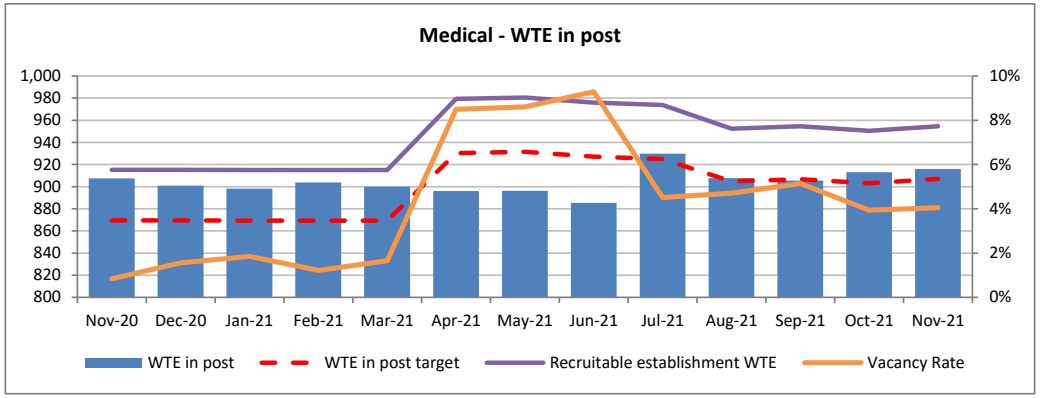
East and North Hertfordshire NHS Trust

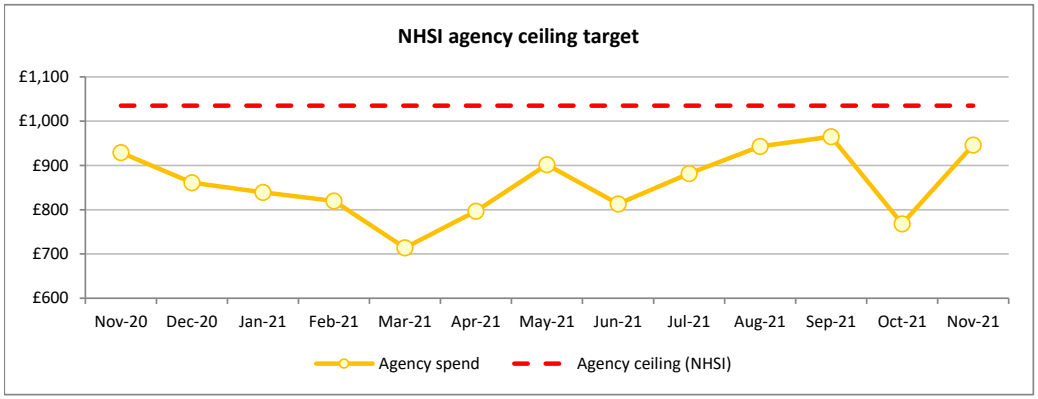
Domain	Metric	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend
Work	Vacancy Rate	6%	5.7%	5.3%	5.7%	4.3%	2.6%	5.0%	5.7%	5.4%	6.3%	6.3%	6.3%	6.1%	6.1%	
	Time to hire (weeks)	10	13.0	9.0	11.0	10.0	10.0	11.0	11.0	10.0	9.0	9.0	9.0	10.0	10.0	
	Recruitment experience	4	4.7	4.5	4.6	4.5	4.4	4.7	4.7	4.7	4.7	4.7	4.6	4.5	4.5	
	Relative likelihood of white applicant being shortlisted and appointed over BAME applicant	1	1.40		2.00			2.00			1.43			tbc		
	Relative likelihood of non-disabled applicant being shortlisted and appointed over disabled applicant	1	0.57		0.70			1.20			1.62			tbc		
	Agency Spend (% of WTE)	4%	4.3%	3.5%	3.4%	3.2%	3.3%	3.5%	2.9%	3.3%	3.3%	3.6%	3.1%	3.0%	3.4%	
	Bank Spend (% of WTE)	10%	9.7%	9.9%	10.5%	11.6%	8.6%	10.4%	8.4%	8.1%	7.9%	9.2%	8.5%	9.0%	8.7%	
	% of Clinical Workforce (AFC) on eRoster	> 90%	80.0%	80.0%	80.0%	80.0%	81.0%	81.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	
	% of Medical & Dental on eRoster	> 60%										83.0%	83.0%	84.0%	83.0%	
	% of Rosters Approved more than 6 weeks in advance (NHS E/I recommended)	> 80%										62.0%	43.5%	63.5%	58.9%	
	% Staff on Annual Leave	13% - 17%	12.7%	12.7%	14.9%	13.0%	17.1%	19.1%	12.0%	12.0%	13.4%	16.7%	15.0%	11.3%	12.7%	
	Pulse survey Flexibility	55%	56.0%		60.0%			64.3%			56.6%			tbc		

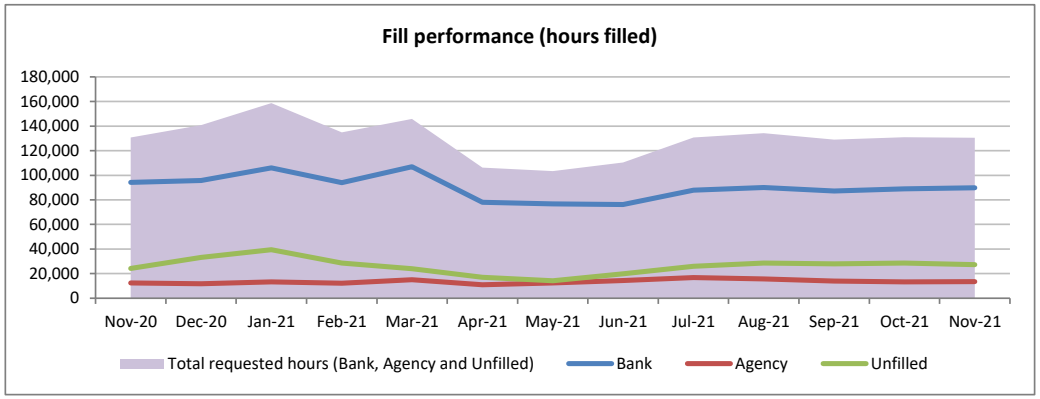


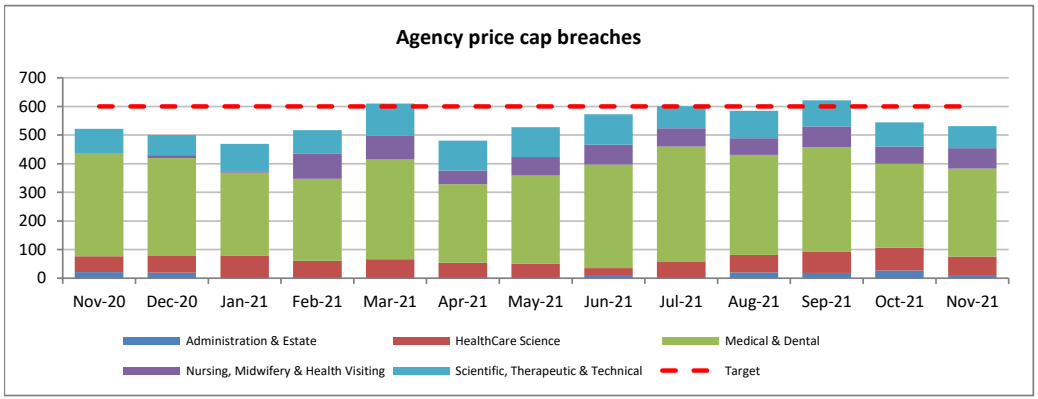


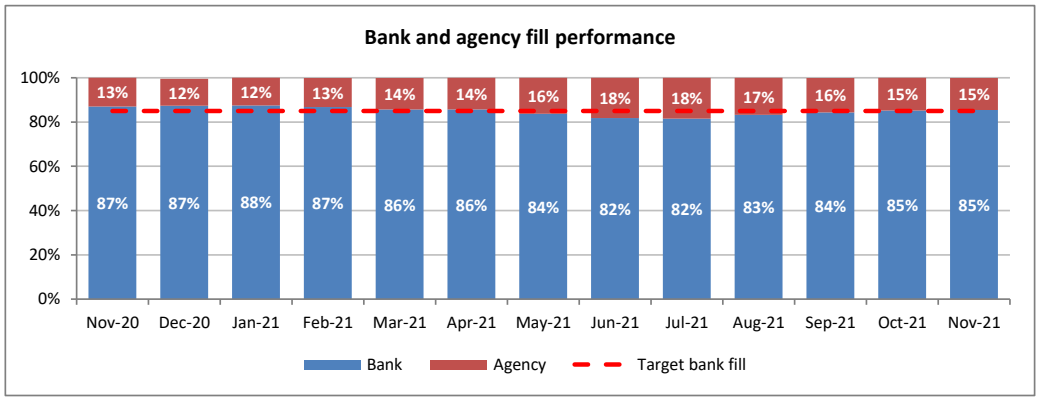

Nursing and Midwifery Qualified - WTE in post
1,900
1,800
1,700
1,600
1,500
1,400
10%
8%
6%
4%
2%
0%
Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21
WTE in post
WTE in post target
Recruitable establishment WTE
Vacancy rate


Medical - WTE in post
1,000
980
960
940
920
900
880
860
840
820
800
10%
8%
6%
4%
2%
0%
Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21
WTE in post
WTE in post target
Recruitable establishment WTE
Vacancy Rate


NHSI agency ceiling target
£1,100
£1,000
£900
£800
£700
£600
Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21
Agency spend
Agency ceiling (NHSI)


Fill performance (hours filled)
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21
Total requested hours (Bank, Agency and Unfilled)
Bank
Agency
Unfilled


Agency price cap breaches
700
600
500
400
300
200
100
0
Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21
Administration & Estate
HealthCare Science
Medical & Dental
Nursing, Midwifery & Health Visiting
Scientific, Therapeutic & Technical
Target

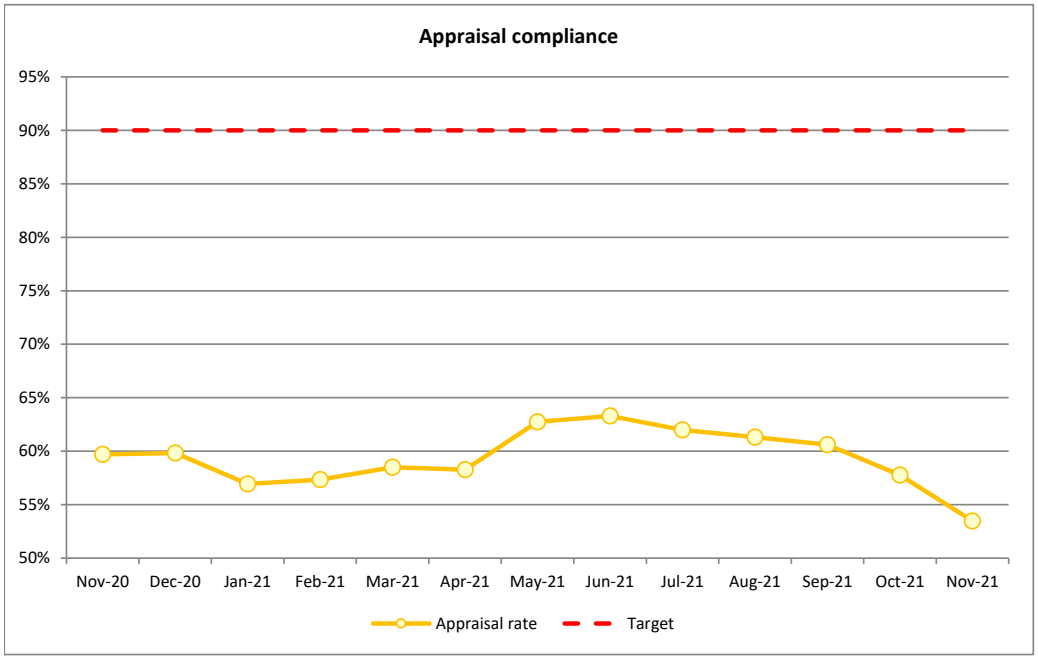

Bank and agency fill performance
100%
80%
60%
40%
20%
0%
13% 12% 12% 13% 14% 14% 16% 18% 18% 17% 16% 15% 15%
87% 87% 88% 87% 86% 86% 84% 82% 82% 83% 84% 85% 85%
Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21
Bank
Agency
Target bank fill

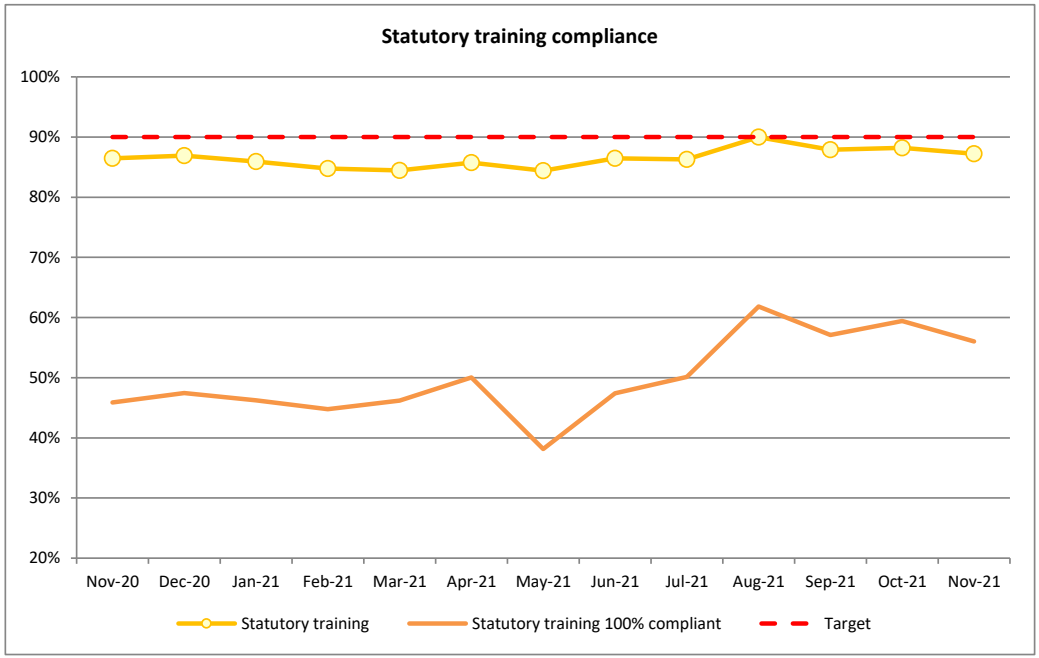
People Report

Grow Together

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend
Grow	Statutory & mandatory training compliance rate	90%	86.5%	86.9%	85.9%	84.8%	84.4%	85.8%	84.4%	86.5%	86.3%	90.0%	87.9%	88.2%	87.2%	
	Appraisal rate	90%	59.7%	59.8%	57.0%	57.3%	58.5%	58.3%	62.7%	63.3%	62.0%	61.3%	60.6%	57.8%	53.5%	
	Pulse survey Training and development opportunities	55%	54.0%		52.1%			55.4%			55.1%			tbc		
	Pulse survey Talent management	55%	55.0%		51.3%			61.8%			55.4%			tbc		
	Likelihood of training and development opportunities (BAME)	1	tbc		tbc			tbc			tbc			tbc		
	Likelihood of training and development opportunities (Disability)	1	tbc		tbc			tbc			tbc			tbc		



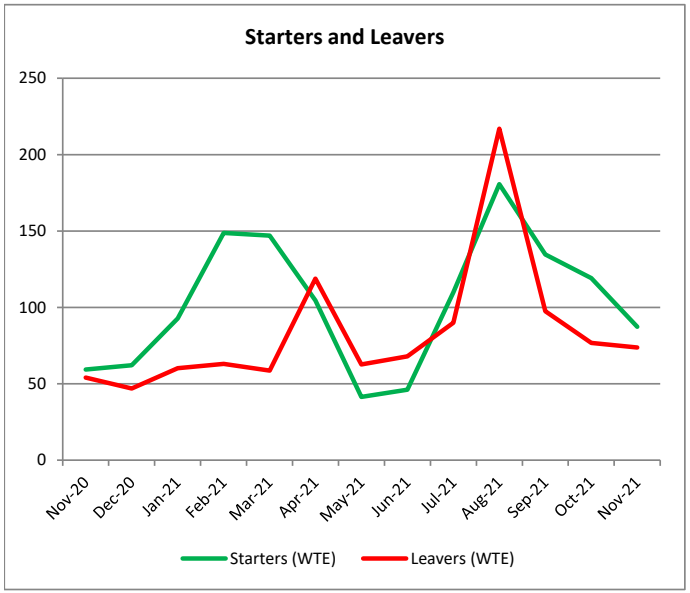


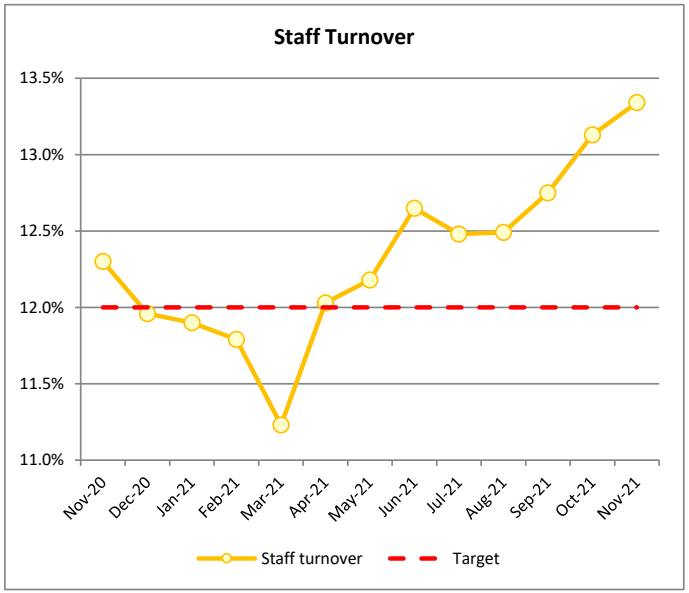
People Report

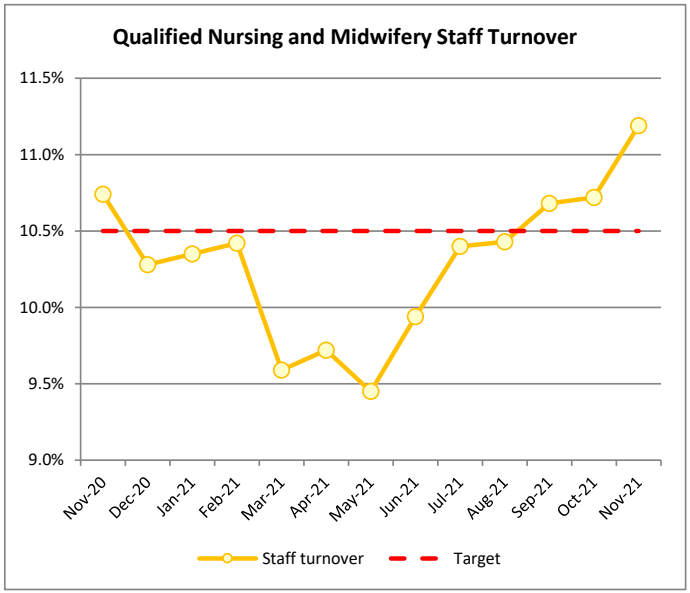
Thrive Together

East and North Hertfordshire NHS Trust

Domain	Metric	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend
Thrive	Pulse survey My leader	75%	87.0%		79.8%			85.5%			79.8%			tbc		
	Pulse survey Harnessing individuality	60%	59.0%		57.7%			61.8%			52.8%			tbc		
	Pulse Survey Not experiencing discrimination	95%	90.5%		68.4%			75.9%			70.8%			tbc		
	Turnover Rate	12.2%	12.3%	12.0%	11.9%	11.8%	11.2%	12.0%	12.2%	12.7%	12.5%	12.5%	12.8%	13.1%	13.3%	
	Model employer targets (% achieved)	100%	83%		67%			50%			67%			tbc		
	Average length of suspension (days)	20	60	22.5	33	43	37	59	57.2	76.6	105	96	142.5	140	177.5	
	Average length of Disciplinary (excluding suspensions) (days)	60	87	74.3	96	102	148	168	63	47.7	86	74	71.6	51	54.9	
	Average length of Grievance (including dignity at work) (days)	60	46	22	114	86	91	82	80	86	74	37.9	23.25	37	46.9	





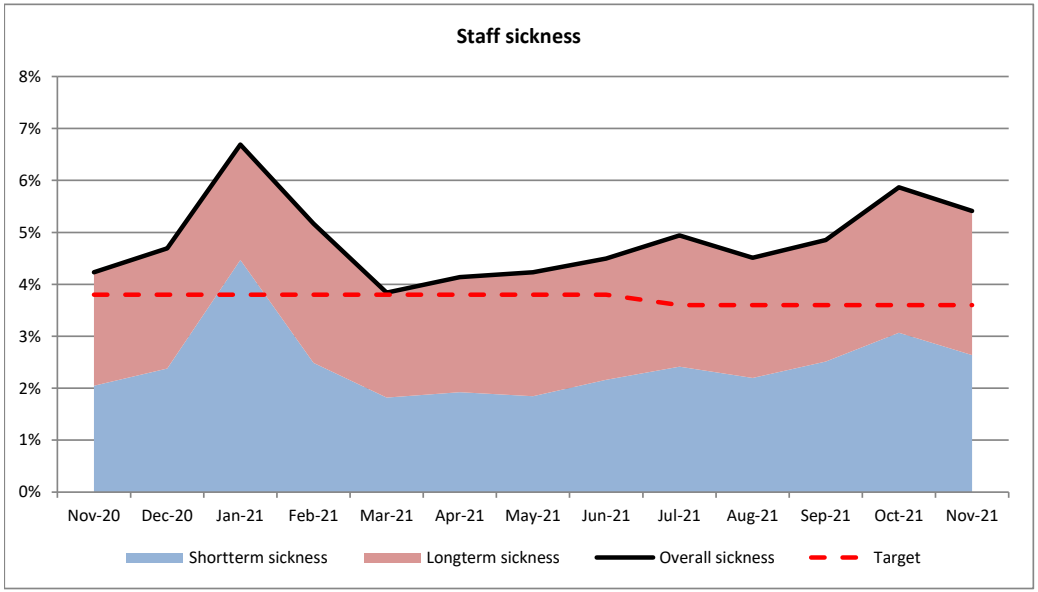


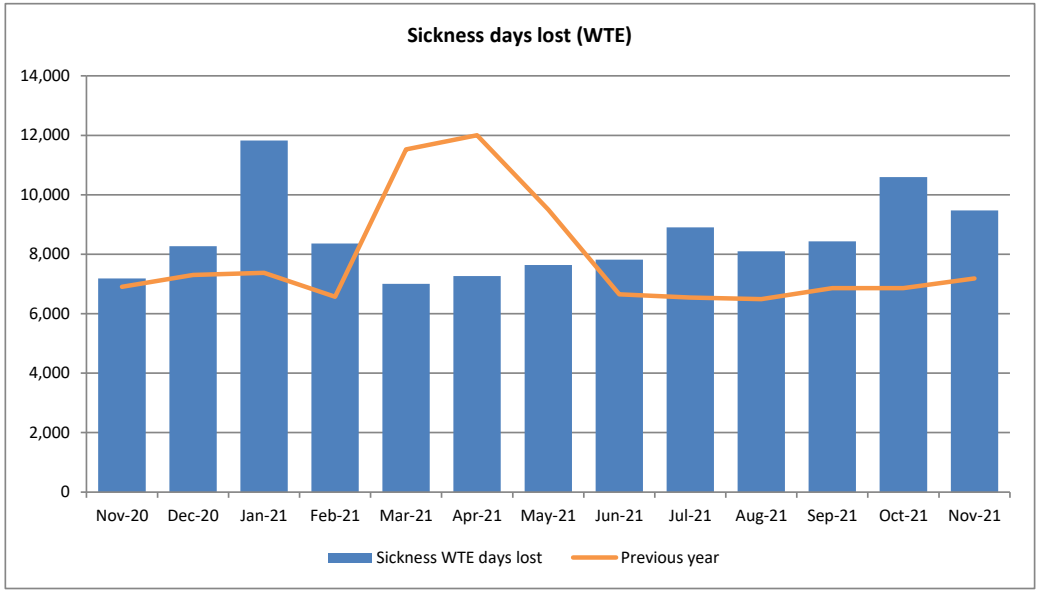
People Report

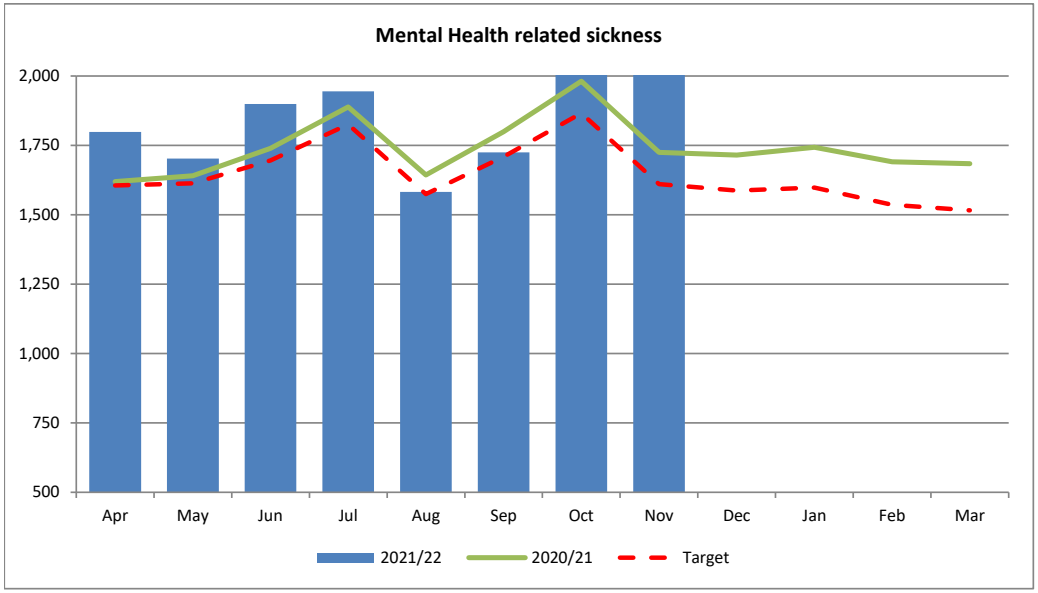
Care Together

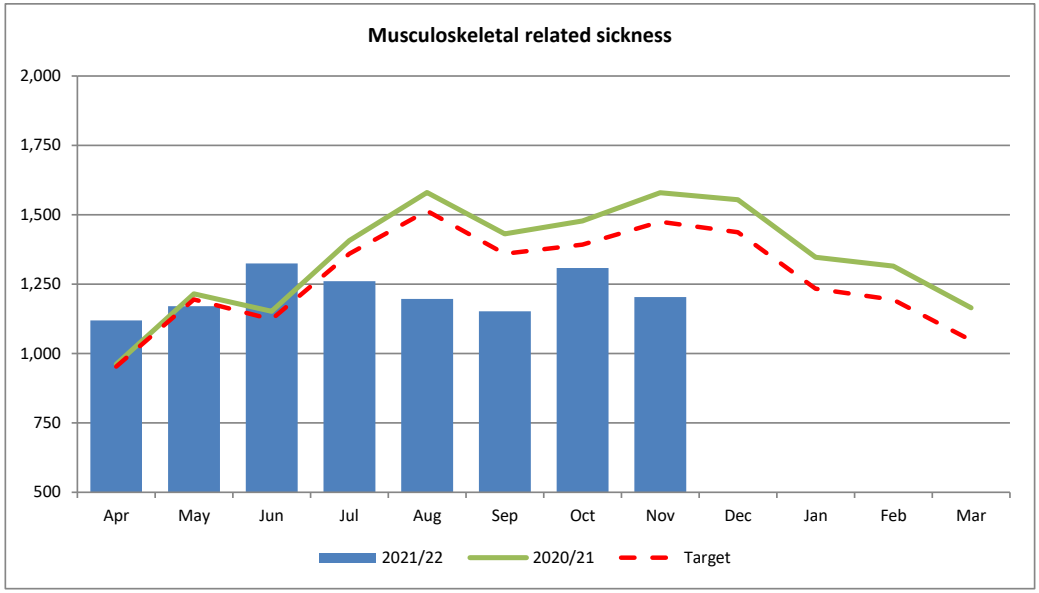
East and North Hertfordshire NHS Trust

Domain	Metric	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend
Care	Pulse survey Well-being	70%	51.0%		68.6%			78.9%			71.5%			tbc		
	Pulse survey Reasonable adjustments	50%	74.0%		60.4%			88.7%			91.4%			tbc		
	Staff FFT Recommend as a place to work	60%	61.0%		47.8%			56.6%			41.7%			tbc		
	Staff FFT Recommend as a place of care	70%	71.0%		70.3%			72.7%			65.9%			tbc		
	Sickness Rate	3.8%	4.23%	4.69%	6.69%	5.17%	3.84%	4.14%	4.23%	4.50%	4.94%	4.51%	4.85%	5.87%	5.41%	
	Sickness FTE Days Lost	6,777	7,183	8,270	11,825	8,357	7,005	7,265	7,633	7,818	8,905	8,102	8,437	10,599	9,474	
	Mental health related absence (days lost)	1,650	1,725	1,716	1,743	1,691	1,684	1,798	1,702	1,899	1,945	1,583	1,725	2,223	2,021	
	MSK related absence (days lost)	1,285	1,580	1,554	1,347	1,315	1,165	1,120	1,170	1,325	1,260	1,196	1,152	1,308	1,204	



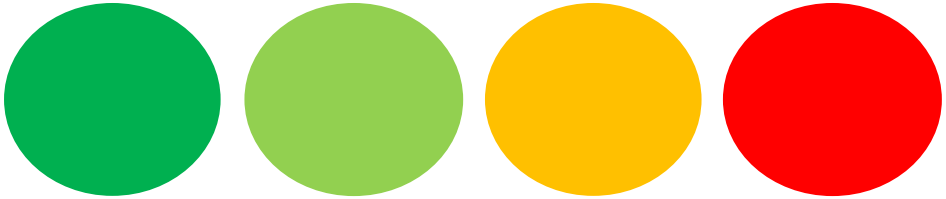



Mental Health related sickness
2,000
1,750
1,500
1,250
1,000
750
500
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2021/22
2020/21
Target


Musculoskeletal related sickness
2,000
1,750
1,500
1,250
1,000
750
500
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2021/22
2020/21
Target

Sustainable Services

Month 08 | 2021-22

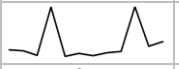
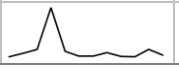
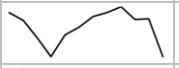


Key Issues	Executive Response
• The financial funding framework for the second half of the current financial year (H2) was published by NHSIE in late September. The Trust has subsequently worked with local partner organisations to agree and confirm the distribution of the notified system envelope. The Trust financial plan for H2 was reviewed and approved by the FPPC at its October meeting. The plan includes a CIP delivery target of £5.7m. • The funding settlements for individual NHS organisations during H2 are based upon a rollover of block, top up and other COVID monies received as key components of financial plans for the second half of 20/21. These allocations included approved distributions of System COVID and growth funds which have provided ENHT with coverage for a range of unavoidable costs resulting from the pandemic and also resources to enable the recovery of elective services. The Trust's financial plan is one component of an overarching balanced system wide financial plan that was submitted to NHSE. • Monthly ICS Directors of Finance meetings remain in place for the system to ensure that in year delivery across partner organisations is co-ordinated to ensure that collective financial balance is achieved. • During 21/22 the delivery of improved levels of elective activity is incentivised through the implementation of the Elective Recovery Fund (ERF). This enables providers to earn additional non recurrent funds should activity achievement exceeding specified thresholds. It is important to note that financial reimbursement through the scheme is assessed at a system level. The basis on which performance is calculated has changed during the course of the year. In July delivery thresholds were adjusted upwards and from H2 the basis of the activity counted as within the scope of the scheme also changed. • The Trust has led work across the ICS to construct a financial and activity monitoring mechanism to allow the system to track delivery and achievement on a monthly basis. In addition, the Trust was worked with ICS colleagues to determine a framework whereby ERF funds earned by the system will be distributed • ERF performance in Q1 was strong, although subsequent delivery has proved more challenging. • At Month 8 the Trust reports a small YTD surplus of £0.7m. The Trust presently reports full achievement of its H2 CIP target. • The management of the Trust pay bill remains closely monitored. A combination of improved recruitment and reduced turnover has seen the number of permanent staff employed by the Trust increase by 296 WTE's since April 2020. As a consequence, vacancy rates across most staff groups and departments have fallen to an all-time low. In response the Trust will need to carefully and flexibly manage the deployment of new staff, the approval of the use of temporary staffing resources and also the pace of future domestic and international recruitment to ensure that it is able to manage its workforce within the boundaries of its approved pay budget.	• The Trust maintains robust mechanisms and systems for monitoring financial performance and maintaining good governance. In addition to its formal Committee structure, the Director of Finance also chairs monthly finance boards which each of the Divisions. Attendance and participation at each of these sessions has been high and they have proved effective in identifying and managing plan delivery and the agreement of remedial action where appropriate. In addition, monthly Delivery Oversight Group (DOG) meetings focusing upon finance and workforce issues have been helpful in promoting mature engagement and discussion of policy and planning issues. • The Trust acknowledges H2 planning guidance that has identified the need for all providers to deliver a stepped change in efficiency levels in the second half of the year. In response the Trust has set out a CIP planning framework to deliver savings plans across divisions and corporate services to the value of £5.7m. Regular reporting arrangements through to FPPC to track delivery progress are in place. • In order to monitor and drive the delivery of improved elective activity the Trust has set up a weekly Demand and Capacity review session. This is chaired by the Managing Director of Planned Services supported by senior corporate officers. The session reviews progress at a service line level, discussing opportunities for improvement or how obstacles to achievement can be addressed. • As a component part of the new 'ENHT Academy' learning management system the Finance and Information team have refreshed and significantly expanded the range of business skills training materials that are available to budget holders and managers to assist in the discharge of their responsibilities. This suite of materials will continue to be monitored, expanded, and enhanced to support both individual and collective training needs and also improved business decision making across the Trust. • Finance and Corporate teams continue to work to develop and enhance business partnering models to support divisional teams. • The availability of accurate and timely business intelligence and modelling has been key in supporting the Trusts agile and flexible response to the rapidly changing environment. It is important therefore that the Trust continues to expand the scope and sophistication of its BI universe at pace to support the need to supply relevant, timely and accurate data to clinicians and managers to enable more effective decision making and plan delivery. This will remain an important component in the Trust's recovery process. • A key priority for the Trust's Finance and Information Team in 21/22 is the development of an effective suite of Population Health Management (PHM) Data products. This specific project co-ordinated by the AD for Planning will be crucial in terms of assisting the Trust and system partners in understanding the patient needs and outcome and provide a framework to set out opportunities for transformation and change. An internal steering group to co-ordinate PHM activities has been set up and project updates and briefing will be provided to Committees on a regular basis. • The Trust continues to work with place-based partners to explore new models of service collaboration moving forward. A number of specific areas of project work have been agreed to test the effectiveness of these models.

Sustainable Services

Finance Plan Performance

East and North Hertfordshire NHS Trust

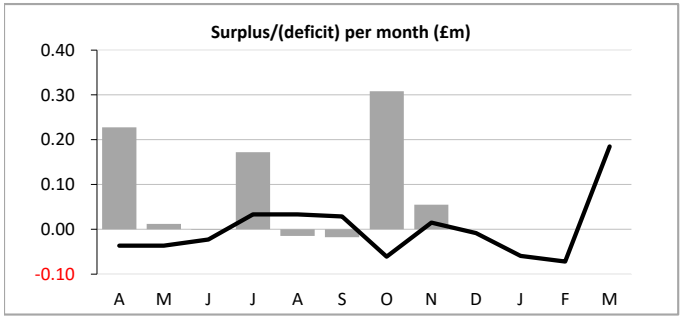
Domain	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend	Plan YTD	Actual YTD	Variance YTD
I&E Performance	SLA Income Earned	36.5	37.1	36.0	37.3	36.4	36.5	37.3	37.2	36.8	40.6	37.2	37.1		294.5	299.0	4.6
	Other Income Earned	2.6	2.9	2.9	10.0	2.6	7.3	5.3	6.0	4.0	5.3	3.8	3.6		27.7	37.9	10.2
	Pay Costs	27.2	27.1	26.6	31.6	26.5	26.8	26.6	26.9	27.0	31.6	27.5	28.0		222.6	221.0	-1.6
	Non Pay Costs inc Financing	16.4	17.2	16.3	17.9	16.6	21.2	20.3	20.4	18.1	19.2	17.4	16.6		134.4	149.8	15.4
	Underlying Surplus / (Deficit)	-4.4	-4.3	-4.0	-2.1	-4.1	-4.3	-4.3	-4.1	-4.3	-5.0	-3.9	-3.9		-34.9	-33.8	1.1
	Top up payments	4.4	4.4	4.3	4.4	4.3	4.3	4.3	4.3	4.3	5.0	4.2	4.0		34.8	34.6	-0.3
	Retained Surplus / Deficit	-0.03	0.13	0.31	2.24	0.23	0.01	-0.00	0.17	-0.01	-0.02	0.31	0.05		-0.05	0.74	0.8
Paybill Metrics	Substantive Pay Costs	23.2	22.0	23.4	27.8	23.4	23.5	23.4	23.0	23.2	26.8	24.0	24.6		207.7	192.0	-15.8
	Premium Pay Costs Overtime & WLI	0.3	0.3	0.1	0.0	0.2	0.2	0.3	0.3	0.4	0.3	0.3	0.0		2.4	1.9	-0.5
	Premium Pay Costs Bank Costs	2.8	3.7	2.3	3.0	2.2	2.2	2.1	2.5	2.5	3.5	2.5	2.4		9.3	20.0	10.7
	Premium Pay Costs Agency Costs	0.9	1.2	0.8	0.8	0.8	0.9	0.8	1.0	1.0	1.0	0.8	0.9		3.2	7.2	4.0
	Premium Pay Costs As % of Paybill	14.7%	18.9%	12.2%	11.9%	11.7%	12.4%	12.1%	14.2%	14.1%	15.2%	13.0%	12.1%		6.7%	13.1%	6.4%

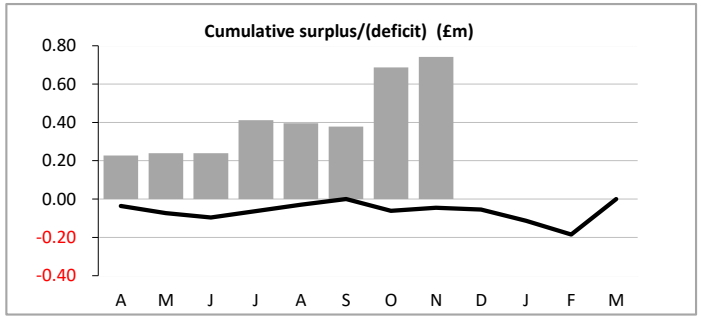
Sustainable Services

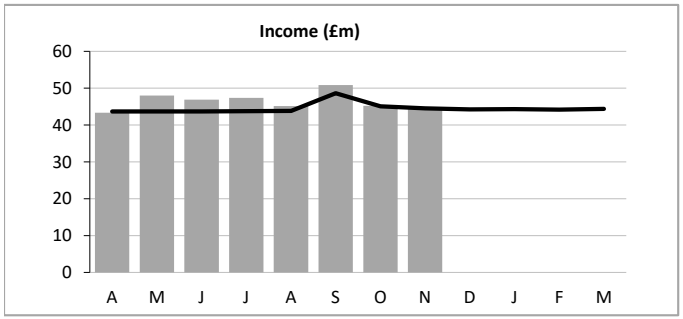
Finance Plan Performance

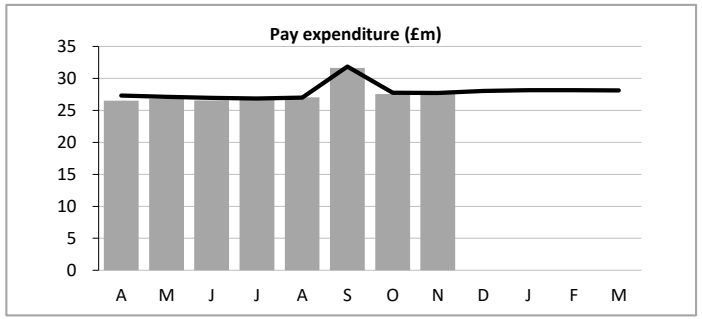
East and North Hertfordshire NHS Trust

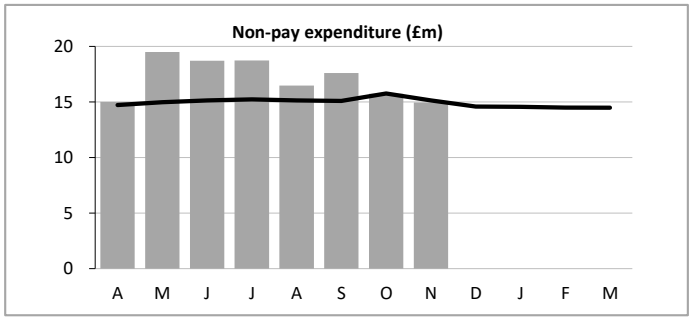
Domain	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend	Plan YTD	Actual YTD	Variance YTD
Single Oversight Framework	Capital Servicing Capacity	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	Liquid Ratio (Days)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	I&E Margin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	Distance from Plan	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	Agency Spend vs. Ceiling	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	
	Overall Finance Metric	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	———	1	n/a	











Sustainable Services

SLA Contracts - Income Performance

East and North Hertfordshire NHS Trust

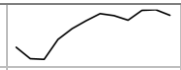
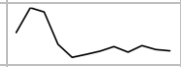
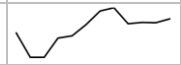
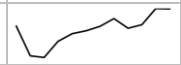
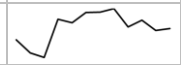
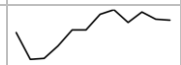
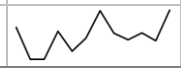
		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Point of Delivery	A&E Attendances	2,372	2,760	388	18,972	21,925	2,953
	Daycases	3,121	3,037	-84	24,968	23,771	-1,197
	Inpatient Elective	1,942	1,793	-150	15,538	13,373	-2,165
	Inpatient Non Elective	9,813	8,406	-1,407	78,506	69,830	-8,677
	Maternity	2,582	2,604	22	20,657	20,915	259
	Other	3,182	3,307	125	27,476	39,091	11,615
	Outpatient First	2,188	2,320	132	17,500	16,488	-1,012
	Outpatient Follow Ups	2,541	3,181	640	20,328	24,473	4,145
	Outpatient Procedures	1,165	1,286	121	9,322	10,361	1,039
	NHSE Block Impact	0	156	156	0	5,232	5,232
	Other SLAs	65	65	0	519	519	0
	Block	847	847	0	6,775	6,775	0
	Drugs & Devices	3,950	4,353	403	31,602	35,101	3,499
	Chemotherapy Delivery	611	659	48	4,885	5,274	389
	Radiotherapy	1,138	1,224	86	9,102	8,897	-204
	Renal Dialysis	1,194	1,199	5	9,553	9,461	-92
	Total	**36,710**	**37,196**	486	**295,703**	**311,486**	15,783

		In-Month			YTD		
		Planned Income	Actual Income	Income Variance	Planned Income	Actual Income	Income Variance
By Commissioner	East & North Herts CCG	0	0	0	0	12,701	12,701
	Specialist Commissioning	192	-0	-192	1,533	-0	-1,533
	Bedfordshire CCG	-126	-467	-341	-252	-2,870	-2,619
	Herts Valleys CCG	224	224	-0	1,798	1,798	-0
	Cancer Drugs Fund	21,996	21,996	-0	176,740	176,739	-0
	Luton CCG	0	0	0	0	0	0
	PH - Screening	-0	11	11	-0	67	67
	Other	14,425	15,432	1,007	115,884	123,051	7,167
	Total	**36,710**	**37,196**	486	**295,703**	**311,486**	15,783
By Division	Cancer Services	6,332	7,117	785	50,654	54,892	4,238
	Unplanned Care	19,077	18,594	-483	152,616	150,426	-2,190
	Planned Care	11,431	11,213	-218	91,448	87,386	-4,062
	Other	-130	272	402	986	18,782	17,797
	Total	**36,710**	**37,196**	486	**295,703**	**311,486**	15,783

Sustainable Services

Activity and Productivity

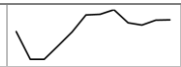
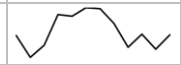
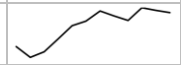
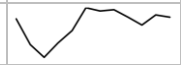
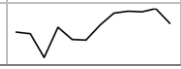
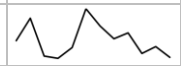
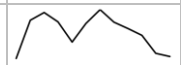
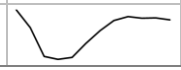
East and North Hertfordshire NHS Trust

Domain	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend	Plan YTD	Actual YTD	Var YTD
Patient Activity Levels	A&E & UCC	10,632	8,951	8,840	11,769	13,380	14,556	15,595	15,337	14,627	16,105	16,215	15,372		93,712	121,187	27,475
	Chemotherapy Atts	2,689	2,232	2,268	2,759	2,457	2,452	2,789	2,677	2,543	2,612	2,491	2,384		15,886	20,405	4,519
	Critical Care (Adult) - OBD's	870	1,170	1,117	731	574	608	650	702	635	714	666	651		4,318	5,200	882
	Critical Care (Paeds) - OBD's	339	268	372	492	466	709	484	451	518	433	408	398		3,885	3,867	-18
	Daycases	2,949	1,920	1,926	2,730	2,827	3,282	3,856	4,003	3,328	3,386	3,366	3,527		27,699	27,575	-124
	Elective Inpatients	441	233	223	334	388	406	438	491	424	448	561	557		3,932	3,713	-219
	Emergency Inpatients	3,936	3,652	3,556	4,371	4,298	4,521	4,526	4,604	4,207	4,350	4,136	4,175		29,965	34,817	4,852
	Home Dialysis	155	148	139	176	154	176	156	177	202	155	196	161		1,157	1,377	220
	Hospital Dialysis	7,521	7,215	6,673	7,557	6,260	6,309	6,317	6,677	6,517	6,531	6,616	6,644		45,103	51,871	6,768
	Maternity Births	368	437	350	448	415	440	441	475	473	454	478	464		3,093	3,640	547
	Maternity Bookings	609	546	533	583	520	517	534	475	422	491	453	493		3,504	3,905	401
	Outpatient First	5,698	3,145	3,018	4,334	7,950	7,944	8,573	7,990	7,436	8,637	8,779	9,711		63,749	67,020	3,271
	Outpatient Follow Up	13,378	5,977	6,012	7,277	20,725	18,500	20,197	18,855	17,548	19,460	18,338	19,864		135,323	153,487	18,164
	Outpatient procedures	6,570	4,788	4,859	5,680	6,727	6,731	7,761	8,084	7,237	7,912	7,448	7,383		51,908	59,283	7,375
	Radiotherapy Fractions	4,321	3,583	3,585	4,233	3,771	4,071	4,704	4,184	4,037	4,195	4,016	4,733		30,144	33,711	3,567

Sustainable Services

Activity and Productivity

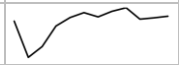
East and North Hertfordshire NHS Trust

Domain	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend	Plan YTD	Actual YTD	Var YTD
Throuhput	Elective Spells per Working Day	161	108	107	133	161	194	195	204	179	174	184	184		186	184	-2
	Emergency Spells per Day	99	92	96	106	106	109	108	103	95	100	95	100		123	143	20
	ED Attendances per Day	343	289	316	380	446	470	520	495	472	537	523	512		384	497	113
	Outpatient Atts per Working Day	1,221	696	694	752	1,007	1,147	1,136	1,137	1,135	1,193	1,215	1,229		1,476	1,646	169
	Elective Bed Days Used	1,077	674	477	699	896	1,253	1,198	1,218	1,102	980	1,139	1,102		0	8,888	8,888
	Emergency Bed Days Used	13,676	13,588	12,361	13,926	13,290	13,253	14,033	14,650	14,758	14,714	14,892	14,119		0	113,709	113,709
Efficiency	Admission Rate from A&E	25%	27%	27%	25%	25%	24%	22%	22%	21%	19%	19%	20%		23.3%	21.5%	-1.8%
	Emergency - Length of Stay	4.3	4.6	4.4	4.1	4.0	3.8	4.2	4.4	4.8	4.7	4.9	4.6		3.7	4.4	0.7
	Emergency - Casemix Value	2,783	2,909	2,907	2,635	2,687	2,602	2,704	2,819	2,864	2,805	2,922	2,789		2,321	2,774	454
	Elective - Length of Stay	2.4	2.9	2.1	2.1	2.3	3.1	2.7	2.5	2.6	2.2	2.3	2.1		2.5	2.5	0.0
	Elective - Casemix Value	1,219	1,105	1,078	1,075	1,172	1,265	1,201	1,156	1,176	1,155	1,188	1,190		2,321	1,188	-1,133
	Elective Surgical DC Rate %	87.0%	89.2%	89.6%	89.1%	87.9%	89.0%	89.8%	89.1%	88.7%	88.3%	87.3%	87.1%		85%	88%	3.4%
	Outpatient DNA Rate % - 1st	6.5%	8.3%	7.1%	7.0%	12.7%	11.3%	10.9%	12.2%	12.4%	11.8%	11.0%	11.9%		6.4%	11.8%	5.4%
	Outpatient DNA Rate % - FUP	6.5%	8.3%	7.1%	7.0%	0.0%	6.0%	4.9%	5.2%	5.6%	6.4%	5.8%	6.2%		7.1%	5.7%	-1.4%
	Outpatient Cancel Rate % - Patient	8.6%	7.2%	5.1%	4.9%	5.1%	6.1%	7.0%	7.8%	8.0%	7.9%	7.9%	7.8%		5.6%	7.4%	1.7%

Sustainable Services

Activity and Productivity

East and North Hertfordshire NHS Trust

Domain	Metric	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Trend	Plan YTD	Actual YTD	Var YTD
Efficiency	Outpatient Cancel Rate % - Hosp	7.4%	11.8%	11.4%	8.9%	8.7%	8.2%	7.9%	7.9%	8.1%	7.8%	7.9%	7.9%		11.1%	8.1%	-3.0%
	Outpatients - 1st to FUP Ratio	2.3	1.9	2.0	1.7	2.6	2.3	2.4	2.4	2.4	2.3	2.1	2.0		2.1	2.3	0.2
	Theatres - Ave Cases Per Hour	2.3	1.7	1.9	2.2	2.4	2.5	2.4	2.5	2.6	2.4	2.4	2.4		2.9	2.4	-0.4
	Theatres - Utilisation of Sessions	82%	80%	85%	90%	85%	84%	83%	85%	83%	80%	81%	83%		85%	83%	-2%
	Theatres - Ave Late Start (mins)	16	17	17	15	21	20	24	28	26	29	25	27		27	25	-1.7
	Theatres - Ave Early Finishes (mins)	48	59	27	41	33	36	32	33	31	32	37	34		39	34	-5.8

Sustainable Services

Productivity and Efficiency of Services - 2020-21 YTD vs. 2021-22 YTD

NHS East and North Hertfordshire NHS Trust

Activity Measures	2020-21 YTD	2021-22 YTD	Change
Emergency Department Attendances	83,854	121,187	37,333
Emergency Department Ave Daily Atts	344	497	153
Admission Rate from ED %	30.8%	21.5%	-9%
Non Elective Inpatient Spells	24,777	25,888	1,111
Ave Daily Non Elective Spells	102	106	5
Daycase Spells	17,255	27,575	10,320
Elective Inpatient Spells	2,578	3,607	1,029
Ave Daily Planned Spells	81	128	47
Day Case Rate	87%	88%	1%
Adult & Paeds Critical Care Bed Days	8,865	9,067	202
Outpatient First Attendances	61,866	67,020	5,154
Outpatient Follow Up Attendances	137,785	153,487	15,702
Outpatient First to Follow Up Ratio	2.2	2.3	0.1
Outpatient Procedures	35,406	59,283	23,877
Ave Daily Outpatient Attendances	963	1,147	183

Workforce Measures	2020-21 YTD	2021-22 YTD	Change
Average Monthly WTE's Utilised	6,075	6,272	197
Average YTD Pay Cost per WTE	34,205	35,232	3.0%
Staff Turnover	12.7%	6.2%	-6.5%
Vacancy WTE's	740	804	65
Vacancy Rate	11.8%	12.0%	0.2%
Sickness Days Lost	62,096	68,234	6,138
Sickness Rate	4.6%	4.8%	0.3%
Agency Spend- £m's	6.9	7.2	0.3
Temp Spend as % of Pay Costs	3.3%	3.2%	-0.1%
Ave Monthlty Consultant WTE's Worked	348.2	346.4	-1.8
Consultant : Junior Training Doctor Ratio	1 : 1.5	1 : 1.7	0.0
Ave Monthly Nursing & CSW WTE's Worked	2,502.0	2,654.9	153.0
Qual ; Unqualified Staff Ratio	25 : 10	28 : 10	0.1
Ave Monthly A&C and Senior Managers WTE's	1,333	1,358	25
A&C and Senior Managers % of Total WTE's	21.9%	21.6%	-0.3%

Sustainable Services

Productivity and Efficiency of Services - 2020-21 YTD vs. 2021-22 YTD

NHS East and North Hertfordshire NHS Trust

Capacity Measures	2020-21 YTD	2021-22 YTD	Change
Non Elective LoS	3.9	4.4	0.5
Elective LoS	2.4	2.5	0.1
Occupied Bed Days	136,286	122,597	-13,689
Adult Critical Care Bed Days	4,912	5,200	288
Paediatric Critical Care Bed Days	3,953	3,867	-86
Outpatient DNA Rate	7%	8%	0.6%
Outpatient Utilisation Rate	35%	44%	9.8%
Total Cancellations	75,904	81,083	5,179
Theatres - Ave Cases per Hour	1.8	2.4	0.7
Theatres - Ave Session Utilisation	76%	83%	6.4%
Theatres - Ave Late Start (mins)	25	25	0
Theatres - Ave Early Finishes (mins)	35.7	33.6	-2
Radiology Examinations	186,079	231,734	45,655
Drug Expenditure (excl HCD & ENH Pharma) - £000s	6,126	7,243	1,117
High Cost Drug Expenditure - £000s	30,185	34,501	4,316

Finance & Quality Measures	2020-21 YTD	2021-22 YTD	Change
Profitability - £000s	-166	887	1,052.3
Monthly SLA Income £000s	36,213	37,378	1,164
Monthly Clinical Income per Consultant WTE	£103,995	£107,903	£3,908
High Cost Drug Spend per Consultant WTE	£86,685	£99,599	£12,914
Average Income per Elective Spell	£2,395	£1,188	-£1,207
Average Income per Non Elective Spell	£2,395	£2,774	£379
Average Income per ED attendance	£177	£181	£4
Average Income per Outpatient Attendance	£130	£142	£11
Ave NEL Coding Depth per Spell	7.4	7.6	0.2
Procedures Not Carried Out	1,603	1,471	-132
Best Practice HRGs (% of all Spells)	4.4%	3.1%	-1.3%
Ambulatory Best Practice (% of Short Stays)	n/a	n/a	n/a
Non-elective re-admissions within 30 days Rolling 12-months to Jun-21	9,368	9,120	-248
Non-elective re-admissions within 30 days % Rolling 12-months to Jun-21	8.67%	8.41%	-0.26%
SLA Contract Fines - £000's	0	0	0

East and North Hertfordshire
NHS Trust
Agenda item: 10

PUBLIC BOARD MEETING 12 JANUARY 2022

Report Title	National Planning Guidance 2022-23
Report Presenter	Deputy CEO
Report Author	Deputy CEO
Executive Lead	Deputy CEO

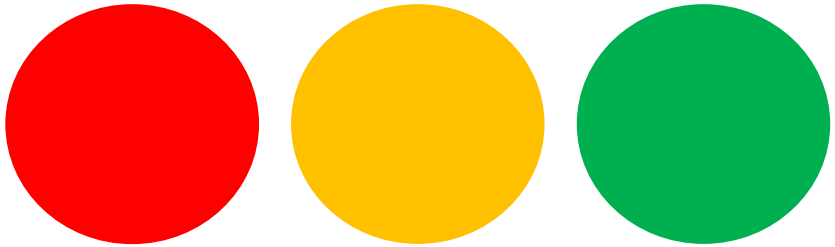
Report Summary *Please summarise the key points from the report and the recommendation that is being made*	The paper summarises the recently published national planning guidance.
Action Required	**For discussion**
Risk Issues *Please specify any links to the BAF or Risk Register*	

Trust Priorities *Please tick any Trust priorities to which the issue relates*		
Quality	To deliver high quality, compassionate services, consistently across all our sites	☒
People	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Previously considered by	
Committee/Board/Group: Executive Committee 6 Jan 22	Date:

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

National Planning Guidance 2022-23



Martin Armstrong, Deputy CEO and Director of Finance

6th January 2022

Key Priorities – National Planning Guidance 22/23

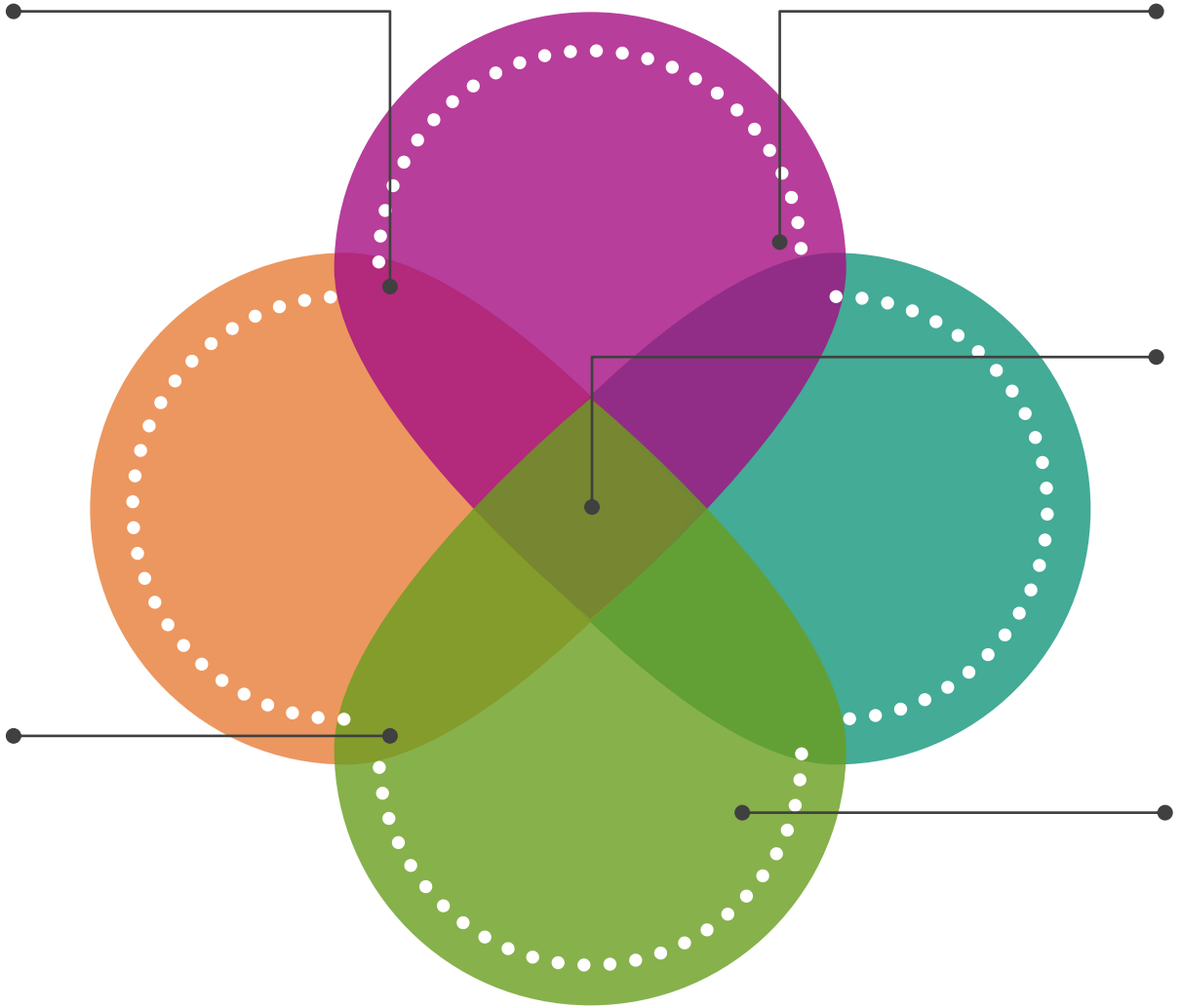
Summary Workforce Priorities - 22/23

Look after our people

Deliver the 20/21 people plan, focusing upon flexible working, career and pension conversations. Sickness absence causes should be addressed, implement the mandatory vaccination guidance and continue to offer effective well being programmes

Improve belonging

Delivery of high impact actions to overhaul recruitment and promotion practices and promote equality.



Work Differently

Increase the scope and scale of new roles, delivering care closer to home, e-job and roster planning and use of volunteers

Prioritising Support for the NHS workforce via.

Grow for the future

Utilising international recruitment options, promoting more collaborative staff banks protected time for supervisors to support training and expanded clinical placement capacity for students.

National planning guidance combined.pdf

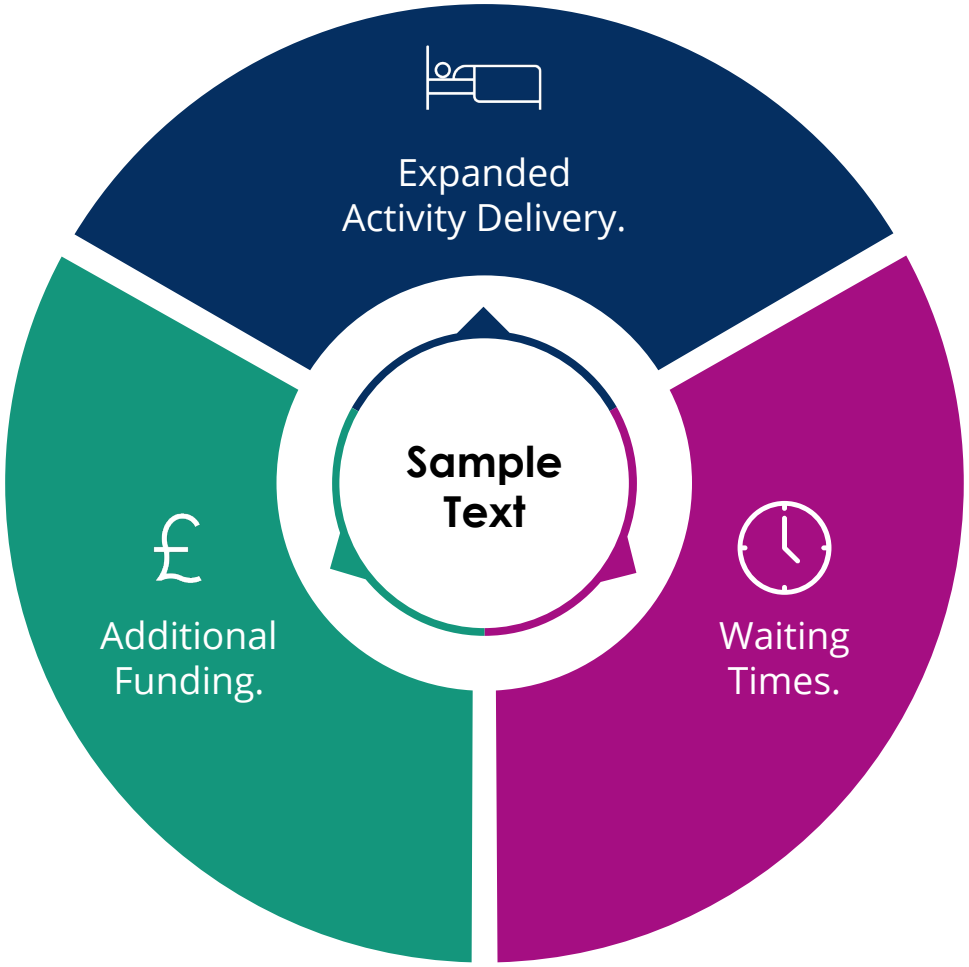
Vaccination Programme

- The guidance details the ask of the NHS to offer every eligible adult over the age of 18 a booster vaccination by 31 December 2021, and the ongoing prioritisation of the vaccination programme for the year ahead.
- Systems are therefore asked to maintain infrastructure to enable the service to respond to need in the vaccination programme as it arises.
- The guidance notes the rollout of new COVID-19 treatments, initially for highest-risk patients, and the launch of a new study into the efficacy of antivirals. Updates on antiviral access are expected in spring.
- For post-COVID services, the guidance asks systems to increase the number of patients seen within six weeks and reduce the number of those waiting longer than 15 weeks. This will be supported by £90 million in 2022/23,

Elective Recovery Programme

Expanding Capacity

- Systems must establish delivery plans across elective inpatient, outpatient and diagnostic services for 2022/23, outlining how they will meet the ambitions for elective recovery, including for systems to deliver over 10% more elective activity than before the pandemic and to reduce long waits.
- These plans should set out how disruptions will be minimised, clarify the use of local independent sector capacity, and show how systems will utilise additional capital and revenue funding and maximise productivity opportunities.



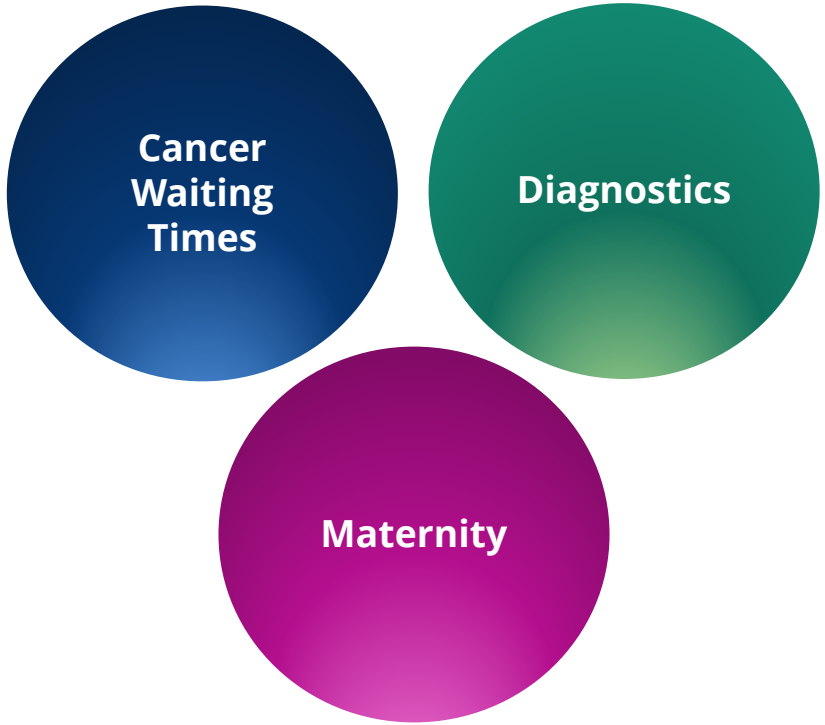
Reduced Waiting

- Systems should eliminate waits of over 104 weeks as a priority and maintain this position through 2022/23 (except where patients choose to wait longer), reduce waits of over 78 weeks, and reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 (and going further where possible).
- The guidance also outlines plans to reduce outpatient follow-ups and to promote more personalised approaches to care

Extra Funding - As part of the additional revenue funding (over £8bn) for elective recovery announced in September, £2.3 billion will be allocated to systems and tied to the delivery of the elective activity target. Systems must also show how their capital proposals will deliver an increase in elective activity to access the £1.5 billion capital funding announced in the Spending Review for surgical hubs and increased bed capacity.

National planning guidance combined.pdf

Cancer Waiting Times, Diagnostics & Maternity



Cancer Waiting Times

- The guidance urges systems to complete any outstanding work on the post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance.
- Cancer Alliances are asked to work with systems to develop and implement a plan to improve performance against all cancer standards, and to make progress against the ambition in the NHS long term plan (LTP) to diagnose more people with cancer at an earlier stage.
- Cancer Alliances and ICBs are also expected to ensure trusts have fully operational patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal and one other cancer by early 2022/23 (and for two other cancers by March 2023), and to increase the recruitment and retention of the wider cancer workforce.

Diagnostics

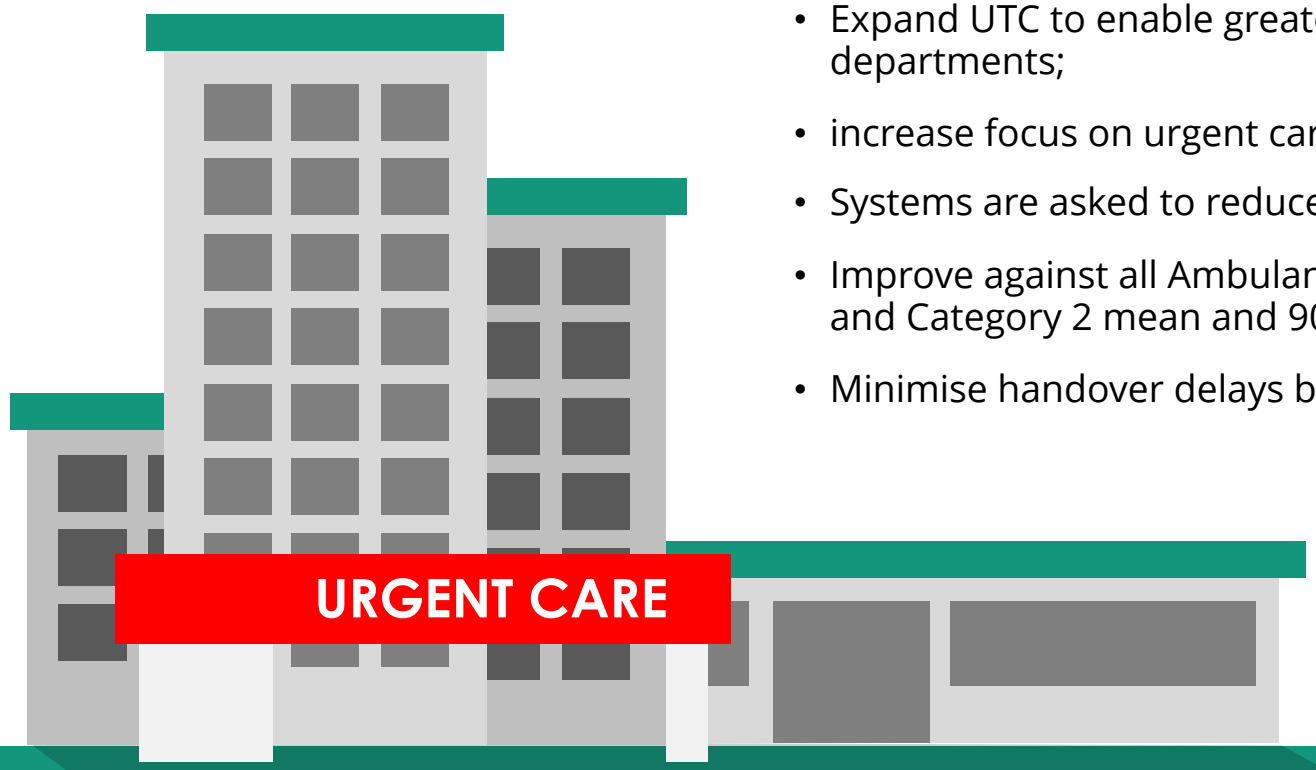
- The ambition is for systems to increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 22/23; & develop investment plans for further capacity expansion via community diagnostic centres (CDCs) in 23/24 & 24/25.
- Expanding supply of and training opportunities for the workforce will be facilitated by national investment through HEE. Systems will be able to access revenue to support set up and running of CDCs (following business case approvals). £21m of programme funding will also support pathology and imaging networks to deliver diagnostic digital roadmaps 2022/23.
- Systems are asked to utilise targeted system capital allocations to increase the number of endoscopy rooms, invest in CT capacity to support expansion of Target Lung Health Checks, develop additional digitally connected imaging capacity, ensure all acute sites have a minimum of two CT scanners, and procure new breast screening units. Operational capital resources should continue to be used to reduce the replacement backlog of diagnostic equipment replacement over 10 years old.

- **Maternity** - ICBs are asked to undertake formal oversight of their Local Maternity Systems (LMS), and providers should continue to embed and deliver the seven immediate and essential actions identified in the interim Ockenden Review. £93m of funding to support the implementation of Ockenden actions (via workforce investment) will go into baselines from 2022/23.
- LMSs should also continue to work with providers to implement local plans to deliver better births, including delivering local plans for midwifery continuity of carer (MCoC), offering every woman a personalised care and support plan in line with the personalised care and support planning guidance. LMSs must also implement the Saving Babies' Lives care bundle.

Urgent & Emergency Care Priorities

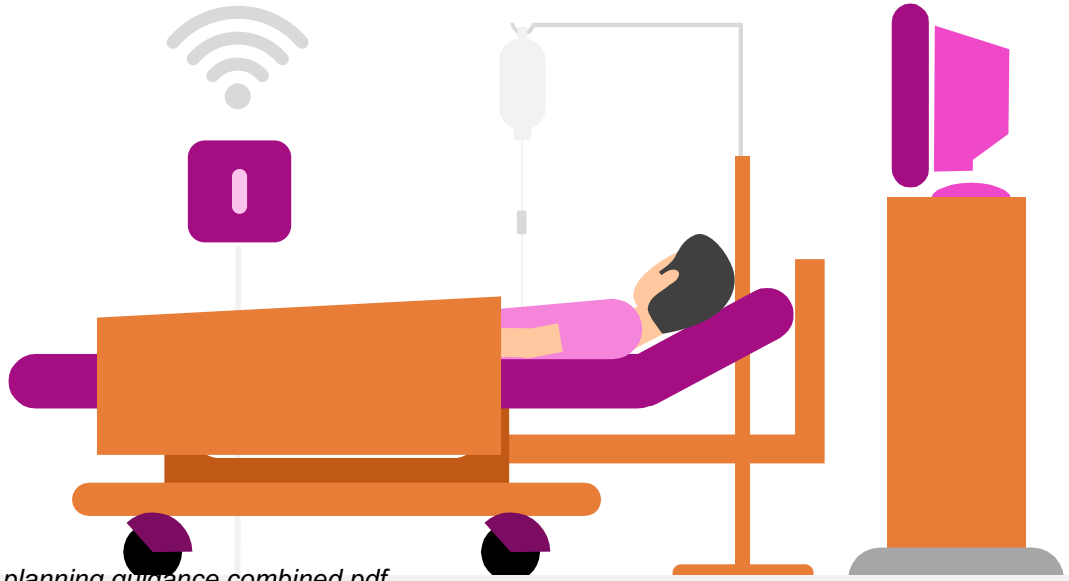
To relieve pressure on urgent and emergency care, systems are expected to limit ambulance handover delays and improve response times;

- Meet growing demand for NHS 111 by enhancing call handling capacity;
- Expand UTC to enable greater focus on higher acuity need within emergency departments;
- increase focus on urgent care provision for children.
- Systems are asked to reduce 12-hour waits in EDs towards zero and no more than 2%
- Improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards
- Minimise handover delays between ambulance and hospital.



Developing Virtual Ward & Community Capacity

- Systems are asked to develop detailed plans to maximise the rollout of virtual wards by enabling earlier supported discharge and providing alternatives to admission. There is an expectation that by December 2023, systems will have moved towards a national ambition of 40–50 virtual wards per 100,000 population.
- NHSE/I is making up to £200m available in 2022/23 and 2023/24 to support systems to implement virtual wards (including hospital at home services) to ease the pressure on acute bed capacity.
- Systems will need to develop two-year plans collaboratively across providers (and the independent sector) to maximise the rollout of virtual wards, which NHSE/I expects to have taken place by December 2023. These virtual wards will be used for patients who would otherwise be admitted to an NHS acute hospital bed or to facilitate early discharge.
- System partners are also asked to plan to reduce backlogs of care and waiting times for community services
- Systems are asked to deliver the LTP goal of responsive, personalised community-based care. This includes enhanced health in care homes; improving quality and availability against national data requirements; and embedding urgent community response with services achieving at least 70% two- hour response times from the end of Q3 2022.
- As central discharge to assess funding will end in March 2022, NHSE/I is asking systems to sustain improvements in delayed discharges in 2022/23 by working with local authorities supported by the Better Care Fund, and via investment in virtual wards.



Mental Health Priorities

Mental health services

The guidance acknowledges that the complexity of demand has increased because of the pandemic and this, in addition to a pre-existing treatment gap within mental health, is increasing pressures within services and pathways across all ages.

To address these pressures systems are asked to:

- increase the provision of alternatives to A&E and improve the ambulance mental health response.
- ensure admissions are intervention-focused, therapeutic, and supported by multidisciplinary teams.
- maintain a focus on improving equalities across all programmes, noting the actions and resources
- identified in the advancing mental health equalities strategy.
- continue expansion and transformation of services. The guidance signposts to the 2022/23 mental health delivery plan to support systems in understanding their delivery requirements.

MH Funding

- On funding, the guidance confirms the delivery of the MHIS remains a mandatory requirement, and that system development funding (SDF) will continue beyond 2023/24.
- Capital funding made available through system allocations is expected to support urgent patient safety projects for mental health trusts, and funding to eradicate mental health dormitories will continue in 2022/23 and 2023/24.
- To support the expansion and transformation of the workforce, systems are asked to develop a mental health workforce plan to 2023/24 in collaboration with mental health providers, HEE and partners in the voluntary care and social enterprise (VCSE) and education sectors.

People with a learning disability & autism

- The guidance recognises the pandemic has exacerbated the significant health inequalities experienced by people with a learning disability and autistic people. This means making reasonable adjustments and tailored responses, including considering the ongoing need for face-to-face appointments as digital healthcare develops.
- Service development funding support of £75 million will be made available to systems in 2022/23 to support people with a learning disability and autistic people. This will help increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24; improve the accuracy of GP learning disability registers, particularly for under-represented groups such as children and young people and people from ethnic minority groups; and implement actions from Learning Disability Mortality Reviews (LeDeRs).

Primary Care Planning Priorities

- The guidance outlines the LTP's commitment to a £4.5 billion increase in real terms investment into primary medical and community services by 2023/24.
- ICBs will be expected to maximise the impact of their investment in primary care and PCNs by driving integrated working at neighbourhood/place level; and including primary care as part of the solution to system-wide challenges.
- ICBs will be the delegated commissioners for primary medical services in 2022/23 and should develop plans to take dental, community pharmacy and optometry commissioning functions from 2023/24.
- Expanding the primary care workforce is a key priority, and all systems are expected to support their PCNs to fill their share of the 20,500 FTE PCN roles by the end of 2022/23, and to increase the number of GPs towards the 6,000 FTE target (commensurate with the October 2021 plan).
- To improve access to primary care, systems have also been asked to implement revised access arrangements via PCNs; secure universal participation in the community pharmacist consultation service to divert lower acuity care away from general practice and 111; and support practices and PCNs to ensure every patient can be offered digital-first primary care by 2023/24.

Health Inequality Priorities 22/23

- The guidance sets out the ambition to continue to develop approaches to population health management and prevention, with ICSs driving the shift towards targeting interventions and supporting prevention as well as treatment.
- Systems are asked to develop plans by June 2022 to put in place the systems, skills and data safeguards necessary for robust population health management, and to have the technical capability in place by April 2023.
- This includes the capacity to use data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.
- The guidance reiterates the importance of adopting culturally competent approaches to increasing vaccination uptake.
- Systems are asked to develop robust plans for the rollout of tobacco dependence services, improve uptake of lifestyle services including the diabetes prevention programme, and restore diagnosis and monitoring of long term conditions including hypertension, atrial fibrillation and diabetes.
- There should be further progress across the LTP's high impact actions, across

  respiratory,
  stroke
  cardiac care,

- with the target of restoring detection and management of hypertension, atrial fibrillation and high cholesterol to pre-pandemic levels.
- Systems are also asked to nominate a senior responsible officer covering prevention deliverables

Digital Priorities 22/23

- The guidance confirms systems will be allocated capital over three years from 2022/23 for digital investment.
- £250m of capital funding will initially be made available to systems in 2022/23 to support the digitisation of services and settings that are currently the least digitally mature.
- Providers must meet the LTP objective of reaching a core level of digitisation by March 2025.
- Costed three-year digital investment plans should be completed by June 2022 to meet expectations set out in the What Good Looks Like framework.

- Systems are expected to exchange information across their collaboratives and ensure suppliers comply with interoperability standards.
- By March 2023, local authorities with care responsibilities within a system's footprint should be connected to their local shared care record.
- The long-term ambition is for the NHSE e-Referral Service (e-RS) to become an 'any-to-any health sector triage, referral and booking system' by 2025.

National planning guidance combined.pdf

ICBs and collaborative system working

- Given the uncertain timeframe for the passage of the Health and Care Bill, the move to placing integrated care systems (ICSs) on a statutory footing will be pushed back to 1 July 2022. Timelines for national and local plans will therefore be adjusted. An extended 'preparatory phase' will begin from 1 April 2022 whereby clinical commissioning groups (CCGs) remain in place as statutory organisations, and CCG leaders are expected to work closely with designate ICB leaders on issues likely to affect future ICBs (particularly commissioning and contracting).
- In Q4 2021/22 NHSE/I will consult with several CCGs about boundary changes to ensure they align with the ICS boundary changes announced in July 2021. NHSE/I does not plan any further CCG mergers before the establishment of ICBs.
- CCGs and ICBs should reset their implementation plans and ensure people, property and liabilities are appropriately and safely transferred from CCGs to future ICBs. This also means designate ICB chairs and chief executives should continue with recruitment plans.
- NHSE/I regional teams, designate ICB leaders, and CCG accountable officers should agree ways of working for 2022/23 by the end of March 2022. The deadline for ICB Readiness to Operate and System Development Plan submissions will be extended (with details about these plans to be set out in January 2022). ICBs refreshed five-year plans are expected in March 2023, and ICBs are expected to undertake preparatory work throughout 2022/23 in collaboration with local authority partners.

Financial Framework 22/23

Financial Balance at System Level

ICBs and partner trusts are collectively tasked with delivering a breakeven financial position across their system and, although possibly delayed, the Health and Care Bill will hold ICBs and trusts responsible for their use of revenue and capital resources.

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Contracts & locally determined prices

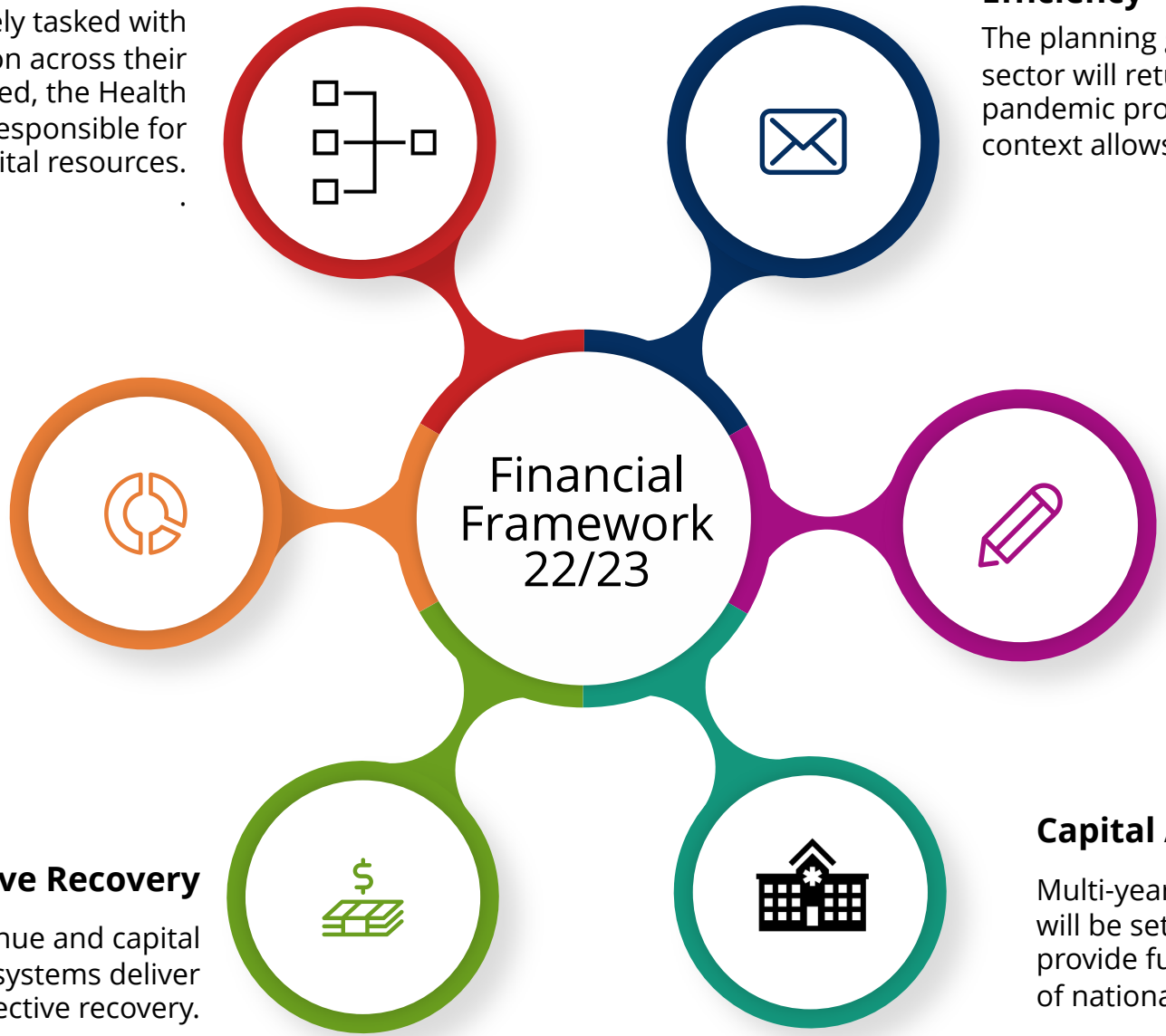
providers are expected to return to signed contracts and local ownership for setting payment values (additional guidance will be provided by NHSE/I).

Written contracts should be signed before the start of the financial year.

The guidance also recommends systems and organisations sustain a 'partnership approach' payment and contracting. The final version of the NHS Standard Contract will be published in Feb 2022.

Enabling Elective Recovery

additional revenue and capital funding will support systems deliver the ambitions for elective recovery.



Efficiency

The planning guidance assumes the provider sector will return (and go beyond) pre-pandemic productivity allows 'when the context allows'..

Returning to Fair Shares Allocations

NHSE/I will continue to enable a system-based approach to funding and planning by issuing ICB revenue allocations (based on current system funding envelopes). On top of the efficiency ask, NHSE/I will apply a convergence adjustment and map out a glidepath from current system revenue envelopes to 'fair shares' allocations

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Capital Allocations

Multi-year operational capital allocations will be set at ICB level, and NHSE/I will provide further clarity about the allocation of national capital programmes

National planning guidance combined.pdf

High Level Planning Expectations & Timelines

April	June / July	Dec	Mar
• Eliminate 104 week waits • 2hr urgent community response service to start • **Final Planning Submission**	• Reduction in over 78 & 52 wk waits • ICS becomes statutory body • **Costed 3-year digital investment plan**		• Deliver 10% more elective activity than pre pandemic • Deliver 120% more diagnostic activity than pre-pandemic • Reduce OP FUPs by at least 25% (incl 5% through PIFU • 16 specialist advice requests (eg. A&G) per 100 OP First appointments • Cancer patients over 62 days to be same level as Feb 20 & 6 patient stratified FUP pathways to be in place • Reduce 12 hr. ED waits to zero or no more than 2%, 100% of ambulance handovers within 60 mins • **5 Year system plan to be in place**
• Anticipatory Care Service to be implemented • Digital first primary care offer as standard • All systems to have technical PHM capability in place		• **40/50 virtual beds per 100,000 population to available**	
			• Deliver 30% more elective activity than pre pandemic • Digital diagnostic investments to improve productivity by at least 10% • E-RS to be triage, referral & booking system across healthcare

National planning guidance combined.pdf

East and North Hertfordshire
NHS Trust
Agenda item: 11

PUBLIC BOARD MEETING 12 JANUARY 2022

Report Title	System Collaboration report
Report Presenter	Deputy CEO
Report Author	Deputy CEO
Executive Lead	Deputy CEO

Report Summary *Please summarise the key points from the report and the recommendation that is being made*	The paper provides a latest position on system collaboration.
Action Required	**For discussion**
Risk Issues *Please specify any links to the BAF or Risk Register*	

Trust Priorities *Please tick any Trust priorities to which the issue relates*		
Quality	To deliver high quality, compassionate services, consistently across all our sites	☒
People	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Previously considered by	
Committee/Board/Group:	Date:

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

East & North Hertfordshire NHS Trust

System Collaboration Activity Report

This reports provides updates to board members in respect of key strands of significant collaborative system activity that the Trust is actively participating in.

System Governance - Design & Reform

Recently published national planning guidance has formalised a delay in the timeframe for placing integrated care systems (ICSs) on a statutory footing. This will now be pushed back from 1 April 22 until 1 July 2022. Timelines for national and local plans will therefore be adjusted. An extended 'preparatory phase' will begin from 1 April 2022 whereby clinical commissioning groups (CCGs) remain in place as statutory organisations, and CCG leaders are expected to work closely with designate ICB leaders on issues likely to affect future ICBs (particularly commissioning and contracting).

Within the context of the revised timeline, it is expected that NHSE/I regional teams, designate ICB leaders, and CCG accountable officers should agree ways of working for 2022/23 by the end of March 2022. The deadline for ICB Readiness to Operate and System Development Plan submissions will be extended (with details about these plans to be set out in January 2022). ICBs refreshed five-year plans are expected in March 2023, and ICBs are expected to undertake preparatory work throughout 2022/23 in collaboration with local authority partners.

In support of this process that Trust has during Q3 participated in local system task and finish groups to inform and shape the structure and nature of future system and place working and arrangements. These groups encompassed

1) governance arrangements,
2) target operating model (TOM) arrangements
3) provider collaborative arrangements
4) validation of system priorities and objectives and finally
5) organisational development proposals.

The Trust has been represented at the meetings of each of these groups by a variety of Executive Directors. Where relevant and appropriate specific issues of escalation and decision making have been referred to both the Executive Directors Committee and also Board Development sessions for discussion and agreement. The output from the five groups was presented at the November ICB Board meeting for review and approval.

The Governance group will continue to meet to pick up technical issues around the constitution and develop a MOU for the ICS relationship with the Region in 22/23. A wider range of actions and issues remain to be discussed through the TOM group, with a need to set up a complimentary Finance group in the new year given the clear linkages between financial flows and operating models

Virtual Ward Expansion
One of the key priorities for 22/23 as outlined in national planning guidance is the necessity of systems and organisations developing plans to further rollout the capacity of virtual ward arrangements that can act as credible alternatives to inpatient admission. Significant additional funding will be made available to support this objective.
Whilst the current virtual ward arrangements that are in place across the E&NH place represent an encouraging but modest start to this service model during 21/22, it is clear to the Trust that the true potential of this method of care remains relatively untapped.

The Trust is keen to explore learnings from other high performing models of virtual ward delivery that exist both locally and nationally to determine how stepped changes in delivery can be achieved. With this in mind the Trust will undertake an internal diagnostic in the coming weeks blended with the experiences of other exemplar services to form a view of the optimal clinical and delivery models to maximise take up and achieve a significant expansion of sustained capacity. This diagnostic process will subsequently enable the Trust to undertake informed discussions with partner organisations across place and sectors to agree how a revised model could be implemented and that roles that organisations and teams might play.

System Oversight & Assurance Group (SOAG)
Operational planning guidance for 21/22 sets out the requirements for all ICSs to work in partnership with NHSE/I to take collective responsibility for the management of system resources and performance. The current year represents a shadow year to ensure that oversight arrangements are in place at ICS, HCP and organisation level. This includes the implementation of regular SOAG meetings. During the course of August and October this bimonthly forum has been established and its Terms of Reference agreed. The Trust has been represented by the CEO / DCEO at this forum. The second formal meeting of the group with representatives on NHSIE took place in December. The Trust continues to work alongside ICS colleagues to provide development support in the design and implementation of sustainable performance reporting mechanisms to support this new framework. Current work is focused upon waiting list management. Proposals to extend the review of appropriate performance discussions to a place level (POAG) are also being discussed.

Enhanced Services Steering Group
During the course of the COVID pandemic a number of new and innovative approaches have been developed or extended in order to help prevent unnecessary admissions into an acute setting or expedite prompt discharge, these include Prevention of Admissions (POA) schemes and Discharge Home to Assess (DH2A)

During the course of 21/22 it has become apparent to partners across the place system that there wasn't jointly designed and aligned framework to determine the impact of these schemes in respect of activity, flow, finance and workforce. It was acknowledged that this presented an impediment to future planning, design and mobilisation arrangements unless addressed. ENHT has therefore taken a lead role in setting up the 'Enhanced Services Steering Group'. This group led by the ENHT Director of Improvement and comprised of Executive Directors across the place ecosystem meets on a bi-weekly basis to progress joint evaluation, design and implementation arrangements. Work to date has focused upon POA

evaluation, and has resulted in a jointly agreed impact statement. This will be helpful in determining the scale, place and impact of this model of delivery in terms of planning for 22/23. Work is presently ongoing to develop a similar joint impact assessment for DH2A.

ENHT / HCT partnership working projects

In April 2021 the two providers-initiated project working arrangements to explore options to maximise service effectiveness and delivery across areas where the organisations currently deliver different aspects of one overarching pathway.

The two areas that have been identified for accelerated development are Stroke / Neuro services and Community Paediatrics. To date work has concentrated upon creating revised lead provider arrangements as a mechanism to provide greater integration and thereby promoting enhanced quality and delivery outputs. It is anticipated that the work across these services areas can subsequently act as a model for lead provider delivery arrangements to a further pipeline of activity.

The group led by Directors of Finance from the two organisations and supported by contracts, operations and clinical staff was working to prioritise the mobilisation of the revised lead provider (ENHT) arrangements for Stroke / Neuro. Progress during Q3 has not proved as swift as hoped and the onset of COVID pressures has meant that this area of focus has now been deferred to the spring.

It may prove a timely opportunity for both organisations to review and reappraise their investment in this process given the time that has elapsed, and the outcomes delivered.

East of England Imaging Network

The EoE region has established 2 imaging networks. These are designed to enable clinical images from care settings close to the patient to be rapidly transferred to specialist clinicians across diverse geographical settings. ENHT is acting as the governance and leadership hub for one of these networks. To date the networks have been successful in developing bids and securing funds that support the expansion of home reporting, iRefer CDS and Imaging sharing capability and infrastructure for providers across the region.

Design and implementation meetings in support of project aims have continued in Q3 and moving forward into Q4.

Community Diagnostic Centres

The expansion of diagnostic services placed within more varied and diverse community settings is a core feature of the government's strategy to improve access to services and address the post pandemic waiting list challenge. The place-based community has responded to this challenge by designing a model for expansion and deployment. This has been achieved through diverse stakeholder design events including acute, community and commissioning colleagues.

Whilst the finalisation of the model across a five-year period and agreement of funding arrangements over this full timeframe is still pending, interim approval has already confirmed the receipt of significant capital and revenue streams to mobilise the model during 21/22. The November meeting of the FPPC approved the Final Business Case submission to NHSI

Pathology Tendering Process

The Trust remains an active partner in the process to tender ICS pathology services. The timeline for the project has slipped as a product of a number of issues and presently the earliest award of any contract is expected during Q1 of the new financial year. A full business case will be produced by the project team for consideration and approval by participant organisations prior to any contract award.

Martin Armstrong
Deputy Chief Executive
Dec 2021

East and North Hertfordshire NHS Trust

Agenda Item:10

PUBLIC BOARD – 12 January 2022 –
Community Diagnostic Hub – Full Business Case

Purpose of report and executive summary (250 words max): Paper 1: The Full Business Case (FBC) sets out the five year transformation plan to fulfil the mandate set by NHS England regarding the establishment of a Community Diagnostic Hub (CDH) model across East and North Hertfordshire Health Care Partnership (ENH HCP). ENHT is the lead provider for this model. The FBC seeks approval of the CDH five year plan, utilising NHS England monies. In addition it sets out the additional revenue expenditure required post NHS England funding to maintain the CDH, and the associated risks. Paper 2: The Community Diagnostic Hub Year 1 2021/2022 Mobilisation Briefing provides assurance regarding the mobilisation plans and the risks associated.		
Action required: For approval		
Previously considered by: **FPPC - 24th November 2021** **Deputies Meeting – 22nd November 2021** **Executive Meeting – 18th November 2021**		
Director: Director of Improvement	**Presented by:** Programme Manager	**Author:** Programme Manager

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
No

Any other risk issues (quality, safety, financial, HR, legal, equality):

1. Funding: If NHS England funding is not approved then the CDH programme will have to be reduced resulting in a reduced impact on activity
2. Workforce: If the required workforce is not available then the mobilisation of the CDH will be compromised resulting in an impact on ENH HCP and ENHT's credibility
3. Funding: There will be a recurrent funding requirement post withdrawal of NHS England funding which will need to be absorbed by the system.

Please see full business case for further details.

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

NHS
East and North Hertfordshire
NHS Trust

ENH Community Diagnostic Hub

Full Business Case

Version	0.7
Date	19th November 2021
Author	Emma Hollingsworth, Programme Manager, ENHT
SRO (ENHT)	Kevin O'Hart, Director of Improvement, ENHT

Purpose of Document

The Full Business Case (FBC) sets out the five year transformation plan to fulfil the mandate set by NHS England (NHSE) regarding the establishment of a Community Diagnostic Hub across the East and North Hertfordshire Health Care Partnership (ENH HCP).

The FBC establishes a compelling case for the development of diagnostic services across ENH HCP. It details the proposed model in accordance with the funding envelope provided by NHSE. It seeks approval for the submission of the model to NHSE.

The FBC has been prepared using the agreed standards and format for business cases set out in Her Majesty's Treasury (HMT) Green Book and guidance developed by NHS Improvement (NHSI). It is formatted using the five case model, comprising;

- Strategic case
- Economic case
- Commercial case
- Estates case
- Financial and Management case

Glossary of Terms

AHSN	Academic Health Science Network	**NHSE**	NHS England
CDH	Community Diagnostic Hub	**NHSI**	NHS Improvement
CT	Computerised Tomography	**PA**	Programmed Activity
CUP	Cancer of Unknown Primary	**PDC**	Public Dividend Capital
DEXA	Dual Energy X-ray Absorptiometry	**PER**	Post Evaluation Review
DM01	Diagnostic Waiting Time and Activity	**PET-CT**	Positron Emission Tomography
ECG	Electro cardiogram	**PHM**	Population Health Management
ED	Emergency Department	**POCT**	Point of Care Testing
ENH	East and North Hertfordshire	**PPIR**	Programme and Project Implementation Review
ENHCCG	East and North Hertfordshire Clinical Commissioning Group	**RDA**	Radiography Assistants
ENHT	East and North Hertfordshire NHS Trust	**RDC/RDS**	Rapid Diagnostic Centre (Service)
FENO	Fractional Exhaled Nitric Oxide	**RTT**	Referral to Treatment Time
FBC	Full Business Case	**SFI**	Standing Financial Instruction
FPCC	Finance, Performance and People Committee	**SPEC-CT**	Single-photon emission computed tomography
GP	General Practitioner	**SRO**	Senior Responsible Officer
HCH	Hertford County Hospital	**TDG**	Transformation Delivery Group
HCP	Health Care Partnership	**UK**	United Kingdom
HCT	Hertfordshire Community NHS Trust	**WECCG**	West Essex Clinical Commissioning Group
HMT	Her Majesty's Treasury	**WTE**	Whole Time Equivalent
HPFT	Hertfordshire Partnership University NHS Foundation Trust	**MEC**	Make every contact count
HWE	Hertfordshire and West Essex		
ICS	Integrated Care Service		
ICT (IT)	Information Computer Technology		

Version Control			
Version	**Date**	**Changes**	**Author**
0.1	30.10.2021	First draft	Emma Hollingsworth
0.2	16.11.2021	Inclusion of financial narrative	Laurence Wong
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0.6	18.11.2021	Additional wording regarding risk share	Emma Hollingsworth
0.7	19.11.2021	Page number formatting	Emma Hollingsworth

Table of Contents

1.0 Executive Summary

1.1 Introduction

The Full Business Case (FBC) has been developed in order to obtain approval for the use of NHS England funding to support the implementation and delivery of a Community Diagnostic Hub (CDH) in East and North Hertfordshire, a nationally mandated project.

The FBC seeks approval of the CDH 5-year plan, utilising the NHS England monies. In addition, it sets out the additional revenue expenditure required post NHS England funding to maintain the CDH and the associated risks.

The FBC sets out the rationale for the transformation of diagnostic delivery based on strategic, economic, commercial, financial and management cases for change. Approval of this business case will enable East and North Hertfordshire to develop a CDH in line with NHS England requirements and respond to the local patient need. A do nothing position has not been included as this is a mandatory NHS England project.

Whilst the main responsibility for the delivery of this project, and therefore the risks, sits with East and North Hertfordshire NHS Trust (ENHT), this is an ENH HCP project and therefore a collaborative risk sharing agreement needs to be in place to fully realise the benefits of this model.

1.2 Strategic Objectives

The strategic objectives are set out in section 3.1. In summary the key strategic objectives of the ENH CDH is to ensure increased capacity and improved access for diagnostic service provision within ENH that aligns with the NHSE mandatory requirements.

- ENH system to deliver on key requirements of the NHS Long Term Plan, particularly with regards to cancer
- Nationally, demand for diagnostics is growing considerably, with CT scanning, MRI scanning, PET-CT, non-obstetric ultrasound and DEXA growing 6.8%, 5.6%, 18.47%, 3.8% and 4% respectively over the past five years
- Implementation will play a significant role in supporting elective recovery
- The model will enable organisations within ENH system to better vertically integrate (e.g. between acute and primary care)
- The model will help tackle some of the widening health inequalities exacerbated by COVID-19, particularly with regards to access to services but strategically placing equipment to local areas
- The programme will support the Trust to better attract income in relation to research opportunities (e.g. Artificial Intelligence and imaging)
- The scheme will support the growing life sciences sector in the county, particularly in the bio campus under development in Stevenage
- The programme will be a major enabler to a range of other initiatives, including the Rapid Diagnostic Centre for cancer
- The programme will play a key role in enabling the ENH system to deliver on its emerging priorities, particularly with regards to better supporting people with Long Term Conditions.

1.3 Strategic Context

1.3.1 National Context

In October 2020 NHSE published an independent review, led by Sir Mike Richards, into diagnostic services in the NHS in England. The report's fourth recommendation was for community diagnostic hubs to be established; '….to provide COVID-19 minimal, highly productive elective diagnostic centres for cancer, cardiac, respiratory and other conditions…'. The emphasis is to increase diagnostic capacity, shift elective diagnostic work to non-acute sites and to transform pathways.

In response NHSE launched a national programme by which Integrated Care Systems (ICS) could bid for both capital and revenue funding over five years to launch CDHs. This is a nationally mandated project with minimum delivery requirements.

1.3.2 ICS Strategic Context

Hertfordshire and West Essex ICS has commenced development of a diagnostics strategy to consider how the recommendations from the Sir Richards' report can be embedded locally.

1.4 Economic Case

A do no nothing position has not been presented within this FBC due to this being a nationally mandated requirement by NHSE. The proposed model detailed within this paper is presented as the single option. However each component has been individually listed to provide an element of option and discussion.

1.5 Commercial Case

1.5.1 Procurement Strategy

ENHT will be working with Hertfordshire and West Essex ICS NHS Procurement Services who will advise on the correct route to market in line with the Trust's Standing Financial Instructions, Standing Orders, Public Contract Regulations (2015) and other agreed protocols. This will ensure compliance and demonstrate value for money has been obtained in relation to cost, quality and specification.

1.6 Estates Case

The New QEII Hospital was identified at an early stage as the appropriate estate for the 'Hub'. This is away from the main acute site (Lister Hospital) and already provides a range of diagnostic services as per the NHSE mandate. From an internal perspective there is an opportunity to enable more space utilisation at this site.

In recognition that ENH is a geographically diverse area, the system supported the development of a 'hub and spoke' model whereby the spoke element would be provided in a community estate. Strategically it was felt this option would also be highly supported by NHSE.

1.7 Financial Case

1.7.1 Financial Expenditure

Comprehensive financial modelling has been led by ENHT finance department. Table 1 shows the 5 year summary financial position.

Table 1: CDH 5-Year Summary Financial Position

Values										
Phase	Spend Type	Sum of 2021/22	Sum of 2022/23	Sum of 2023/24	Sum of 2024/25	Sum of 2025/26	Sum of 2026/27	Sum of 5 year costs Year 1-5	Sum of 5 year costs year 2-6	Sum of years 2-5
Phase 1	1) Pay	355,156	3,127,492	3,190,042	2,192,215	2,236,059	2,280,780	8,864,904	13,026,587	10,745,807
	2) Non Pay	252,841	1,195,847	1,227,398	1,259,961	1,293,576	1,328,285	3,936,046	6,305,067	4,976,782
	3b) Depreciation	154,873	154,873	154,873	154,873	154,873	154,873	619,493	774,366	619,493
	4) PDC	24,393	18,972	13,551	8,131	2,710	0	65,047	43,364	43,364
	5) Contingency	60,800	432,334	441,744	345,218	352,964	360,906	1,280,095	1,933,165	1,572,259
	6) Overhead (25%)	167,199	1,188,918	1,214,796	949,348	970,650	992,493	3,520,261	5,316,205	4,323,712
	8) Capital	851,803						851,803	0	0
Phase 1 Total		1,867,065	6,118,436	6,242,404	4,909,745	5,010,832	5,117,338	19,137,649	27,398,754	22,281,417
Phase 2	1) Pay	0	449,307	458,293	2,228,793	2,273,369	1,545,891	3,136,393	6,955,654	5,409,762
	2) Non Pay		430,905	439,523	2,357,661	2,589,136	2,837,122	3,228,089	6,136,264	5,817,224
	3a) Amortisation			2,857	2,857	2,857	2,857	5,714	11,429	8,571
	3b) Depreciation		12,771	398,486	398,486	398,486	398,486	809,743	1,593,943	1,208,229
	4) PDC		2,696	90,649	76,602	62,555	48,508	169,946	280,100	232,500
	5) Contingency	0	88,368	137,815	505,309	531,543	482,224	731,493	1,745,260	1,263,036
	6) Overhead (25%)	0	246,012	381,906	1,392,427	1,464,486	1,328,772	2,020,344	4,813,603	3,484,831
	7) Dilapidations Provision				300,000	0	0	300,000	300,000	300,000
	8) Capital		83,400	2,720,000				2,803,400	2,803,400	2,803,400
Phase 2 Total		0	1,313,459	4,629,528	7,262,134	7,322,432	6,643,859	13,205,122	24,639,651	20,527,554
Grand Total		1,867,065	7,431,895	10,871,932	12,171,880	12,333,264	11,761,196	32,342,771	52,038,405	42,808,970

1.7.2 Overall Affordability

ENHT has already been awarded and received funding for Year 1 (2021/2022); both capital and revenue.

The NHSE financial envelope for Years 2-5 is unknown. All systems need to develop a costed model and bid for the monies. This paper details the proposed ENH model but with the caveat that should the NHSE funding be less than required, adjustments to the model will need to be made.

There will be a Trust revenue impact post the NHSE funding which is detailed in this paper. Whilst the Trust is the lead provider for this service, it remains a system wide bid therefore it is recommended there is an element of risk sharing across ENH HCP.

1.8 Management Case

1.8.1 Project Management Arrangements

ENHT's Director of Improvement is the programme SRO with system support provided by ENH HCP Development Director. ENHT's Transformation Office is responsible for the programme management.

Governance arrangements for this project are detailed under section 8.2.

1.8.2 Benefits Realisation and Risk Management

The benefits realisation plan for this programme has been developed in conjunction with key stakeholders.

Risks are managed in line with ENHT Trust Risk Management Procedure. Risks that have materialised, or that are now forecast to happen outside of tolerances and unforeseen events, will be managed as issues. Issues will follow the change control process where appropriate and will be escalated through the project and Trust governance structure.

1.9 Recommendation

The board is asked to approve;

1. The recommendation to bid to NHSE for sufficient monies (capital and revenue) to implement the Years 2-5 CDH service model
2. The recommendation that a risk share agreement is developed across ENH HCP, particularly in relation to finance

2.0 The Outline Proposal

2.1 Vision for Diagnostic Services in the future

NHSE states a CDH should be a free standing, digitally connected, multi-diagnostic facility that can be combined with mobile units. CDH provision should be located separately from the main acute hospital facilities. In ENH the main acute site is Lister Hospital, Stevenage. There are three 'CDH facility' archetypes identified by NHSE. The proposed model should fit one of these archetypes or can be a blend of the models providing the diagnostic services identified by NHSE as a minimum requirement are met. **Appendix One** lists the minimum diagnostic tests that need to be provided at a CDH. However, it is important to note that there is a remarkable level of flexibility within this programme, with NHSE keen to stress that local models must reflect local needs. Therefore, a range of other diagnostic services may also be included in the model such as:

- Mammography
- Ophthalmology
- DEXA scan
- Antenatal screening
- Hysteroscopy and colposcopy
- Cystoscopy
- Urodynamics
- Audiology
- Fibroscan

Table 2: NHS England Community Diagnostic Hub 'archetypes'[1]

Model 'archetype'	Description
Standard	A CDH that provides the minimum diagnostic tests, except for endoscopy, and any other diagnostic test deemed a priority locally. Only diagnostic testing is required to be carried out in this archetype; however, provision of consulting rooms should be considered if there is an opportunity for streamlining and providing more efficient overall patient pathways.
Large	A large CDH that offers all minimum services and endoscopy, and potentially provides some of the optional components in the diagnostic pathway e.g. consultation. Delivery of endoscopy needs to be embedded within a Regional Network and be aligned to any local endoscopy training academies.
Hub and spoke	The central hub must include all minimum diagnostic tests to support a coordinated service for patients that requires multiple tests. CDH 'spokes' provide further

[1] https://www.england.nhs.uk/wp-content/uploads/2020/11/diagnostics-recovery-and-renewal-independent-review-of-diagnostic-services-for-nhs-england-2.pdf

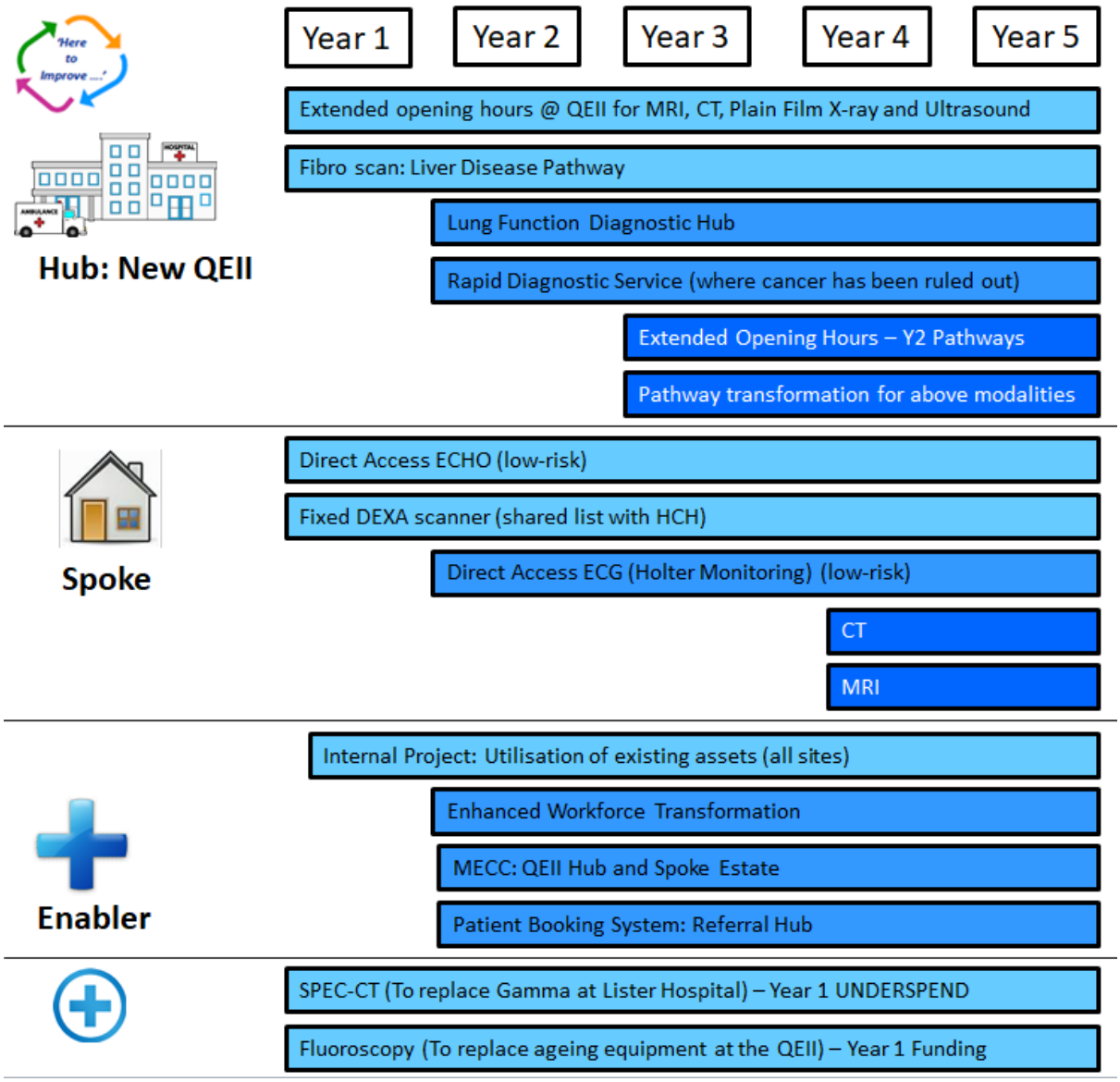
	capacity to 'hubs' for specific tests through a satellite location, mobile unit or pop-up. Spokes can be used to meet specific service needs (e.g.to reach certain populations or increase local capacity for specific tests). The spokes can help integrate CDH models with other community diagnostic expansion (e.g. primary care diagnostic services) or to deliver care at home where this helps to progress the intended aims of the programme.

2.2 Proposed Service Model

2.2.1 Proposed Service Model

The preferred option is a 'Hub and Spoke' model. This utilises, and expands the existing diagnostic service provision at the New QEII site, as well as implementing a community spoke option to support the reduction in health inequalities.

Figure 1: ENH Community Diagnostic Hub Model



Please note the extended opening hours at the New QEII Hospital will enable service delivery 8am-8pm Monday-Sunday.

The rationale for the service model and enhancements can be found in **Appendix Two**.

A business case for Year 1 was submitted to NHSE in July 2021. Formal funding was approved in October 2021 with the expectation that mobilisation occurs within 2021/2022. The scope of Year 1 cannot be changed without submission of a formal change request to HWE ICS and NHSE.

NHSE requested a high level submission of local systems' statement of intent for Years 2-5. This was completed and submitted in September 2021 to support NHSE's discussions as part of the Treasury Review. A confirmed financial envelope is pending. In the interim ENH has reviewed and refined the Years 2-5 proposal to ensure this remains ambitious, aligns with the NHSE requirements but is deliverable. The revised model is detailed in this FBC.

2.3 Implementation Programme

(i) Year 1 (2021/2022):

NHSE has requested Year 1 mobilisation in 2021/2022. Due to workforce pressures and to ensure a safe service the intention is for a phased mobilisation;

- Phase 1 – mid February 2021: Mobilisation of the extended opening hours at the New QEII – weekday evenings only.
- Phase 2 – mid March 2021: Mobilisation of the extended opening hours at the New QEII – weekends and delivery of the community spoke element.

A weekly internal (ENHT) mobilisation meeting is ongoing to support the process.

Earlier mobilisation is not possible due to a) the delayed notification in funding from NHSE and b) workforce challenges which are detailed in section 3.8.

(ii) Year 2-5:

The FBC presents a high level plan – specific details will need to be worked through following funding confirmation from NHSE.

Mobilisation for Year 2 will need to commence within 2022/2023 although there is a degree of flexibility as to the exact start point within that financial year. The go-live date will be dependent on release of funding, lag time for equipment order and delivery and other mobilisation requirements.

2.4 Capital Investments

The capital investments for Years 1-5 are detailed below. Please note that Year 1 capital funding has already been awarded by NHSE on the proviso the monies must be spent by 31st March 2022.

Table 3: Capital Investment Summary

YEAR	TOTAL	BREAKDOWN
Year 1 2021/2022	£1.774m	• Dexa: £119,000 • Fibroscan: £206,000 • Fluoroscopy: £582,000 • ECHO Machine: £143,000 • SPEC CT Scanner: £724,000*
Year 2 2022/2023	£83,400k	• Lung Function Diagnostics: £83,400k
Year 3 2023/2024	£0	N/A
Year 4 2024/2025	£2.72m	• MRI: £1.5m • CT: £1.2m • Digital infrastructure: £200k
Year 5 2025/2026	£0	N/A

*The SPEC CT Scanner was awarded to ENH through Year 1 underspend funding. The SPEC CT Scanner will replace an out of date Gamma at the Lister Hospital site. Whilst NHSE may request activity data, this does not form part of the main CDH model.

The Year 1 NHSE funding does not correlate with the capital funding listed in the finance table (see section 1.7). The Year 1 submission to NHSE represented a 'worst case scenario' – the actual costs following procurement review are much less hence the disparity.

2.5 Revenue Investment

Table 4: Revenue Investment Summary

YEAR	TOTAL	BREAKDOWN
Year 1 2021/2022	£1.078m	• Pay: £679k • Non-Pay: £216k • Depreciation: £150k • PDC Dividends: £35k
Year 2 2022/2023	£7.4m	• Pay: £3,576,799 • Non-Pay: £1,626,752 • Depreciation: £167,645 • PDC Dividends: £21,667
Year 3 2023/2024	£8.2m	• Pay: £3,648,335 • Non-Pay: £1,666,921 • Depreciation: £553,359 • PDC Dividends: £104,200
Year 4 2024/2025	£12.2m	• Pay: £4,421,008 • Non-Pay: £3,617,622 • Depreciation: £553,359 • PDC Dividends: £84,732
Year 5 2025/2026	£12.3m	• Pay: £4,509,428 • Non-Pay: £3,882,712 • Depreciation: £553,359 • PDC Dividends: £62,625

2.6 Current Activity Levels

2020/2021 data has been used to determine current activity levels and average monthly activity. The rationale is to ensure requirements such as social distancing are recognised as opposed to pre-pandemic activity information.

The below tables highlight total diagnostic activity (core modalities only) across all sites, as well as an average monthly activity.

Table 5: 2020/2021 Diagnostic Modality Activity (Total and per Site)

Modality	Lister	HCH	QE2	Total
CT	8893	0	4841	13734
Dexa	1	1769	0	1770
Fluoroscopy	522	0	478	1000
MRI	5623	0	2504	8127
Radiology	17250	6514	9558	33322
Ultrasound	24869	4749	7694	37312
Total	95695	13778	35252	144725

Source: Qlikview – GP Direct Access and Outpatient

Table 6: 2020/2021 Diagnostic Modality Activity (Average Monthly)

Modality	Lister	HCH	QE2
CT	741	0	403
Dexa	1	147	0
Fluoroscopy	44	0	40
MRI	469	0	209
Radiology	1438	543	797
Ultrasound	2072	396	642

Source: Qlikview – GP Direct Access and Outpatient

There continues to be significant pressure on diagnostic services, despite the impact of COVID-19 causing slight decrease in activity demand in 2020/2021. The largest impact can be evidenced in GP to outpatient appointment turnaround time for the core modalities which have all seen a waiting time increase from between 12 days to 63 days.

The six week diagnostic wait was initially introduced as a 'milestone' in March 2008 to support the achievement of the 18-week referral to treatment (RTT) target. Diagnostic waiting times are now part of the NHS Constitution which gives patients the legal right to have a diagnostic test within 6 weeks of the request being sent. Based on 2020/2021 data the average wait time for the core diagnostics exceeded six weeks (i.e. 30 days).

HWE ICS is leading a Demand and Capacity work stream, linked to the individual acute Trusts, that will articulate true demand and capacity; both the do nothing position and in response to the proposed models.

2.7 Projected Future Activity Levels

In Professor Richards' report it states that additional CT scanning capacity will be clearly needed in CDHs. "These could be used for patients referred directly by GPs (currently 300,000 p.a. across England, equivalent to around 30 scanners) and the nearly 2.5 million patients who are currently referred to CT scanning from outpatients (equivalent to around 250 CT scanners), including for some patients with suspected cancer to facilitate achievement of the Faster Diagnostic Standard.

Recommendation 8 within the report states that CT scanning capacity should be expanded by 100% over the next five years to meet increasing demand and to match other developed countries. In the COVID-19 recovery phase, priority should be given to ensuring each acute site with an ED has access to a minimum of two CT scanners so that patients known to be COVID-19 negative can be kept separate from those who are COVID-19 uncertain or COVID-19 positive. Other additional scanners should be deployed to CDHs.

The following activity assumptions detail the anticipated increased capacity. NHSE will require monthly reporting of actual activity against the planned assumptions.

Table 7: Projected Additional Activity – Full Year (Single Equipment)

	Monthly Additional Capacity	Annual Additional Capacity
MRI	169	2,028
CT	169	2,028
ECHO cardiography	260	3,120
Plain X-Ray	506	6,072
Fibroscan	504	6,048
Ultrasound non-obstetric	701	8,412
Lung Function	100*	1,200*
DEXA	150	1,800
Holter Monitor (cardiology)	260*	260*

**Data needs to be validated by the clinical team*

Capital funding has also been provided for DEXA, Fluoroscopy and SPEC-CT. The activity projections for this equipment are subject to ongoing discussion with NHSE.

- DEXA Scanner: The original Year 1 submission included Peripheral Dexa to be used at a community spoke site. On further investigation by clinical and operational teams, the equipment is not supported. A change request is being submitted to NHSE for a static DEXA to be placed at a to be determined estate. This will provide additional activity.
- Fluoroscopy: Fluoroscopy was included within the original Year 1 submission but without agreement by the operational or clinical team. A change request is being submitted to NHSE for the capital funding to be used to replace ageing equipment at the QEII. Internally the team is exploring utilising spare revenue funds to enable extended opening hours for this piece of equipment that will deliver additional capacity.
- SPEC-CT: This was funded through Year 1 underspend money and will be based at the Lister site. Clarification is being sought from NHSE as to whether this activity will also be monitored.

2.8 Workforce

The workforce model has been developed based on a historic model of diagnostic service provision, and supported by guidance issued by NHSE. This represents the worst case scenario from a revenue perspective.

However there is an opportunity to develop a dynamic and multi-skilled workforce through;

1. Upskill areas of the existing workforce to undertake dual roles
2. Explore accreditation and apprenticeships
3. Upskilling system partners

Workforce is a significant risk to this programme and is recognised as a national issue. ENHT is engaged with the HWE ICS Workforce Group to explore options for recruitment, training and retention.

Please see **Appendix Three** for a workforce profile.

3.0 Strategic Case

3.1 The Case for Change

3.1.1 Clinical Case for Change

Transforming diagnostic services is arguably the crucial underpinning component which will enable the delivery of the NHS Long Term Plan. Whether it is in regards to improving earlier diagnosis of cancer, the implementation of genomic testing, research and innovation into diagnostic modalities, the development of imaging networks, or in the need for investment in replacing existing equipment, diagnostics feature prominently.

Diagnostic activity currently forms over 85% of clinical pathways, and is therefore a crucial backbone in effectively diagnosing, treatment and managing people with healthcare needs. Early diagnosis is critical to supporting people to manage their conditions for better clinical, personal, and quality of life outcomes. Without developing, expanding, and transforming existing service provision and changing how it is delivered, there will inevitably be deepening challenges in terms of population health, elective recovery and widening health inequalities.

3.1.2 Investment Objective

Investment in the development of the CDH will;

- Increase capacity of key diagnostics
- Support management and eventual reduction in the diagnostic backlog caused by the COVID-19 pandemic
- Achieve DM01 compliance and sustain good performance
- Improve access to diagnostic tests; both in terms of additional capacity and location of service provision but also the bundling of tests to support one stop shop models.

The long term ambition is for all diagnostic tests to be completed, and reported, within 2 weeks as per the 2ww pathways.

3.2 National Strategy

Transforming diagnostic services is arguably the crucial underpinning component which will enable the delivery of the NHS Long Term Plan. Whether it is in regards to improving earlier diagnosis of cancer, the implementation of genomic testing, research and innovation into diagnostic modalities, the development of imaging networks, or in the need for investment in replacing existing equipment, diagnostics feature prominently in future planning.

Diagnostic activity currently forms over 85% of clinical pathways, and is therefore a crucial backbone in effectively diagnosing, treating, and managing people with healthcare needs. Early diagnosis is critical to supporting people to manage their conditions for better clinical, personal, and quality of life outcomes. Without developing, expanding, and transforming existing service provision and changing how it is delivered, there will inevitably be deepening challenges in terms of population health, elective recovery, and widening health inequalities.

In October 2020 NHSE published an independent review, led by Sir Mike Richards, into diagnostic services in the NHS in England. The report's fourth recommendation was for community diagnostics hubs to be established: '…to provide Covid-19 minimal, highly productive elective diagnostic centres

for cancer, cardiac, respiratory, and other conditions…'. Earlier this year, NHSE launched a national programme by which Integrated Care Systems (ICSs) could bid for both capital and revenue funding over five years to launch Community Diagnostic Hubs.

To effectively respond to this opportunity an East and North Hertfordshire Health Care Partnership (HCP) Community Diagnostics Steering Group was established to engage with a wide range of stakeholders to develop a model of Community Diagnostic Hub for submission to NHSE.

3.3 ICS Strategy

In response to the publication of Professor Sir Richards' report and the NHS England drive, Hertfordshire and West Essex ICS has commenced development of a diagnostics strategy to consider how the recommendations from the report can be embedded locally. The starting point for the development of an ICS diagnostic strategy is establishing a community diagnostic hub in each of the HCP systems.

3.4 Alignment with Partner Strategies

3.4.1 East and North Hertfordshire NHS Trust

ENHT Clinical Strategy (2019/2024) details five strategic priorities. The aim of the CDH programme is to support all of the priorities;

- People: To create a dynamic and flexible service provision promoting the upskilling and training of staff
- Pathways: To co-produce pathways with key stakeholders from across HCP to ensure efficient and clinically effective pathways
- Ease of Use: To increase the capacity and accessibility for diagnostic services thereby reducing wait times
- Quality: To ensure that all elements of the service deliver a safe and compassionate service
- Sustainability: To develop a service plan that supports the sustainability of the service and ensures the positive impact on other parts of the system

Figure 2: ENHT Clinical Strategy (2019/2024) – Strategic Priorities

In terms of ENHT diagnostic service provision there are a number of work streams that are aiming to improve the capacity and access for both elective and non-elective activity, including the CDH programme. It is imperative the work flows are mapped; firstly to ensure a coherent plan for diagnostic services but also to ensure long term demand and capacity is both understood and met.

3.4.2 East and North Hertfordshire HCP

Please see the table below which outlines a summary of the partnership's strategic objectives, their respective priorities, and how CDHs would be supportive of delivery.

Table 8: ENH partnership strategy strategic objectives and priorities

Strategic objective 1: transform health, care, and wellbeing services to meet population needs.		**Strategic objective 2:** improve health and wellbeing for people who need it most.	
Priority 1: implement and embed the population health management approach.	Supports	**Priority 1:** reduced health inequalities experienced by people.	Delivers
Priority 2: improved and timely access to services when people need them.	Delivers	**Priority 2:** improved outcomes for adults with Long Term Conditions.	Delivers
Priority 3: improved co-ordination, join-up, and organisation of care around people.	Delivers	**Priority 3:** improved outcomes for children and young people.	Supports

3.5 Consultation

3.5.1 Staff consultation and engagement

A staff consultation document has been completed and submitted to the Trust Partnership at the beginning of December 2021. A 30 day consultation will commence in the New Year.

Due to the scale of the CDH programme, alongside other transformation programmes occurring within radiology, additional staff support has been identified. This is being explored in conjunction with ENHT's People Partners and the wider HWE ICS to ensure staff feel engaged, supported and listened to.

3.5.2 Involving patients and carers

ENHCCG identified a patient representative to support the programme development. This individual has been valuable in their contribution to the proposed model and subsequent amendments.

Going forward the ambition is to establish a patient reference group to support with the co-production of the pathways. The patient and carer voice will be integral in understanding access and experience.

3.5.3 Plans for patient engagement going forward

A communications plan will be developed to support with the implementation of the CDH. The purpose of the communication plan will be to;

- Make sure key audiences – internally and externally – are aware and, where possible, supportive of the project's progression, emphasising the clinical benefits that the CDH will bring
- Target the Trust's staff, particularly those that work within radiology
- Overall to ensure our patients, stakeholders, staff and local media are fully informed

3.6 Main Benefits

The intended outcomes of this project include:

- Improved clinical outcomes for specific cohorts (e.g. frail elderly).
- Improved quality of life for people with LTCs.
- Improved access to healthcare for specified population cohorts.
- Reduction in health inequalities in relation to diagnostics.
- Improved use of hospital resources.
- Improvements in workforce innovation, retention, and training.
- Improved relationships between system partners.
- Improved sustainability of diagnostic services.

3.7 Main Risks

The following risks have been identified as key to implementation of the CDH.

Table 9: Main CDH Risks

Risk Description	Score	Mitigation
If Year 2-5 NHSE funding is not approved then the CDH programme will have to be reduced resulting in a reduced impact on activity	9	A high level submission was provided to NHSE in September 2021 to inform the Treasury Review. The total cost of the submission was significantly higher than detailed in this FBC. The Years 2-5 model has been reviewed and revised to ensure it

		continues to meet the challenge set by NHSE but is deliverable, provides value for model and its sustainable.
If required workforce is not available then the mobilisation of the CDH will be compromised resulting in an impact on ENH HCP and ENHT's credibility	20	Workforce remains the biggest risk to mobilisation. There are existing challenges within ENHT's core radiology service that need to be mitigated prior to recruitment for the CDH. The Trust has already commenced overseas recruitment in response to this risk and a workforce plan developed. The Trust is also engaged with a HWE ICS workforce group seeking to address similar issues across a wider geographical footprint.
If the activity assumptions are incorrect then there could be under utilisation of the CDH resulting in poor value for money and wasted resources	4	The activity assumptions have been cautious and based on existing data, alongside clinical and operational opinion. Activity completed will be closely monitored internally and by NHSE.
Any material changes to the model could risk disengaging clinicians who have been heavily involved in the bid.	9	Changes to the model to be fully communicated to key stakeholders with a robust rationale for the amendment.
There will be a recurrent funding requirement post withdrawal of NHSE funding which will need to be absorbed by the system.	16	The funding envelope from NHSE remains unknown for Years 2-5 and the model will need to be adjusted to fit within that envelope. However there will be a revenue pressure post Year 5. Further detail can be found in Section 7.

The recurrent revenue funding requirement post Year 5 is a significant risk which is currently sitting with ENHT as the lead provider. This risk is being echoed by a number of systems across the country with escalation to NHSE but resolution is unlikely from a national position.

The CDH programme is nationally mandated at system level. Therefore whilst ENHT is the lead provider, long term financial risk post NHSE funding (Year 5 onwards) will need to be shared across the ENH system, and will not sit solely with ENHT. Negotiations with Finance Directors across the ENH HCP will commence imminently and an agreement reached before this model can be submitted to NHSE.

3.8 Constraints

There are three key constraints for this programme;

1. The availability of both capital and revenue and reliance on securing the NHSE funding to develop the proposed model over the 5-year period.
2. The availability of workforce to operate the full extent of the model

3. The ability of ENHT, and ENH HCP, to absorb the revenue costs post Year 5

3.9 Dependencies

Rapid Diagnostic Service (RDS): ENHT are in year 3 of developing the diagnostic service and are currently providing a Vague Symptoms pathway at the Lister site, and recently commenced at QEII site. The Trust continues to develop the vision to incorporate other tumour sites into the model, with CUP (Cancer of Unknown Primary) to be the first. ENHT will also be reviewing other site-specific pathways to ensure that RDS component compliance is in place and facilitates a more streamlined pathway and process for the patient. The pathway will also develop to adhere to the 28 day diagnosis model in order to ensure a swift outcome for the patient.

Funding for the current pathway model is on a short term basis via Cancer Alliance Transformation Funding and supports additional posts to enhance the service. A creation of a business plan to embed these roles as business as usual beyond Cancer Alliance funding will be required to secure an ongoing effective service.

There are also opportunities to utilise the CDH model to deliver the following;

- Increase the access for cervical screening, i.e. to offer appointments outside of core working hours
- To liaise with the national cancer screening team to explore coordination of sites for breast cancer screening and CDH
- To support further opportunities to utilise the 'Cytosponge Bus' as provided by HeartBurn UK. The approach would be similar to the breast screening service in terms of potential co-location with the CDH site.

East of England Imaging Network: a regional network has been established in response to the National Imaging Strategy and Diagnostics Report by Professor Sir Richards. The Network will work towards reducing unwarranted variation and improve efficiencies across patient pathways; drive the development of capacity and capability through the growth and development of workforce; support and harness economies of scale and enabling sharing of best practice.

Pathology: Phlebotomy is in scope within the ICS Pathology procurement. Consideration will need to be given around the CDH's link and use of phlebotomy services going forward once the ICS procurement is complete.

ENH HCP Transformation and Delivery Group programmes: The implementation of the CDH model will support a wide range of transformation programmes across the East and North Hertfordshire Health and Care Partnership, overseen by the partnership's Transformation and Delivery Group (TDG). These include the integrated delivery groups regarding frailty, long-term conditions, planned care, and urgent and emergency care.

Elective recovery programme: To support the recovery from the COVID-19 pandemic NHS England has set a recovery plan for elective services. The plan accelerates the delivery of operations and non-urgent services to support healthcare recovery. Diagnostics form 85% of clinical pathways.

Increasing activity, reducing wait times and implementing further efficient clinical pathways will support the backlog management and overall system recovery.

4.0 Economic Case

4.1 Economic Case

A system-wide Steering Group used established criteria to inform the proposal for a high level view of the preferred option for the ENH system. There is no do nothing position as this is a NHSE mandated project.

4.2 Qualitative Benefits Appraisal

4.2.1 Methodology

Table 10: Options Appraisal Framework – CDH model

Assessment Criteria	Weighting
Clinical effectiveness and quality of care for patients	20%
Quality of estate and compliant, fit for purpose accommodation	20%
Implementation and delivery	15%
Staff satisfaction	10%
Capacity	20%
Future flexibility and strategic fit	5%
Clinical adjacencies	10%

4.2.2 Qualitative Benefits Scoring

Table 11: Options Appraisal Scoring – CDH Model

Assessment Criteria	**Weighting**	**Option 1.0** Standard CDH – QE2 Hub and no spoke	**Option 2.0** Large CDH – QE2 Hub with endoscopy and no spoke	**Option 3.0** Hub @ QE2, Pilot Spoke (one locality) and evaluation	**Option 4.0** Hub @ QE2, roll out of fixed site spoke to SOME localities	**Option 5.a** Hub@QE2, roll out of fixed site spoke to ALL localities	**Option 5.b** Hub@QE2, roll out of mobile spoke to ALL localities	**Option 6.0** Hub @QE2, removal of Spoke and source additional Hub
Clinical effectiveness and quality of care for patients	20%	4 (0.8)	5 (1.0)	6 (1.2)	7 (1.4)	8 (1.6)	9 (1.8)	5 (1.0)
Quality of estate and compliant, fit for purpose accommodation	20%	8 (1.6)	8 (1.6)	6 (1.2)	6 (1.2)	6 (1.2)	6 (1.2)	7 (1.4)
Implementation and delivery	15%	8 (1.2)	8 (1.2)	7 (1.05)	7 (1.05)	7 (1.05)	7 (1.05)	7 (1.05)
Staff satisfaction	10%	7 (0.7)	7 (0.7)	7 (0.7)	7 (0.7)	8 (0.8)	8 (0.8)	7 (0.7)
Capacity	20%	7 (1.4)	7 (1.4)	7 (1.4)	8 (1.6)	9 (1.8)	9 (1.8)	7 (1.4)
Future flexibility and strategic fit	5%	4 (0.2)	4 (0.2)	6 (0.3)	7 (0.35)	9 (0.45)	9 (0.45)	7 (0.35)
Clinical	10%	6 (0.6)	6 (0.6)	6 (0.6)	6 (0.6)	6 (0.6)	6 (0.6)	6 (0.6)

adjacencies								
Weighted Average		**6.5**	**6.7**	**6.45**	**6.9**	**7.5**	**7.7**	**6.5**
Ranking					3rd	2nd	1st	

4.2.3 Analysis of Key Results

Given that; (1) Lister Hospital is an acute site; (2) the New QEII Hospital is a non-acute site and provides a range of diagnostic services as per the NHS mandate and; (3) in recognition that ENH is a geographically diverse area, it was widely agreed that a 'hub and spoke' model be explored as the preferred option. This option scored highest in clinical effectiveness and quality of care for patients.

5.0 Commercial Case

5.1 Procurement Strategy

5.1.1 Equipment

ENHT will be working with Hertfordshire and West Essex ICS NHS Procurement Services who will advise on the correct route to market in line with the Trust's Standing Financial Instructions, Standing Orders, Public Contract Regulations (2015) and other agreed protocols. This will ensure compliance and demonstrate value for money has been obtained in relation to cost, quality and specification.

5.1.2 ICT Equipment

Purchase of IT equipment will be performed by the in-house Digital Team and will be from frameworks where possibly. Supporting ICT infrastructure will follow the Trust procurement regulation and SFIs.

5.2 Final Contract

Year 1 capital funding was issued directly by NHSE to ENHT and subject to a MOU signed by the relevant Executive Team. The Year 1 revenue funding has been released to WECCG, as the HWE ICS 'bank', to onward release to ENHT.

As of November 2021 the assumption is that future funding will be issued as part of a revised block contract. Further details regarding the contract and funding release is pending confirmation by NHSE and is being chased by HWE ICS.

6.0 Estates Case

6.1 Estates Strategy Alignment

ENHT is currently in the process of refreshing their long-term estates strategy. The developments pre and post COVID-19 to the hospital site have been considered against the schemes and there is no risk to implementation for the CDH Hub at the New QEII Hospital.

The Hub proposal is within existing building footprints. However the community spoke seeks to utilise non-ENHT estate and therefore provide 'care closer to home'. Partner estates, such as HCT and GP practices, have been explored as potential options.

6.2 Hub

The NHSE mandate is CDH provision should be located separately from main acute hospital facilities. The New QEII site is already a central hub for diagnostic capabilities situated on a non-acute site and in the heart of the geography of east and north Hertfordshire.

The development of a CDH at the New QEII maximises the capacity of diagnostics in a central location, with good access.

ENHT Estates Team has led negotiations with the QEII Landlord. Official approval has been granted to enable the diagnostic services to operate 8am-8pm/ 7days per week at an appropriate cost – this was already factored into the Year 1 submission. The QEII Landlord requires a 2 week notification prior to mobilisation of the service.

Discussions will remain ongoing with the QEII should additional space, i.e. clinic rooms, be required to fully mobilise the CDH and develop 'one stop shop' models.

6.3 Options Appraisal - Spoke

An options appraisal framework was developed to support appropriate identification of spoke site locations. The purpose is to ensure the identified site is affordable, viable and addresses a specific patient/disease need.

Figure 3: Options Appraisal Framework – Spoke

No.	Area	Description	SCORING				
			1 Point	2 Points	3 Points	4 Points	5 Points
1.0	PHM	Does Population Health Management data identify a patient need in that location?	No	Yes – all areas bar health	Yes - health	Yes – health and deprivation	Yes – geography, deprivation and health
2.0	Estate	Is there availability for multiple clinic rooms to run concurrently?	No	-	Partial i.e. 1-2 rooms	-	Yes
3.0	Estate	Is there cost for utilising the estate?	Yes – recurrent and set-up	Yes – recurrent	Yes – end of use cost	Yes – set-up	No
4.0	Estate	Is the estate clinically appropriate, i.e. are there works that need to be completed?	No	Yes – major capital works required (floor strength)	Yes – minor capital works required	Yes – some superficial works required	Yes – no works required
5.0	Access	Is the estate accessible for patients?	No	-	Good public transport – no parking	-	Yes – public transport and parking
6.0	Access	Is there a lack of other local diagnostic services (within a 25min journey)?	No	-	Closest is 25mins		Yes
7.0	Staffing	Is there additional staffing consultation requirements? i.e. if considered outside of ENHT area?	Yes - full	-	Yes - partial	-	No
8.0	Long Term	Is the estate available for ongoing utilisation post Y1 including out of hours?	No	-	Yes – but no OOH	-	Yes - no issues

REJECTION	POSSIBLE INCLUSION	INCLUSION
0-16	17-31	32-45

6.4 Scoring Criteria – Spoke

HPFT and HCT's Associate Director of Estates was asked to explore viable options within existing community and mental health estates that could be utilised for the community spoke element of

this model. Five options were provided which were assessed using the options appraisal framework scoring criteria.

The Queensway Health Centre is subject to a proposal for refurbishment and therefore no current estate space. For this reason the option was ruled out of consideration.

Table 12: Options Appraisal Scoring Criteria – Spoke

Location	Area								TOTAL
	1.0	2.0	3.0	4.0	5.0	6.0	7.0	8.0	
Hoddesdon Health Centre	5	5	5	4	5	1	1	5	**31**
Cheshunt Community Hospital	5	5	5	4	5	1	1	5	**31**
Waltham Cross Health Centre	5	5	5	4	3	1	1	5	**29**
Nevells Road Health Centre, Letchworth	5	5	5	4	5	3	3	5	**35**
Queensway Health Centre, Hatfield	4	0							

NB. In terms of cost for utilising the estate, this is subject to further negotiation between ENH HCP Director of Development and HCT/HPFT.

The preferred option for further exploration is Nevells Road Health Centre, Letchworth Garden City. Estate plans and a site visit is pending and due to be completed before the end of November 2021.

6.5 Spoke

The initial Year 1 bid to NHSE sought to establish a pilot for a spoke community model in a fixed estate. The purpose of the spoke model is to contribute to reducing health inequalities across ENH through targeting areas of deprivation and areas with health service access issues.

Table 13: Spoke 5-Year Plan

Period	Location	Proposal
Year 1 2021/2022	Nevells Road Health Centre, Letchworth*	DEXA and Direct Access ECHO
Year 2 2022/2023		DEXA, Direct Access ECHO and Direct Access ECG
Year 3 2023/2024		
Year 4 2024/2025	Letchworth Heritage Foundation: New Build	DEXA, Direct Access ECHO, Direct Access ECG, MRI and CT
Year 5 2025/2026		

**Location is being explored – no final decision has been made*

The spoke site at Nevells Road Health Centre is a short term plan (1-2 years). The Letchworth Heritage Foundation is planning to redevelop the town centre, including new build developments. There will be a dedicated healthcare space which will consolidate the primary care practices in the area. Early discussions with the developers have indicated an opportunity to relocate the spoke to this site upon build completion. The ENH HCP is keen to then further expand on the spoke model by incorporating both MRI and CT. This will provide additional capacity in accordance with the requirements set by Prof. Richard's.

In respect of the above opportunity, costs have been built into the model (Year 4) for equipment, workforce but importantly estates. The latter is an unknown figure at this stage and will need to be refined as the programme progresses. Should the Letchworth Heritage Foundation proposal become

non-viable the alternative will be to use the allocated monies to commission MRI and CT services from providers such as InHealth.

6.6 Associated Disposals

There are no associated disposals with this scheme.

7.0 Financial Case

This section describes the methodology and output determining the capital and revenue implications of the CDH model.

The methodology underpins the subsequent financial appraisal and affordability assessment of the project and assesses the impact of ENHT's Statement of Financial Position.

7.1 Capital Affordability

Year 1 funding has already been awarded and received by ENHT – please see Section 7.3.3 for a breakdown of the monies. The financial envelope for Years 2-5 is unknown and whilst timescales for submission are yet to be confirmed, the expectation is a submission to NHSE will be required within Quarter 3 2021/2022.

The Trust received notification in October 2021 for the award of £1.744m of Public Dividend Capital associated with successful capital bids, including the Community Diagnostics Hub (£1.05m) and a Spec CT (£0.724m). This is outlined under section 7.6.

Should the financial envelope be smaller than required then adjustments will need to be made with the CDH model. This will be fully communicated to the Board.

7.2 Revenue Affordability

7.2.1 Methodology

A cash envelope has not been provided to the Trust for the purposes of establishing a service delivery model. Therefore, the costings supporting both Phases 1 and 2 have been driven based on a zero cost base model where the financial resource required is based on physical planned opening times and capacity which can be booked into.

Workforce costs have been obtained based on shift plans provided by key operational and clinical leads where possible, otherwise appropriate estimates have been provided based on a staffing skill mix of Medical Staffing, and Agenda for Change time, based on a set rota Monday to Friday. Any expenditure required above and beyond this will need to be mitigated by contingency (see 7.6). Future years' costs have included 2% inflation assumptions covering pay and non-pay costs to accommodate the impact of future pay awards, incremental drift and inflation.

A Trust overhead rate of 25% has been added to recognise a contribution to shared costs for this service development.

The annual revenue costs have been summarised below and it is assumed that corresponding values of income is required for the Trust to remain in financial balance.

Figure 4: Annual Revenue Costs

East & North Herts NHS SOCI Extract	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27
	£000	£000	£000	£000	£000	£000
Operating Income						
Operating Expenditure	1,016	7,349	8,152	12,172	12,334	11,762
Sub total	1016	7349	8152	12172	12334	11762

7.2.2 Revenue Impact

A summary of the revenue impact to ENHT is summarised in the table below. As noted from 7.3.1, a corresponding amount of income would be required to ensure that the impact of the service development for the CDH is net zero.

Figure 5: Revenue Impact

East & North Herts NHS Trust SOFP Extract	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	5 year costs	5 year costs	Costs years 2-5
	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	Year 1-5	year 2-6	
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical Costs	653	6,449	6,760	9,454	9,880	9,267	23,316	39,340	32,543
Non Clinical Costs	183	710	732	2,077	1,832	1,889	3,701	7,192	5,350
Depreciation	155	168	553	553	553	553	1,429	2,368	1,828
Amortisation	-	-	3	3	3	3	6	11	9
PDC	24	22	104	85	65	49	235	323	276
	1,016	7,349	8,152	12,172	12,334	11,762	28,688	49,236	40,006

7.2.3 Capital and Financing Charges

A summary of anticipated capital costs incurred by the CDH service development are summarised below. The financial assumptions include provisions for medical equipment and associated works (estate and digital) to enable them. Use of estates has been assumed as revenue where the lease of premises is required.

The Phase 2 of the CDH does not at present have a confirmed, identified site and therefore Estates costs have been estimated based on £1m revenue per year assuming all leasing and service charges are included. Any change to the Estates model will see a switch from revenue to Capital funding.

Figure 6: Capital Costs

East & North Herts NHS Trust SOFP Extract	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	5 year costs
	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	Year 1-5
	£000	£000	£000	£000	£000	£000	£000
Capital Costs (Financed by Public Dividend Capital)	852	83	2,720	-	-	-	3,655

Table 14: Projected Capital and Revenue Funding Requirements

Values										
Phase	Spend Type	Sum of 2021/22	Sum of 2022/23	Sum of 2023/24	Sum of 2024/25	Sum of 2025/26	Sum of 2026/27	Sum of 5 year costs Year 1-5	Sum of 5 year costs year 2-6	Sum of years 2-5
Phase 1	1) Pay	355,156	3,127,492	3,190,042	2,192,215	2,236,059	2,280,780	8,864,904	13,026,587	10,745,807
	2) Non Pay	252,841	1,195,847	1,227,398	1,259,961	1,293,576	1,328,285	3,936,046	6,305,067	4,976,782
	3b) Depreciation	154,873	154,873	154,873	154,873	154,873	154,873	619,493	774,366	619,493
	4) PDC	24,393	18,972	13,551	8,131	2,710	0	65,047	43,364	43,364
	5) Contingency	60,800	432,334	441,744	345,218	352,964	360,906	1,280,095	1,933,165	1,572,259
	6) Overhead (25%)	167,199	1,188,918	1,214,796	949,348	970,650	992,493	3,520,261	5,316,205	4,323,712
	8) Capital	851,803						851,803	0	0
Phase 1 Total		1,867,065	6,118,436	6,242,404	4,909,745	5,010,832	5,117,338	19,137,649	27,398,754	22,281,417
Phase 2	1) Pay	0	449,307	458,293	2,228,793	2,273,369	1,545,891	3,136,393	6,955,654	5,409,762
	2) Non Pay		430,905	439,523	2,357,661	2,589,136	2,837,122	3,228,089	6,136,264	5,817,224
	3a) Amortisation			2,857	2,857	2,857	2,857	5,714	11,429	8,571
	3b) Depreciation		12,771	398,486	398,486	398,486	398,486	809,743	1,593,943	1,208,229
	4) PDC		2,696	90,649	76,602	62,555	48,508	169,946	280,100	232,500
	5) Contingency	0	88,368	137,815	505,309	531,543	482,224	731,493	1,745,260	1,263,036
	6) Overhead (25%)	0	246,012	381,906	1,392,427	1,464,486	1,328,772	2,020,344	4,813,603	3,484,831
	7) Dilapidations Provision				300,000	0	0	300,000	300,000	300,000
	8) Capital		83,400	2,720,000				2,803,400	2,803,400	2,803,400
Phase 2 Total		0	1,313,459	4,629,528	7,262,134	7,322,432	6,643,859	13,205,122	24,639,651	20,527,554
Grand Total		1,867,065	7,431,895	10,871,932	12,171,880	12,333,264	11,761,196	32,342,771	52,038,405	42,808,970

Please see **Appendix Four** for a detailed financial breakdown.

7.3 Workforce

The table below summarises the incremental change in staffing resource required for the CDH: Year 1 2021/2022. There is a requirement to significantly increase the headcount of Radiographers to support the extended opening hours at the New QEII for the core modalities, as well as the DEXA.

Table 15: Summary of additional workforce required (Headcount) – Year 1

	Head Count	PF X-Ray	CT/MRI	SPEC –CT NM	DEXA	Fluoroscopy	Ultrasound	Operational Lead	Reporting	Fibroscan	ECHO	Data A/ Admin	Clinical IT Support	Booking Clerk	Reception
Radiographer	**29**	3	15	2	1	1		1	6						
Sonographer	**3**						3								
Consultant	**3**		1.8			1				0.2					
Clinical RDA	**15**	3	6	1	1	1	3								
Assistant Practitioner	**3**	3													
Clerical RDA	**5**													1	4
Clinical IT Support	**1**												1		
Data Analyst/Admin	**1**											1			
Fibroscan Nurse Technician	**1**									1					
Cardiology Nurse	**1**										1				
Cardiographer	**1**										1				

7.4 Efficiency

The funding model includes allowances for the use of agency spend in the first 2 full years of implementation for phase 1, (ending 31st March 2024) and the first 2 full years of phase 2 (ending 31st March 2026). All workforce costs have been costed based on substantive rates, however a 50%

allowance has been included within the costings in anticipation of a requirement to utilise temporary staffing. Radiology and Cardiology in particular have struggled with substantive recruitment, where retention premier have been utilised to retain and attract staff. Despite this there are existing workforce vacancies notwithstanding the need to recruit more substantive staff to deliver a successful CDH.

Initiatives such as targeting of overseas recruitment are being utilised however the services will need to develop a recurrent, sustainable workforce model to ensure that the service delivery model is not put at risk.

Figure 7: Agency Allowance

Modality	Spend Type	2021/22	2022/23	2023/24	2024/25	2025/26
		£000	£000	£000	£000	£000
Agency allowance (50%)	Phase 1	118	1,020	1,041	-	-
	Phase 2	-	150	153	743	758
		118	1,170	1,194	743	758

7.5 Contingencies/Other Funding Sources

In the event of cost overrun for the project any additional capital costs incurred would be required to be funded from within the system's internally funded capital programme.

The development of the CDH would transform the ability of the NHS in Hertfordshire to support the UK Life Sciences Vision which sets out a 10-year strategy to accelerate research and the delivery of innovations to patients. This is because diagnostic capacity limits the amount and type of research which can take place.

The expectation is that that the current level of commercial research, worth approx. £750k per annum could be doubled in 3 years given additional diagnostic capacity. All the research diagnostics would be funded and a 20% surplus would be provided to support further research activity. The increase in diagnostic capacity would therefore a disproportionate benefit to the wider research endeavor in the local area with a number of direct and in-direct benefits on patient care through an overall increase in research activity. In addition, the CDH are working closely with the Eastern AHSN to be a site for the early adoption of new and emerging innovation.

Building in a research and innovation capability into the hub will support the general health service provision and particular attention can be paid to areas requiring additional attention from a population health perspective. Overall the Community Diagnostic Hub would help the UK Clinical Research Delivery vision to unleash the full potential of clinical research delivery to tackle health inequalities, bolster economic recovery and to improve the lives of people across Hertfordshire and the UK.

Within the Revenue spend a 10% contingency has been built in to cover unplanned expenditure within the project to mitigate against future risk and uncertainty. Key areas of uncertainty include the future Estates Model for phase 2, and the service delivery model for respiratory.

7.6 Impact on Trust Balance Sheets

Early Drawdown of Public Dividend Capital (PDC) is required to support the funding of key diagnostic equipment as part of the phase 1 implantation. From an MOU issued to the Trust in October 2021 from the Department of Health and Social Care (DHSC) PDC was awarded to the value of £1.774m for equipment and associated capital and build costs associated with the CDH for phase 1. Within this award, there was also an award for £0.724m to fund a Spec-CT scanner not linked with the CDH bid.

Phase 2 funding has yet to be confirmed however the Trust would require a similar facility to be set up to support phase 2 of the CDH to support the Trust cash position.

A summary of anticipated phasing of the capital requirements are summarised below. Current prices quoted include all capital works associated with the purchase, acquisition and set-up of all equipment including allowances made for estates and digital costs.

Figure 8: Capital

East & North Herts NHS Trust SOFP Extract		Year 1 2021/22	Year 2 2022/23	Year 3 2023/24	Year 4 2024/25	Year 5 2025/26	Year 6 2026/27	Total
		£000	£000	£000	£000	£000	£000	
Capital Associated with Community Diagnostics Hub	Property plant and Equipment	1,050	83	2,700				3,833
	Spec CT	724						724
	Digital infrastructure			20				20
								-
		1,774	83	2,720				4,577

7.7 Conclusion

The development of the CDH in ENH requires significant investment in both capital (mainly equipment) and staffing resource to deliver a high quality service in line with required standards. The financial analysis considers the cost impact for East & North Herts NHS Trust and does not consider the impact of any system savings. Based on the removal of allowances of agency usage in 25-26, it is anticipated that the Trust will require recurrent revenue costs of £11.7m from 26-27 before inflation and price increases.

8.0 Management Case

8.1 Project Plan

The programme timeline has been subject to slippage as a result of delays in confirmation of funding from NHSE. This relates to Year 1 (2021/22) only.

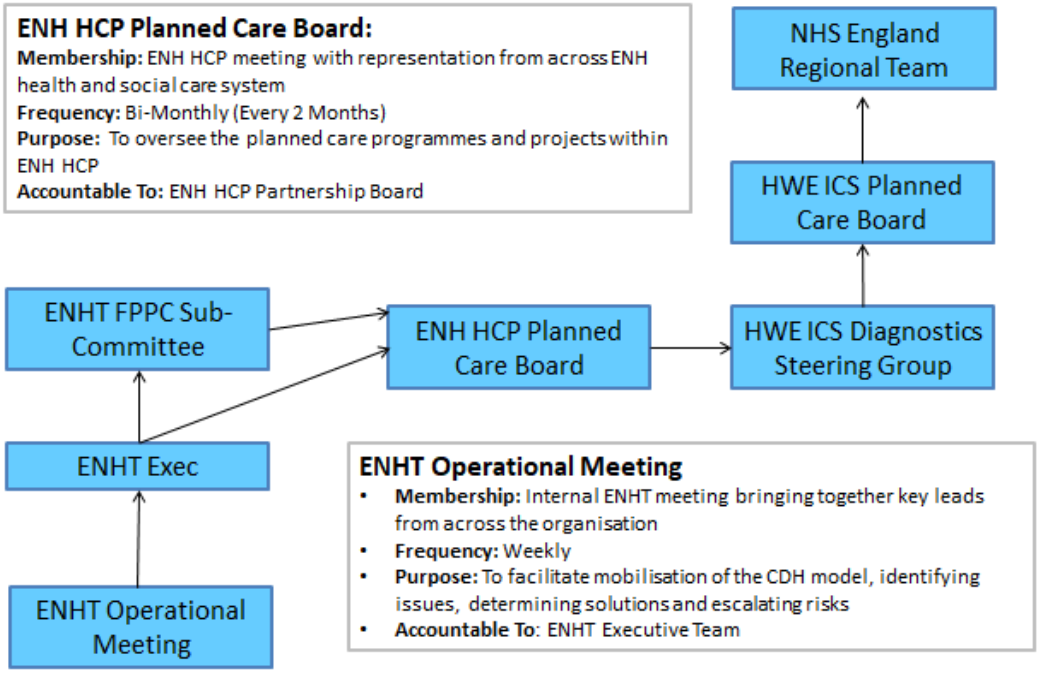
8.2 Project Management

ENHT's Director of Improvement is the programme SRO with system support provided by ENH HCP Development Director. ENHT's Transformation Office is responsible for the programme management.

Whilst the CDH is an ENH HCP programme driven by HWE ICS, ENHT is the lead provider for the model. Therefore the governance structure needs to reflect the complexity of the system.

The internal ENHT Operational Meeting reports into the ENHT Executive Team and the FPPC as required. To fulfil the governance requirements of ENH HCP, the programme will provide regular updates to the ENH HCP Planned Care Board.

Figure 9: CDH Governance Structure



8.3 Benefits/Risk Management

8.3.1 Benefits Realisation Plan

NHSE will require regular activity submission detailing the 'new' activity being delivered from the CDH. Work is ongoing with the BI and Reporting Team to enable isolated and ease of reporting.

A more detailed evaluation framework has been developed to ensure a full review of the programme is possible at agreed intervals, including end of programme review.

Table 16: Evaluation Framework

No.	Metric	Source	Target
1.0	CDH activity per equipment	Qlikview	As per activity assumptions
2.0	Did Not Attend: CDH activity per equipment	Qlikview	0
3.0	Patient Cancellations: CDH activity per equipment	Qlikview	0
4.0	Waiting Time: CDH activity per equipment	Qlikview	As per DM01 Standards

5.0	Patient Experience: Patient and carer satisfaction	Manual	75% satisfaction
6.0	Staff Satisfaction	Manual	75% satisfaction

8.4 Post Project Evaluation

The Programme Manager will be responsible for initiating the project closure process through the preparation of a Programme and Project Implementation Review (PPIR). This will include;

- A review of the programme and projects original intent as agreed in the initiation stage
- A review of the approved changes
- The Programme Manager's view of;
  - How the project performed
  - An assessment of the results of the project against the expected benefits in the business case
  - How the project performed in relation to its planned targets and tolerances
  - The project's team performance
  - The project's products and any follow up actions
- A Lessons Learned Report to capture lessons that can be applied to future projects including;
  - A review of what went well, what went badly and any recommendations for corporate or programme management consideration – and in particular, the project management method, any specialist methods used, project strategies and controls, and abnormal events causing deviations
  - A review of useful measurements such as: how much effort was required to create the CDH; how effective was quality management and statistics on issues and risks
  - Any useful knowledge gained regarding the management of projects within the ENHT environment

Six to 12 months following the closure of the project a Post Evaluation Review (PER) will be undertaken in line with the benefits realisation plan.

9.0 Quality Case

ENH HCP's Prioritisation Framework has been completed and embedded within this document to identify the potential quality impact as a result of the CDH programme.

Based on initial completion there are no immediate quality concerns to escalate. The ambition of the programme is to enable a) improved access for patients, b) reduced time from referral to diagnostic test and c) improved patient pathways improving both outcomes and experience. The evaluation framework will be essential in monitoring the progress with these ambitions.

The Prioritisation Framework will need to be reviewed at key stages throughout the programme and any changes scrutinised by the relevant Boards.

Please see **Appendix Five** for the ENH HCP Prioritisation Framework.

10.0 Recommendation

The Board is asked to approve;

1. The recommendation to bid to NHSE for sufficient monies (capital and revenue) to implement the Years 2-5 CDH service model

2. The recommendation that a risk share agreement is developed across ENH HCP, particularly in relation to finance

Appendices

Appendix One: NHSE Mandatory Requirements

CDH Service Offer: Minimum Required Tests

NB: There is a clear need for local decision-making on what diagnostic tests to include in a CDH. Regions and systems should look at local need to identify what tests beyond the minimum requirements to include in their CDH design. For some systems, there may be a strong reason to not undertake a test that is nationally considered a minimum requirement. In this circumstance, systems will be required to justify their rationale to regions.

Draft minimum requirements for CDHs

		All CDHs	Large CDHs
Imaging	• CT • MRI • Ultrasound • Plain X-Ray	✓	
Physiological Measurement	• Electrocardiogram (ECG) including 24 hour and longer tape recordings of heart rhythm monitoring • Ambulatory blood pressure monitoring • Echocardiography (ECHO) • Oximetry • Spirometry, including reversibility testing for inhaled bronchodilators • FeNo, exhaled carbon monoxide &f ull lung function tests • Blood gas analysis via POCT • Simple Field Tests (eg six min walk) • Issuing of multichannel equipment for recording home 'limited' sleep studies	✓	
Pathology *(CDHs take samples – not responsible for analyzing them other than POCT)*	• Phlebotomy • Point of Care Testing • Simple Biopsies • NT-Pro BNP • Urine testing • D-dimer	✓	
Endoscopy	• Gastroscopy • Colonoscopy • Flexi sigmoidoscopy		✓

Potential optional diagnostic tests appropriate for inclusion in a CDH

Diagnostic Modality	Test	
Imaging	Mammography Elastography (eg Fibroscan)	DEXA scan PET scan CT colonography
Physiological Measurement	Simple pH monitoring Simple sleep studies Urodynamics Electrophysiological tests	Audiology services Non-complex neurophysiology services
Endoscopy	Colon capsule endoscopy Transnasal endoscopy	Cystoscopy Hysteroscopy Colposcopy

Diagnostic tests that are not be appropriate for delivery through a CDH

Endoscopic Retrograde Cholangiopancreatography
Complex sleep studies that include monitoring of ECTG
Bronchoscopy and endobronchial ultrasound (EBUS)
Complex interventional procedures including biopsies of internal organs
Trans-oesophageal and Stress ECHO
Cardiopulmonary exercise tests
Some challenge tests
Complex sleep studies that include monitoring of ECG

Please note: this is a **non-exhaustive list** of optional and non-appropriate tests
CDHs should be COVID secure sites

Appendix Two: Rationale for Service Model

Item	Rationale	Equipment	Workforce	Estate	Mobilisation Date
Year 1 2021/2022					
Extended Opening Hours: MRI (8am-8pm/7 days per week)*	Nationally the demand for diagnostics is increasing with CT and MRI growing 6.8% and 5.6% respectively over the last five years. Within ENH the core modalities have all seen increased waiting times due to the COVID-19 pandemic, as well as a general long-term increase in demand. Extended opening hours at the New QEII will increase capacity and improve access by offering out of hours appointments.	None – using existing equipment	**Evening:** RDA/Nurse Band 3: 0.15 WTE AHP Band 6: 0.32 WTE **Weekend:** RDA/Nurse Band 3: 0.67WTE AHP Band 6: 1.32 WTE	QEII	Evening: mid-February 2022 Weekend: mid-March 2022
Extended Opening Hours: CT (8am-8pm/ 7 days per week)*			**Evening:** RDA/Nurse Band 3: 0.64WTE AHP Band 5: 0.64 WTE AHP Band 6: 0.64 WTE **Weekend:** RDA/Nurse Band 3: 0.78 WTE AHP Band 5: 0.78 WTE AHP Band 6: 0.78 WTE		
Extended Opening Hours: Plain Film X-ray (8am-8pm/ 7 days per week)*			**Evening:** RDA/Nurse Band 2: 0.64 WTE AHP Band 5: 0.64 WTE AHP Band 6: 0.64 WTE **Weekend:** RDA/Nurse Band 2: 0.64 WTE		

			AHP Band 5: 0.64 WTE AHP Band 6: 0.64 WTE		
Extended Opening Hours: Ultrasound (8am-8pm / 7 days per week)*			**Evening:** RDA/Nurse Band 3: 0.64 WTE AHP Band 7: 0.64 WTE **Weekend:** RDA/Nurse Band 3: 0.78 WTE AHP Band 7: 0.78 WTE		
Fibroscan (Gastroenterology)	NICE Guidance states that every patient with liver disease should have fibroscans. By closing the gap in diagnostics within ENH we will be able to provide the right care for patients, reducing deterioration and improving outcomes. Whilst this is currently situated in the Hub, there is the potential to scope a roving model in primary care at a later date.	Yes: Fibroscan X1 clinic room	Band 3 Fibroscan Nurse: 1.0 WTE Consultant: x1 PA for Fibroscan interpretation	QEII	Quarter 4 2021/2022 – exact date to be determined.
ECHO cardiogram (Cardiology)	The ENHCCG Long Term Conditions Strategy articulates that "identifying, diagnosing and staging of LTCs at the earliest opportunity can ensure patients are placed on the appropriate care pathways to maximise outcome opportunities." Heart failure is a key driver of demand in ENH, and by increasing the diagnostic capabilities within the community to identify heart failure we will be able to minimise the risk of disease progression, improve outcomes and quality of life and reduce costs of NHS services.	Yes: ECHO machine Probes ECG machine BP machine X2 clinic rooms	Band 7 Nurse: 1.0 WTE Band 3 Support Worker (Cardiographer): 1.0 WTE Consultant: 5.6 hours per week	Spoke	To be determined
DEXA Scanner	There is limited capability and capacity within	Yes: DEXA	AHP Band 6: 1.53 WTE	Spoke	To be determined

	ENH for DEXA scanning. In ENH we conduct 25% less DEXA scans than in other similar areas, meaning that patients can experience a long wait for this service. <<waiting list>> In addition many of the patients are aged over 70years, either not willing or able to travel to Hertford County Hospital, or Lister Hospital, where this service is currently offered and therefore do not receive the necessary scans. This means that osteoporosis is likely underdiagnosed in ENH, resulting in patients falling and suffering fractures which might have otherwise been preventable. These preventable fractures lead to very poor outcomes for patients and significant costs to the NHS and to social care when patients are no longer able to live independently following the fracture.	X1 clinic room	Nurse Band 2: 1.53 WTE Consultant Reporting: 1.23 WTE		
Utilisation of Existing Assets	As part of due diligence there is an opportunity to review the utilisation of existing assets across ENHT sites. This is an internal project and not reportable to NHSE.	N/A	Programme Manager Band 8a: 1.0 WTE (will assume responsibility for the entire project)	Enabler	Q1 2022/2023 (dependent on date funding issued and recruitment)
Year 2 2022/2023					
Lung Function Diagnostic Hub	Respiratory diagnostics (spirometry and FeNO) is one of the NHSE minimum requirements for CDH. Therefore inclusion of this diagnostic provision at the QEII will enable ENH to be compliant with the NHSE requirements. The respiratory team are keen to develop a lung function diagnostic hub at the QEII to support primary care and provide additional capacity.	Yes: FeNO Lung Function Machine	Physiologist: x1 Consultant PA Sessions Administration	QEII	To be determined
Rapid Diagnostic Service	The Rapid Diagnosis Centre (Vague Symptoms Pathway) is in place at the New QEII Hospital.	N/A	N/A	QEII	To be determined

	The national RDC implementation specification defines the requirements of a RDC pathway and in particular the key components which define a RDC compliant pathway:- 1. Early Identification 2. Timely referral 3. Broad assessment of symptoms 4. Coordinated testing 5. Timely diagnosis of patient's symptoms 6. Appropriate onward referral 7. Excellent patient coordination and support There is significant overlap between the RDC and the CDH, particularly in relation to patients where cancer has been ruled out but further investigation is required. Therefore the focus is around pathway transformation and service collaboration.				
Holter Monitoring (Cardiology)	Direct Access ECG (Holter Monitoring) has been a long-standing commissioning ambition to support the diagnosis of low-risk suspected palpitations. Patients identified by the GP as low-risk are referred into the clinic whereby their Holter Monitoring is completed. A virtual cardiology review is undertaken and only if the patient requires further cardiology input will they be seen by a cardiologist. As well as providing this service in the community, there is an opportunity to reduce the number of 1st OPAs.	YES: Analyser (remote access) Monitors x25-30	Cardiographer Band 3: 1.0 WTE Physiologist Band 6: 1.0 WTE Consultant PA: 5.6h per week Admin Band 3: 1.0 WTE	Spoke	To be determined
Enhanced Workforce	This programme would explore improved linkages with the University of Hertfordshire,	N/A	No specific role required although revenue funding	Enabler	To be determined

Transformation	alongside the development of multi-roles to support the spokes, and consider rotational training between different disciplines. Furthermore, the programme would look to upskill primary care clinicians, establish stronger links with the growing life sciences sector in Hertfordshire, and identify experienced clinicians throughout the system to support the model.		to be utilised to support development of training programmes, apprenticeships and other schemes to support sustainability.		
Make Every Contact Count	The CDH would benefit from a range of potential interventions to be delivered in both the hub and spokes of the model. These could include advice on alcohol, obesity, or smoking cessation.[2] The partnership would design the model by working with experts from Hertfordshire County Council's Public Health Team.	N/A	N/A The proposal is for ring fenced funding to support the development and embedding of literature and digital education – linking with existing services	Enabler	To be determined
Patient Booking System: Referral	The purpose of this hub will be to ensure patients and professionals have an accessible, co-ordinated, and effective route to discuss referrals, book appointments, and receive advice. The ambition is to ensure patients can pick appointment dates, locations, and times that are convenient to them to maximise attendance, to simplify access to the range of diagnostic services, and to improve acute to community clinician relationships.	Action	To be determined Additional workforce may be required to fully realise the ambition of the patient booking system. The exact head count is to be determined.	Enabler	To be determined
Year 3 2023/2024					
Extended Opening Hours – Year 2 Pathways	There will be the opportunity to explore the extended opening hours for the Lung Function Diagnostic Hub (QE2) and the spoke services.	None – using existing equipment	Additional workforce and potentially further estates costs will be required to	QEII	To be determined

[2] https://www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf

	However this was decision will need to be reviewed and confirmed in Year 2 dependent on demand and capacity requirements. Workforce has been costed as part of this business case for due diligence.		support the extended opening hours.		
Pathway Transformation	Pathway transformation represents the biggest opportunity for impact, particularly where additional equipment/opening hours is being funded to increase capacity. A system-wide working group will be established that will review diagnostic access, one-stop shop clinics, bundling of tests etc. This will focus on CT, MRI, Ultrasound and Plain Film X-Ray in the main but expand to all diagnostic pathways.	None – pathway transformation	None	QEII	To be determined
Year 4 2024/2025					
MRI	The system is keen to ensure a further increase in both MRI and CT capacity to exploit the opportunities presented by this programme. The ambition is to situate the equipment in the community spoke model. If this is not possible the ring-fenced monies will be used to commission capacity from mobile units (e.g. InHealth) Action	MRI + turnkey	Specific WTE to be determined but will include Radiographer, Consultant, Clinical RDA and administration support.	Spoke	To be determined
CT		CT + turnkey		Spoke	To be determined

*Reporting and Administration requirements for extended hours at the QEII have been incorporated within the workforce model;

- Reporting: AHP Band 7 – 2 WTE and Medical Consultation – 2.4 WTE
- Administration:
  - Evening: Band 2 0.64 WTE; Band 3 1.22 WTE and Band 7 1.22 WTE
  - Weekend: Band 2: 0.78 WTE

Appendix Three: Workforce Profile

(i) Current Vacancies & Recruitment Trajectory - Core Service

Staff Group	WTE	November	December	January	February	March	April
Radiographer	10.0 WTE	2.0 WTE		4.0 WTE	3.0 WTE		

(ii) Recruitment Plan

The following details the core recruitment plan for Radiology. This does not take into account recruitment that is required for specialty specific pathways such as respiratory, cardiology etc.

- Radiographers: Overseas recruitment has already commenced and student recruitment to start in early summer.
- Associate Practitioners: An increase in capacity will enable increased activity and staff development from RDAs which will also increase retention. Advertisement to commence immediately. The division is also linking with HWE ICS apprenticeships. There is currently no provision at local universities. A case is to be put together in conjunction with the ICS – the earliest possible enrolment is September 2022.
- RDA: There has been a previous successful recruitment – advert to recommence in January 2021.

The team is also exploring anaesthetic support at The New QEII for contrasting work.

The immediate actions are;

1. Recruitment and Retention Premia to be drafted
2. Recruitment brochure currently being developed
3. Marketing strategy to be developed including a) linking in with NHSE marketing and social media lead and b) linking in with resourcing regarding posters and media campaigns.
4. Discussion with the Resourcing Team to see whether a CDH recruitment campaign is possible.

(iii) Retention Plan

Staff retention, including support and wellbeing strategies, is going to be essential. The following key actions have been identified;

1. Review of hygiene factors; parking, toilet facilities, lockers, staff room
2. Shuttle bus for The New QEII Hospital
3. Continued work with Steve Andrews, Associate Director of Leadership and Change, ENHT
4. Retention Premia to be drafted

Appendix Four: Financial Breakdown

Phase 1 and 2
Costing (Submission 1

Appendix Five: Prioritisation Framework

Strategic Fit

Very low	Low	Moderate	High	Very High
				X

(i) National

In October 2020 the NHS published a report, "Diagnostics: Recovery and Renewal setting out the case for increasing diagnostic capacity in England for a new model of diagnostic service provision" following an independent review of NHS diagnostic services by Professor Sir Mike Richards.

A key recommendation of the report is for the rapid establishment of CDHs in order to support the separation of urgent and elective diagnostics to improve efficiencies. In April 2021 NHS England released guidance and opportunities for funding for the establishment of this service over a 5 year period. This is therefore a NHS England mandated project.

(ii) ICS

In response to the above HWE ICS has commenced the development of a diagnostics strategy to consider how the recommendations of the report can be embedded locally. The starting point for the development of an ICS diagnostic strategy is establishing a community diagnostic hub in each of the HCP systems.

(iii) HCP

The establishment of a CDH meets the following ENH HCP objectives;

Strategic objective 1: transform health, care, and wellbeing services to meet population needs.		**Strategic objective 2:** improve health and wellbeing for people who need it most.	
Priority 1: implement and embed the population health management approach.	Supports	**Priority 1:** reduce the health inequalities experienced by people.	Delivers
Priority 2: improved and timely access to services when people need them.	Delivers	**Priority 2:** improved outcomes for adults with Long Term Conditions.	Delivers
Priority 3: improved co-ordination, join-up, and organisation of care around people.	Delivers	**Priority 3:** improved outcomes for children and young people.	Supports

(iv) ENHT

ENHT Clinical Strategy (2019/2024) details five strategic priorities. The aim of the CDH programme is to support all of the priorities;

- People: To create a dynamic and flexible service provision promoting the upskilling and training of staff
- Pathways: To co-produce pathways with key stakeholders from across HCP to ensure efficient and clinically effective pathways
- Ease of Use: To increase the capacity and accessibility for diagnostic services thereby reducing wait times
- Quality: To ensure that all elements of the service deliver a safe and compassionate service
- Sustainability: To develop a service plan that supports the sustainability of the service and ensures the positive impact on other parts of the system

	Is the proposal aligned to the local place based and ICS strategic priorities Yes
Evidence of effective-ness on Health & Wellbeing	

Very low	Low	Moderate	High	Very High
			X	

Diagnostics form 85% of all clinical pathways and are an integral part of a patient's care pathway. NICE Guidelines for specific conditions detail the diagnostic requirements however the purpose of this project is to a) increase overall capacity and b) transform access.

The COVID-19 pandemic has further exacerbated the capacity and demand challenges in accessing diagnostic services. However the pandemic has accelerated the implementation of many positive changes such as increased use of virtual consultations and community services. This proposal seeks to build on those changes to embed more efficient and clinically appropriate patient pathways.

The ENH model is based on the recommendations within Professor Sir Mike Richards' report. In the document Professor Richards advised that full establishment of networks will be the driver for change at local level and should lead to improved clinical outcomes in cancer, stroke, heart disease, respiratory diseases and other conditions in line with the NHS Long Term Plan commitments. A full Benefits Realisation Plan will be developed to measure the impact on clinical effectiveness and clinical outcomes.

The ENH model also proposes to commission services relating to Making Every Contact Count initiatives and signposting for patients accessing diagnostic services. This should promote wellbeing and lifestyle advice, as well as wider social support.

Have these considerations been covered in the business case? Y

Anticipated Health Benefits/ Health Gains

Very low	Low	Moderate	High	Very High
			X	

1. **Preventing people from dying prematurely**

There is anticipated to be a positive impact.
The model will support the increase in capacity for key diagnostic tests, thereby reducing waiting times, and improve the service access by enabling more services to be provided 'closer to home' Enabling patients to access their tests in a more convenient way and to reduce the waiting time will support quicker diagnosis. By facilitating patients being placed on the appropriate care pathway at the earliest opportunity this should support improved management of patients and better clinical outcomes.

2. **Enhancing quality of life**

There is anticipated to be a positive impact.
As detailed above.
The model will also utilise Make Every Contact Count initiatives to promote wellbeing and healthy lifestyles.

	3. Helping people recovery from episodes of ill health or following injury There is anticipated to be a positive impact. As above. By increasing both capacity and access to core modalities such as CT, MRI, Plain Film and X-Ray it should support quicker access to elective diagnostic tests. This should also release diagnostic capacity at the Lister Hospital to support improved inpatient and non-elective flow. **4. Ensuring people have a positive experience of care** There is anticipated to be a positive impact. There five core ambitions which should result in a positive experience of care; • By increasing the opening hours of core modalities at the New QEII Hospital, patients will have greater flexibility in the time they can attend for their diagnostic service including evening and weekends. The aim is to reduce the number of cancellations and DNAs by offering a more convenient service. • The spoke community model will enable patients to receive care closer to home. For example DEXA scans are currently undertaken at Hertford County Hospital. For a patient in North Hertfordshire this is a significant journey particularly if required to use public transport. By implementing a DEXA scan in another locality there will be easier access. • New streamlined, and co-produced, pathways will aim to offer coordinated diagnostic tests reducing the need to attend multiple diagnostic appointments. • The inclusion of Make Every Contact Count and signposting should enrich the patient's experience by providing extra support and information at no extra inconvenience • The ambition is to transform the service access model that will allow coordinated diagnostics on a larger scale therefore reducing multiple attendances Measuring patient feedback will be an essential part of the project mobilisation and evaluation. **5. Treating and caring for people in a safe environment and protecting them from avoidable harm** There is anticipated to be a positive impact. The New QEII Hospital is already established with diagnostic services. Increasing the opening hours and implementing new pathways will support the ongoing diagnostic transformation, whilst providing in an existing and safe healthcare setting. The fixed estate spoke elements will need careful consideration at mobilisation to ensure the access and environment is safe. The workforce will be managed by ENHT and therefore will fall under the remit of their policies, governance and guidance. The capacity impact is being worked through as part of the NHS England bid submission and supporting business case however this should have a moderate health gain for the majority of the population. **Have these considerations been covered in the business case? Y**
Quality,	

Safety and Patient Experience

Very low	Low	Moderate	High	Very High
				X

There is anticipated to be no negative impact on the quality of service delivered or patient experience.

- Access: The proposal is to firstly increase the capacity of diagnostic services at The New QEII – an established acute site with good transport links. The implementation of the community spoke model will support delivery of diagnostic testing closer to home. The location of the spoke is data driven, i.e. to ensure implementation based on population health management need. This will be overlayed with information from the Shape Atlas, and other tools, detailing public transport routes, current service access patterns and other challenges. Engagement will also need to be made with EEAST as the non-emergency patient transport service provider.
- Patient Choice: Patients will be able to choose where they receive their diagnostic tests; New QEII Hospital, community spoke model as well as Lister Hospital and Hertford County Hospital. Consideration is built into the business case as to how those booking lists can be effectively managed to support patient choice and manage the capacity/demand.
- Waiting Times: Waiting times for diagnostics has been steadily increasing as the demand for services grow. The impact of the COVID-19 pandemic has further exacerbated this position. The aim of the project will be to reduce waiting times for the diagnostics detailed within the business case to support quicker access. This will be a key measure in the Benefits Realisation Plan.
- Workforce: Workforce is a significant national issue, particularly in relation to diagnostic staffing. Clinical and operational teams are reviewing the workforce requirements to ensure a clinically appropriate and safe skill mix. A dynamic and transformative workforce solution will be required for a sustainable service. Go/No Go criteria will be developed ahead of each stage of mobilisation to ensure patient and staff safety.
- Clinical Governance: ENHT is the lead organisation for this project and therefore clinical governance will fall under the acute Trust remit.
- Infection Prevention and Control: The New QEII Hospital is an existing acute site already providing diagnostic services. The expansion and implementation of pathways will be in addition to this provision and any additional requirements, e.g. IPC will be considered. The Spoke model will need to be reviewed as part of the mobilisation process to ensure IPC requirements are met and maintained.
- Patients: All patients will be treated with dignity, respect and compassion as part of ENHT's core values. The model is exploring the use of Chaperones, particularly in the spoke community model to provide additional support to patients.
- Self-Care: Please see details of Make Every Contact Count and signposting referenced earlier in the document.
- Benefits Realisation Plan: A full Benefits Realisation Plan will be developed to support the ongoing monitoring and evaluation of the project.
- Safeguarding Adults/Children: There is likely to be no negative impact on safeguarding adults or children. All staff will be required to undertake appropriate safeguarding training in line with their role requirements. The service is initially for adults aged 18 years and over. Consideration will be given post mobilisation to increasing the access criteria to children. At

<table>
<tr><td></td><td>this point Safeguarding Children team will be engaged to ensure all requirements are worked through.

Where the business case covers areas detailed above please reference this; however this section must be completed within the Prioritisation Framework to meet requirements of QIA completion.</td></tr>
<tr><td>Cost effectiveness (inc. comparison to alternative models of care)</td><td>
<table>
<tr><th>Very low</th><th>Low</th><th>Moderate</th><th>High</th><th>Very High</th></tr>
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Due to the timescales involved with the NHS England submission the true cost effectiveness is still to be determined.

The investment to mobilise and maintain the services is largely dependent on the funding from NHSE England which, at the point of writing, is still to be confirmed.

By increasing access and timeliness to diagnostics, and coordination of tests, there is expected to be a reduction in secondary care outpatient activity, as well as potential impact on ED and other urgent care flows. There should also be an increase in productivity. Diagnostics is bottleneck for many activities (inpatient and outpatient) therefore by increasing capacity more activity can be undertaken.

The ability to calculate and monitor this will need to be carefully considered.

Have these considerations been covered in the business case? Y
</td></tr>
<tr><td>Affordability (inc. impact on wider health and care system)</td><td>
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As detailed above the investment to mobilise and maintain the service is largely dependent on funding from NHS England. The FBC has been developed detailing the ENH ambition by each element has been itemised to support a reactive review once the funding envelope is known.

There is an opportunity to consider economies of scale which is being led through the HWE ICS Diagnostics Group.

Potential revenue costs also need to be considered as a result of funding not ongoing past Year 5 and this is detailed within the business case.

Have these considerations been covered in the business case? Y
</td></tr>
<tr><td>Impact on Health Inequalities</td><td>
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1. What evidence have you considered to determine what health inequalities exist in relation to your work?
• Population Health management data has been used to inform demographic profiles, disease profiles and service access.
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- The Shape Atlas has been used to determine areas of deprivation, areas with a high elderly population and access to healthcare (including by public transport)
- There is a need to tackle Health Inequalities and the mobile element of this model in particular can support to do this

2. *What is the potential impact of your work on health inequalities?*

- Increasing the opening hours at the New QEII Hospital will support working age people to access diagnostic services outside of core working hours. This is particularly important for those areas of employment where release is not granted to attend healthcare appointments.
- The community spoke will enable diagnostic services to be available in an additional locality – informed by population health need.
- There will also be an impact on inequality of outcome, e.g. by being more accessible people will be diagnosed earlier.

3. How can you make sure that your work has the best chance of reducing health inequalities?

- As per the above.

4.How will you monitor and evaluate the effect of your work on health inequalities?

- A full Benefits Realisation Plan will be developed so we can accurately measure the impact on health inequalities.

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<tr><td>Feasibility</td><td>

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The feasibility of this project is dependent on the funding from NHS England. At this stage the exact funding available is unknown. This poses one of the biggest risks to the project.

Another significant risk is workforce which is detailed earlier in this paper and reflected in the business case. The 5 year plan is ambitious but achievable.

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Community Diagnostic Hub: Year 1 2021/2022 Mobilisation Briefing

1.0 Background

NHS England (NHSE) has mandated that all local systems need to implement 'Community Diagnostic Hubs' that will increase diagnostic capacity, shift elective diagnostic work to non-acute sites and transform pathways.

Within East and North Hertfordshire it was agreed to implement a 'Hub and Spoke' model. This utilises, and expands the existing diagnostic service provision at the New QEII site, as well as implementing a community spoke option to support the reduction in health inequalities. Whilst the programme is 'system-wide', the lead provider is ENHT.

This is a 5-year programme with both capital and revenue funding available. ENHT was selected as a Year 1 site meaning mobilisation is expected within 2021/2021. NHSE has awarded £1.078m revenue and £1.774m capital to facilitate implementation. The funding decision was received in October 2021 which has significantly impacted ENHT's ability to fully mobilise within the financial year.

The purpose of this briefing document is to provide ENHT Executive Team with an update on the current mobilisation and the associated risks.

2.0 Hub: The New QEII

(i) Extended Opening Hours for Core Modalities

The opening hours for the core modalities; MRI, CT, Plain Film X-Ray and Ultrasound, will be extended to 8am-8pm Monday-Sunday. Due to the challenges with workforce the implementation is phased.

Extended evening (weekday) opening hours was due to commence in mid-January 2022. The operational team has revised the implementation date to mid-February 2022. As a result the extended weekend opening hours has also been pushed back until mid-March 2022.

Table 1: QEII Extended Opening Hours – Mobilisation Plan

November				December				January				February				March			
					QEII Site Visit														
										Notification to QEII Landlord									
Recruitment																			
								Go/No Go Decision											
												IMPLEMENTATION DATE: Weekday evenings only							
																		IMPLEMENTATION: Weekend evenings	

Risk to Mobilisation

1. **Estate:** Negotiations with the QEII Landlord are complete and the extended opening hours is supported subject to a financial cost – this was factored into the Year 1 bid to NHSE. A site walk is due to take place on 9th December 2021 to identify shared services that may be required. No significant estates work needs to be take place.
2. **Workforce:** Mobilisation of this element of the CDH requires an increase in head count across a range of roles. There are existing vacancies within the core radiology service which are being mitigated through an overseas recruitment programme. A recent recruitment campaign has been successful and there is expected to be a full establishment of radiographers within the core service by the end of Quarter 4 2021/2022.

(ii) Fibroscan: Liver Disease Pathway

Table 2: QEII Fibroscan – Mobilisation Plan

November				December				January				February				March			
	Equipment purchase and delivery																		
										Equipment test and implementation									
					QEII Site Visit														
	Space Utilisation Request: Clinic Room @ QEII																		
Recruitment: Band 3 Fibroscan Technician																			
Contract review to determine if commissioned activity																			
								Go/No Go Decision											
														IMPLEMENTATION DATE					

Risks to Mobilisation

1. **Equipment:** The equipment is due to be ordered imminently; with a lead in time of 6-7 weeks meaning it is due to be received in early January 2022.
2. **Estate:** An additional clinic room at the New QEII is required. This is subject to approval through the Space Utilisation process.
3. **Workforce:** Approval has been given for the Gastroenterology Team to commence recruitment and this is underway.
4. **Pathway:** ENHT Contracts Team has identified this will be a new pathway for the Trust and is therefore not commissioned. Advice is being sought from the Contracts Team regarding opening dialogue with East and North Hertfordshire Clinical Commissioning Groups about the future delivery of this diagnostic pathway. There is a significant possibility negotiations will impact on implementation timescales.

(iii) Fluoroscopy

Fluoroscopy was included within the original Year 1 bid submission to NHSE without discussion with clinical or operational leads. ENHT has made no further reference to Fluoroscopy in any correspondence to NHSE, including activity projections however capital funding has been received.

The operational team wish to use the funding to replace ageing kit at the New QEII Hospital. NHSE is scrutinising additional capacity provision as a result of the funding. Whilst new equipment may be more efficient and therefore provide limited additional capacity this is tenuous. A change request has been submitted to NHSE regarding this.

Please note there is an 8-week lead in time for equipment delivery.

(iv) SPEC-CT

As part of a Year 1 underspend opportunity, ENHT was successful in bidding for capital funding to contribute to the purchase of a SPEC-CT. This piece of equipment will replace an unsupported Gamma Ray at the Lister site. Whilst this funded through the CDH programme it is not considered to be part of the overall CDH model.

The SPEC-CT has a six-month lead in time for delivery and estate work will be required on receipt. Therefore this piece of equipment is not expected to mobilise until 2022/2023. ENHT Contracts Team has concerns with the commissioning arrangements for the SPEC-CT which is currently being explored between the operational team and contracts team.

3.0 Spoke

The Year 1 bid sought to establish a pilot for a spoke community model in a fixed estate. The purpose of the spoke is to contribute to reducing health inequalities across ENH through informed targeting.

(i) DEXA Scan

Table 3: DEXA Scan – Mobilisation Plan

November				December				January				February				March			
	Equipment purchase and delivery																		
												Equipment implementation and test							
			Spoke Site Visit																
				Spoke Site Decision															
					Spoke Site Preparation														
																Final Site Visit			
		Recruitment																	
													Digital connectivity						
										Go/No Go Decision									
																	IMPLEMENTATION		

Risks to Mobilisation

1. **Equipment:** There is a 10 week lead in time for delivery of the equipment and minor estates work will be required to support implementation.
2. **Estate:** The spoke site remains unconfirmed. The Operational Team are due to undertake a site visit to Nevells Road Health Centre, Letchworth Garden City and a decision will be made as to suitability of the estate. Please note HCT are yet to communicate estate lead in times should this site be viable.
3. **Workforce:** Recruitment is required to mobilise the DEXA Scanner.

(ii) ECHO Cardiogram (Direct Access ECHO)

Table 4: ECHO Cardiogram – Mobilisation Plan

November				December				January				February				March			
	Equipment purchase and delivery																		
												Equipment implementation and test							
			Spoke Site Visit																
				Spoke Site Decision															
					Spoke Site Preparation														
																Final Site Visit			
		Recruitment																	
												Digital connectivity							
										Go/No Go Decision									
																		IMPLEMENTATION	

Risks to Mobilisation

1. **Equipment:** There is a 6-8 week lead in time for delivery of the equipment. Additional time has been built into the process as the cardiology team are not yet ready to commence purchasing.
2. **Estate:** The spoke site remains unconfirmed. The Operational Team are due to undertake a site visit to Nevells Road Health Centre, Letchworth Garden City and a decision will be made as to suitability of the estate. Please note HCT are yet to communicate estate lead in times should this site be viable.
3. **Workforce:** Recruitment is required to mobilise the DEXA Scanner.

4.0 Summary

The mobilisation of all individual elements of the CDH within Year 1 2021/2022 is a significant challenge.

The delay in NHSE notification of funding until October 2021 meant the operational team could not commence purchasing of equipment or recruitment campaigns until after this date. Workforce is a significant national issue and will be the determining factor in the Trust's ability to mobilise within proposed timescales. The clinical and operational team have developed an action plan to mitigate the risk and are fully engaged in ICS working groups to manage this issue across a wider geographical footprint.

If the recruitment issues can be overcome, the mobilisation of the Hub (New QEII) remains a possibility within the financial year. Concerns remain around the spoke site with firstly a lack of existing viable options and secondly no confirmed space that will meet the needs of the CDH and the specific services. The ability to mobilise this element of the CDH within Year 1 2021/2022 is extremely ambitious and will need to be tracked closely.

Concerns regarding mobilisation in line with NHSE's expectations have been informally discussed with HWE ICS. Final confirmation of key deadlines is pending from the operational team before a formal approach will be made to NHSE regarding a) the proposed new mobilisation dates (as detailed in the above tables) and b) known risks which may result in further slippage. It is unknown whether NHSE will require a return of revenue as a result of this action.

Author	Emma Hollingsworth, Programme Manager, ENHT
Date	12th November 2021

East and North Hertfordshire NHS Trust

Agenda Item: 13

TRUST BOARD - PUBLIC SESSION – January 2022
Learning from Deaths Summary Report

Purpose of report and executive summary (250 words max):
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.
Action required: For discussion
Previously considered by: This summary report has been included in the full Learning from Deaths report considered by Mortality Surveillance Committee and Quality & Safety Committee.

Director:	**Presented by:**	**Author:**
Medical Director	**Medical Director**	**Mortality Improvement Lead**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☐
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☐
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☐

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) **No**
Any other risk issues (quality, safety, financial, HR, legal, equality): **Detailed on page 5 of report.**

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

1. Key mortality metrics

Table 1 below provides headline information on the Trust's current mortality performance.

Table 1: Key mortality metrics

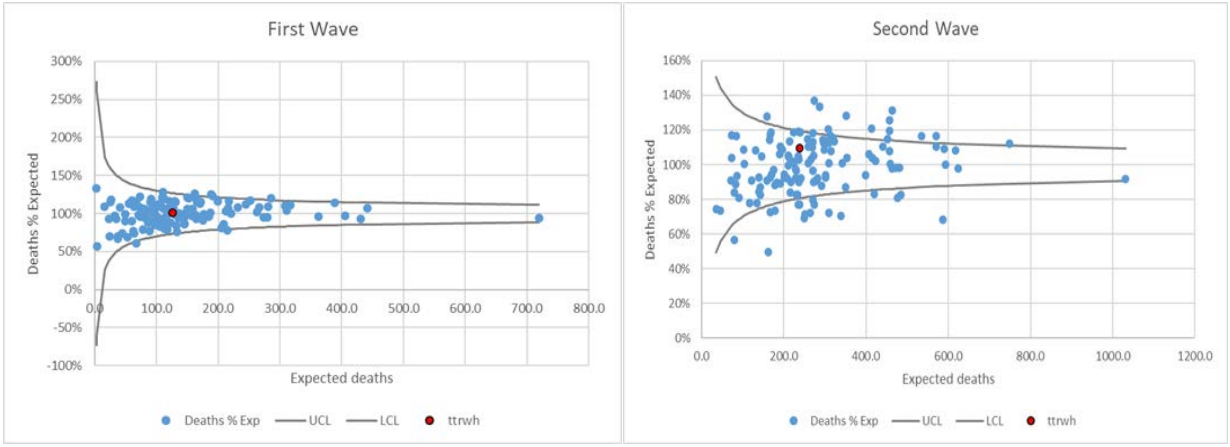
Metric	Result
Crude mortality	Crude mortality is 1.42% for the 12-month period to October 2021 compared to 1.27% for the latest 3 years.
HSMR: (data period Sep20 – Aug21)	HSMR for the 12 month period is **82.49, 'First quartile'.**
SHMI: (data period Jun20 – May21)	Headline SHMI for the 12 month period is **86.78 'lower than expected band 3'. One of only 14 Trusts of 123 in top band.**
HSMR – Peer comparison	ENHT ranked 1st (of 8) 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 2021), rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

2. COVID-19

The following charts provided by CHKS show the Trust's central position relative to national peers in both the first and second COVID waves.

Fig 1: Covid-19 First Wave (March to May 2020) vs Second Wave (October 2020 to March 2021) funnel plots



3. Mortality alerts

3.1 CUSUM alerts

The latest release from CHKS showed one HSMR CUSUM red alert for the rolling year to August 2021 and no SHMI outliers.

Table 2: HSMR CUSUM Alerts September 2020 to August 2021

	Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths
133 - Other lower respiratory disease	157.35	16	10.2	5.8

Source: CHKS (CUSUM alerts coloured)

3.2 External alerts

National Hip Fracture Database (NHFD) mortality alert (August 2019)

Latest data from the National Hip Fracture Database shows 30-day mortality to February 2021. Following a peak in December 2020 of 12.0% the rate has since reduced to 10.8%, which is still significantly above the national average. Improvement work continues.

4. Focus areas for improvement

Table 3: Focus Areas for Improvement

Diagnosis group	Summary update
Acute Myocardial Infarct	Six month joint Cardiology-Coding initiative to review all MI deaths continues.
Sepsis	HSMR performance relative to national peer, although reduced, is still good. There has been some improvement regarding achievement of sepsis targets but compliance with Sepsis 6 is still poor.
Stroke	SSNAP rating remains C. Stroke HSMR is high relative to national peer, but not statistically significant. We are not an outlier for SSNAP risk adjusted mortality that takes account of our Hyper Acute Stroke Unit status.
Emergency Laparotomy	Sixth NELA report saw multiple improvements for the Trust with our adjusted mortality reducing from 13.0 to 10.3. Spike in deaths in 2021. Focussed improvement work remains on-going and has resulted in the service being much better placed to monitor monthly outcomes and drive down mortality.

5. Learning from deaths data

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. In this report data has been provided for Q2 2021-22.

Table 4: Q2 2021-22: Learning from deaths data

	Jul-21	Aug-21	Sep-21
Total in-patient deaths	95	131	118
Mortality reviews completed	52	62	66
Total new ACONs raised	5	3	7
Concluded ACONs: probably ≥50% due to problem in care	0	0	0
Learning disability deaths	1	1	0
Mental illness deaths	1	0	2
Stillbirths	1	1	2
Child deaths (including neonats/CED)*	0	1	0
Maternity deaths	0	0	0
SIs declared regarding deceased patient	13	7	2
SIs approved regarding deceased patient	0	0	0
Complaints regarding deceased patient	1	2	0
Requests for a Report to the Coroner	10	5	12
Regulation 28 (Prevention of Future Deaths)	0	0	0

**Provisional data under review*

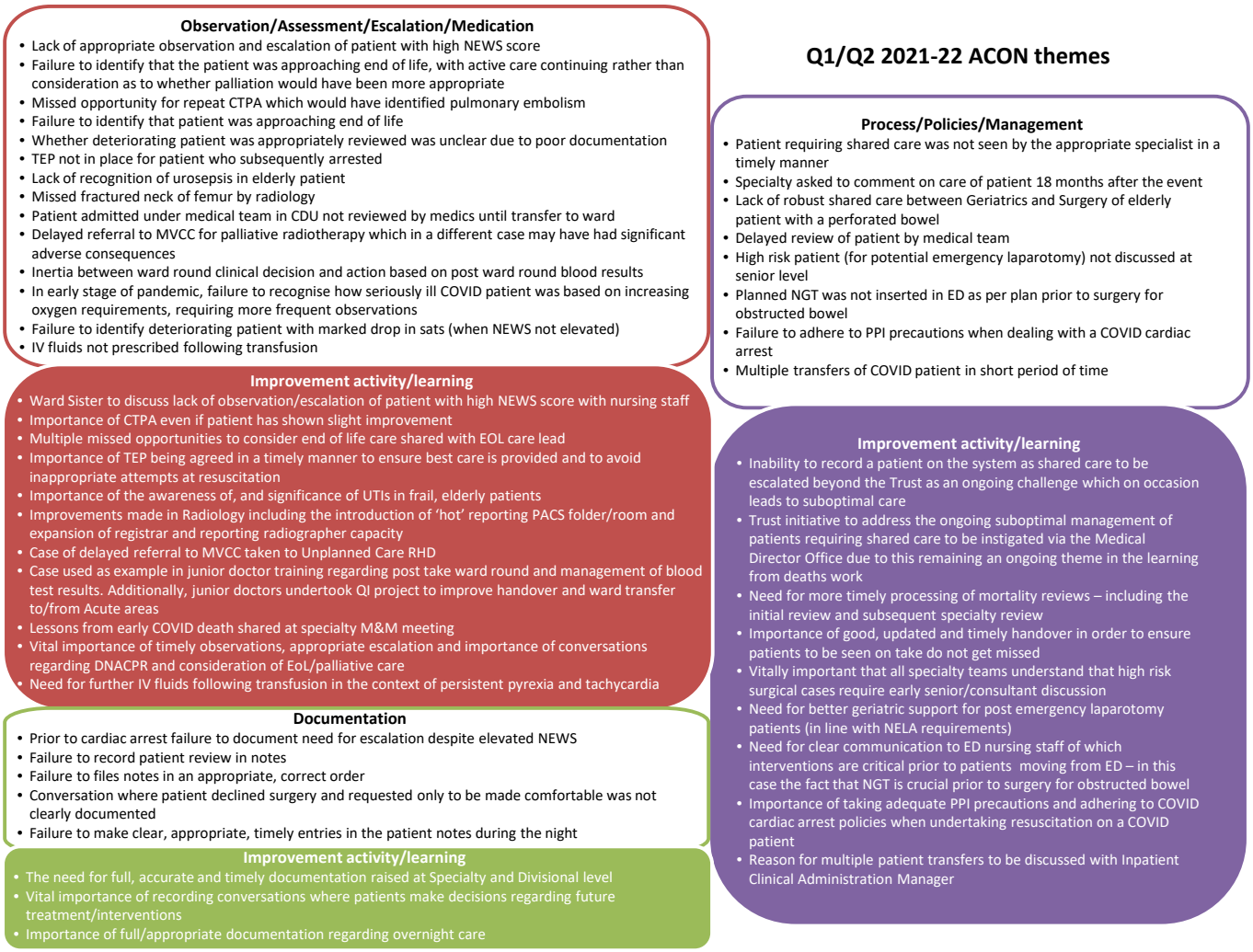
5.2 Learning from deaths dashboard

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

It should be noted that for cases where Areas of Concern (ACONs) are raised, the current lapse in time between the death and completion of Stages 1, 2 and 3 of the review process, means that the avoidability of death score is often not decided in the same review year. This should be borne in mind when viewing the data contained in the dashboard at Appendix 1, which only details the conclusion details for 2021-22 deaths which can appear to skew the data. Therefore for the sake of transparency and robust governance this report details ACONs relating to all deaths which have been concluded during the quarter in question where the Mortality Surveillance Committee agreed an avoidability of death score of 3 or less (irrespective of the year in which the death occurred). Due to the usual summer break for the Mortality Surveillance Committee, and further cancellations due to operational pressures and staffing issues no ACONs were concluded in Q2, resulting in no avoidability of death or quality of care ratings being reported.

6. Learning and themes from concluded mortality reviews highlighted for concerns and learning opportunities (ACONs)

Figure 2: April to September 2021 ACON Themes



7. Current risks

Table 5 below summarises key risks identified:

Table 5: Current risks

Risks	Red/amber/green rating
COVID-19	
Fractured Neck of Femur mortality	
Medical Examiner Integration & Community expansion	
Mortality Review – need for content/IT development	
Mortality module incorporation onto Datix iCloud platform	
Severe Mental Illness – Identification/flagging of patients	

The full Learning from Deaths report incorporating more detailed information on the key metrics, developments and current risks summarised in this report was scrutinised by both the Mortality Surveillance Committee and the Quality & Safety Committee in December.

Appendix 1: ENHT Learning from deaths dashboard September 2021

East and North Hertfordshire NHS Trust: Learning from Deaths Dashboard: September 2021

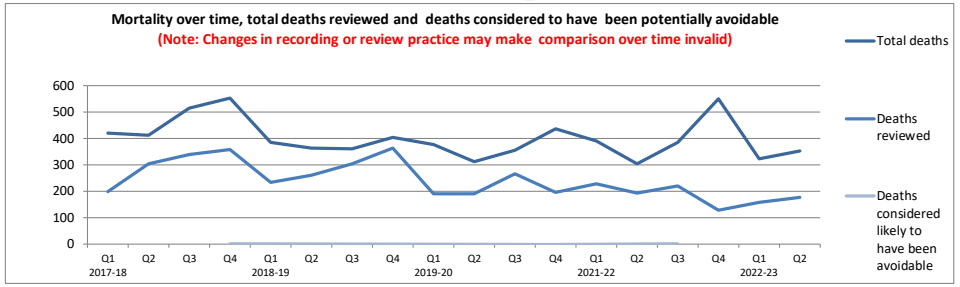
Description:
This dashboard is a tool to aid the systematic recording of deaths and learning from the care provided by East and North Hertfordshire NHS Trust and is based on the dashboard suggested by the National Quality Board in its Learning from Deaths Guidance published in March 2017. Its purpose is to record relevant incidents of mortality, deaths reviewed and lessons learnt to encourage future learning and the improvement of care.

Summary of total number of deaths and total number of cases reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
121	134	66	61	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
354	323	178	157	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
677	1634	335	769	0	2

Time Series: Start date 2017-18 Q1 End date 2021-22 Q2



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	62	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	164	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	3	0.9%	This Year (YTD)	4	1.2%	This Year (YTD)	328	97.9%

Summary of total number of learning disability deaths and total number reviewed under ENHT Structured Mortality Case Record Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	5	2	5	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
7	22	7	23	0	0

Time Series: Start date 2017-18 Q1 End date 2021-22 Q2

East and North Hertfordshire NHS Trust

Agenda Item: 14

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022

Nursing Establishment Review October 2021

Executive Summary:

The nursing establishment review was undertaken during October 2021. Actual worked staffing, patient acuity and dependency data, was collected over a 20 day period on all inpatient wards. The data was then analysed using validated frameworks, professional judgement, quality and safety indicators, benchmarking with other Trusts using NHSI Model Health system [Appendix 1] and national guidance for safe staffing.

Non ward based areas were also reviewed for the first time, reviewing activity, using national guidance, benchmarking and professional judgement. Whilst shift plans have been revised according to patient acuity and current activity using winter initiative funds, these areas will be brought back in January as part of annual budget setting to reflect ongoing staffing need.

The key recommendations from the review:

- To flexibly recruit fully into our 22% budgeted headroom for inpatient wards, ED and Renal
- To agree the changes and uplifts to ward and department shift plans
- 3 x band 6 bleep holders 24/7 to ensure senior nurse support
- Band 6 cover 24/7 in all inpatient wards to ensure leadership
- Vacancy posts advertised as substantive rather than short term / temporary to attract and fill posts (*sec 7*)

Action required: For approval

Previously considered by: Quality & Safety Committee (14 December, 2021) & Finance, Performance & People Committee (15 December, 2021). Elements of content previously considered by the Nursing and Midwifery Excellence Board (NMEB) and the Clinical Workforce Group.

Director: Chief Nurse	**Presented by: Chief Nurse**	**Author: Deputy Chief Nurse, Workforce Lead Nurse, E Roster Manager**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) 2 = People 8 = Quality

Any other risk issues (quality, safety, financial, HR, legal, equality): Nurse Staffing Shortages 6839

1. Introduction

Trust Boards have a duty to ensure safe staffing levels are in place and patients have a right to be cared for by appropriately qualified and experienced staff in a safe environment. These rights are set out within the National Health Service (NHS) Constitution, and the Health and Social Care Act (2012) which make explicit the Board's corporate accountability for quality and safety.

Developing workforce safeguards (NHS England, 2019) states that effective workforce planning is vital to ensure appropriate levels and skills of staff are available to deliver safe, high quality care to patients and service users. Establishment setting must be done annually, with a mid-year review, and should take account of:

- Patient acuity and dependency using an evidence-based tool (as designed and where available)
- Activity levels
- Seasonal variation in demand
- Service developments
- contract commissioning
- Service changes
- Staff supply and experience issues
- Where temporary staff has been required above the set planned establishment
- Patient and staff outcome measures.

The guidance also states the importance that all stakeholders, including commissioners, are sighted on all recommendations to maintain or change establishments. Stakeholders should understand the rationale behind such recommendations and their anticipated impact.

The Nursing and Midwifery Council (NMC) sets out nurses responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the six essential standards that all healthcare providers must meet to comply with the Care Quality Commission (CQC) regulation. This is also incorporated within the RCN (2021) Nursing workforce standards and the NICE guidelines 'Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals' (2014).

The Carter report (2016) recommends the implementation of care hours per patient day (CHPPD). This preferred metric provides NHS Trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards. The Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2021) and NICE 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014), suggest wards have a planned registered nurse to patient ratio of no more than eight patients to one registered nurse on day shifts.

For nursing and midwifery, the budgeted establishment and required ward/department roster template must be aligned. They must be determined by factoring in headroom and outputs from the recommended six-monthly safe staffing establishment reviews. These reviews should use the National Quality Board's (2018) evidence-based guidance.

Considerations that are facing the Nursing and Midwifery Workforce are as follows;

- Non ward based areas have not previously had a full review and shift plans signed off as part of our establishment review process
- The COVID 19 pandemic has had a huge impact on the nursing and midwifery workforce and continues to create ever increasing challenges
- Winter pressures and COVID surge plans may reduce the availability of the nursing and midwifery workforce
- It is well documented the effect the pandemic has had on our workforce with an increased focus on recovery and how we support our staff health and wellbeing

- Increasing patients with mental health needs both adult and children, all requiring different skill set and patient pathway
- The result of funding and successful international recruitment has enabled the Trust to improve vacancies for registered nurses, however is still reliant on temporary staffing with no resilience in flex to meet surge plans and support well-being initiatives
- International recruits and grow our own initiatives have increased our requirements for study leave
- Our bank staff are mainly trust staff, the split of multi-post holder and bank only is 75/25, putting more pressure on our nursing teams to pick up bank shifts when they are already tired
- The continued growth in services, and recovery plans requiring a constant focus on finding creative ways to recruit and retain
- Safely staffing across a 24 hour period 7 days a week in a fair and consistent way to all, whilst also trying to meet the flexibility staff now require
- Implementation of the NHS People Plan

2. Establishment Review Methodology

In order to undertake the establishment review, various national guidance validation tools were used to help with this calculation:

- Current assumptions & validation
- Care Hours Per Patient Day
- Safer Nursing Care Tool
- Professional Judgement
- National Benchmarks

The review consisted of having full clinical engagement involving Ward Managers, Matrons, Divisional Nursing and Quality Directors / Deputies, the people team and financial colleagues, ensuring robust clinical discussions and context were captured. Table 1 demonstrates methodology tools for each service that were utilised.

Table 1

Area	Methodology
Wards - AMU, Paediatrics, A+E	Safer Nursing Care Tool (SNCT) Professional Judgement Benchmarking + Model Hospital Review of quality indicators
The following areas were also included in the establishment review and any existing amendments to shift plans agreed using winter initiative funding. These areas will be brought back in January as part of annual budget setting / planning cycle.	
Outpatient Departments	Professional judgement as no current validated tool
Neonatal Unit	British association of perinatal medicine (BAPM) Guidelines and professional judgment
Critical Care	ICS guidelines and professional Judgement
Maternity	Birth Rate + and professional judgement
Endoscopy	Joint advisory group (JAG) guidance and professional judgement
Theatres	Not included, will be undertaking an external review
Renal	British Renal Standards, professional judgement

A full review of the data, collection processes and methodologies can be found in Appendix 3.

2.1 Current assumptions – Skill Mix and Registered Nurse to bed ratio

The nurse to patient ratio describes the number of patients allocated to each registered nurse. Nurse patient allocations are based on the acuity or needs of the patients on the ward. In critical care the ratio may be 1:1 for the sickest patients or 1:2 or 1:3 for patients who are acutely ill but stable. On general wards the nurse to patient ratio is higher, for example 1:6 or 1:8 depending on the type of service delivered and the needs of the patients. This type of nurse patient ratio is based on guidelines from professional organisations and accreditation bodies, but also reflects the needs of the individual patients at a given point in time.

A full ward breakdown of the service model skill mix and the actual worked skill mix for the reference period can be found in Appendix 4.

Table 2

Planned Registered Nurse to Patient ratio per division

Division	RN to Bed Ratio		
	Early	Late	Night
Unplanned	1/5	1/6	1/6
Planned (Excluding Critical Care)	1/6	1/7	1/7
Cancer	1/5	1/5	1/7

2.2 Care Hours per Patient Day (CHPPD)

At ENHT care hours per patient day (CHPPD) is a productivity model that has been used, in triangulation with other methods, to set the nursing establishments. The review of NHS productivity, chaired by Lord Carter, highlighted CHPPD as the preferred metric to provide NHS Trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards. The methodology for calculating CHPPD used in this review can be found in Appendix 3.

CHPPD is used prospectively to identify the likely care time required for expected patient type for a service. This is then compared to the required CHPPD for actual patients using the service, and then comparing the actual CHPPD provided by staff on the ward to assess if wards were appropriately staffed for actual patients.

Table 2 below shows the summary of the three dynamics of the continuous linear CHPPD cycle per Division. A full breakdown per ward can be seen in Appendix 5.

Table 3

Average Care Hours per Patient Day service model, required, and actual worked per division during the 20 day data collection period.

Division	Service Model CHPPD	Required CHPPD SafeCare	Actual worked CHPPD
Unplanned	7.00	7.08	6.59
Planned (Excluding Critical Care)	5.55	6.13	5.73
Cancer	6.15	5.41	9.45

2.3 Safer Nursing Care Tool (SNCT)

The SNCT is an evidence-based tool developed to help NHS hospitals measure patient acuity and dependency to inform decision making on staffing and workforce. The tool enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/ dependency terms. SNCT is NICE approved as an effective evidence based staffing tool.

The process involves using the acuity tool, over a period of 20 days on each inpatient ward to establish patient need and dependency. The tool is based on 4 levels of care, defined by National guidance.

The SNCT multipliers are based on dependency, workload literature and empirical data. The Trust uses the licensed software to gain this information.

Table 3 below shows the occupancy information for each division for the sample period, with the SNCT recommended establishment (whole time equivalent - WTE), current funded establishment and the variance between the two metrics. The table shows the cumulative divisional position.

Table 4

Average Divisional bed occupancy, SNCT recommended WTE, Total Funded WTE based on occupancy and variance

Division	Bed Occupancy %	CHPPD Bench Marking Data			SNCT Recommended Data	
		Total Funded Est. based on occupancy	Total Funded Establishment (21% Headroom)	Recruitable Establishment Oct 2021	SNCT recommended WTE (22% Headroom)	Variance of Total Funded Est. based on occupancy to SNCT recommended
Unplanned	93%	33.80	36.24	34.14	31.90	1.90
Planned (Excluding Critical Care)	89%	32.89	37.09	35.04	34.80	-1.91
Cancer	61%	19.67	32.05	30.49	17.45	2.21

When using this tool other variables should also be taken into consideration:

- Clinical speciality
- Ward size and layout (evidence suggests the tool does not work well in small wards)
- Side rooms
- Staff capacity, skill mix, competence and leadership
- Organisational support and support roles
- Ward manager supervisory time

The outlying variances are discussed per individual unit further in Appendix 2.

The combined data demonstrating CHPPD Benchmark Recommended WTE compared to the SNCT Recommended WTE can be found in Appendix 6.

2.4 Professional Judgement

All Ward Managers, Matrons, Divisional Nursing and Quality Director / Deputies, Finance, workforce leads and the E-roster team met with the Deputy Chief Nurse to review all the above data and triangulate associated quality indicators, datix incidents and themes, and red flag events. The recommended adjustments to shift plans are based on the data review and robust discussions with all present. This process added specific clinical context to the discussions and provided an evidence based approach ensuring Ward Managers, Matrons and Divisional Nursing and Quality Directors were engaged and took ownership of their clinical areas.

2.5 National Benchmarks

The latest available August 2021 data was taken as a benchmark which compares local peers with the NHSI Model health system. ENHT was rated in the lowest quartile for CHPPD for total nursing. The Trust was rated in the lowest quartile for cost per patient day. This has been considered and will be in part addressed within the recommendations set out with the proposed uplifts described in 6.1. See Appendix 1 for the data.

2.6 Data Validation

The following actions were taken to validate the data collection from the SNCT specifically for the establishment review:

- SNCT training was delivered throughout September – this was to ensure that the SNCT data was validated and consistent, inter-rater reliability exercises were undertaken with the nursing teams to ensure consistent application of the acuity multipliers
- Comparing recommended establishment for both CHPPD and SNCT
- Senior Nurse Acuity Audits - throughout the data collection period senior nurses peer audited wards to validate data inputs. Any discrepancies in the acuity data scoring were corrected and senior nurses worked with wards to ensure consistent application of the tool. Audit scores can be seen in Appendix 7. It should be noted that further training is required with SNCT scoring in areas below 90% accuracy (prior to validation and correction). Ongoing workshops continue and the wards acuity scoring closely monitored on a daily basis.
- There has been no manipulation of the data to maintain the reliability and validity of the tool and this allows for benchmarking
- External benchmarking with other organisations using the NHS Improvement (NHSI) Model health system [See appendix 1]
- Professional Judgement
- Review and discussion at ward board rounds and quality huddles

2.7 Nursing and Midwifery Quality Indicators

The Trust uses information and statistical tools to examine indicators of care. These indicators include; pressure ulcer prevalence, complaints, patient falls, drug administration errors, Clostridium-difficile rates, MRSA rates. Standardising these metrics by occupancy and length of stay creates a statistical tool that highlights outlying areas whose indicators are higher than anticipated.

Any indicator triggering above established threshold is subject to detailed root cause analysis and an action plan developed where appropriate to improve patient safety and experience.

3. Study Leave

The Trust has committed to continued international nurse recruitment and grow your own programmes such as the student nurse associate, top up degree and the four year degree apprenticeship. The trust has agreed to recruit 100 International nurses, 30 student nurse associates, 10 degree apprenticeships, 10 top up degree apprenticeships in 2022. The programmes currently running which are 40 international recruits, and 51 for the other programmes in 2021.

It is recognised that our actual study leave is above the 3% headroom threshold in most inpatient wards and will continue to be so next year to support these initiatives which will push wards and departments over their budgeted headroom allowance. It is proposed that a central pool is set up to fund the backfill of staff for this additional training commitment. Proposals for this will be included in the budget setting for the next financial year.

Work is currently ongoing looking at streamlining study leave processes reducing time out of clinical practice, undertaking a full Training Needs Analysis for each department. This has been an ongoing challenge due to increasing level of staff turnover, new starters, and experienced staff leaving and as such, the study leave proposal will be included in the annual planning cycle and budget setting in January 2022.

4. Band 6 senior roles

Out of hours, during weekends and nights there is a reduced skill mix and support to staff and patients across the Trust. There is a large body of evidence related to patient safety and that patients are at higher risk of harm during these times.

As part of the hospital at night work, it is proposed that there is a review of the current structure and resources. Part of this review includes ensuring a band 6 on every ward 24/7 and three supernumerary band 6 divisional bleep holders 24/7 to support the patients; the bleep holders would be split with one in planned care and two in unplanned care to support safe staffing, site safety, patient flow and support emergencies. These shifts will be staffed by current ward band 6s and will participate in a bleep holder rota. All inpatient wards will participate in this rota. The bleep holders for the shift will be responsible for ensuring that each area is safely staffed, monitoring quality and safety, support with patient flow and support with any issues or emergencies. They will report into the head of nursing for the day or site matron out of hours and ensure the site is safe. The cost of backfilling to release the band 6s is as follows:

Winter cost (21-22) - until March 2022

Additional supernumerary (bleep holders) 24/7*

Staff Group	WTE	(£)
Band 6 Nurses	15.37	215,400
TOTAL	**15.37**	**215,400**

** including headroom of 22%*

The additional band 6 cover would be supported using winter initiative funding until end of March 2022, but will need to be included as part of 2022/23 budgeted establishments to support ongoing patient safety.

5. Ward Managers supervisory time

In 2012, the Department of Health published Compassion in Practice, which included six areas for action. Action area four outlined the need for ward managers and leaders to be supervisory, and not included in ward staff numbers to support lessons learned from the Francis inquiry and give them time to lead.

The RCN (2011) suggests that high-quality leadership and supervision are vital for improving care, and that including ward managers in staffing numbers is a false economy. The guidance identifies several benefits to supervisory status, including being visible and accessible, working alongside teams in different ways, monitoring quality of care so that it is safe, effective and person centred, providing regular feedback, and creating a culture of learning and development.

It also suggests that by making ward managers totally supervisory the results would see a transformation of care and services, achievement of goals and action plans and a reduction in the number of safety incidents. This was echoed in the Francis report (2013) which concluded that a decline in standards had been associated with staff behaviour, inadequate staffing levels and skills, and a lack of effective leadership and support.

Currently the ward managers have three supervisory shifts per week but are continually moved into the clinical numbers due to staff shortages and sickness. It is therefore proposed that ward managers are supervisory five days per week to ensure strong leadership, support for staff training and well-being and quality and safety within the wards. To make ward managers totally supervisory they would be back filled by a band five, at a cost of £567,168. As such, the report recommends this being included in the budget setting for the next financial year and considered in the round as part of the trust wide quality initiatives that require further investment.

6. Ward and non ward based areas

6.1 Inpatient wards

Proposed changes to the inpatient establishments are as set out below. Details are included in Appendix 2.

Establishment Review - Wards and Depts *(see breakdown by cost centre)*
Annual cost (22-23)

Division	Specialty	Budget WTE	Proposed WTE	Diff WTE	Diff (£)	Description of change
Cancer	**MV Wards**	33.26	33.27	0.01	**1,191**	MV Ward 10
Unplanned	**Wards**	534.25	554.10	19.85	**634,299**	*Additional CSW 24/7 across Elderly wards, 11A & 10B*
Planned	**Wards (P)**	197.99	201.42	3.43	**101,063**	Swift ward - uplift of CSW 24/7
Planned	**ITU**	108.23	110.08	1.85	**68,681**	Based on 18 beds (9 level 3 and 9 level 2).
TOTAL		**873.73**	**898.86**	**25.13**	**805,235**	

6.2 Emergency Department (ED)

The ED is currently undergoing major estates work and transformation and is currently run via two pathways, red and yellow. The department is currently split into disparate areas with consistently high volumes of patients in each. These areas need to be staffed adequately and staff cannot be flexed across areas due to the distance between them.

The department undertook the new ED SNCT data collection over a 12 day period in October. It is advised that SNCT data collection should be done on three separate occasions before any changes to staffing are agreed and professional judgement should be applied. The follow up two periods of data collection are being completed within the next few months and will be considered in the next establishment review.

6.3 Endoscopy

Endoscopy services were included in the annual acuity review as these services have not been reviewed previously. Due to increased demand for services and to ensure safe staffing to meet patient need, it is proposed that staffing is uplifted to increase cover from four days to five days for Endoscopy services at the QEII.

The proposed shift plan includes the introduction of a clinical practice team. The creation of a clinical practice team is the first step to developing a centralised team. The aim of this would be to co-ordinate and support the team training for the department in line with JAG requirements as well as taking a lead on supporting the governance agenda, staff well-being and the streamlining of the training process. The aspiration is to reduce the length of endoscopy training without compromising quality or safety. It's also an opportunity to provide career progression and staff retention.

6.4 Cancer services

A full review of cancer services and staffing is required in line with activity review and as such will be included in the establishment budget setting for 2022/23.

Currently, for the Lister Macmillan Cancer Centre, the unit is currently spending £15,000 a month on agency staff to safely meet capacity demands so although the new shift plan would increase the budget by £149,526.75, this equates to £12,460 per month which is less than the current agency spend.

6.5 Renal

In order to bring the renal units in line with the rostering principles for all inpatient areas, including allocation of % headroom uplift, winter funding has been allocated to increase WTE temporarily and recurrent investment will be included in the budget setting process in January 2022.

6.6 Outpatients

The Outpatients department covers three sites - Lister, QE2 and Hertford County Hospital (HCH).

An establishment review has been completed and will be incorporated into the annual budget setting / planning cycle in January.

6.7 Maternity

The birth rate for maternity services has increased over the last six months compared to the same period in 2020, from 5252 to 5542 births (annualised), predicted to continue at this rate coupled with increasing acuity.

Shift plans have been reviewed for maternity services and reflect what is required to meet the current service, including recommendations within the Birth rate+ (2019) and the Ockenden requirements. Recruitment to the 9.8 wte midwives, funded through the Ockenden transformation in 2020, is underway and is reflected in the current rosters and funded establishment.

The Birth rate+ review concluded that there is a gap of 6.05 WTE clinical midwives and 7.11 WTE specialist midwives. A workforce plan is in place to recruit to the current vacancies and therefore the current gap between the funded establishment and the gap in the BR+ recommendations will be considered in the budget setting process for 2022 reflecting the ambitious recruitment trajectory in year.

The current funded establishment supports the role out of Continuity of Carer requirements (51% by end of March 2023), however the board are asked to note that further role out, including reviews following each wave of implementation, will require all vacant posts to be filled and the further uplift to the establishment as reflected in the BR+ recommendations.

The full Birth rate + report (October 2021) has been through the maternity process.

6.8 Children's Emergency Department and Assessment unit

The acute paediatric service is hosted in a temporary area whilst building work is undertaken for the new ED build. This area has a much larger footprint and uplift in staffing and increased senior nurse support was built into the shift plan to safely staff the ED and assessment areas. Requirements for staffing of the new ED footprint will be considered as part of the 2022 budget setting process.

6.9 Neonatal Unit

The reviewed shift plan for NICU includes the staffing required for the transitional care cot's and is proposed that the staffing uplift is approved to ensure staffing is skilled and safe within the unit to support this requirement.

6.10 Critical Care

The Critical care department has been reviewed using the Intensive Care society's guidelines and professional judgement based on 18 beds, 9 level 3 patients and 9 level 2 on floor 4. This takes into consideration the layout of the department which is spread out over 3 areas and mixes level 2 and 3 patients so are unable to be cohort nursed. The shift plan is based on the recommended guidelines to have two supernumerary registered nurses to manage the care of critical care patients safely. It is proposed that this shift plan is agreed.

1. Headroom

Headroom (or timeout) refers to the calculation made by the organisation to account for managing unavailability (Hurst 2003). It is the allowance within a trust's budget that covers staff absence. The headroom allowance typically comprises annual leave (at an average 15% of the total headroom, this is the largest component of staff unavailability), sickness and study leave. Parenting/maternity leave is held in a central pot and not included in the headroom calculation.

At the April 2021 review the board approved an uplift of the headroom from 21% to 22% with a plan to increase this over a phased approach to 26%. The Trust currently breaks the headroom calculation down to 17% recruitable and 5% non recruitable; this 5% is then covered with temporary staff which means that even when shift plans are fully recruited too, temporary staffing is still required to cover the 5% headroom.

To enable ward managers to manage their unavailability flexibly within allocated budget, and to meet national recommendations of headroom above 22%, it is proposed that the Trust uplifts the inpatient ward budgets headroom to 23% and fully recruit into budgeted headroom. When benchmarking with other organisations we are the only trust that doesn't fully recruit into the budgeted headroom. This will also ensure there is a plan to meet the recovery post COVID with regards to training, clinical supervision, staff wellbeing and support. It will ensure quality and safety outcomes are improved by having a higher substantive workforce, and will enable us to place our international registered nurses to support the national initiatives to continue to recruit internationally.

It is also proposed that there should be no restrictions on the approval process within Trac. It is fully recognised and evidenced the difficulty of recruiting into temporary posts (if only agreed until the end of March 2022) so the recommendation is that wards can put permanent posts on Trac and manage their staffing flexibly within the headroom. In the unlikely event that areas may become over staffed, staff can be redeployed within the division. This will reduce our reliance and spend on temporary staffing to fill these posts, provide assurance to nursing and clinical teams about safe staffing levels, and most importantly, provide safer patient care with having consistent, substantive staff in clinical areas.

The chart below shows the cost of investment required. This will be considered in the budget setting for 2022.

Increase of Headroom from 22% to 23%

Staff Group	WTE	(£)
Unregistered Nurses	3.57	108,780
Registered Nurses	8.86	420,192
TOTAL	**12.43**	**528,972**

2. Summary

This establishment review has considered and analysed the data relating to shift plans and actual staffing requirements to continue to deliver safe and effective care to our patients using evidence based tools and safer staffing guidance. A full narrative of the ward recommendations made can be seen in Appendix 2.

The total cost for the ward and department reviews is;

Establishment Review - Wards and Depts *(see breakdown by cost centre)*
Annual cost (22-23)

Division	Specialty	Budget WTE	Proposed WTE	Diff WTE	Diff (£)
Cancer	**MV Wards**	33.26	33.27	0.01	**1,191**
Unplanned	**Wards**	534.25	554.10	19.85	**634,299**
Planned	**Wards (P)**	197.99	201.42	3.43	**101,063**
Planned	**ITU**	108.23	110.08	1.85	**68,681**
TOTAL		**873.73**	**898.86**	**25.13**	**805,235**

Description of change
MV Ward 10
Additional CSW 24/7 across Elderly wards, 11A & 10B
Swift ward - uplift of CSW 24/7
Based on 18 beds (9 level 3 and 9 level 2).

Winter cost (21-22) - until March 2022

Scheme	WTE	(£)
Bleep holders - Band 6 24/7	15.37	**215,400**
ITU additional nurse in charge	4.40	**51,282**
TOTAL	**19.77**	**266,682**

Description of change
Additional supernumerary Bleep holders 24/7 - Band 6 posts
ITU - additional nurse in charge. Increase of 1 nurse in charge to 2 nurses 24/7

3. Recommendations for Board

- Support the temporary investment in the winter initiatives costing £266,682
- Approve the changes to inpatient ward establishments as reviewed and recommended by the senior nurse teams to the cost of £805, 235.
- Note the maternity recommendations following the Birth Rate+ review from October 2021

4. Next Steps

- Develop case of change to reflect the service and quality investments required ahead of budget setting 2022/23
- Continue to work collaboratively across the system to maximise domestic recruits and increase students entering training
- Continue to scope and support flexible routes into nursing
- Continue with overseas recruitment to ensure a consistent pipeline for registered nurses
- Continue to monitor key performance indicators and incidents to ensure pro-active staffing reviews are carried out in a timely fashion
- Progress work on clinical pathways and multi-professional delivery review
- Continued investment in recruitment and retention initiatives
- Implement a plan to improve our sickness rates and improve staff health and wellbeing
- To have flexibility in the rosters for staff to attend wellbeing and restorative clinical supervision sessions
- These recommendations will support the Excellence Pathway and improve patient outcomes and staff satisfaction levels
- Ensure budget setting reflects accurate, safe staffing need for 2022/23

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- NICE (2013) Safe Staffing for nursing in adult inpatient wards in acute hospitals.
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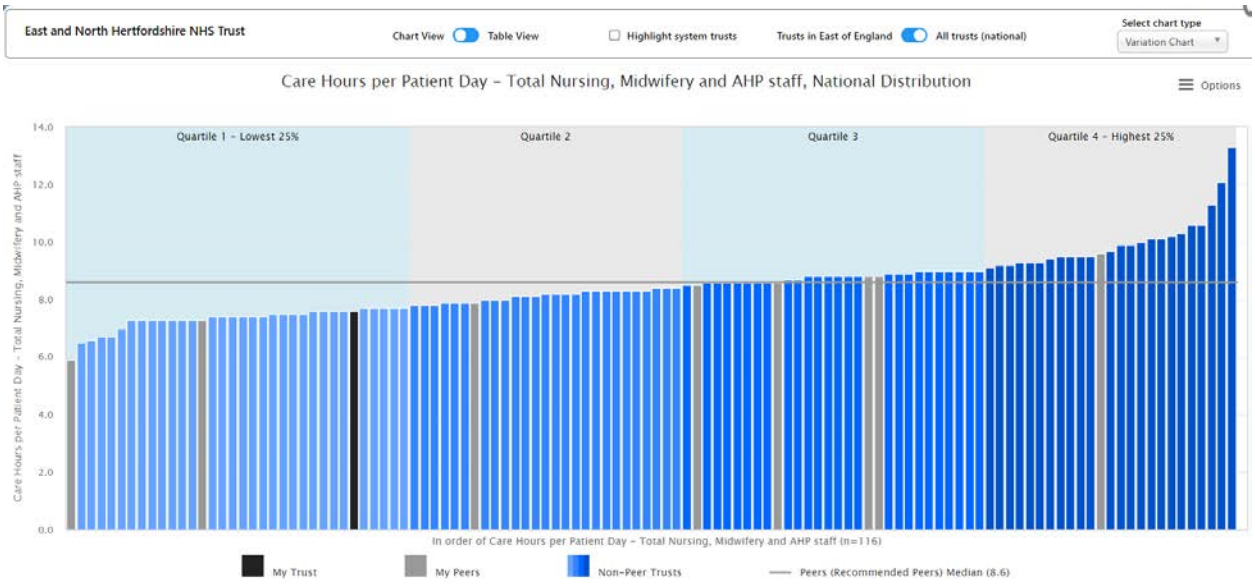
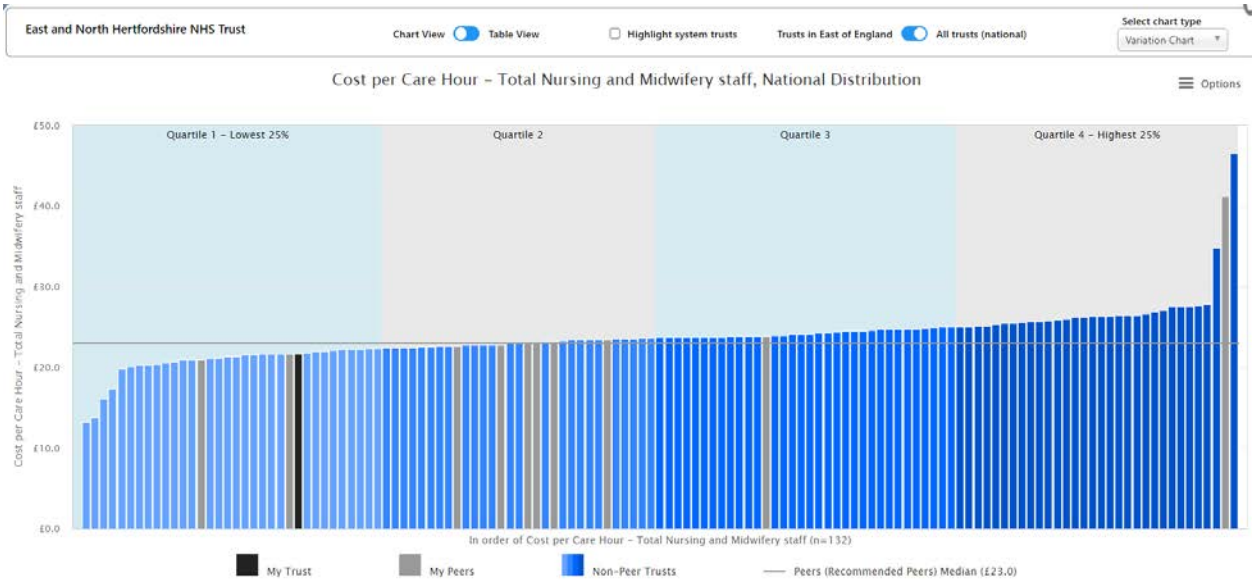
Appendix 1

Benchmarking data comparing local peers From the NHSI Model health system – latest data available August 2021





Appendix 2

Summary Change Request Table

Unplanned care

Unit	Narrative	Change Request
Division Unplanned Care		
AMU-1		
Acute Medical Ward (AMU-2)	AMU2 SNCT data collection was reveiwed and shows that they may be overstaffed based on the SNCT data. However the SNCT does not work well in a small ward area, and it does not take into account that the ward is all side rooms. The tool also doesn't take into account the requirement for donning and doffing for the high number of COVID patients AMU2 has. Therfore professional judgement should be applied. The ward has been flexed between 12-16 beds depending on speciality demand. It is therfore recommended that AMU2 is funded for the 16 side rooms, taking COVID patients so should have a shift plan of 4 RNs and 3 CSWs, these staffing levels would be able to accomodate 2 enhanced care beds if required.	Increase CSW day and night
Short Stay Unit (SSU)	SNCT data in line with acuity and dependancy on the ward. No change to current shift plan.	No Change
Same Day Emergency Care (SDEC)	No Change to current shift plan, will review prior to move to new facility	
Ambulatory Care QE2 (ACC)	No Change to current shift plan.	
10A	SNCT data shows that 10A may be over staffed, however evidence suggests the SNCT tool does not work in small wards therefore professional judgement should be used. Following robust discussions 10A will remain on their current shift plan.	No change
10B Endocrinology/Gen Med	SNCT shows 10B to have a shortfall of -6.45 WTE, this is supported by the April 2021 review which was -5.64 WTE short. 10B has a large number of complex diabetic patients and a high number of patients with confusion or mental health challenges. The quality data shows a high number of falls in 10B, all the specialling requirements cannot be met by the specialling team. It has been requested to uplift 10B with a CSW day and night 7 days a week.	Increase CSW LD and Night
11A Respiratory	SNCT shows 11A to be -5.02 WTE defecit. 11A is a busy respiartory ward that has the majority of its patients requiring xrays and scans who need a support worker to escourt them to radiology at all times of the day and night due to oxygen therapy. It is requested that 11A have an uplift of 1 CSW day and night 7 days a week to support this workload	Increase CSW LD and Night
11B RSU	11B is only funded for 6 level 2 beds, however the ward has been running to 12 beds since Spetemberand will continue to do so over the winter. They also have a high number of COVID patients so need additional support with donning and doffing. It is therfore requested that 11B is funded for their current shift plan of 3 RNs and 3 CSWs so they can recruit into these posts. Using temporary staffing to fill the gaps is not sustainable or safe.	Funding for 12 beds. Staff to 3 RNs, 1 AP and 2 CSWs
9A Elderly care	SNCT shows a defecit of -10.08 on 9A. There are ongoing challenges with acuity scoring on this ward which the matron is addressing. It is recognised that 9A has high dependancy with a large number of enhanced care patients, the quality data suggests a high number of patients with pressure damage. It is therfore recommended that 9A has an uplift of a CSW day and night to support the dependancy within the ward.	Increase CSW LD and Night
9B Elderly Care	SNCT shows a defecit of -8.22 on 9B, this is supported comparing the model hospital benchmarking data that 9B care hours are lower than our peers. 9B also has a high number of confised dependant patients and have seen a high number of skin damage incidents. It is therfore requested that 9B has an uplift of 1 CSW day and night 7 days per week to support the dependancy on this ward.	Increase CSW LD and Night
8BN (Winter Ward)	8BN is a 15 bedded medical ward opened in July for bed pressures. It is not funded untill January and is high risk due to a temporary team and high levels of tempoarry staff. There have been a high number of quality and safety incidents, more reported during the night shift. It is has been agreed to uplift the night shift by 1 CSW at night. This has been adjusted in November following reveiw to support patient safety risks.	Increase CSW Night
8A	SNCT data in line with acuity and dependancy on the ward. No change to current shift plan.	No change
6A Medical/Renal	SNCT data shows a defecit of -2.47, however there are no concerns with quality and safety and the ward manager and matron confirmed the establishment is adequate for the acuioty and dependancy of patients.	Increase band 6 cover 24/7
6B Renal		No change
Acute Cardiac Unit (ACU)	ACU covers a large footprint with a large number of side rooms. The ward layout does not get captured when using the SNCT. Therfore a profesional judgement should be made. For 22 beds across the current ward layout it is recommended ACU should have a 3rd CSW day and night to ensure the footprint of the ward is covered, to ensure patient safety. It also covers the PPCI out of hours which takes a registered nurse out of the ward to support the emergency call.	Funded to 4-2 (as per tower block bed configuration) require funding to 4-3 for new ward clock
Ashwell Frailty	Ashwell is relatively in line with the SNCT data. No change to current shift plan.	No change
Pirton Hyper Acute Stroke	Pirton is relatively in line with the SNCT data, no change to current shift plan.	No change
Barley Stroke Rehab	Barley is relatively in line with the SNCT data, no change to current shift plan.	No change
Bluebell	Ward requires band 6 Clinical Practice Facilitator to support with specialist training (Mental Health, Eating Disorders, PIMS and training shortfalls within the unit). Band 6 can also be flexed to support staffing shortfalls where required.	1 band 6 CPF
Children's ED	Chnages based on new build shift plan. Increase Band 7 coverage at Night (reduce planned Band 6)	Band 7 at Night
NICU	Uplift the budget to include the transitional 6 transitional care beds, requireing 2 RNs long day and night	Increase 2 band 5 RNs long day and night

Planned Care

Division Planned		
5A	SNCT data showed that 5A possibly were over staffed for the Acuity and dependancy at the time of data collection. However during the collection they had lower acuity which doesn't reflect the usual case load for airway and gynae patients. We will monitor for the next 6 months and reveiw activity/case load in April 2022. Staff are redeployed on the day if acuity and dependancy are low.	No Change
5B	SNCT data show that 5B may be understaffed. Due to the nature of #NOF patients dependancy is high in this ward. Quality data in this ward is good with the exception of medication incidents which they have completed an action plan and have greatly improved current practice. The ward has had a high number of OSCE nurses who have now got their Pins. 5B will remain on their current shift plan with close monitoring of SNCT scoring and reveiw in 6 months.	No Change
7A	SNCT data is in line with current acuity and dependancy, 7A is the only ward in planned care without band 6 cover day and night 7 days per week. It is recommended that 7A uplifts a band 5 post to have 7 day+ night band 6 cover to ensure senior support out of hours. This will also phase in senior skilled staff for when the Vascular hub is implemented.	Increase band 6 cover 24/7
7B	SNCT data in line with acuity and dependancy on the ward. No change to current shift plan.	No Change
Swift	Swift SNCT and CHPPD is showing they may need an uplift to their staffing plan due to the change in patient caseload. Swift now takes the trauma and orthopaedic emergency patients and have a higher number of level 1B and enhanced care patients. It is also more difficult to manage this cohort of patients due to the footprint and hihger number of side rooms on Swift ward compared to the general wards. It is therefore recommended that Swift has an uplift of a CSW at weekends and nights so their shift plan is 4 RNs and 3 CSWs 24/7	Increase CSW weekend days and all night shifts
Critical Care	Shift plan remodelled for 18 Beds on Level 4 (9 Level 3 and 9 Level 2 patients) with Critical Care staffing guidelines. Includes 2 x SNAs	Benchmarking with other trusts re: SN Nurse

Cancer

Division Cancer		
Ward 10	Ward 10 SNCT data shows they may be possibly overstaffed. However professional judgement should be applied, as they are a lone ward and cover the acute oncology phone as well this is not captured. It is therfore recommended there will be no changes to ward 10s establishment.	No Change

Methodology

The following information was also collected and reviewed; a review of all relevant literature and guidelines was undertaken prior to commencement of this review, these included:

- NICE Guidance on Safer Staffing for nursing in adult inpatient wards in acute hospitals (2012)
- Compassion in Practice, NHS England (2012)
- Safer Nursing Care Tool
- Nurse sensitive quality indicators
- Safer Staffing Guidance, Trust Development Authority (2015)
- Leading Change Adding Value (2016)
- Lord Carter Report (2016)
- Lord Willis Report (2015)

As part of this review, all calculations utilising validated tools were in line with the national guidance. Methods of data collection, calculation and evaluation as applied in the establishment review. These are set out for each information process below:

Skill Mix:

Data for this metric is collected from the approved shift plans defining each service model and actual hours worked on the roster system. It is assumed that the roster template is an accurate representation of the shift plan, that the shift plan is an accurate representation of the service model and that the hours worked on the roster are true reflection of what was worked. The calculations for this metric are:

Service model skills mix:
Total number of clinical hours available on shift plan for registered/unregistered staff
Total number of clinical hours available on shift plan

Actual skills mix:
Total number of clinical hours worked for registered/unregistered staff for the reference period
Total number of clinical hours worked for the reference period

Registered nurse to bed ratio:

The data for this metric is collected from the daily staff sheet and the shift plan, it is assumed that the number of available beds on the daily staffing return is correct and the number of registered nurses on shift on the shift plan is an accurate representation of what could be rostered to work. The calculations for this metric are:

Number of registered nurse on shift
Number of available beds for reference period

Care Hours per patient day (CHPPD)

The data for this metric is collected from the service model shift plans, the Trusts e-roster system and SafeCare. It is assumed that the service model shift plan is an accurate representation of the service, the roster is an accurate reflection of the hours worked and SafeCare has accurate patient acuity and dependency scores input for each patient. As SafeCare uses an external formula to calculate the required and actual CHPPD values, it is assumed that this formula is correct and the Shelford Acuity and Dependency model is appropriate for the service. The calculations for this metric are:

Service Model CHPPD:
Total service model care hours (clinical care hours for registered and unregistered staff)
Total beds

Required CHPPD:
Required hours of work based on standardised SNCT model
Average patients per 24 hours in reference period (Patient days)

Actual CHPPD:
Actual Hours Worked
Average patients per 24 hours in reference period (Patient days)

Safer Nursing Care Tool: Summary of SNCT Classifications

Level Descriptor

0 Patients requiring hospitalisation whose needs are met by normal ward care
1a Acutely ill patients needing intervention or who are unstable with a greater potential to deteriorate
1b Patients who are stable, but depend on nursing care to meet most or all of the activities of daily living
2 Patients who can be managed within clearly identified and designated beds and resources with the required expertise and staffing level or may require Dictated Level 2 facility/unit
3 Patients needing advanced respiratory support and/or therapeutic support of multiple organs

The Safer Nursing Care Tool helps nurses decide on safe nurse staffing for acute wards based on patients' level of sickness and dependency. Acuity data is collected over a 20 day period and the licenced spreadsheet is used to compare with best practice wards data
It also includes quality indicators linked to nursing care to help ensure staffing levels achieve best patient care. The tool must be applied correctly and consistently for data to be valid, and to allow benchmarking against agreed standards. It should be combined with nurses' professional judgement and account for local factors. Fenton et al (2015)

Professional Judgement:

All ward managers, matrons, heads of nursing, finance, Human resources and the e-roster team met with the deputy director of nursing to review all the above data and triangulate associated quality indicators, incidents and red triggered shifts. The recommended adjustments to shift plans are based on the data review and robust discussions with all present. This process added specific clinical context to the discussions and provided an evidence based approach ensuring ward managers, matrons and heads of nursing were engaged and took ownership of their clinical areas.

Table 1

The table below shows the registered and unregistered nurse % for each ward:

Div	Speciality	Ward	Service model registered nurse %	Service model unregistered nurse %	Actual registered nurse %	Actual unregistered nurse %
Unplanned	Respiratory	**11A**	54%	46%	61%	39%
		11B RSU	50%	50%	63%	37%
	Oncology	**10A**	57%	43%	63%	37%
	General	**10B**	59%	41%	56%	44%
	Renal	**6A**	58%	42%	60%	40%
	General / Renal	**6B**	67%	33%	60%	40%
	Gastro	**8A**	58%	42%	59%	41%
	Winter Ward	**8BN**	57%	43%	64%	36%
	Care of the Elderly	**9A**	57%	43%	53%	47%
		9B	57%	43%	53%	47%
	Cardiology	**ACU**	57%	43%	60%	40%
	Acute	**AMU-1**	47%	68%	48%	52%
		AMU-2	50%	50%	51%	49%
		SSU	63%	38%	61%	39%
	Frailty	**Ashwell**	52%	48%	50%	50%
	Stroke	**Barley**	52%	48%	53%	47%
		Pirton	66%	34%	66%	34%
	Paediatrics	**Bluebell**	73%	27%	73%	27%
Planned	General Surgery & Vascular	**7A**	59%	41%	60%	40%
	Urology & Colorectal	**7B**	59%	41%	58%	42%
	Plastics & ENT, Female Surgery	**5A**	59%	41%	58%	42%
	T&O & NoF	**5B**	58%	42%	59%	41%
	Elective Surgery	**Swift**	63%	37%	57%	43%
	ATCC	**Critical Care**	85%	15%	95%	5%
Cancer	Oncology	**Ward 10**	57%	43%	61%	39%

Table 2

The table below shows the available staff on shift as per the agreed shift plan and the Registered Nurse to bed ratio

Div	Speciality	Ward	Number of Beds	Available Shifts (RN + Unreg)						RN to Bed Ratio			Actual per day)
				Early Reg	Early Unreg	Late Reg	Late Unreg	Night Reg	Night Unreg	Early	Late	Night	
Unplanned	Respiratory	**11A**	**29**	4	4	4	4	4	2	1/7	1/7	1/7	1:7.46
		11B RSU	**12**	3	3	3	3	3	3	1/4	1/4	1/4	1:4.10
	Oncology	**10A**	**10**	2	2	2	2	2	1	1/5	1/5	1/5	1:4.95
	General	**10B**	**30**	5	4	4	4	4	2	1/6	1/7	1/7	1:7.56
	Renal	**6A**	**30**	5	4	4	4	4	2	1/6	1/7	1/7	1:7.77
	General / Renal	**6B**	**24**	5	3	5	3	4	1	1/5	1/5	1/6	1:5.94
	Gastro	**8A**	**29**	5	4	4	4	4	2	1/6	1/7	1/7	1:7.19
	Winter Ward	**8BN**	**15**	2	2	2	2	2	1	1/7	1/7	1/7	1:7.78
	Care of the Elderly	**9A**	**30**	4	4	4	4	4	2	1/7	1/7	1/7	1:8.25
		9B	**30**	4	4	4	4	4	2	1/7	1/7	1/7	1:7.77
	Cardiology	**ACU**	**22**	4	3	4	3	4	3	1/5	1/5	1/5	1:5.21
	Acute	**AMU-1**	**44**	8	8	8	8	8	8	1/5	1/5	1/5	1:4.06
		AMU-2	**12**	3	3	3	3	3	3	1/4	1/4	1/4	1:4.72
		SSU	**15**	3	2	3	2	2	1	1/5	1/5	1/7	1:6.53
	Frailty	**Ashwell**	**24**	4	4	4	3	3	3	1/6	1/6	1/8	1:7.42
	Stroke	**Barley**	**24**	4	4	4	3	3	3	1/6	1/6	1/8	1:7.42
		Pirton	**22**	5	2	5	2	3	2	2/9	2/9	1/7	1:5.15
	Paediatrics	**Bluebell**	**16**	4	2	4	2	4	1	1/4	1/4	1/4	1:4.12
Planned	General Surgery & Vascular	**7A**	**29**	4	4	4	3	4	2	1/7	1/7	1/7	1:7.21
	Urology & Colorectal	**7B**	**30**	5	4	4	4	4	2	1/6	1/7	1/7	1:7.04
	Plastics & ENT, Female Surgery	**5A**	**30**	5	4	5	4	4	2	1/6	1/6	1/7	1:6.69
	T&O & NoF	**5B**	**30**	5	4	4	4	4	2	1/6	1/7	1/7	1:7.32
	Elective Surgery	**Swift**	**26**	4	3	4	3	4	2	1/6	1/6	1/6	1:7.36
	ATCC	**Critical Care**	**18**	14	3	14	3	14	3	7/9	7/9	7/9	1:1.30
Cancer	Oncology	**Ward 10**	**22**	4	3	4	3	3	2	1/5	1/5	1/7	1:4.14

Care Hours per Patient Day service model, required, and actual worked

The table below shows Care Hours per Patient Day service model, required and actual worked

Div	Speciality	Ward	Service Model CHPPD	Required CHPPD SafeCare	Actual worked CHPPD
Unplanned	Respiratory	**11A**	5.45	6.35	5.26
		11B RSU	13.54	7.23	9.46
	Oncology	**10A**	7.96	5.06	7.69
	General	**10B**	5.47	7.15	5.54
	Renal	**6A**	5.50	6.17	5.16
	General / Renal	**6B**	6.43	7.30	6.60
	Gastro	**8A**	5.61	5.83	5.53
	Winter Ward	**8BN**	6.00	6.72	4.77
	Care of the Elderly	**9A**	5.28	7.30	5.41
		9B	5.26	7.09	5.74
	Cardiology	**ACU**	7.18	6.50	8.03
	Acute	**AMU-1**	8.18	8.85	12.80
		AMU-2	11.41	7.93	9.98
		SSU	6.00	6.56	5.85
	Frailty	**Ashwell**	6.37	7.91	6.38
	Stroke	**Barley**	6.29	7.48	5.92
		Pirton	6.19	7.21	6.78
	Paediatrics	**Bluebell**	7.91	10.65	7.94
Planned	General Surgery & Vascular	**7A**	5.10	5.52	5.56
	Urology & Colorectal	**7B**	5.46	5.35	5.76
	Plastics & ENT, Female Surgery	**5A**	5.74	5.86	6.14
	T&O & NoF	**5B**	5.51	7.26	5.45
	Elective Surgery	**Swift**	5.93	6.68	5.75
	ATCC	**Critical Care**	21.72	19.99	19.46
Cancer	Oncology	**Ward 10**	6.15	5.41	9.45

The table below shows the CHPPD Benchmark Recommended WTE compared to the SNCT Recommended WTE.

Div	Speciality	Ward		CHPPD Bench Marking Data			SNCT Recommended Data	
			Bed Occupancy %	Total Funded Est. based on occupancy	Total Funded Establishment	Recruitable Establishment Oct 2021	SNCT recommended WTE (22% Headroom)	Variance of Total Funded Est. based on occupancy to SNCT recommended
Unplanned	Respiratory	**11A**	95.17%	34.93	36.70	34.56	39.94	-5.02
		11B RSU	83.75%	26.98	32.21	30.81	16.64	10.33
	Oncology	**10A**	98.50%	18.58	18.86	17.75	11.19	7.38
	General	**10B**	96.67%	36.84	38.11	36.04	43.29	-6.45
	Renal	**6A**	97.50%	37.35	38.31	36.4	39.82	-2.47
	General / Renal	**6B**	97.71%	35.03	35.85	34.21	32.16	2.87
	Gastro	**8A**	91.50%	34.56	37.77	35.88	34.02	0.54
	Winter Ward	**8BN**	99.33%	18.73	18.86	17.75	22.06	-3.33
	Care of the Elderly	**9A**	99.83%	36.74	36.80	34.95	46.82	-10.08
		9B	98.67%	36.21	36.70	34.67	44.43	-8.22
	Cardiology	**ACU**	82.50%	32.79	39.75	35.32	26.50	6.29
	Acute	**AMU-1**	96.36%	93.03	96.54	92.08	53.30	39.72
		AMU-2	84.69%	27.03	31.92	30.1	19.30	7.73
		SSU	89.00%	18.09	20.33	17.98	18.48	-0.39
	Frailty	**Ashwell**	95.83%	34.07	35.55	33.58	34.79	-0.72
	Stroke	**Barley**	95.00%	33.35	35.11	33.15	34.82	-1.47
		Pirton	86.36%	27.65	32.01	30.36	29.07	-1.42
	Paediatrics	**Bluebell**	85.31%	26.45	31.00	29.01	27.62	-1.17
Planned	General Surgery & Vascular	**7A**	82.07%	29.18	35.55	33.61	29.69	-0.51
	Urology & Colorectal	**7B**	87.83%	33.39	38.02	35.95	31.80	1.60
	Plastics & ENT, Female Surgery	**5A**	87.50%	34.95	39.94	37.97	31.26	3.69
	T&O & NoF	**5B**	93.33%	35.85	38.41	36.15	45.76	-9.91
	Elective Surgery	**Swift**	92.69%	31.10	33.55	31.5	35.52	-4.42
	ATCC	**Critical Care**	82.50%	86.00	104.24	92.29		86.00
Cancer	Oncology	**Ward 10**	61.36%	19.67	32.05	30.49	17.45	2.21

Ward SNCT Acuity Audit Results

Results by league table

East and North Hertfordshire NHS Trust

Date range: Oct 2021	Ward Acuity Audit Ward League table	Level: Ward Section: All items selected Question: All items selected View: Ward

Rank	Movement	Ward	Score	Returns
1		6A	100.00	1
1		MVCC Ward 10/11	100.00	3
1		AMU1	100.00	1
1		AMU2	100.00	1
2		Swift Ward	99.02	22
3		5B	98.25	3
4		5A	97.67	2
5	-2	7B	94.70	5
6		10B	92.98	2
7		ICU1	92.31	1
8		8B	87.50	2
9		11B	86.36	2
10		6B	85.96	3
11		SSU	83.33	1
12	-11	Barley	79.31	5
13	-8	7A	78.57	1
14	-13	Pirton	76.62	4
15		8A	75.00	2
16		Acute Cardiac Unit (ACU)	72.55	3
17		9A	56.67	2

12/01/2022

Report Title	The ENH Green Plan
Report Presenter	
Report Author	**Deputy Director of Estates**
Executive Lead	**Kevin Howell**

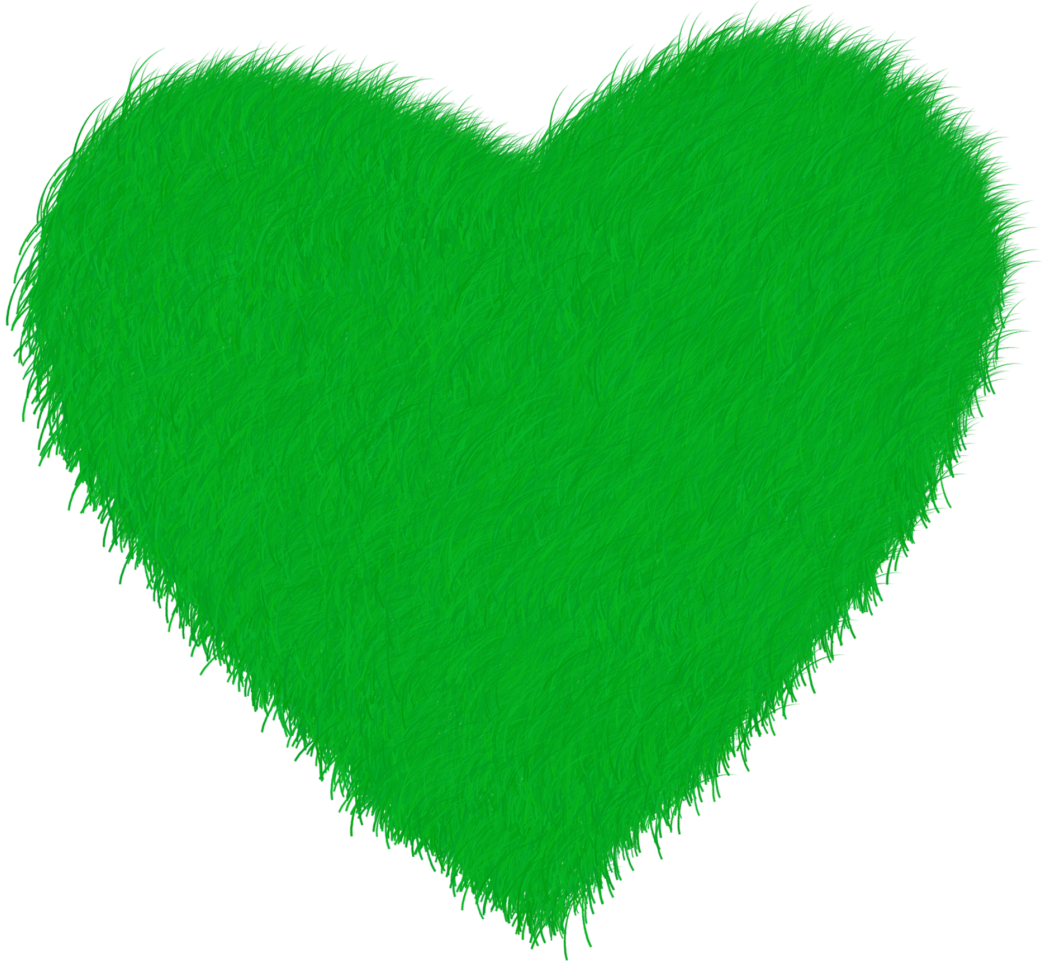
Report Summary *Please summarise the key points from the report and the recommendation that is being made*	In 2019, the UK government made a world-leading legal commitment to achieve net zero emissions by 2050. The NHS is proud to be the world's first health system to commit to reaching net zero by 2045, supporting improvements in health now and for future generations. The ENH Green Plan, a 3 year plan, covers the full spectrum of sustainability issues and sets out our goals, objectives and actions**.** The plan has been tested, and developed by the ENH Sustainability Committee, presented and approve at the Strategy Committee and previewed by the Hertfordshire and West Essex ICS.
Action Required	**For approval**
Risk Issues *Please specify any links to the BAF or Risk Register*	• Quality of care • Financial • Equality- Health inequalities

Trust Priorities *Please tick any Trust priorities to which the issue relates*		
Quality	To deliver high quality, compassionate services, consistently across all our sites	☒
People	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Previously considered by	
Committee/Board/Group: Sustainability Committee Strategy Board	Date:

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

East and North Hertfordshire
NHS Trust



East and North Hertfordshire NHS Trust

Green Plan (2021 - 2024)

Content

Foreword

Karen McConnell
Non-Executive Director, and Deputy Chair

Our patients are at the heart of all that we do. And while we must care for the patients of today, we must also plan ahead so that the NHS is able to care for the patients of tomorrow.

In May 2020, a study by the Global Carbon project identified that there had been as much as a 7% fall in CO2 emissions during the global pandemic shutdown - demonstrating how quickly we can adapt to the need for change and have a positive impact on our environment. This also resonates at a Trust level with the enthusiasm and practical ideas coming from our sustainability group, and the commitment of the Board to address, head-on, issues of sustainability at all levels across the Trust.

We need to be realistic about the challenges ahead as progress will only be made if steps are practical and integrated into our business. The process of integrating these changes into the Trust's strategy is in its early stages but there has been real commitment and engagement from our staff to make changes.

We are striving to deliver a net zero health service as defined by the government, and the national ambition "to deliver the world's first net zero health service and respond to climate change, improving health now and for future generations". We know that working closely with our staff, partners, stakeholders and patients, together we can make a difference.

Foreword

Adam Sewell-Jones
Chief Executive

Now, more than ever, we must consider the impact of our actions - on our planet and on our public health.

We have a responsibility to show how seriously we take the issue of sustainability – both as a provider of healthcare, and as a large employer in the local area – one that by necessity uses many single-use consumables, and has a large carbon footprint.

We know our staff share that responsibility – over 91% of staff surveyed consider sustainability issues as extremely or very important. With around 6,500 staff in our Trust alone, that's a lot of people power.

We must do all that we can to:

- **Raise awareness of the actions that individuals can take, which although small in isolation, collectively can make a difference**
- **Explore how we can reduce our organisation's carbon footprint – changing how we do things on a larger scale to become more sustainable.**
- **Maintain momentum so that this remains a long-term priority for the future**

I look forward to leading a greener, more sustainable Trust.

Introduction

Introduction

The climate emergency is a healthcare emergency. Rising global temperatures are already having devastating effects on global health due to more frequent extreme weather events, heatwaves, food insecurity, a rise in climate-related migration, biodiversity loss, a spread in infectious diseases and worsening air pollution. Without urgent action, the climate emergency threatens to undermine all the progress made in public health over the last 50 years.

An estimated 4-5% of England's carbon footprint is produced by its health and care system. This provides a huge opportunity for the NHS to decarbonise and reduce its impact. Radical changes are needed in all sectors of society to reduce our environmental impact, and healthcare services are no exception.

The Greener NHS has defined two net zero targets:

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

This Green Plan has been approved by our board and is a live strategy document outlining our aims, objectives, and delivery plans for sustainable development. There is a requirement for green plans under the NHS Operational Planning and Guidance and Standard Contract and they are a key tool in making demonstrable progress towards net zero carbon targets. All Trusts will need to produce a Green Plan by January 2022, following the Greener NHS guidance. Green plans also support sustainability requirements under the Social Value Act and Local authority contracts.

Our objectives set out the Trust carbon emission reduction targets and resource use reduction targets in line with the Greener NHS 'Net Zero NHS' national ambitions and the UK Climate Change Act (2008). They cover the NHS Long Term Plan commitments related to health and the environment, including efforts to tackle climate change, reduce single-use plastics, improve air quality, and minimise waste and water use.

We want sustainability to be embedded across all of our trust enabling strategies and operations so that we can effectively deliver on these commitments.

This plan will guide our organisation, staff, suppliers, patients and communities to take action on sustainability, working together helping to make a difference to reduce our impacts and improve health and social care outcomes.

Introduction

‘What is sustainability’

Sustainability, at its heart, is the idea of ensuring a better quality of life for everyone, now and for generations to come. There are three pillars to sustainability: environmental, social and economic.

Our sustainable vision

East and North Hertfordshire’s NHS Trust vision is to deliver high-quality, compassionate care to our community. Our strategic priorities are quality, people, pathways, ease of use, and sustainability.

Environmental sustainability is recognised by the Royal College of Physicians as a key domain of quality care. We will embed sustainability across all aspects of trust operations, contributing to the UN sustainable development goals and achieving Net Zero NHS carbon emissions targets.

We share NHS England’s objective of sustainable development:

“We recognise that Sustainable Development is a critical factor in our organisation being able to deliver world class healthcare, both now and in the future. We are therefore dedicated to ensuring we create and embed sustainable models of care throughout our operations and to ensuring our operations, and our estate(s), are as efficient, sustainable and resilient as they possibly can be”

Our Green Plan goals

Our Green Plan is anchored around 4 key goals that reflect the ambition and need for action within our Trust. These goals were developed and approved by our Trust’s Sustainability Working Group. Our full action plan covers 10 areas of focus in support of these overarching goals.

Trust Green Plan Goals	
1. Increase sustainability awareness	Increasing numbers of staff to demonstrate awareness of sustainability in healthcare, including carbon reduction and climate change adaptation, as appropriate to their role
2. Support our community	Actively engage all our communities, focusing on areas which reduce health and social inequalities through sustainable actions and behaviours
3. Improve resource efficiency	Zero waste to landfill by 2025 and reducing our consumption of energy and water year on year
4. Reduce carbon emissions	Net zero by 2040 for the emissions we control directly, with the ambition to reach 80% reduction by 2028-2032

Further details of what specific actions and initiatives we will prioritise over the next three years to deliver a net zero NHS are captured in pages of this report.

About the Trust

About the Trust

At East and North Hertfordshire Trust we provide acute and tertiary care services. We manage four hospitals – Hertford County (Hertford), the Lister (Stevenage), Mount Vernon Cancer Centre (Northwood) and the New QEII (Welwyn Garden City) we have around 6,000 members of staff. The Trust was created in April 2000, following the merger of two former NHS trusts serving the east and north Hertfordshire areas.

Since 2014, the Lister has been the Trust's main hospital for specialist inpatient and emergency care. The New QEII hospital, commissioned by the East and North Hertfordshire Clinical Commissioning Group, opened in June 2015 and provides outpatient, diagnostic and antenatal services, along with a 24/7 urgent care centre. Hertford County provides outpatient and diagnostic services and the Mount Vernon Cancer Centre (MVCC) provides tertiary radiotherapy and local chemotherapy services.

Acute hospital care by the Trust covers an area of over 600,000 people, covering south, east and north Hertfordshire, as well as parts of Bedfordshire. The Mount Vernon Cancer Centre (MVCC) provides specialist cancer services to approximately three million people from across Hertfordshire, Bedfordshire, north - west London and parts of the Thames Valley.

Clockwise from top left: Lister Hospital, Hertford County Hospital, Mount Vernon Cancer Centre and New QEII Hospital

Our local area

We will ensure that we work together with local authorities in our area towards our common goals for sustainable development.

Sustainable Hertfordshire Strategy (2020)

The ambitions for enabling and inspiring a sustainable county are:

- A net-zero greenhouse gas county before 2050
- Communities are ready for future climates
- Improved wildlife and water by 20% by 2050
- Clean air for all by 2030
- Increase resource efficiency threefold in the county by 2050

“As the County of Opportunity, we want Hertfordshire to be a county where people live healthy, fulfilling lives in thriving, prosperous communities. We will be a role model for environmental leadership in our own operations, showing how a large organisation can both take action and be a catalyst for others to act.

We will enable and inspire environmental action across the county; from delivering net zero carbon to making sure that we are prepared for extreme weather. From improving wildlife to using material more wisely, the environmental actions we take will provide real opportunities for Hertfordshire and deliver the goals of our Corporate Plan; to create ‘a cleaner, greener and more environmentally sustainable county.”

Stevenage Borough Council

Stevenage Borough Council declared a climate emergency in June 2019. The council have stated their vision is to focus on cutting their emissions to net zero and supporting their businesses and residents to do the same by 2030.

Stevenage have highlighted the following priority areas for action: better cycling facilities, more carbon education, better recycling facilities, cheaper public transport, carbon neutral new builds, green energy, greater consideration for green spaces, energy efficient housing, reduced energy usage.

Upgrading the insulation of 2,088 homes per year within the Stevenage area will ensure all homes are properly insulated by 2030, lifting as many people as possible out of fuel poverty. A switch from gas central heating, will be needed to eco-heating or electric (renewably sourced). There are only 15 government funded eco-heating systems in the Stevenage area, yet the UK needs to fit around 1 million per year. Stevenage needs to be fitting 1,387 eco-heating systems every year.

Currently the Stevenage area has 3MW of renewable power. If the Stevenage area matched the best of similar Local Authority areas, it would have 22MW. Their goals are to promote cross county purchase of renewable energy supply and identify the opportunity for local renewable energy generation.

The Stevenage Borough Council Climate Change Strategy is a live document that will be updated as actions are progressed. Following Hertfordshire County Council, they will be looking to approach the climate emergency through three specific themes: Enable, Lead, and Inspire.

Our local area

Welwyn Hatfield Borough Council

Welwyn Hatfield Borough Council are the local authority area for the New QEII hospital. Welwyn Hatfield Council declared a climate emergency in 2019 and set five key targets:

1. To reduce carbon emissions from our own estate and operations to net zero by 2030, or a justification for a later date if the review finds this unachievable
2. To comply with statutory obligations to mitigate and adapt to climate change
3. To work with, support, encourage and engage residents, communities, businesses and other partners in initiatives to reduce carbon emissions
4. To embed climate change mitigation and adaptation into our plans, strategies and policies
5. To reduce carbon emissions across the borough by promoting energy efficiency measures, sustainable construction, renewable energy, sustainable transport and behavioural change

London Borough of Hillingdon

The London Borough of Hillingdon, where the Mount Vernon Cancer Centre is located, declared a climate emergency on 16 January 2020. In alignment with other local authorities, they plan to become carbon neutral by 2030 and have produced a strategic climate action plan. They plan to achieve clean energy via the use of wind turbines, solar energy and energy supplied by the local and national grid. They aim to reduce the use of fossil fuels where possible and keep carbon offsetting to a minimum.

Our local area

Sustainability at East and North Herts NHS Trust

The East and North Hertfordshire NHS Trust's 2015 – 2020 sustainability strategy recognised steps we need to take to improve the environmental and social sustainability of our operations. Our strategy focussed on carbon reduction, community resilience and social and health sustainability. We have reviewed our performance against our previous strategy, adopted lessons learnt and developed it into this new Green Plan for 2021 – 2024.

We have also reinvigorated our trust wide approach to sustainability and a new sustainability group, with over 25 representatives from across the trust, is working together to identify opportunities to improve our environmental and social sustainability performance. The group also aims to raise awareness on sustainable healthcare and support our communities in more sustainable behaviours. This group is led by the Estates and Facilities Directorate and reports into the Trust Strategy Committee.

Plans are in place for sub-groups to work on sustainability in specific areas of the trust. One of these is within our digital team, recognising the huge benefits of technologies to support more sustainable service delivery. Another is within pharmacy, whereby medicines, packaging waste and anaesthetic gasses are priority areas. We also have an active group of environmental sustainability volunteers at the Mount Vernon Cancer Centre (MVCC) to assist MVCC and allied organisations in ensuring optimum environmental stewardship and sustainable best possible practices.

Specifically for our Trust, feedback from engagement with staff has shown that raising awareness and supporting our staff and communities to be sustainable is a key opportunity area. Our first two goals are to improve awareness, and engage with our staff, patients, suppliers and communities on sustainability initiatives. To support this, we will provide robust sustainability reporting centred around our Green Plan targets.

We ran a Staff Sustainability Survey in 2021 to understand awareness and priorities in relation to sustainability for our staff.

- 91% of respondents personally consider sustainability and environmental issues to be extremely or very important.
- 78% of staff respondents consider it extremely important that the trust acts on sustainability and environmental issues.
- Over 64% of respondents said that they are only somewhat aware or not at all aware of what can be done in the workplace to be more sustainable and reduce environmental impact

The results demonstrated that we must focus on raising awareness and supporting our staff to take practical action on an issue they consider extremely important.

Drivers for Change

Drivers for change

In April 2021, the UK government announced it will set the world's most ambitious climate change target into law to reduce emissions by 78% by 2035 compared to 1990 levels. This commitment and carbon budget will ensure the UK remains consistent with the Paris Agreement temperature goal to limit global warming to well below 2°C and pursue efforts towards 1.5°C.

In order for the UK to meet these targets, all industry areas and organisations will need to take action. The health and care system in England is responsible for an estimated 4-5% of the country's carbon footprint. England's National Health Service (NHS) has become the first health system in the world to make a commitment to achieving net zero-emissions.

Sustainable healthcare in the NHS is driven through local and national policy, legislative and mandated requirements and healthcare specifications from the Department of Health and NHS England. The NHS Long Term Plan includes several commitments related to health and the environment, including efforts to tackle climate change, reduce single-use plastics, improve air quality, and minimise waste and water use. We want sustainability to be embedded across all of our trust enabling strategies and operations so that we can effectively deliver on these commitments.

"While the NHS is already a world leader in sustainability, as the biggest employer in this country and comprising nearly a tenth of the UK economy, we're both part of the problem and part of the solution. Indeed if health services across the world were their own country, they'd be the fifth-largest emitter on the planet. That's why we are mobilising our 1.3 million staff to take action for a greener NHS, and it's why we have worked with the world's leading experts to help set a practical, evidence-based and ambitious route map and date for the NHS to reach net zero."

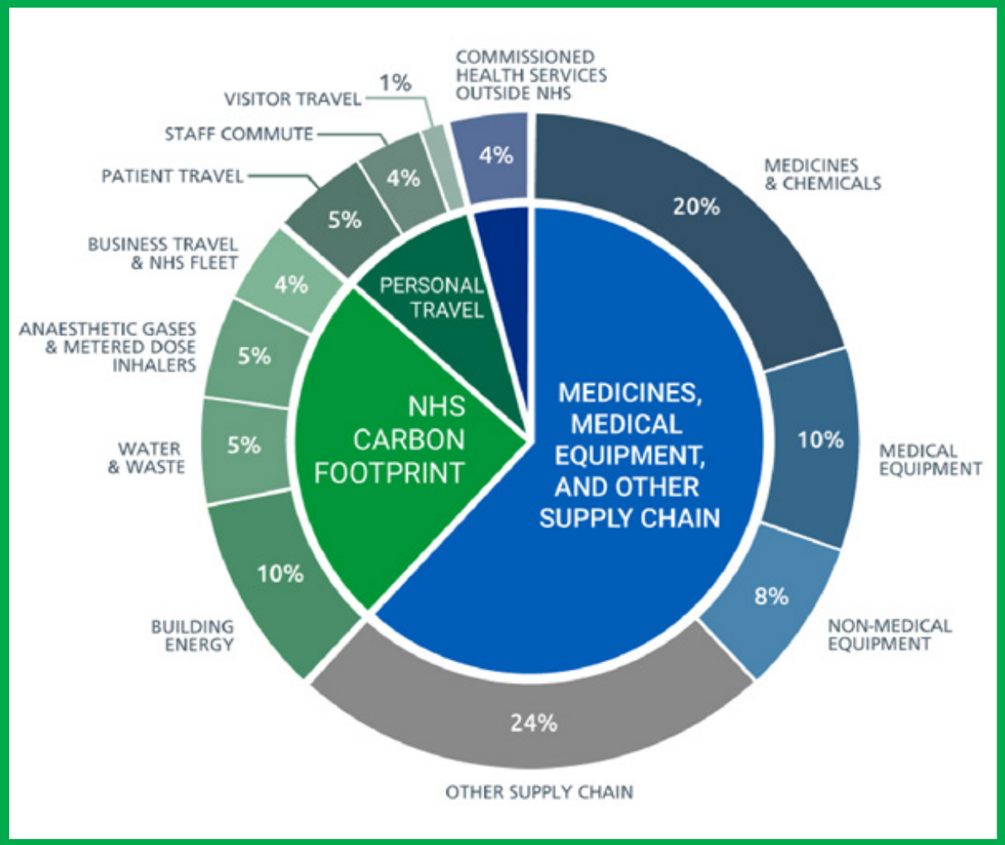
Sir Simon Stevens, former Chief Executive, NHS England

We are in a climate and biodiversity crisis. The risks presented by this crisis have both direct and indirect impacts on the ability of the Trust to provide effective healthcare. These include the direct health impacts of more extreme temperatures and increased disease transmission and the indirect effects of biodiversity loss and ecological damage on society, the economy and our ability to treat illness.

Drivers for change

Medicines account for 25% of emissions within the NHS. A small number of medicines account for a large portion of the emissions, and there is already a significant focus on two such groups – anaesthetic gases (2% of emissions) and inhalers (3% of emissions) – where emissions occur at the 'point of use'. Delivering a Net Zero National Health Service, 2020

The NHS Delivering a 'Net Zero' National Health Service report evaluated the sources of carbon emissions by proportion of NHS Carbon Footprint. Figure 2 demonstrates that the greatest areas of opportunity, and also challenge, to change are in the supply chain, estates and facilities, pharmaceuticals and medical devices, and travel. Our Green Plan will address these areas and identify the actions required to minimise our impact.



Sources of carbon emissions by proportion of NHS Carbon Footprint Plus

Drivers for change

United Nations Sustainable Development Goals

United Nations member states adopted the 17 Sustainable Development Goals (SDGs) in 2015. These goals are a call to action for members, in addressing the needs of people in both developed and developing countries and are a blueprint in sustainable development for all. The Trust is starting to contribute to these 17 goals, shown in Figure 3, at a local level and this Green Plan has been developed to enhance our contributions over the coming years.

United Nations Sustainable Development Goals

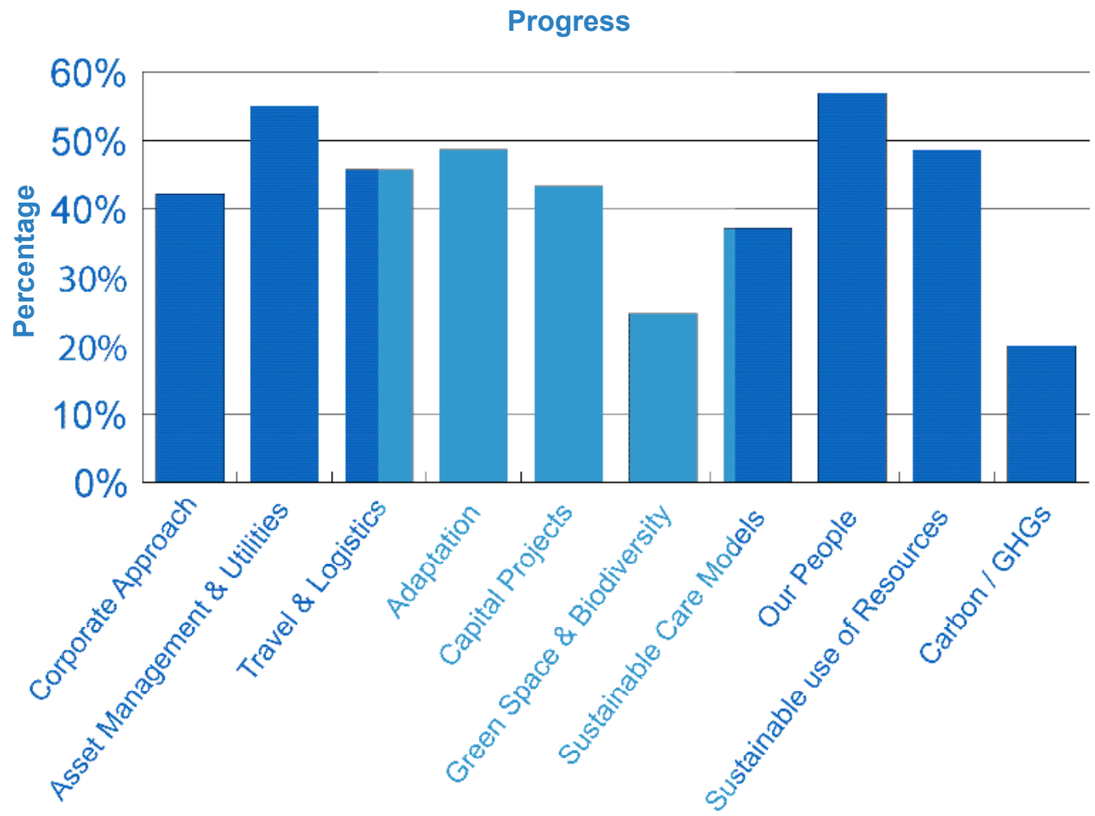
Measuring Progress

Measuring progress

Progress against our green plan goals will be monitored through specific objectives under 10 areas of focus. Each area of focus has key performance indicators aligning with trust reporting requirements.

The sustainable development assessment tool (SDAT) has been decommissioned and will be replaced with an updated tool. To inform this Green Plan, we reviewed the most recent estimated SDAT score for the trust, which was 41% in 2018, see Figure 4 below. This trended slightly below other comparable acute trusts and highlighted specific areas to work on including:

- greenhouse gas emissions
- sustainable care models
- green space and biodiversity
- travel



East and North Hertfordshire NHS Trust SDAT Score 2018

Areas of focus

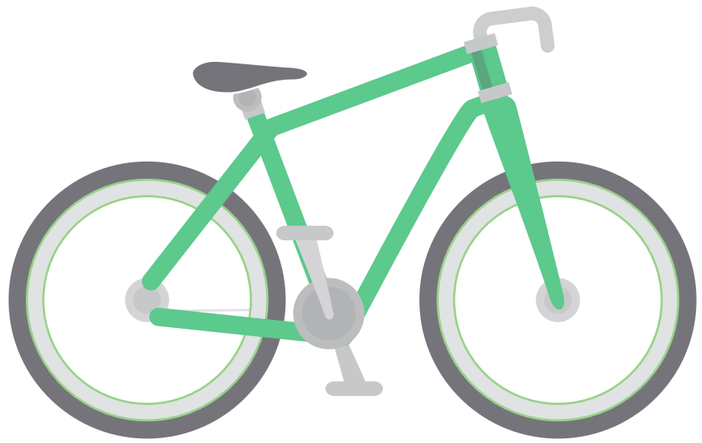
Areas of focus

Our Trust has identified 10 key areas of focus in line with the SDAT themes. Each area has an overarching aim, details the work the Trust have carried out to date, lists **what we will do** in the next three years and how we will measure our performance against these objectives.

The areas of focus are:

- **Corporate approach**
- **Our people**
- **Sustainable care models**
- **Travel and logistics**
- **Asset management and utilities**
- **Sustainable use of resources**
- **Capital projects**
- **Climate change adaptation**
- **Greenspace and biodiversity**
- **Carbon and greenhouse gases**

The actions across these areas address the social, environmental and economic aspects of sustainability. Our specific actions to reduce our emissions are detailed in the carbon and greenhouse gases section and pulled out in the ‘Delivering a Net Zero NHS’ section of this Green Plan. As a trust we are prioritising interventions which simultaneously improve patient care and community wellbeing while tackling climate change and broader sustainability issues.



Corporate approach

Sustainability must be embedded into all aspects of our work. We will benchmark ourselves against other healthcare providers and review our progress against targets set.

Aim: Embed sustainability throughout the entirety of our organisation, so all staff, patients and the community are engaged

What we have done already

- We created a three-year Green Plan for 2021 to 2024 which forms our guiding principles
- We have engaged with our staff through a sustainability survey, to identify levels of awareness and priority areas
- We will continue to engage with the local community and patients to develop schemes which prioritise the needs of the community and generate maximum social value

Lister Hospital

Corporate approach

What we will do

- Enable staff, patients, our local community and our strategic partners to provide regular **feedback and suggestions to improve sustainability** performance and prioritise the needs of the community
- **Deliver, monitor and report on our green plan** performance supported by a nominated board level sustainability lead and our trust Sustainability Group
- Identify and provide training to staff on improved processes to fully embed sustainability
- Build environmental, social and economic sustainability into all our strategies and plans and make investment decisions that support sustainability
- Have a named, visible and **accountable senior leader** with responsibility for all aspects of sustainable procurement and social value
- Name a board level lead for Net Zero and work with the regional Greener NHS team and Hertfordshire and West Essex **ICS**
- Invite and **reward innovative solutions** from suppliers that achieve both our financial and sustainability goals

Measuring progress

- 100% of business cases over £100,000 in value to have a Sustainability Impact Assessment
- 33% of all spend will be with Small Medium Enterprises (SMEs)
- Annual improvements on annual staff sustainability awareness survey score
- Up to date board approved Green Plan

Our people

To successfully achieve our targets and reduce our environmental impact, engagement and participation from all our people is vital. Education and training are a priority to enable staff to reduce their emissions, carbon footprint and waste at home as well as at the Trust.

Aim: Support staff to improve sustainability at work and home and empower them to make sustainable choices in their everyday lives.

This directly supports our first Green Plan goal to increase sustainability awareness. We will use evidence based scientific research and publications on key topics related to public health issues to promote sustainable solutions and address key health inequalities.

What we have done already

- Established a trust Sustainability Group who meet monthly to deliver against this Green Plan
- We have an active volunteer environmental sustainability group at the Mount Vernon Cancer Centre (MVCC) to assist MVCC and allied organisations in ensuring optimum environmental stewardship and sustainable best possible practices
- Published this 3 year Green Plan demonstrating what we will do, and how our staff, and communities can take action too.
- Our staff are fully supported by the Health at Work service, policies, initiatives and health and wellbeing advice
- The staff engagement survey score in 2020 was 69%. The monthly staff pulse survey demonstrates an improving picture through 2021
- Volunteering hours reached over 60,000 and 87 work experience placements in 2019/20
- Working with local job centres to help long-term unemployed people into work

Our people

What we will do

- Identify a people lead for sustainability. Include sustainability in job descriptions, new joiner information and performance reviews
- Provide a variety of staff development and training opportunities that support our Green Plan and drive behaviour change
- Develop a network of ‘green ambassadors’ across the trust, enabling staff to get involved and make a difference
- Publish trust progress against the Green Plan, celebrate staff initiatives and share knowledge in our trust communications
- Follow our action plan for staff health and wellbeing and support healthy choices in all parts of the workplace and offsite

Measuring progress

- % of staff completing sustainability essentials e-learning.
- 1 x monthly comms piece on our Green Plan initiatives
- Staff sickness target rate of 3.80%, Staff turnover target of 12%, Annual & pulse staff survey wellbeing score target of 70%
- Annual sustainability awareness staff survey

Our staff

Sustainable care models

Our Trust is fully committed to embedding and delivering sustainable models of care, creating better and more efficient experiences for our patients.

Aim: Take a whole systems approach to deliver the best quality of care whilst being mindful of the social, environmental and economic impacts

What we have done already

- We consider and quantify direct financial and economic impact and co-benefits when emerging sustainable care models are developed
- Resilience and flexibility are incorporated into our emerging care models. Capacity and demand planning with data from national modelling informs service development. In 2020 we used a pathway analysis tool to discover pinch points in the cancer pathway, since then we have had sustainable performance with achievement of cancer targets for the past 11 months despite the pandemic
- Replaced and upgraded 1500 laptops with energy efficient alternatives and have delivered 775 video meetings and 232,750 instant messages throughout the pandemic
- 250 new virtual desktops have been set up to support virtual clinics and one million patient observations recorded digitally
- Electronic prescribing has removed the need for a 32 page paper drug chart per inpatient
- Reduced the number of letters sent to patients and GPs and issuing text appointment reminders in some departments reducing Did Not Attend (DNA)

Sustainable care models

What we will do

- Incorporate existing and new digital technologies and processes to improve the efficiency and quality of care for our patients
- Encourage move to digital and paper-less provision and management of services
- Review use of digital solutions in support of estate and facilities management for real time monitoring.
- Work with supporting partners to increase the amount of services and treatment that can be offered closer to home, reducing the number of hospital visits
- We will provide training regarding sustainable care models, which will help to embed new processes effectively and improve the delivery of care
- Promote sustainable health and social care to our board and establish board level clinical care lead for developing sustainable care models
- Resilience, flexibility and sustainable use of resources will be incorporated into our emerging care models

Measuring progress

- Where outpatient appointments are clinically necessary, at least 25% of outpatient activity should be delivered remotely
- Adoption and usage of remote and flexible working services – number of VDI/VPN access deployed
- Increase in patient feedback scores
- Increase in staff feedback scores
- Reduction on month of previous year of patient DNA rates
- Reduction in printing (from moves to digital prescribing and online appointment service)

Travel and logistics

Approximately 3.5% (9.5 billion miles) of all road travel in England relates to patients, visitors, staff and suppliers to the NHS, contributing around 14% of the system's total emissions. Providing and promoting sustainable transport options will reduce emissions and improve air quality in our local area. This includes staff commuting and business travel, logistics and patient travel.

Aim: Minimise the environmental and health impacts associated with our supply chain and to encourage sustainable and active travel wherever possible

What we have done already

- Installation of 30 electric vehicle charging points at the Lister Hospital site
- Car parking policy review
- Digital enabled 1,500 home workers, reducing the need to commute to the hospital this year
- Introduction of video calling and instant messaging to reduce the need for face-to-face contact (775 video meetings. 232,750 instant messages)
- A travel and transport review to provide recommendations for the trust travel plan and processes in 2021. We are reviewing patient transport and non-clinical opportunities for example further implementation of electric/hybrid vehicles, reduce route planning and review runs, and support to outpatients and pharmacy with delivery of medicines
- Car sharing activity has declined, particularly during 2020/21 due to COVID-19. There are allocated car share parking spaces at the Lister hospital site and we have previously used a car sharing platform, though this has not been active in the last few years

Travel and logistics

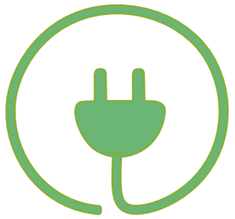
During 2020-2021 the NHS delivered over 22 million virtual outpatient appointments providing high-quality care, as well as a carbon saving of over 111kt CO2e (the equivalent of over 888,000 flights between London and Paris).

What we will do

- Publish and resource a **new travel** plan to help, staff, patients, visitors and the local community reduce transport emissions
- Review **active travel infrastructure** across all sites and develop plans to improve it
- Ensure **all new Trust vehicles are low carbon** (ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs)) and reduce the environmental impact of our fleet
- Adopt and follow the **Clear Air Hospital Framework**
- Ensure staff have access to, and encourage use of facilities (e.g. VDI/VPN and teams' access) **supporting flexible working** and video/teleconferencing to reduce business miles
- Encourage and monitor the use of electric charging points available to staff and visitors, increase relative to demand
- Deliver a programme of sustainable and active travel events across all main sites and clearly communicate any changes to local transport services. Work with local council to support the Car Free Zones
- Work with supply chain to reduce transport and delivery emissions

Measuring progress

- Carbon emissions from travel – year-on-year reduction
- Clean Air Hospital Framework score
- Annual staff travel survey
- Number of staff using Trust's cycle-scheme, car sharing, and discounted bus fares
- Number of communications /events promoting sustainable travel
- % key contracts with transport sustainability criteria and clauses - consolidated deliveries, emissions reduction, local suppliers
- Adoption and use of remote and flexible working services
- 20% of vehicle fleet to be electric/hybrid by 2025



Asset management and utilities

The continual management of our assets and utilities is fundamental in reducing our carbon footprint and environmental impacts.

Aim: Continual improvement in our energy and water efficiency, delivering year-on-year reductions in consumption

What we have done already

- Energy saving initiatives including the replacement of fluorescent lights with LEDs in some areas
- Combined heat and power plant operating reducing grid energy consumption
- An energy cost review is currently being undertaken to determine implications and support decision making on renewable energy procurement
- Offer energy efficiency advice and warm homes support for vulnerable respiratory patients via Herts Help and Hertfordshire Warmer Homes
- Catering and medical equipment upgrades and replacements with energy efficient alternatives

Asset management and utilities

What we will do

- **Accurately measure, monitor and reduce** our utilities consumption
- Deliver a programme of **energy and water saving initiatives** across our existing estate
- **Improve staff awareness** and provide training on user controls and sustainable behaviour
- Offer **energy efficiency advice and warm homes support** to patients, users, carers and the local community to improve their health and wellbeing
- Specify **100% renewable energy**, with REGO certification, when we enter all new supplier agreements for electricity
- Assess **lifecycle costs of energy and water** as part of procurement process when purchasing new equipment, and request Life Cycle Assessment information from suppliers

Measuring progress

- Reduction in electricity consumption compared to same month of previous year (kWh/m²)
- Reduction in water consumption compared to same month of previous year (m³/m²)
- Reduction gas consumption compared to same month of previous year (kWh/m²)
- % of energy procured with REGO renewable certification

Sustainable use of resources

We are committed to working with our suppliers and contractors to reduce our environmental impact of the goods and services we use. Our procurement processes will ensure our suppliers are providing products that meet our goals.

Aim: Reduce our resource consumption and waste volumes produced year on year through improving our processes, raising awareness and changing procurement specifications

What we have done already

- Direct ward ordering in pharmacy to improve efficiency and reduce the time taken to process stock, reducing waste
- Reduced disposables in catering through removing plastic straws and introducing recyclable containers and Vegware products.
- Reduced food miles for produce used in meal preparation. Chilled and ambient foods are now delivered in the same transport journey.
- Recently awarded facilities contracts include new sustainability clauses for our suppliers to reduce and manage their environmental impact of their operations. This includes ISO accreditations, reducing travel emissions, energy and water consumption and minimising hazardous chemicals.
- Domestic waste contract continues to operate on a zero waste to landfill basis, whereby domestic (black bag waste) is treated as refuse derived fuel
- Recycle fluorescent tubes, lamps, batteries, food and waste electrical and electronic equipment (WEEE waste.)
- Waste - Waste disposal and recycling has been challenging during the 2020/2021 year as a result of the Covid pandemic. Clinical waste has increased by 8.72% against 2019/2020 data. This is believed to be as a result of the additional PPE required by staff in treating patients with Covid . Domestic waste disposed of has increased by 11.03% against 2019/2020, with recycling having reduced by 27.93% against 2019/2020

Sustainable use of resources

What we will do

- Improve **recycling and reuse of materials** following the waste hierarchy by **making it easy to recycle**, providing bins, labelling and training
- Work with our suppliers to **procure sustainable products, and eliminate waste to landfill**, driving a circular economy
- Target **zero waste** to landfill by 2025 with interim supporting targets to reduce volume of waste produced year on year.
- We will adopt the **NHS plastic pledge**, replacing single use products with reusable alternatives
- Deliver initiatives to **reduce food waste**
- Include **procurement contract specifications** that minimise waste and environmental impact (including local suppliers, reducing packaging and fewer deliveries) and monitor over time
- Consider **re-useable PPE or PPE recycling schemes**

Measuring progress

- 100% of procurement of Trust services will have sustainability requirements embedded by 2024
- 100% of suppliers will be engaged with making sustainability improvements by 2024
- 100% of suppliers to have carbon neutral operations by 2030
- No further purchasing of single use plastics from 2023 onwards
- Improvement in proportion recycled as a % of waste generated per month
- Waste to landfill will be reduced – with the target of a reduction on month of the previous year, working towards zero by 2024

Capital projects

We are committed to embedding sustainable design and energy efficient technologies throughout our capital projects, for both new build and refurbishment.

Aim: Our new build and refurbishment projects will follow sustainable design principles and reduce their impact through all project lifecycle stages

What we have done already

- Implemented opportunities for improving sustainability of the existing estate including the installation of LED lighting
- We are carrying out an ongoing review of funding and grant opportunities for sustainable upgrades to our estates

Construction of new emergency department

Capital projects

What we will do

- Opportunities for **improving the sustainability of the existing estate** will be identified and actioned in the short term; and a **heat decarbonisation** plan will be developed for the long term strategy and interim milestones
- Develop **sustainability guidelines** for all capital projects, including major refurbishments, driving sustainable development through the Estates Strategy
- New buildings will be **BREEAM Excellent certified** and major refurbishment projects will be BREEAM Very Good
- **Whole life costing and embodied carbon analysis** will be undertaken for any new construction projects
- Post completion, we will review building performance and share the key **lessons learnt** from the project
- We will ensure all **delivery partners within the supply chain align with our Green Plan standards** and assess them, pre-award for their own sustainability goals
- We will ensure that all **standards, and associated costs for net zero carbon are embedded** in project plans and we will not derogate from these without due diligence

Measuring progress

- 100% of new build capital projects will achieve BREEAM Excellent
- 100% of refurbishment capital projects will achieve BREEAM Very Good or actions will be implemented where BREEAM is not applicable
- 100% of completed capital projects will undertake lessons learnt reviews
- All new build and refurbishment projects will to be designed to accommodate low carbon heating systems

Climate change adaptation

Planning and the efficient delivery of processes and buildings that are climate resilient is essential for adaptation to climate change.

Aim: Ensure our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events

What we have done already

- The Trust clinical strategy was updated in 2019 and incorporates services sustainability and resilience
- When periods of heat, cold, flooding and other extreme events occur it is vulnerable people and communities that suffer the worst. The Trust has an Extreme Weather Conditions Policy. We are not in a defined flood plan risk but we are fully engaged with the Local Resilience Forum and Environmental Agency
- The Trust works closely with Public Health, Hertfordshire County Council and across the ICS and ICP in which changes to population health and pathways are reviewed. Key examples over 2020/21 have included different pathways and way of working due to the Covid pandemic. Including virtual wards and use of technology to enable outpatient clinics virtually
- Emergency Planning Core Standards in 2019 – fully compliant.
- Established a trust Sustainability Group who meet monthly to deliver against this Green Plan
- Created a new role, Trust Sustainability Manager, to lead on delivering against our commitments and drive our energy and resource use efficiency

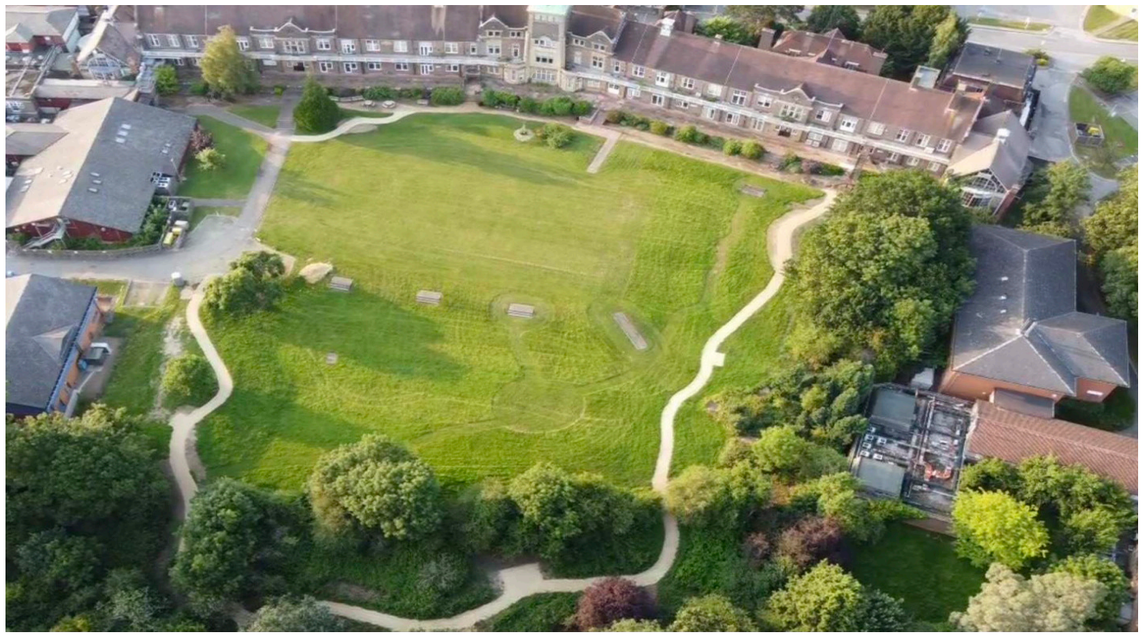
Climate change adaptation

What we will do

- Follow NHS policy guidance for climate adaptation. Work collaboratively with staff and partner organisations to **develop a climate change adaptation strategy,** and update business contingency plans to **include climate risks**
- Ensure our **infrastructure, services, supply chain**, local communities and staff are prepared for the impacts of climate change reducing the impact on public health from climate change.
- **Nominate an Adaptation Lead** and incorporate adaptation into our sustainability governance structure, corporate risk register and reporting processes
- Ensure that our emergency plans consider that **vulnerable communities are supported** during any extreme weather events and identify partners to work with to increase community resilience
- Provide **guidance for staff and patients** on predicted impacts of climate change
- **Review of climate change to be undertaken**, to address the extremes of weather and climate change regarding the potential impact upon the organisation

Measuring progress

- Corporate risk register climate related risks assessed, and managed with a risk rating of low
- 100% of capital and Estates projects incorporating future climate predictions in design
- Climate change adaptation included as part of the trust disaster recovery plan



Greenspace and biodiversity

Biodiversity is of great value not only in terms of its environmental benefits, but also socially, improving our health, patient recovery rates and patient experience. Improving and maintaining green infrastructure across our Estate is key to creating a sustainable environment.

Aim: Enhance the quality of our green spaces and reduce biodiversity loss by protecting and enhancing natural assets

What we have done already

- This has been identified as a priority area for the trust across our sites, requiring a coordinated effort to improve the quality of spaces
- Charity funded outside space opened in maternity for children in 2019
- Staff at Mount Vernon Cancer Centre engage with the Nature Recovery Ranger initiatives
- Initiatives include securing funding to refurbish a woodland walk to upgrade green spaces and improve biodiversity

Figure 10 – Opening of new hospital outside space in maternity

Greenspace and biodiversity

What we will do

- Develop a **biodiversity and green space management plan** that encompasses the challenges and opportunities across each of our sites and provides quality and accessible green spaces for patients, staff and visitors
- By collaborating with partners and local communities we will **contribute to local biodiversity** and make the best use of available green space - seek to appoint a nature recovery ranger or internal lead for development of green spaces
- **Raise awareness of the benefits of natural capital** for physical and mental health and wellbeing by providing opportunities for staff to get involved in Trust-wide initiatives such as beekeeping and gardening schemes
- Run **litter reduction initiatives** across our sites
- Ensure or new capital builds **prioritise and maximise rewilding and biodiversity** wherever possible and take thoughtful person-centric design principles into account
- Consider adoption of the National Indicator (N197) to **measure the implementation of active conservation management** and biodiversity

Measuring progress

- Number of Trust sites with a biodiversity and green space strategy
- Increase in area (m^2) of our sites improved/managed for biodiversity and staff wellbeing

Carbon / greenhouse gases

Reducing carbon emissions at East and North Hertfordshire Trust requires a Trust-wide approach, as carbon emissions are associated with every part of our organisation.

Aim: Net zero by 2040 for the emissions we control directly, with the ambition to reach 80% reduction by 2028-2032 (set against a 1990 baseline)

What we have done already

- Established a trust Sustainability Group who meet monthly to deliver against this Green Plan
- Created a new role, Trust Sustainability Manager, to lead on delivering against our commitments and drive our energy and resource use efficiency
- Prescribed dry powder inhalers (DPI), which are lower carbon inhalers, over MDI where appropriate. In 2019/20 the Lister site removed the anaesthetic gas, Desflurane from use
- Carbon Emissions - While we have achieved a reduction in our carbon emission footprint, we have not hit our carbon emission reduction target of 34% by 2020 based on a 2007 baseline. This was a challenging national target for all NHS trusts and the ongoing challenge is greater still, with the Climate Change Act and Net Zero NHS ambitions

Carbon / greenhouse gases

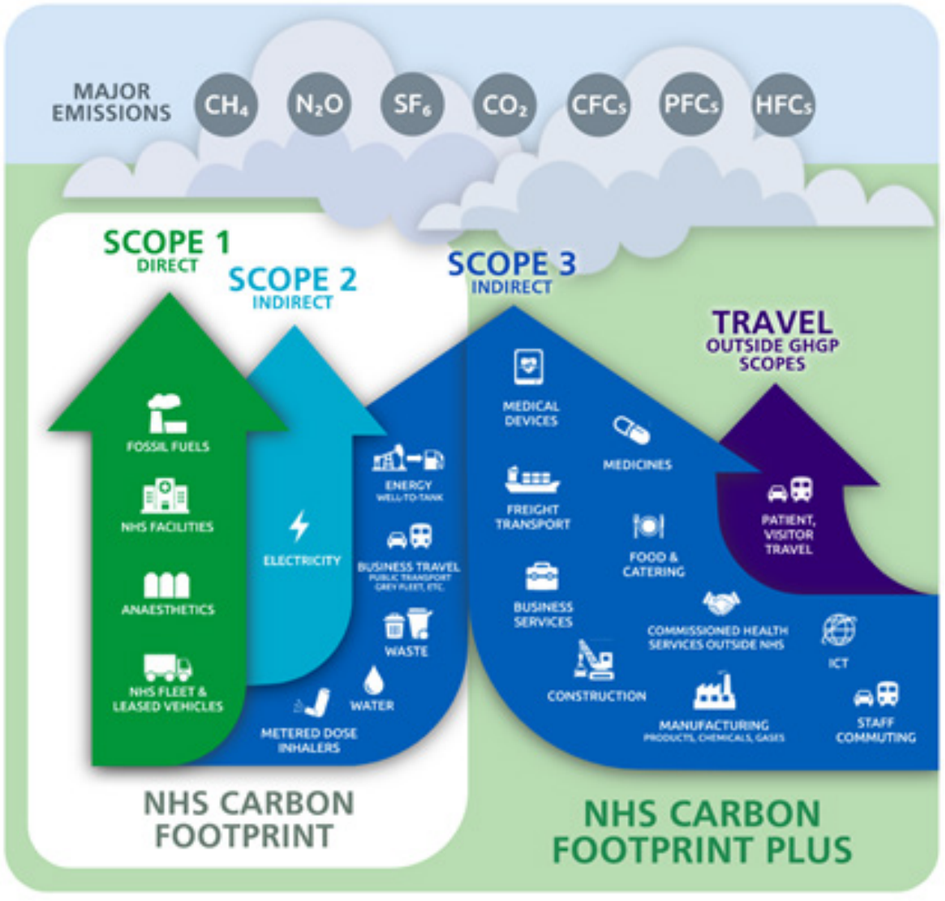
What we will do

- Improve accuracy of our **carbon baseline measurement** by end of 2021 for Scope 1 and 2 direct emissions
- **Ongoing measurement** of our carbon emissions, identify hotspots and take targeted action to reduce this year-on-year in line with our 2040 net zero carbon target
- Prepare an **action plan for net zero carbon**: Models of Care, Workforce, Medicines, Estate and Facilities, Travel and Transport, Supply Chain and Food and Nutrition
- Assess the trust energy saving initiatives and consolidate into a **trust wide energy strategy and heat decarbonisation plan** by end of fiancial year 2022/23
- Extend our carbon baseline to include **indirect emissions** (e.g. procurement and supply chain), identify areas for reduction and implement actions
- **Engage staff, suppliers and contractors** with our Green Plan to reduce our carbon footprint
- We will ensure **desflurane use remains less than 10%** of our total volatile anaesthetic gas use by volume

Measuring progress

- Reduction in carbon footprint from energy, water and anaesthetic gases to achieve net Zero Scope 1 and 2 carbon emissions by 2040
- % reduction year-on-year of carbon footprint from waste
- % reduction year-on-year from travel and transport
- % reduction year-on-year in carbon footprint from procurement broken down by key areas
- 100% of suppliers engaged in reduction in carbon footprint by 2024

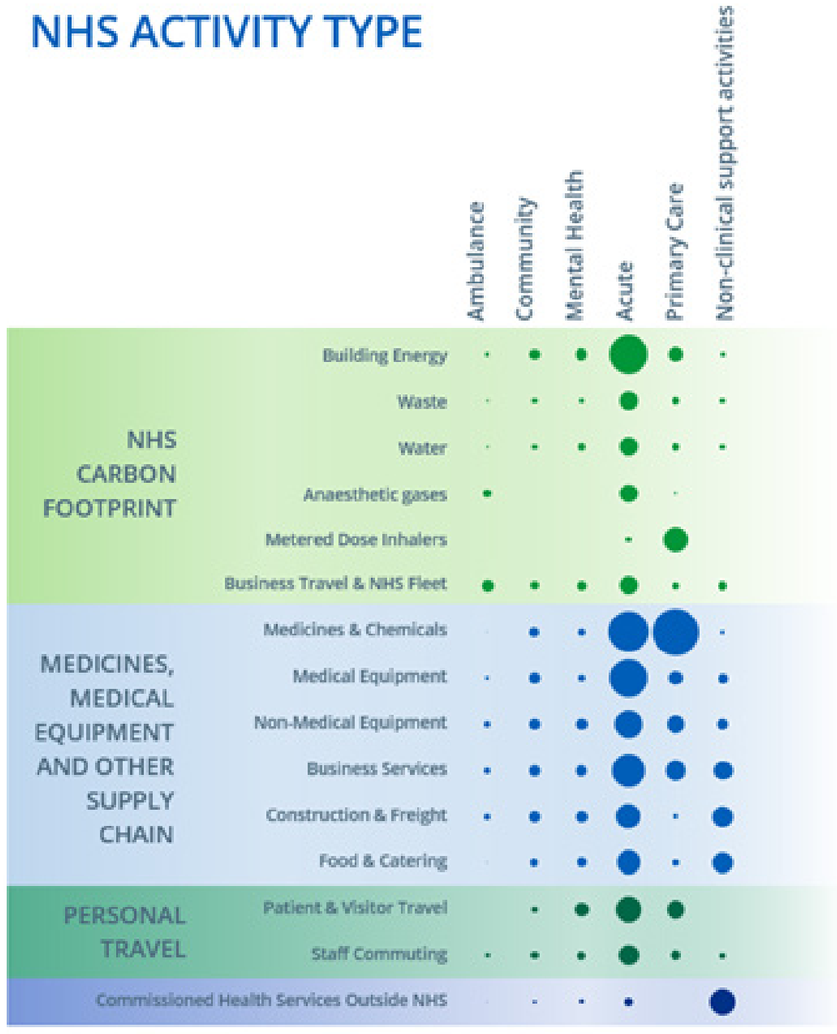
Carbon / greenhouse gases



Greenhous Gas Protocol scopes in the context of the NHS. The emissions we control directly are demonstrated in the NHS Carbon Footprint section of the diagram. We aim to be net zero by 2040 for the emissions we control directly, with the ambition to reach an interim 80% reduction by 2028-2032.

page 44 - can be found on PAGE 11 of delivering-a-net-zero-national-health-service.pdf (england.nhs.uk)

Carbon / greenhouse gases



Sources of carbon emissions by activity type and setting of care demonstrating the significant contribution by acute care and also the hotspots beyond the direct NHS carbon footprint.

page 45 - can be found on PAGE 13 of delivering-a-net-zero-national-health-service.pdf (england.nhs.uk)

Delivering a Net Zero NHS

Delivering a Net Zero NHS

A national ambition

The Delivering a Net Zero National Health System report in 2020 highlighted that, left unabated, climate change will disrupt care, with poor environmental health contributing to major diseases, including cardiac problems, asthma, and cancer.

Two ambitious, yet feasible targets were set within the Delivering a net zero National Health Service strategy measured against a 1900 baseline:

1) net zero by 2040 for the emissions we control directly (the NHS Carbon Footprint), with an 80% reduction by 2028-2032
2) net zero by 2045 for the broader emissions we can influence (the NHS carbon footprint plus), with an 80% reduction by 2036-2039 .

This strategy, approved unanimously by the NHS England and NHS Improvement boards, remains the most comprehensive of any healthcare system in the world.

To support this ambition, East and North Hertfordshire Trust has established our organisational strategy and ambitions to reduce emissions in line with the national trajectory. Net zero actions are embedded within our Green Plan goals and objectives. Sustainability to us, is ensuring we make decisions and take actions that have a positive outcome environmentally, economically, and socially.

Our Green Plan will feed into our ICS and regional Greener NHS consolidated strategies for net zero carbon and we look forward to working with our partners and the Greener NHS on this.

Our Net Zero actions

Our actions towards net zero are embedded within the areas of focus sections in this Green Plan, particularly within the carbon & greenhouse gases section.

The following list is a short summary of these actions and objectives, specifically addressing the net zero requirements and guidance set out by the Greener NHS.

Delivering a Net Zero NHS

Workforce and system leadership

- Have a **named board level lead for Net Zero** and work with the regional Greener NHS team and Hertfordshire and West Essex ICS
- **Improve staff awareness** and provide training on user controls and sustainable behaviour
- **Ongoing measurement** of our carbon emissions, identify hotspots and take targeted action to reduce this year-on-year in line with our 2040 net zero carbon target
- **Engage staff, suppliers and contractors** with our Green Plan to reduce our carbon footprint
- Develop a **network of 'green ambassadors'** across the trust, enabling staff to get involved and make a difference

Medicines

- We will ensure desflurane use remains less than 10% of our total volatile anaesthetic gas use by volume
- We have already switched to some low carbon inhalers and will review new types for suitability
- Medical gas committee to measure and review nitrous oxide use and waste and include this in the committees regular meeting agenda

Food and nutrition

- Deliver initiatives to reduce food waste such as:
- Research and implement digital food ordering system by 2022
- Annual review of menus and investigation of more frequent reviews to use seasonal ingredients
- Investigate adding a plant based menu for patients and staff

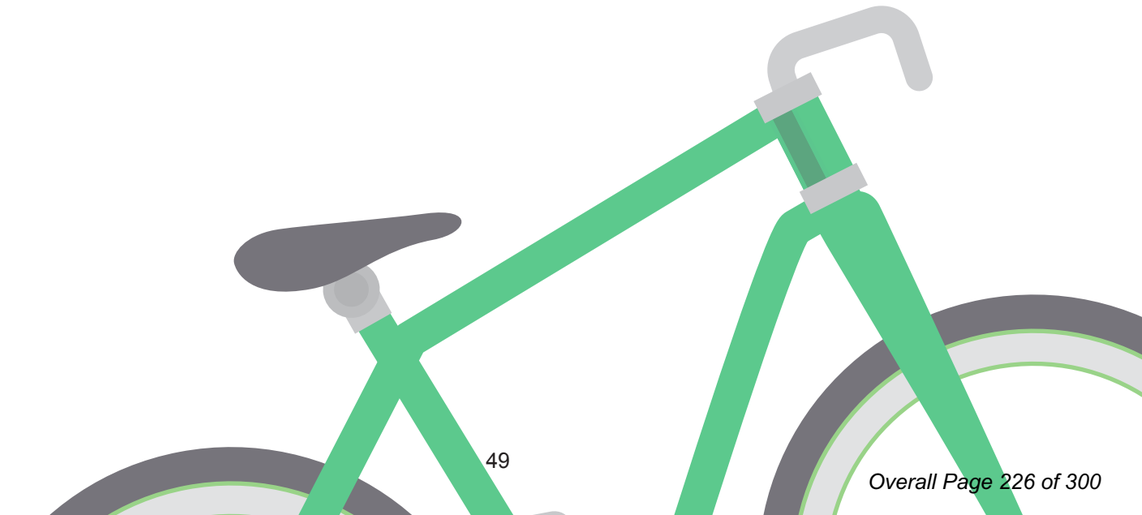
Delivering a Net Zero NHS

Sustainable models of care

- Work with supporting partners to increase the amount of services and **treatment that can be offered closer to home**, reducing the number of hospital visits
- Where outpatient appointments are clinically necessary, at least 25% of outpatient activity should be delivered remotely and at least 60% of follow up appointments

Estates and facilities

- Opportunities for **improving the sustainability of the existing estate** will be identified and actioned in the short term
- Assess the trust energy saving initiatives and consolidate into a t**rust wide energy strategy and heat decarbonisation plan** by end of financial year 2022/23
- We will ensure that all **standards, and associated costs for net zero carbon are embedded** in project plans and we will not derogate from these without due diligence
- **Accurately measure, monitor and reduce** our utilities consumption
- Deliver a programme of e**nergy and water saving initiatives** across our existing Estate, engaging with our staff
- Specify **100% renewable energy**, with REGO certification, when we enter all new supplier agreements for electricity
- Target **zero waste to landfill by 2025** with interim supporting targets to reduce volume of waste produced year on year



Delivering a Net Zero NHS

Travel and transport

- Publish and resource a **new travel plan** to help, staff, patients, visitors and the local community reduce transport emissions
- Ensure all new **Trust vehicles** are low carbon (ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs)) and reduce the environmental impact of our fleet

Supply chain and procurement

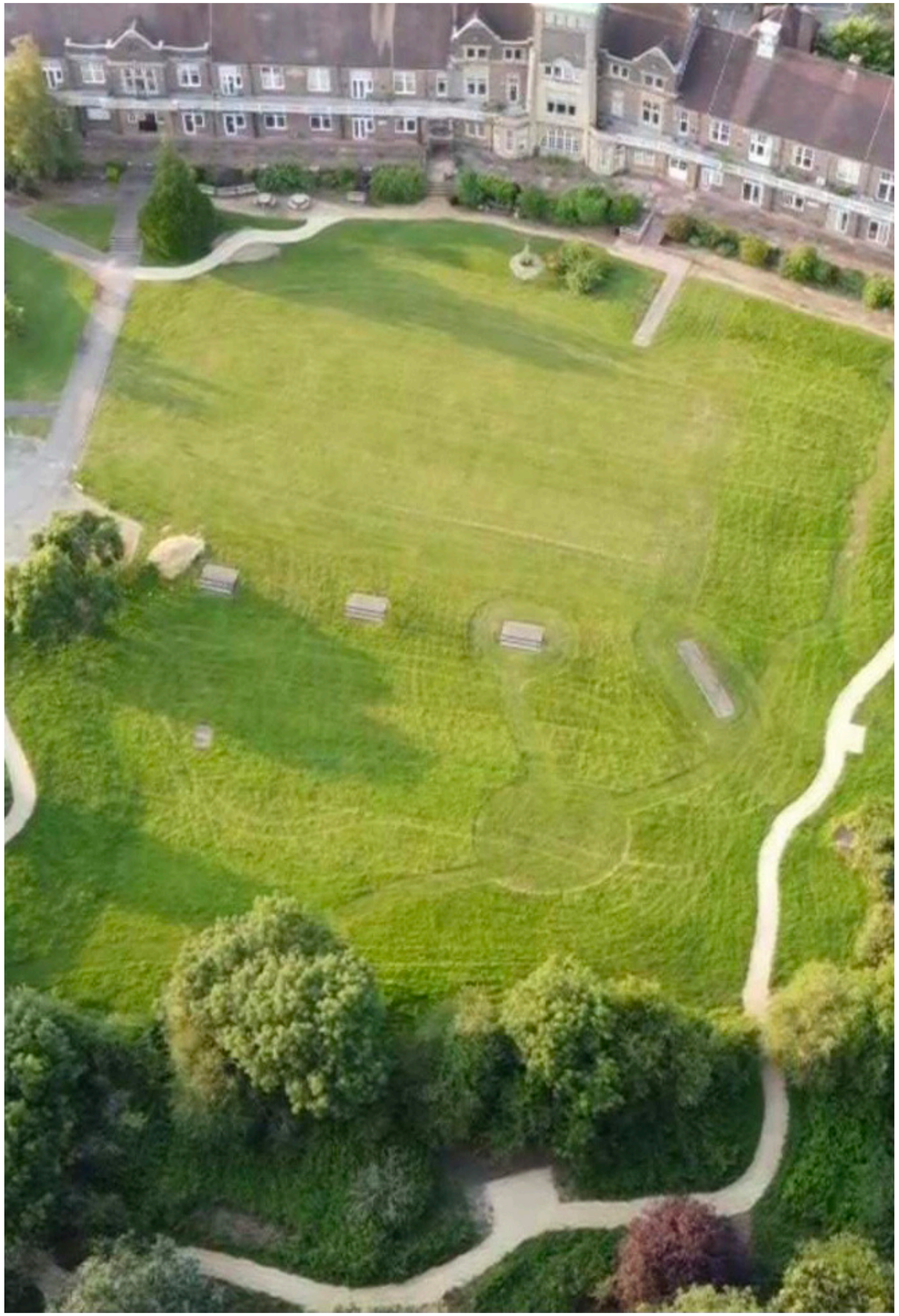
- Work with our suppliers to **procure sustainable products, and eliminate waste to landfill**, driving a circular economy
- Extend our carbon baseline to **include indirect emissions** (e.g. procurement and supply chain), identify areas for reduction and implement actions
- Include **procurement contract specifications** that minimise waste and environmental impact (including local suppliers, reducing packaging and fewer deliveries) and monitor over time

Digital transformation

- Explore opportunities in adopting an electronic patient record system to improve efficiency, cancellation rates and experience
- Scale up the use of digital solutions for patient letters and appointment reminders
- Encourage move to digital and **paper-less provision** and management of services
- Review use of **digital solutions in support of estate and facilities management** for real time monitoring

Adaptation

- Ensure our **infrastructure, services, supply chain, local communities and staff** are prepared for the impacts of climate change reducing the impact on public health from climate change
- **Nominate an Adaptation Lead** and incorporate adaptation into our sustainability governance structure, corporate risk register and reporting processes



Implementing the Green Plan

Implementing the Green Plan

Our Green Plan incorporates objectives and targets across a wide range of our activities and impacts. Our ability to deliver on these targets will be the real test of our plan. Many of our targets reflect national or NHS goals to which we are also committed, whereas others are designed to reflect our own priorities. Examples of external targets that we must work to address include:

- Net zero carbon for our direct impact by 2040 (aspiring to an 80% reduction by 2028-32)
- Net zero carbon for our wider impact by 2045 (aspiring to an 80% reduction by 2036-39)
- Achieving BREEAM Excellent (new build) and Very Good (refurbishment) rating for our estate projects.

Tools for delivering our goals

We will implement the Green Plan through a variety of actions. Some of these will incur additional capital investment, whereas others will require changes to the way we do things, for example:

- Development of processes that enable individuals to embed sustainability goals into key decision making, for example in the development, review and approval of business cases.
- Introduction of carefully designed procurement requirements and contract clauses that help align our supply chain to our goals. We believe that substantial benefits can be achieved through effectively engaging our suppliers on sustainability and drawing on their ideas to help meet our goals
- Effective communications to all members of staff and stakeholders so that they can play their part, and so they can take advantage of the opportunities arising from the plan actions
- Clear training to staff members, covering our approach and how their actions will help us achieve our goals
- Progressing our existing commitments around digital delivery and staff welfare with some additional criteria to ensure these initiatives also help contribute to our sustainability goals. For example, ensuring that our IT standards prolong device life by including for maintenance and upgrades, and that materials are recoverable at end of life.
- Incorporating sustainability features into our estates management, maintenance and lifecycle expenditures. For example, seizing opportunities to create new green space or to add biodiversity habitat and reviewing specifications for lifecycle renewal of plant and building fabric that will help us to save energy and prepare for a zero carbon operations

Securing necessary capital investment

While the above approaches are essential and impactful, it is important to recognise that some of the changes we want to see in our hospitals will require significant additional capital investment. Most significant amongst these will be upgrading and decarbonisation of our heating and steam system and the transition to a low carbon vehicle fleet. We recognise that these steps are both capital intensive and present risks to our operations and revenue costs, it is essential therefore that they well-conceived and appropriately funded.

We are committed to the preparation of an estate decarbonisation strategy by end FY2022/23. This will provide the detailed route map for this phase of our plan including:

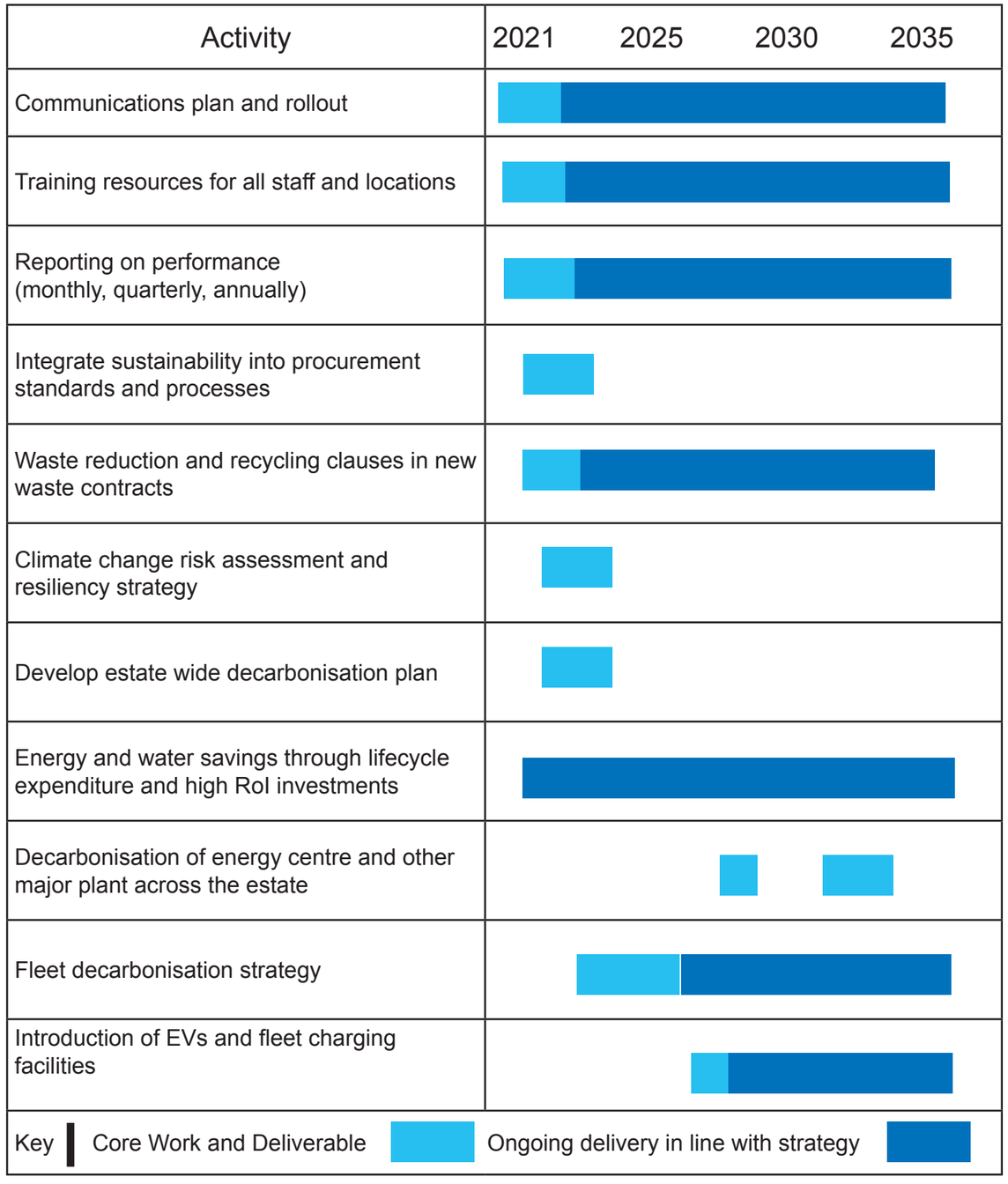
- Development of a carbon reduction pathway that addresses our resilience, operating costs and return on investment requirements as well as carbon emissions. The pathway will consider the appropriate sequencing of measures to minimise our energy demand and to align with our Estate Strategy,
- A funding model that draws on public funding where available, for example through securing 100% grant funding where possible via the Public Sector Decarbonisation Scheme and other suitable sources – e.g. energy performance contracts that will help us realise our own and the NHS's wider expectations

We realise that to secure public funds for our decarbonisation plans we will need to be able to respond rapidly and convincingly in grant applications. We will use our decarbonisation strategy to provide this framework and list of impactful projects that we can deliver quickly as monies become available.

Our programme

The challenge of climate change and sustainability is urgent and imperative and so we must begin to implement our plan immediately, however we recognise that this is a long term transition that will proceed at different paces across our activity areas and locations. We cannot risk our service, staff or patient wellbeing in delivering our plan. Therefore, we will ensure we make the most of every opportunity that presents itself to progress our goals whilst careful planning and preparing for the step change interventions, for example in our energy centre, that will move us to the next level of performance.

Implementing the Green Plan



Tracking progress and reporting

Tracking progress and reporting

We have numerous commitments and reporting obligations to meet regarding sustainable development. Reporting on sustainability needs to be robust and our review this year highlighted that we have improvements to make in our data collection and reporting processes to ensure they are integrated within our trust operations.

Therefore, we have implemented a key performance indicator matrix underpinning our Green Plan for which the Sustainability and Energy Manager and the Sustainability Group have responsibility. These metrics are listed in the 'measuring progress' section of each area of focus.

We will also be undertaking a review of our baseline carbon emissions as well as aligning our data collection with the existing ERIC reporting, Sustainability Reporting Portal (SRP) and the new Greener NHS reporting requirements. These will together inform the sustainability section of the Trust's Annual Report and calculate the Trust's carbon emissions (Scope 1, 2 and 3). The following table summarises our reporting plan.

Annual	Quarterly	Monthly
• Sustainability section in Annual Report Annual Green Plan progress report to the Strategy Committee • ERIC (Estate Return Information Collection) • Greener NHS Sustainability Reporting Portal – frequency and format to be agreed with the relevant regional greener NHS team	• Progress reports to the Strategy Committee • Greener NHS Data Collections	• Green Plan performance tracker and action plan in Sustainability Group meetings • Data collection – including utilities, waste data and other data required for KPIs

The goals and objectives listed in this green plan are for the duration of the strategy, with some specific measures having a set target date. The reporting and measuring of targets are ongoing. This green plan will be refreshed after 3 years and reviewed in detail at least once in the interim.

Communications

Communications

Effective implementation of sustainable healthcare requires system wide engagement, participation and collaboration. We communicate with our staff, patients and wider community through a variety of channels including online media, internal communications, and events. We will develop a network of ‘green ambassadors’ across the trust, enabling staff to get involved and make a difference. The green ambassadors will then form our sustainability network, a forum for sharing opportunities, concerns, best practice and progress.

Specific communications activity, led by the ENH Comms team includes:

- Dedicated intranet pages on sustainability so that our staff can find out information about how we are tackling green issues, and make suggestions for further activity
- A dedicated web page for the public to be kept updated and to make suggestions
- Sustainability to have a monthly standing item in Trust News, highlighting updates and featuring staff stories and case studies
- Sustainability to have a standing item in our forthcoming member’s bulletin
- Consideration of a regular green bulletin
- Communications activity around key sustainability awareness days
- Information in the Annual Report
- Updates at leadership briefing for senior leaders, at key points of progress

Get involved

All our communities are encouraged to get involved where you feel able. We will be continuously working towards these Green Plan targets and need your help to get there. Keep an eye out for our sustainability communications and activities that you can get involved in. More information on the Greener NHS can be found on their website at **Greener NHS (england.nhs.uk)**.
If you have an idea that we can work on, do get in touch with the trust sustainability group at **sustainability.enh-tr@nhs.net**

Governance

Governance is key to the effective implementation of the actions and commitments made in this Green Plan. Everyone within the Trust has a responsibility to ensure the objectives defined in this Green Plan are met.

A Trust Sustainability Group with over 25 representatives from across the trust works together to identify opportunities to improve our environmental and social performance and deliver against the Green Plan objectives. They seek value for money solutions that also enable the achievement of the Trust's service and estate strategies.

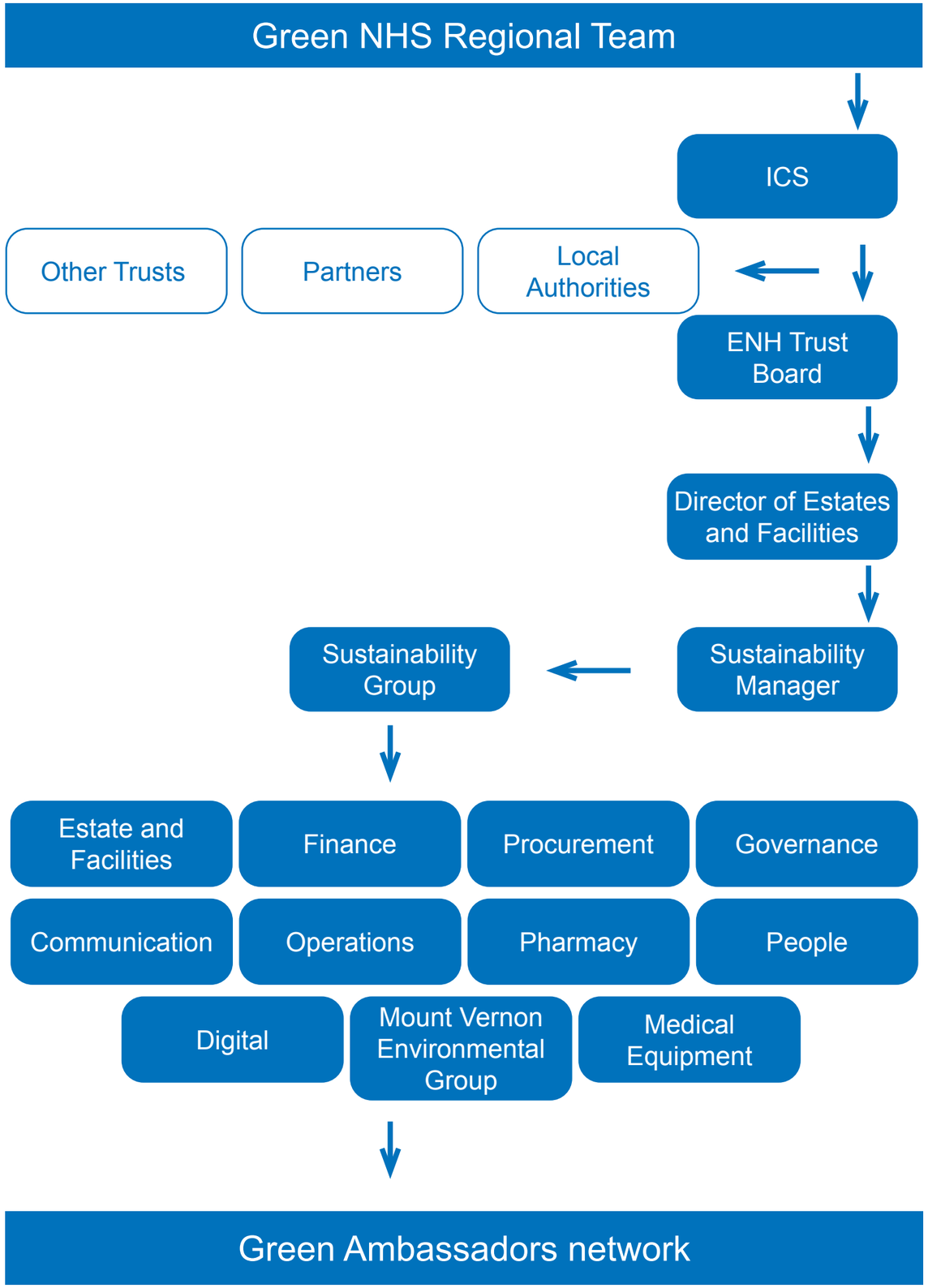
The group meets on a monthly basis and stakeholders join from across the trust, including but not limited to: Estates and Facilities, Strategy, Finance, Procurement, Governance, Operations, Communications, Pharmacy, People, Medical Equipment and Catering.

The purpose of the Group is to:

- Provide leadership on sustainability for the trust
- Develop, advise and implement the new trust Green Plan
- Monitor the achievement of sustainability objectives and hold responsibility for data collection and KPI reporting
- Implement best practice and continuous improvement for trust sustainability initiatives

Director of Estates and Facilities chairs the sustainability group, supported by our sustainability manager who leads on delivering against our commitments and drives energy and resource use efficiency. This role is part of the Estates and Facilities directorate.
The group will report on progress against the action plan and escalate issues or risk items as appropriate to the trust Strategy Committee and through this forum to the Trust Board. The Strategy Committee will have oversight of the implementation of the Green Plan. It will ensure that a detailed Sustainable Development update is included in the Trust Annual Report.
The Trust Board will consider and approve the Green Plan and associated monitoring and reviewing of performance against targets and approve any changes to the plan over the course of its duration.

Governance



Risk and Finance

Risk

In order to successfully deliver our Green Plan, we will need to proactively identify, manage and mitigate any risk. Any risks identified will be logged, managed and mitigated in accordance with the processes defined in the East & North Hertfordshire Clinical Commissioning Group Risk Management Policy v2.1 Engagement with our staff and the public is key to the successful delivery of this Green Plan.
Our Green Plan is supported by performance indicators and tracking these is the responsibility of the sustainability group on a quarterly basis. We acknowledge the risk that Covid-19 may impact our ability to deliver against the targets outlined in this Green Plan but will ensure mitigation actions are in place to reduce this risk. We have a recovery plan to bring us back on track should we fall behind on our performance against the Green Plan goals.

Finance

Financial support will be needed to successfully deliver the commitments made in this Green Plan. We may have upfront capital expenditure in order to realise long-term cost savings from energy efficient features, construction and more efficient ways of working. We will maintain senior support and transparent reporting.

We will also take advantage of local and national schemes which support investment in energy efficiency initiatives and sustainable innovations. Involvement in local strategic partnerships and regional economic forums will play a key part in knowledge sharing and developing a sustainable and resilient health economy.

Acknowledgements

We would like to thank the following groups for their time and input to the production of this Green Plan: Trust Sustainability Group and MVCC Environmental Group. We would also like to thank our staff for completing the Staff Sustainability Survey.

East and North Hertfordshire
NHS Trust

Agenda item: 16

PUBLIC BOARD MEETING
12 JANUARY 2022

Report Title	Reducing the governance burden during COVID
Report Presenter	Trust Secretary
Report Author	Trust Secretary
Executive Lead	Deputy CEO

Report Summary *Please summarise the key points from the report and the recommendation that is being made*	This paper presents the recommendations to implement the NHS England guidance "Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic" issued on 24 December, which reflects the outcome of discussions with NEDs and Executives on 5 and 6 January. The intention is to ensure ongoing good governance and compliance, whilst freeing up officer capacity to focus on the COVID surge. **Recommendation:** The Board is asked to approve the recommended short-term changes to governance or identify any improvements to the proposals
Action Required	**For approval**
Risk Issues *Please specify any links to the BAF or Risk Register*	N/A

Trust Priorities *Please tick any Trust priorities to which the issue relates*		
Quality	To deliver high quality, compassionate services, consistently across all our sites	☒
People	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways	To develop pathways across care boundaries, where this delivers best patient care	☐
Ease of Use	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☐
Sustainability	To provide a portfolio of services that is financially and clinically sustainable in the long term	☐

Previously considered by	
Committee/Board/Group: NEDs bi-weekly COVID briefing 5 January 2022 Executive Committee 6 January 2022	Date:

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REDUCING THE GOVERNANCE BURDEN DURING COVID

Exec Summary: NHSE issued guidance "Reducing the burden of reporting and releasing capacity to manage the COVID-19 pandemic" on 24 Dec. The below summarises the proposed way forward that was discussed by NEDs on 5 January and Executive Committee on 6 January.

A) Governance & meetings

No.	NHSE recommendation	Proposed actions and options
1	Reduce committee/meetings burden "Trusts and CCGs should continue to hold board meetings but streamline papers and focus agendas." "For board committee meetings, trusts should continue quality committees, but consider streamlining other committees."	<u>Which meetings to cancel?</u> In light of experience from 2021, the recommendation is not to cancel or combine core committees: **QSC; FPPC**, **Audit** and **Exec** Com to stay (but reduce to 90 mins) Jan **Rem Com** cancelled **Strategy** Com 16 Feb; & **E&I** Com 22 Mar – NEDs preference to continue but streamline to 60 mins **Kings Fund** work in Jan to be postponed. Keeping Feb in diary and assess closer whether to cancel **Board development sessions:** NEDs agreement for the Executive to decide if the session needs to be cancelled. Executive lead for strategy, the Deputy CEO, determining. <u>Proposals to lighten to burden:</u> • Board – not proposing reduced Executive attendance • Shorten committee meetings – as above • Streamline agendas, sub-committee mtgs and core attendees – Executive lead & Committee Chair with Trust Secretary • Flexibility for officer attendance at committees so if necessary an officer only attends for the necessary item(s) • Audit Committee: BAF deep dives removed from Jan/Mar agenda <u>Directors to identify meetings within their Directorates that can be stepped down, shortened or the purpose can be achieved in a less burdensome way</u> • Directors to identify with their senior teams. Agreed at 6 January Executive Committee <u>Engagement, approval and cascade</u> • Bi-weekly Weds NEDS mtg with CEO reintroduced • External and Internal Audit firms alerted to the changes and sense check with auditors any concerns or suggested alternatives • Cascade to mgrs via Silver/Gold Command [if needed, involve Comms]

	"All system meetings to be virtual unless there is a specific business reason to meet face to face."	Board & Committees already remote
4	Annual accounts – same timetable & same streamlined approach	No action. Inform Exec, Board and Audit Com
5	Quality Accounts – requirements will be provided in due course	No action. Inform Exec, QSC and Audit Com
6	Quality Accounts – not needed in Annual Report	No action. Inform Exec, QSC and Audit Com
7	Annual reports – same lightened approach as 20-21	No action. Inform Board, Exec and Audit Com
8	Emergency-decision-making – ensure processes in place	Agreement with NEDs that a Board meeting may needed to be called at short notice for emergency decisions. Standing Orders allow the Chair to call a Board "at any time" for an extraordinary emergency Board. Whilst the Chair and CEO consulting 2 NEDs can make an emergency decision, agreement this will only be used as a last resort

B) Reporting and Assurance

No.	NHSE recommendation	Proposed actions and options
1	Constitutional standards	No changes
2	Friends and Family Test	No changes - FFT reported. Note that trusts have flexibility to change their arrangements under the new guidance, and published case studies show how trusts can continue to hear from patients while adapting to pressures and needs. Inform Patient Carer Experience Group.
3	Long Term Plan: mental health	No change. To note systems should continue to expand services in line with the LTP.
4	Long Term Plan: learning disability and autism	No change. To note systems should continue to expand services in line with the LTP.
5	Long Term Plan: cancer	No change. To note NHSE/I will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response and restoration and maintenance of cancer screening programmes (including bowel and targeted lung checks) and symptomatic pathways.
6	Long Term Plan: maternity and neonatal	No change: initiatives such as Saving Babies' Lives and the seven Immediate and Essential Actions from the Ockenden report and continuity of carer remain priorities.
7	GIRFT and transformation programmes	Routine GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge co-ordination and HVLC work. National transformation programmes (outpatients, diagnostics and pathways) now focus on activity that directly supports the COVID response or recovery, eg video consultation,

		personalised outpatients and patient-initiated follow-up, maximising diagnostics and clinical service capacity, supporting discharge priorities, etc. Action: Medical Directors office to review any scheduled GIRFT's
8	NHS England and NHS Improvement oversight meetings	No change - Oversight meetings will continue virtually. Streamlining agendas to focus on COVID-19 issues/discharge/recovery/ winter and support needs.
9	ICS - revised target date of July 2022	No action – already understood
10	Corporate data - AGS	Work towards normal timetable and content unless any concrete changes
11	CQC routine assessments, Use of Resources assessments, HSIB investigations	No action. CQC has suspended routine assessments, NHSE/I suspended use of resources assessments and HSIB investigations reduced.
12	Provider transaction appraisals – mergers and subsidiaries Service reconfigurations	To note, potential for NHSE/I to deprioritise or delay transactions assurance if in the local interest given COVID-19 factors. To note, Urgent temporary service changes on safety grounds in response to COVID-19 or other pressures can still be made with agreement from system partners. Should systems look to make these permanent, normal reconfiguration assurance processes will apply at a later stage.
13	7-day services assurance	No changes – self-cert statements to continue. MD office informed
14	Clinical audit	No change. Data collections remain open. Noted clinical teams should always prioritise clinical care over data collection and submission. MD Office informed.
15	Pathology services	No change

C) Other areas including primary care, HR and staff-related activities

No.	NHSE recommendation	Proposed actions and options
1	HR - With staff absences likely to rise, new training activities – eg refresher training for staff and new training to expand the number of ICU staff – are likely to continue to be necessary. Reduce other mandatory training as appropriate.	Already in train via Silver Command – HR reducing training requirement to core requirements during this period Alert Tom NHSE actively encouraging
2	Appraisals and revalidation - Professional standards activities may need to be reprioritised: eg appraisals can be postponed or cancelled. Appraisal is a support for many doctors, so it is helpful to keep the option available, but if going ahead, please use the shortened Appraisal 2020 model. Medical directors may also use discretion to decide which concerns require urgent action and which can be deferred.	People and Medical Directors progressing

East and North Hertfordshire NHS Trust

Agenda Item:17.1

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING HELD ON 24 NOVEMBER 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the report from the FPPC meeting on 24 November 2021.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) The discussions at the meetings reflect the BAF risks assigned to the FPPC.
Any other risk issues (quality, safety, financial, HR, legal, equality): N/A

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING
24 NOVEMBER 2021

SUMMARY TO THE TRUST BOARD MEETING HELD ON 12 JANUARY 2022

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair), Biraj Parmar, and Jonathan Silver

Procurement Strategy Update
The FPPC received an update on the Procurement Transformation where five Integrated Care System (ICS) provider Trusts have been combined into one ICS Procurement Service. This went live on 2 August 2021. The Committee discussed and approved the future proposed structure and timing of reports it will receive going forward including thoughts for 14-16 key performance indicators covering the full range of the procurement service.

Finance Report Month 7 and Outturn Forecast
The FPPC considered the key points in relation to financial performance for month 7. The Trust is reporting against a break-even plan for H2 which has been agreed by the ICS and NHS England. The H2 financial plan includes an agreed CIP plan of £5.7m. The Trust is looking at additional winter capacity to build into the system along with delivery of improvement in the size of waiting lists and the 104 week waits.

The Committee were advised the Trust is reporting a £700k surplus and plans to break-even at year end.

Progress against the capital programme was discussed by the Committee including work undertaken to review and prioritise medical equipment that requires replacing. Going forward the FPPC were advised that one of the biggest potential changes will be moving to a three year capital envelope which will improve the Trust's ability to plan capital expenditure.

H2 CIP Delivery
The Committee considered the key points in relation to H2 CIP delivery. An over achievement in the month of 7% was noted with all areas being ahead of target with the exception of estates and facilities where the shortfall was linked to the carbon tax net reduction scheme.

The Committee were advised of a shortfall in private patient income, noting there was a high private patient target for the second half of the year which is an important component of the CIP going into next year. A new private patient steering group has been initiated to aid delivery of the private patient target in the new financial year.

ED Capital Build Update

The FPPC were provided with an overview of the Emergency Department capital spend against key milestones, risks and financial constraints. The project remains on track.

Business and Budget Planning
The FPPC discussed the 2021/22 business and budget planning paper, noting the steps the Trust is taking to plan effectively for the future. This included the over-arching business planning structure, anticipated national priorities, the changing planning environment, local system priorities, the impact of changing demand and capacity and the financial framework.

The need to drive transformation and efficiency and the governance cycle for this was highlighted.

The FPPC approved the paper.

Community Diagnostic Centre Full Business Case Approval (FBC)
The FPPC considered the Community Diagnostic Centre FBC that had been brought to the Committee for approval prior to Board. The FBC sets out the five year transformation plan to fulfil the mandate set by NHS England regarding establishment of a Community Diagnostic Centre model across East and North Hertfordshire Health Care Partnership, with East and North Hertfordshire NHS Trust being the lead provider.

The Full Business Case was approved by the Committee, subject to the development of a risk sharing agreement and final approval by the Board in January 2022.

PTL Strategy
The FPPC received a presentation on Referral to Treatment (RTT) including discussion of the five elements considered key for RTT recovery. The Committee received assurance on the plans in place to support the target that no patients would be waiting for their treatment for more than 104 weeks by March 2022, and a reduction of patients waiting more than 52 weeks. All patients on the waiting list are risk assessed and prioritised in line with the national / royal college guidance.

Performance Report Month 7
The FPPC considered key points in relation to performance for month 7. ED performance was 70.09%, an increase on the previous month. There were zero twelve hour trolley waits reported in October.

The Committee were advised of a new winter resilience team being created which will be managed through the senior operational team.

Opportunities were highlighted for the new ED capital build which will provide a new ambulance offloading area, providing six additional spaces to manage and monitor patients to reduce waiting times.

The Committee were advised of an additional stroke therapist being recruited using the winter initiative funding.

People Report Month 7
The FPPC considered key points of the people report for month 7. The vacancy rate overall had decreased to 6.1% There was a positive shift in recruitment in the month with an additional 42 people in post. The nurse vacancy rate had also improved, decreasing from 3.2% to 2.8%. This is expected to continue to improve to year end with new students and international recruits joining the Trust. There was also a reduction in spending on temporary staffing with agency spend decreasing.

Increased staff absences resulted in increased pressure on the workforce. Sickness absence remains a challenge. Muscular skeletal absences have improved from last year. Key actions being taken including the mobilisation of a Winter staffing support unit were discussed.

The Committee were advised staff turnover had increased from 12.8% to 13.1% with one of the highest reasons for leaving being promotion outside of the organisation followed by work/life balance and relocation. One third of voluntary leavers did not provide a reason why they were leaving on their exit form.

The Committee learned that mechanisms for individuals to speak up have improved with a new Freedom to Speak Up Guardian starting with the Trust in January 2022. Common themes discussed will be investigated.

The Committee noted a variety of schemes to thank and reward staff.

The Committee considered new legislation regarding mandatory vaccinations for staff and await the formal guidance due next month.

Board Assurance Framework
The FPPC considered the key risks on the Board Assurance Framework. Actions and assurances regarding the ED capital review and new guidance for financial planning will be reflected in next month's Board Assurance Framework.

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Karen McConnell
Finance, Performance and People Committee Chair
November 2021

East and North Hertfordshire NHS Trust

Agenda Item: 17.1

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING HELD ON 15 DECEMBER 2021

EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the report from the FPPC meeting on 15 December 2021.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of FPPC	**Presented by:** Chair of FPPC	**Author:** Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
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Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) The discussions at the meetings reflect the BAF risks assigned to the FPPC.
Any other risk issues (quality, safety, financial, HR, legal, equality): N/A

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

FINANCE, PERFORMANCE AND PEOPLE COMMITTEE MEETING
15 DECEMBER 2021

SUMMARY TO THE TRUST BOARD MEETING HELD ON 12 JANUARY 2022

The following Non-Executive Directors were present:
Karen McConnell (Chair), Ellen Schroder (Trust Chair), Biraj Parmar, and Jonathan Silver

Theatre Transformation
The FPPC were presented with the theatre transformation update. Some good progress had been made including the successful bid for a new theatre system to be implemented by 31 March, the successful recruitment of anaesthetic consultants and plans to build three new procedure rooms. A robust clinical stratification process is in place to support elective recovery. The Surgical pathway programme including the governance, timeline and next steps were discussed.

There is strong engagement with anaesthetics and surgeons with improvements in performance relating to late starts and early finishes. Despite current challenges the team are experiencing, performance is above peer average and they are working towards exemplar recognition.

The Committee noted capital has been a challenge for theatres for some time, however there has been significant investment into theatres recently for replacement of equipment and fittings.

Outpatients Improvement Plan
The Outpatients Transformation and elective recovery priorities in 2021/21, achievements governance structures and next steps in 2022 were presented. The FPPC were advised that clinic utilisation and location of clinics will be reviewed using the same improvement process that is being used in theatres in order to allocate and use resources efficiently and to improve performance. This will include increasing the number of specialities and patients on Patient Initiative Follow Up (PIFU) pathways. Face to face and non-face to face activity continues to be reviewed with Transformation and Infection Prevention and Control and Business Intelligence colleagues.

Imaging Network Update
The FPPC were updated on the aims, governance structures and progress to date of the East Imaging network 2. This was set in the context of the national framework.

There has been capital investment to set up the imaging network which is required to be spent by the end of March 2022.

Workforce Report Month 8
A verbal update was provided by the Chief People Officer. Sickness spiked in October alongside a spike in Covid infection rates, however this reduced in November but was still above the same period last year. Absence due to mental health has increased.

There has been an increase in turnover and there will be a deep dive to review this in March 2022.

The Trust is focussing on mandatory requirements for Covid vaccines with the status of the number of staff not yet vaccinated being verified and awaiting formal national guidance.

Rostering
The FFPC were provided with a review of e-Rostering activities and performance between August 2021 and November 2021. The Committee were provided with an update on the use of workforce systems to help improve staff work-life balance, staff satisfaction and wellbeing.

Progress had been made including during the last 8 months 22 new rosters being delivered for 234 additional staff but there is still some critical work to be completed. Key areas were highlighted including the planned migration of operational medical rosters onto a new rostering platform when agreed.

Staff Assurance Framework for Winter 2021
The FPPC considered the key actions outlined in the Winter 2021 preparedness: Nursing and Midwifery safer staffing (November 2021) from NHSEI. Key actions required and responsibilities were set out to assure the Committee of preparedness, decision making and escalation processes to support safer nursing and midwifery staffing during the winter. The challenge will be identifying staff that can be safely redeployed to provide support when needed. The redeployment hub will be stood back up to support this.

Nursing Establishment Review
The Committee were advised that a nursing establishment review was undertaken in October 2021. An evidence based review is usually carried out twice yearly, however this is the first full review since the pandemic.

The nursing establishment review has considered and analysed the data relating to shift plans and staffing requirements to continue to deliver safe and effective care to patients using evidence based tools and safer staffing guidance.

The Committee were asked to approve the changes to nurse establishments, non-ward based shift plans and recruitment. The paper had been previously considered by the Quality and Safety Committee. The financial investment was approved by the FPPC.

Engagement and Staff Experience
The FPPC considered the upcoming staff experience and engagement results and next steps. There was a 42% response to the staff survey. Data will be reviewed, improvements identified and a series of interventions and measures put in place. Management reports will be sent out by 20 February 2022.

Exit interviews are being redesigned to remove ambiguity and improve understanding of the key reasons for leaving. A new staff engagement lead has started with the Trust. There has been positive feedback from listening sessions.

Finance Report Month 8 and Outturn Forecast
The FPPC considered the key points in relation to financial performance for month 8. There was a small surplus in November and a year to date surplus of £700k.

The Committee were advised of a challenge next year with reductions in Covid funding. Final planning guidance for 2022/23 will be received within the next few weeks.

H2 CIP Delivery
The Committee considered the key points in relation to H2 CIP delivery and noted £2.1m identified in the second half of the year against a plan of £1.9m.

The focus going forward will be on developing CIP plans for the next year. The Unplanned Care division have continued to develop CIPs with seven working groups with their own CIP focus led by divisional leads. Planned Care and Cancer divisions have started that process.

Costing Action Plan Update
The FPPC were presented with a costing action plan update which highlighted actions and progress to deliver improvements against four high risk areas. Two are now complete and two are ongoing. A multi-disciplinary steering group and costing team are involved to ensure processes and standards are in place.

The NHSE submission window for collection closed at the end of November 2021, which was later than planned. This will have an impact on the publication timetable with final results not being published until later in the spring of 2022.

Performance Report Month 8
The FPPC received a verbal update in relation to performance for month 8. ED performance continues to be challenging with deterioration to 68.8% on the four hour wait. The focus has been on twelve hour trolley breaches.

Reducing and minimising ambulance offload delays remains challenging and an area of focus. The National Urgent and Emergency Care Team visited the department. They were supportive of the actions the Trust was taking and offered advice on earlier escalation of the surge plans. There will be a new designated Same Day Emergency Care (SDEC) area in December which will alleviate some of the pressures in ED. Some of the winter initiatives funding is also supporting additional staffing in ED.

The Trust is one of only seven trusts who are compliant for the 62 day Cancer target.

Board Assurance Framework
The FPPC considered the key risks on the Board Assurance Framework. It is anticipated that the risk scores will remain the same this month and any additional assurances and challenges will be reflected to the Board.

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Karen McConnell
Finance, Performance and People Committee Chair
December 2021

East and North Hertfordshire NHS Trust

Agenda Item: 14.2

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 23 NOVEMBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary:		
To present the report from the QSC meeting of 23 November 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicab**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
The discussions at the meetings reflect the BAF risks assigned to the QSC.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

QUALITY AND SAFETY COMMITTEE MEETING – 23 NOVEMBER 2021
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 12 JANUARY 2022

The following Non-Executive Directors were present:

Peter Carter, Ellen Schroder, David Buckle, Val Moore

The following core attendees were present:

Nick Carver, Michael Chilvers, Julie Smith, Jude Archer, Rachael Corser, Mel Gunstone

Matters Considered by the Committee:

Board Assurance Framework

The Committee received the latest edition of the Board Assurance Framework. The Committee heard that the report outlined strategic objectives and risks and covered key issues and risks facing the Committee along with assurances.

The Committee noted that an assurance paper would be brought to the December meeting in regard to risks surrounding Estates and Facilities.

New and Emerging Risks

The Committee was informed that nine new risks had been added to the corporate risk register since the last reporting period. Three had received final approval by the Divisions and six still required final approval. Mitigating actions were in place for each of the risks. The Committee noted the themes on equipment and staffing.

Clinical Harm Reviews Update

The Committee discussed the latest position in relation to the clinical harms review process. The Committee was informed around 4,400 patients treated after 52 weeks required a clinical harm review and the plan was for these to be completed by 31 March 2022. The reviews would be managed within the specialties by consultants and going forward, the intention was that any patients treated who had been waiting over 52 weeks would have the clinical harm review carried out when they were seen by the clinician.

Deep Dive: Pathway to Excellence / Magnet4Europe

The Committee received an update to the progress to date toward the Pathway to Excellence, noting the Trust's submission was due 1 February 2022. The following points were highlighted:

- The programme supported embedding a culture of excellence.
- Sixteen wards had achieved accreditation so far and four others had achieved 'gold'. Three wards remaining.
- A baseline survey with nursing and medical staff had been conducted which enabled a gap analysis to be produced to help the Trust prepare for the actual survey expected in Spring 2022.
- Work had been undertaken with the Cavell Nurses' Trust and 18 staff so far had been awarded the Cavell Star Award for nursing and midwifery staff.
- Shared decision making had been introduced which was a platform for staff to have a voice and be involved with change and improvement. This also allowed networking across the Trust with the opportunity to learn from others.

Clinical Audit and Effectiveness Reports (Q1 and Q2)

The Committee received the Clinical Audit and Effectiveness Reports for Quarters 1 and 2.

The Committee was informed of the challenges managing the COVID recovery programme alongside increasing OPEL 4 incidences being declared which impacted on the ability to complete audits and review Gap Analysis/Action Plans. It was noted that efforts were being made to produce amalgamated audit and effectiveness reports for specialties which would enable full oversight of all actions agreed.

Quality and Safety Report (Month 7)

The Committee received the latest edition of the Quality and Safety Report.

Key points discussed included:

- The challenge continued around managing the backlog of serious incidents (SIs). A clear trajectory was in place including an approach to clustering items and sharing lessons learnt.
- A session on patient safety had been scheduled at the Board Development meeting of 1 December.
- In regard to infection control, there had been two new outbreaks in October, however, the numbers were low and the impact had been managed with minimal disruption to capacity in the organisation.
- There had been a noted reduction in surgical site infections of knee replacements.
- Good progress had been made with complaints and the team was continuing to address any that were overdue.
- Work was progressing on sepsis compliance and VTE although there were still challenges in these areas.
- The Keeping Our Patients Safe process had been launched and this would assist with recognition and escalation in the area of deteriorating patients.

Maternity Reports

The Committee received the Maternity Safety Highlight Report which provided the data measures for overview as per the perinatal quality surveillance model. The Committee heard there were still challenges in relation to training compliance.

The Committee was informed that there was currently intense scrutiny around maternity however the report highlighted that the Trust was in good standing. There were some safety alerts, however, plans had been put in place to mitigate these.

In regard to the Continuity of Carer, the Committee noted that there had been recognition of the impact of COVID on systems. A new framework of guidance had been released by NHS Resolution and a local implementation plan would be agreed by the Local Maternity and Neonatal System.

The Committee was informed that the Ockenden report published in December 2020 had identified seven immediate and essential actions that the Trust initially implemented. Maternity units were then asked to submit evidence to support the implementation. The Diamond Jubilee Maternity Unit achieved compliance with 112 of the 122 queries raised in the review.

As to further steps it was noted:

- Benchmarking would take place both regionally and nationally, with results available the end of November/beginning of December.
- Learning would continue to be shared across the Local Maternity and Neonatal System (LMNS).
- The next Ockenden recommendation was expected in Spring 2022.

The Committee noted the latest maternity reports.

Complaints, PALS and Patient Experience Quarterly Report

The Committee noted the quarterly update. It was highlighted that there had been an improved position in complaints and the team was looking at the processes to enable the system to become more streamlined. It was also recognised that some complaints were complex and took time to resolve.

The majority of the feedback via the Trust's patient experience surveys was positive. The Patient Advice Liaison Service (PALS) had received concerns in relation to delays to treatment and communication.

Dementia Strategy Update

The Committee received an update on the Trust's dementia strategy and noted that it was a work in progress and reflected the Trust's priorities over the next three years in order to give clear direction to facilitate and support the delivery of high quality care to people with dementia as well as their families and carers.

The five priority areas were:

- People, training and culture.
- Partnership in care.
- Assessment.
- Person-centred care.
- Environment.

The Dementia Steering Group had been relaunched to oversee the implementation of the strategy.

Learning and Education Capability Report and National Trainee Survey

The Committee received and noted an update on the people capability strategy and the results from the National Education and Training Survey.

Statutory / Mandatory Training and Appraisals

The Committee received and noted the report on appraisals and statutory and mandatory training. Overall current statutory compliance was at 89%.

Litigation Annual Report

The Committee received and noted the Litigation Annual Report which outlined a summary of clinical claims, highlighted notable developments and key themes and provided an update on the Early Notification scheme and Getting It Right First Time (GIRFT).

The Committee noted the following reports:

- Integrated Performance Report
- Maternity and Neonatal Dashboards
- QSC Sub-Committee Escalation Report
- CQC State of Care 2020/21 Exception Report
- Specialty reports

Peter Carter
Quality and Safety Committee Chair
January 2022

East and North Hertfordshire NHS Trust

Agenda Item: 14.2

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022
QUALITY & SAFETY COMMITTEE – MEETING HELD ON 14 DECEMBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary: To present the report from the QSC meeting of 14 December 2021 to the Board.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of QSC	**Presented by:** Chair of QSC	**Author:** Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
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Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) The discussions at the meetings reflect the BAF risks assigned to the QSC.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

QUALITY AND SAFETY COMMITTEE MEETING – 14 DECEMBER 2021
SUMMARY TO THE TRUST BOARD MEETING HELD WEDNESDAY 12 JANUARY 2022

The following Non-Executive Directors were present:

Peter Carter, Ellen Schroder, David Buckle, Val Moore

The following core attendees were present:

Michael Chilvers, Julie Smith, Jude Archer, Rachael Corser, Thomas Pounds

Matters Considered by the Committee:

Board Assurance Framework

The Committee received the latest edition of the Board Assurance Framework. The Committee heard that the continued challenges and operational pressures over the last three months were having a compounding impact.

Quarterly Risk Report

The Committee received the Quarterly Risk Report and were informed that the risks fell under three key themes around equipment, premises and management of clinical care. It was noted that due to timing of the Committee some of the risks were still subject to test and challenge through the divisional governance structures.

Maternity Reports

The Committee received and noted the Maternity Safety Highlight Report which provided the data measures for overview as per the perinatal quality surveillance model. The Committee were informed that there were no issues to escalate.

The Committee also received and noted the Continuity of Carer Action Plan.

Complaints, PALS and Patient Experience Annual Report

The Committee received the Patient Experience Annual Report and were informed that the information had been based on the quarterly reports which had previously been brought to the relevant committees and boards.

The Committee heard that a new Patient and Carer Lead was joining who would bring a fresh approach to the management of the patient experience agenda.

It was noted that communication was one of the biggest challenges and there was recognition that there would be challenges around response rates going into January as operational teams would be focusing on service delivery. Please see Board agenda item 14.2.1 for the full report.

Learning from Deaths Report

The Committee received the Learning from Deaths report. The Committee heard that the Trust was in the first quartile for HSMR and in the 'lower than expected band 3' for SHMI, one of only 14 Trusts of 123 in the top band. Crude mortality was 1.42% for the 12 month period to October 2021 compared to 1.27% for the latest 3 years. For the full report see Board agenda item 10.

Liberty Protection Safeguards

The Committee was informed that nationally (following a change to legislation) the Deprivation of Liberty Safeguards (DoLS) would be replaced with a completely new system, the Liberty Protection Safeguards (LPS) and that this was one of the biggest changes to occur in safeguarding. The change was necessary as there had been significant delays in authorisation processes which led to breaches of human rights. This change was due to be implemented from April 2022. The Committee was assured on the preparatory work the team were undertaking in readiness.

Compliance Report

The Committee received the latest compliance report.

A CQC Transitional Monitoring Approach (TMA) virtual assessment had taken place with the Radiology Team for diagnostic imaging; this was positive. It was noted that due to the current level of the pandemic, the CQC were pausing inspections nationally until 2022.

There was a focus on ensuring policies were up-to-date and reflected current practice.

Estates and Facilities Premises Assurance Model (PAM) Update

The Committee received the PAM update on the management action plan developed in response to key recommendations from a PAM Assessment Audit conducted in October 2021 by the internal auditors which concluded "limited assurance". A gap analysis had been undertaken and documentation and assurance and governance updates would be brought back to the QSC in March/April 2022.

Emergency Preparedness

The Committee was informed that the Trust remained fully compliant against the Emergency Preparedness Resilience and Response (EPRR) standards. A letter had been received from NHS England requesting assistance around the COVID vaccination and booster programme and the Trust had provided some support and were identifying those who could further assist.

Nursing Establishment Review

The Committee noted the paper and the key recommendations from the review and agreed these would have a positive impact on the workforce.

The key recommendations were:

- Approve the changes to nurse establishments as reviewed and recommended by the senior nurse teams.
- Approve non ward based shift plans and align budgets where included as part of safer nursing establishment / acuity review.
- Recruit to the budgeted headroom 22% for inpatient wards and ED and Renal.
- Agree approval for permanent posts on Trac as fixed term are extremely difficult to recruit to.
- Approve band 6 cover 24/7 in inpatient wards.
- Approve band 6 supernumerary bleep holders 24/7.

The QSC approved the Nursing Establishment Review for consideration by the Trust Board (Please see agenda item 11).

The Committee noted the following reports:

- Maternity Dashboard
- QSC Sub-Committee Escalation Report
- Specialty assurance reports
- Staff testing and vaccinations

Peter Carter
Quality and Safety Committee Chair
January 2022

East and North Hertfordshire NHS Trust

Agenda Item: 17.2.1

TRUST BOARD – PUBLIC SESSION - 12 JANUARY 2022

Annual Complaints, PALS and Patient Experience Report

Purpose of report and executive summary (250 words max):		
To present to Board a summary of Complaints activity during financial year 2020/21; reviewing data over time and by Division and by subject. It also highlights the activity amongst the top 6 specialties and how that has changed during the pandemic. There is also a review of the papers considered by the PHSO during 2020/21. An update on the patient and carer experience data is included for assurance as well as the innovative work done in response to Covid to ensure patient and carer experience was being addressed despite the challenges presented by COVID-19.		
Action required: For discussion		
Previously considered by: 14 Dec QSC; Patient and Carer Experience Group		
Director: **Chief Nurse**	**Presented by:** **Chief Nurse**	**Author:** **Head of Continuous Quality Improvement, Patient and Carer Experience Lead (acting), Governance and Legal Lead**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
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Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk)
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

East and North Hertfordshire NHS Trust

Patient Experience Annual Report 20-2021

Including Complaints and Patient Advice and Liaison Service (PALS)

Introduction

#hello my name is…

Rachael Corser

We aim to provide our patients and their carers with the best possible experience whilst they are using our services. We encourage patients and carers to provide feedback and raise questions or concerns about their hospital experiences in a variety of ways including talking to staff in the wards/departments, completing one of our patient surveys, including the Friends and Family Test question (how likely are you to recommend our ward/department to friends and family if they needed similar care or treatment?), completing one of the national patient experience surveys, sharing their patient story, posting comments on social media/NHS Choices, contacting PALS or making a formal complaint.

All feedback is shared with the relevant ward or department to enable teams to share positive feedback and consider suggestions for improvements made by patients and carers. Each ward/department has a 'learning from your experience' poster which is updated monthly to share the actions that have been taken as a result of patient and carer feedback. Each Division has a patient and carer experience action plan which is discussed and monitored by the Trust's Patient and Carer Experience Committee.

The Trust takes part in the national patient experience surveys co-ordinated by the Care Quality Commission and Department of Health. This feedback is valuable as it enables the Trust to compare performance with other trusts throughout the country. In 2020-21, the Trust received feedback from the following national surveys: Inpatients 2019 and Cancer 2019. The timeframe for publication of national survey data is approximately 10-12 months after the survey month. For example, the Inpatient survey 2019 was sent to patients who were in hospital in July 2019, the survey results were published by the Care Quality Commission in July 2020. A summary of results from these national surveys is included in the 'Facts and Figures' section of this report. This section also shows the full breakdown of patient experience survey responses during 2020-21 and a breakdown of complaints and PALS enquiries. This wealth of feedback has helped the Trust prioritise areas for improvement which are incorporated within the Divisional patient and carer experience action plans.

This year's patient and carer experience annual report is different to previous years in light of the resources required to deal with Covid-19. This has been a particularly challenging time for staff and trusts have been encouraged to look at different ways of working, prioritising patient care. Details of actions to improve patient and carer experience in the trust are published in the trusts Quality Account as well as on social media and the trusts website. We encourage you to view these sources of information to keep up to date with actions to improve patient and carer experience.

Contents

1. Volunteers supporting improvements in patient and carer experience

Voluntary Services transformed the way they worked in response to the pandemic. Many of the registered volunteers at the time fell in to vulnerable categories and were unable to continue with their usual shifts. Volunteers, who were willing and able to, registered as 'Team Support Workers' along with the overwhelming support of new recruits.

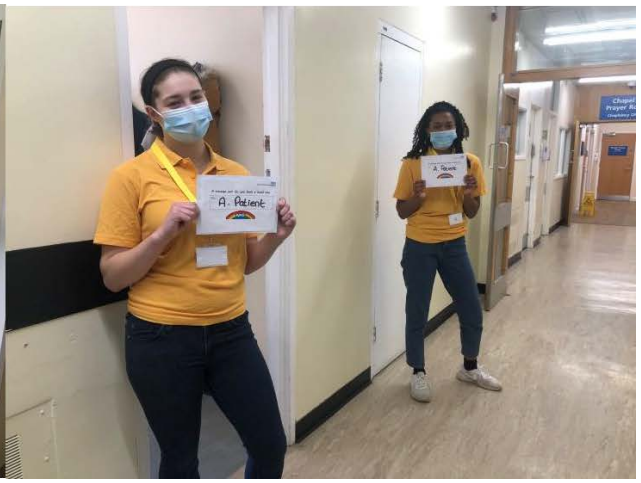
Following the 'first wave' the Response Volunteer model was launched in August 2020. Response Volunteers provide a flexible service which staff can call upon whenever a need for an extra pair of hands arises. They are able to access all areas of the hospital and can undertake any task which can be reasonably asked of a volunteer. This enables staff to access support for one-off or short notice tasks without having to recruit a permanent volunteer to their team. The flexibility also suits many volunteers, as they do not have to commit to a regular shift each week, but can book onto shifts to suit the time they have available. Response Volunteers have supported a wide range of teams across the hospital including; phlebotomy, pharmacy, Health@Work, maternity, charity, estates and facilities etc.

The Response Volunteers also delivered the 'Stay in Touch' letters written to patients from loved ones (1,553 letters delivered between April '20 and March '21). This was set up in response to government guidelines restricting visiting in hospitals.

Response volunteers supporting our phlebotomy service

Patients and family/loved ones can also make direct requests of the Response Volunteers. At a time when visiting was particularly limited in the hospital – Voluntary Services fielded calls from family members wanting to arrange for items to be delivered to patients, to arrange for volunteers to support them with a virtual visit (video call), for volunteers to sit with particularly lonely patients or read to them etc.. Not only did this new system empower patients and their loved ones to improve their own experience while in hospital – it also meant that the onus wasn't always on already-pressured staff to make the contact and request the volunteer support. The reactive nature of this volunteer project means that the Trust provides a responsive service – one that meets the changing needs and priorities in the hospital.

Staying in touch with family and friends with letters and pictures delivered to the patient's bedside



Butterflies are a team of volunteers who support people at the end of life. The team managed to maintain a service 7 days a week during the pandemic despite their numbers being reduced to 6 people. The reduced numbers were due to many volunteers falling into vulnerable categories and also due to lock down periods. At Christmas time the team did a recruitment campaign and had 250 applications to join the team and going into 2021 they had a larger team with representation from a more diverse section of the community.

In June 2020 the team were awarded a Queen's Award for Voluntary services the highest award a voluntary group can receive in the UK. The presentation ceremony was deferred to 2021

2. Improving experience for people with learning disabilities

Improvements made:

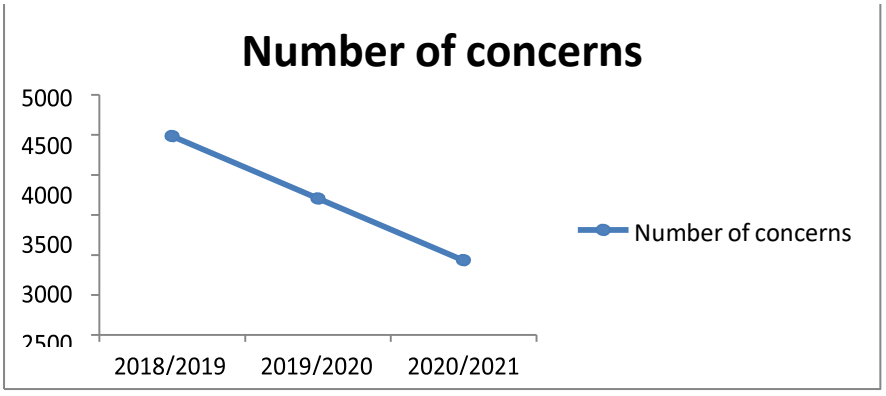
- Imbedded the purple wrist band scheme for people with LD's to opt into if they would like to be identified in this way so that our teams are aware of the need to check if the person has specific requirements for individualised reasonable adjustments to their communication or behaviour.
- Restarted bespoke LD face: face training.
- Added LD awareness mandatory training for all staff on the academy.
- Introduced Easy read appointment letters.
- Made routine visiting restriction exemptions for relatives/carers of individuals with LD on a risk assessment basis during the pandemic.
- Continual audit conducted to ensure that there were no inequalities in resuscitation (DNACPR) and treatment escalation plan (TEP) decisions amongst inpatients and ensured that clinical staff did not use Rockwood frailty scoring as a basis for making key decisions on ceilings of care for individuals with a LD.
- Participated in feedback sessions with individuals who have an LD to feedback and gauged what really matters to them during a hospital admission.
- Continued to work towards achieving NHS E/I improvement standards for individuals with LD in acute Hospitals and participated in the 3rd national LD audits.
- Autism awareness flag added to NerveCentre to prompt that individuals with autism will need individualised reasonable adjustments.
- Continued to participate in LeDeR program and implement improvements as identified through HSAB's improving healthcare outcomes group.

Ambitions for the year ahead:

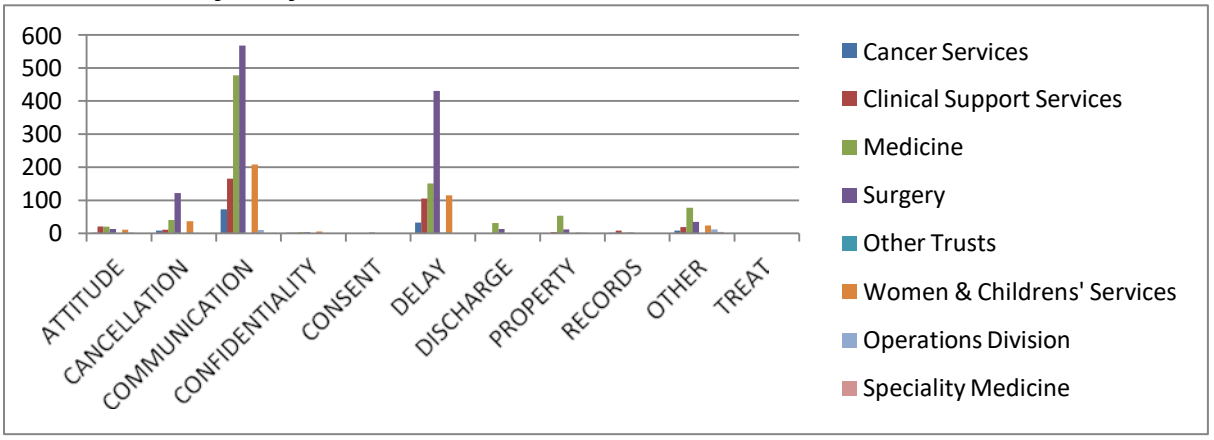
- For changing places toilet facility to be installed in outpatients/radiology department
- Finalise virtual tour of hospital
- Work toward introducing 'Ask', 'Listen', 'do' system which is a model recommended by NHS E for improving LD patient experience through provision of easy read guidance and easy to negotiate raising concerns complaints processes etc, https://www.england.nhs.uk/wp-content/uploads/2019/07/ask-listen-do-v2.pdf
- Increase the use of WIDGIT symbols beyond the radiology department to enhance communication between staff and individuals with LD (particularly important for children with LD)
- We have an individual with LD supporting delivery of bespoke LD training as an expert by experience relationship is managed by the HLT, we would like to the increase engagement of individuals with LD when designing Trust services.
- To develop a nursing associates LD role (working with partner agencies to students to identify a suitable number of students to create a viable university-based course

3. Learning from concerns

The numbers of concerns dropped from 3703 to 2932. There has been a reduction in the numbers of concerns over the last 3 years however we cannot draw conclusions from this at present as the reduction is likely to be due to the pandemic.



Divisions concerns by subject



The highest number of concerns raised related to communication. As this is such a large number of complaints we need to break this down to understand the specific issues of concern next year. However, when visiting was stopped in accordance with government guidance we knew that a big concern for families was being able to stay in touch with their loved ones. As a result of this we did several things, below are a few of these changes.

- Firstly there was a project on 10B to try and encourage more regular contact with family members of our patients. The team did see results while the project was running with more reliable contact with families within 48 hours of admission. The team got funding to create a video about the importance of including family members in their care planning.
- We started a 'what matters to you?' campaign to encourage better conversations between our teams and our patients and carers so that we ask, listen and do what matters most.
- Set up the keeping in touch and staying in touch services in response to restricted visiting to enhance communication between families and their loved ones in hospital and the tem and the

families. Staying in touch was a message delivery service and the keeping in touch service enable virtual visiting and the family liaison clinicians to update families on their loved ones medical condition.

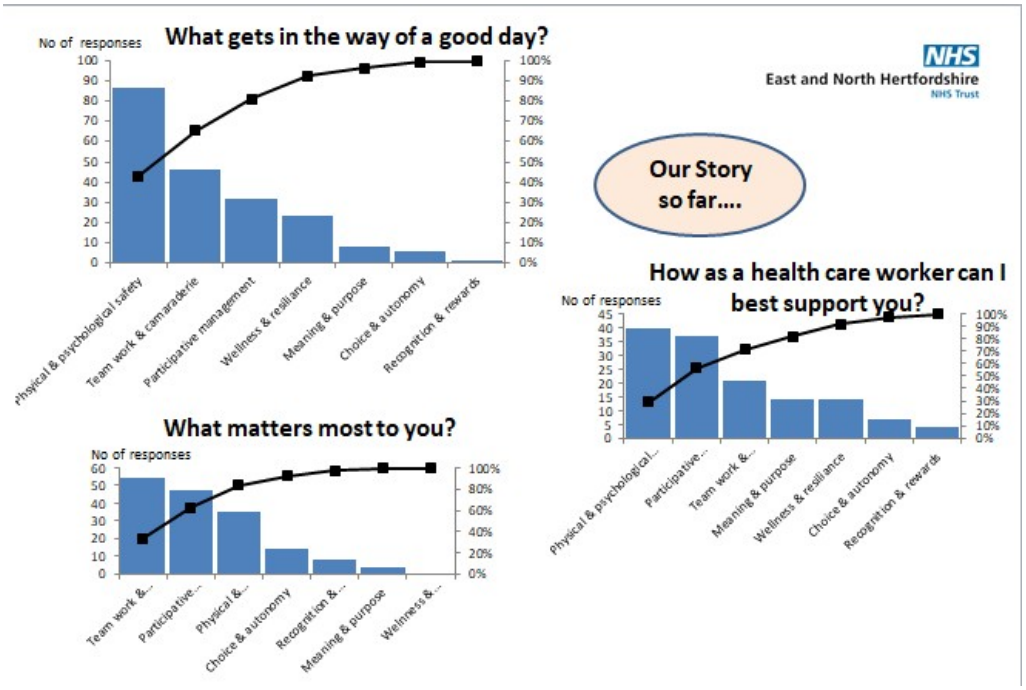
4. 'What matters to you?'

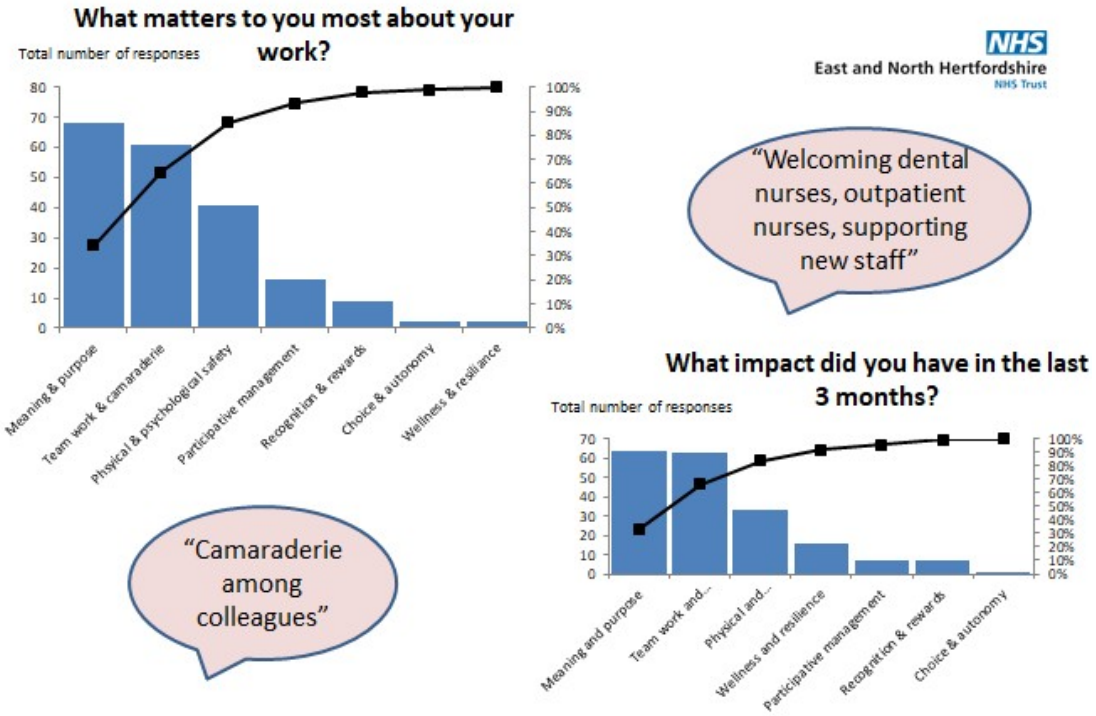
An improvement programme paper for patient and carer experience was published in 2020. The underlying principle of finding out what matters most to our patients and carers underpins the entire programme. We can ask, listen and do what matters most in the moment and we can also extract themes for improvement work by having these conversations.

'**What matters to you?**' is now part of the following:

- Patient & Carer Experience strategy – September 2020
- QISW certificate of presentation for our WMTY work @ International virtual QISW conference under category of Safety, Wellbeing & Quality care , September 2020
- The here to improve ENHT model – Our very own 7 step Model for Continuous Improvement , December 2020 asks WMTY in step 1 of the Model
- Integrated into our Appraisals & Shared Decision making councils
- WMTY Celebration certificates given out to staff on a regular basis

We held two awareness events in June and December 2020. We had over 300 what matters to you conversations with our teams to encourage them to see the value of these conversations and to find out what matters most to our teams. The evidence suggests that teams that are satisfied deliver high quality, excellent patient and carer so this work was a precursor to initiating improvement work to encourage our teams to have these conversations with patient and carers. The data has been fed into the staff experience group to link patient and carer experience with staff experience.





5. Keeping in touch service

The Keeping In Touch Service was set up and run from January 2021. The service was set up in order to:

- Support communication for patients and their families who cannot visit due to government guidelines.

- Improve patient and carer experience through introduction of an innovative service.
- Reduce the call volumes directed at wards causing distractions for already stretched teams
- Reduce PALS concerns and complaints related to communication
- Support staff health and wellbeing
- Aim for a 90% KIT service user satisfaction rate by the end of February

The service involved a digital call centre staffed by redeployed shielding team members from around the trust as well as a team of support workers and clinicians who carried out the calls and gathered information from the wards. Families and friend of patient could call in and request a clinical update more easily as the phone was manned Monday to Friday 8-5. They could also request that a virtual visit was set up and a team member would connect them with their loved one using digital devices donated by the charity and the new MS teams functionality that the trust acquired. The project was co-delivered with our digital partners.

	1st February Number of jobs requests	Number of job requests completed by the team In February	Percentage answered or fulfilled
Calls taken by call centre	449	382	85%
Virtual visits	213	204	96%
Clinical updates	117	112	96%
Other	52	52	100%
Total	382	316	

6. Task teams

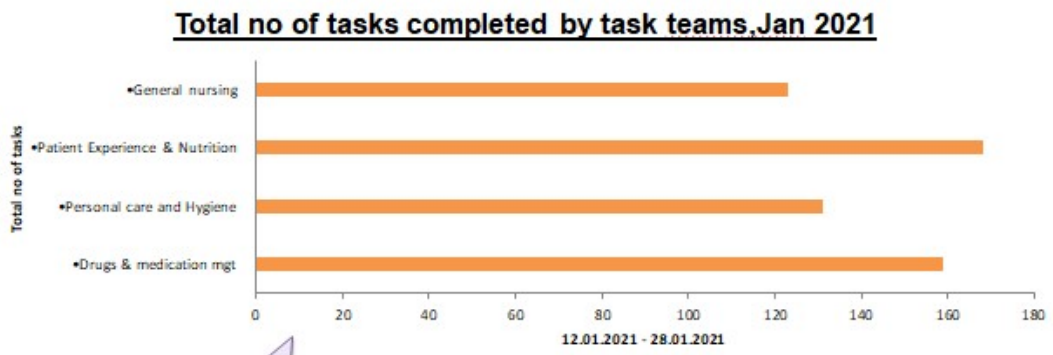
In the second wave of the pandemic from December 2020 to March 2021 the trust responded by setting up emergency task teams. This was in response to the increased demands on our services due the numbers of people with Covid in the trust and reduced staffing due to Covid related absences. In order to maintain a focus on quality and safety the task teams were set up and run using learning cycles. The teams were deployed to areas of highest need and their approach was standardised to ensure a focus on patient safety and patient and staff experience.

The data shows that most tasks were related to patient experience. This included help with nutrition and hydration, providing boredom busters or newspapers or spending time with people who were feeling lonely.

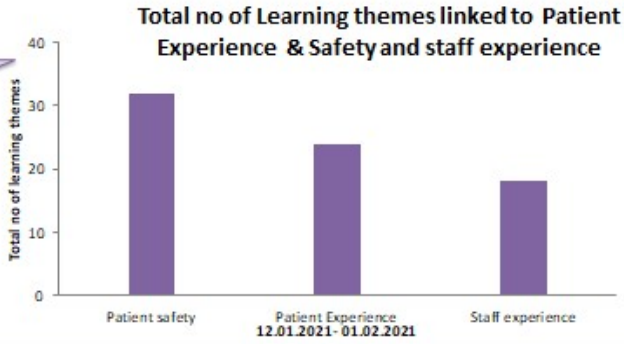
All task team members were trained to have what matters to you conversations. The learning from the day was summarised at a team debrief and action was taken to ensure the system was operating as safely as possible and where patient experience was noted to be inadequate we deployed staff to assist in those areas.

Task team Data...

East and North Hertfordshire NHS Trust



Cumulative total no of task team members trained: 145



Complaints Annual Report 2020-21

This report provides a summary of formal complaints received in 2020-21 in accordance with the NHS Complaints Regulations (2009).

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

Users of the services are encouraged to discuss their concerns with staff at the point an issue is identified. However, during 2020/21 with the COVID-19 pandemic and restricted visiting in place, the Trust recognised that it was not possible to have these discussions in person. The keeping in touch service (KIT) offered virtual video visits and/or clinical update calls to patients and their families. Families booked via a virtual call centre which was set up with redeployed and shielding staff. Clinical information from the ward teams was collated on a proforma and relayed to the family.

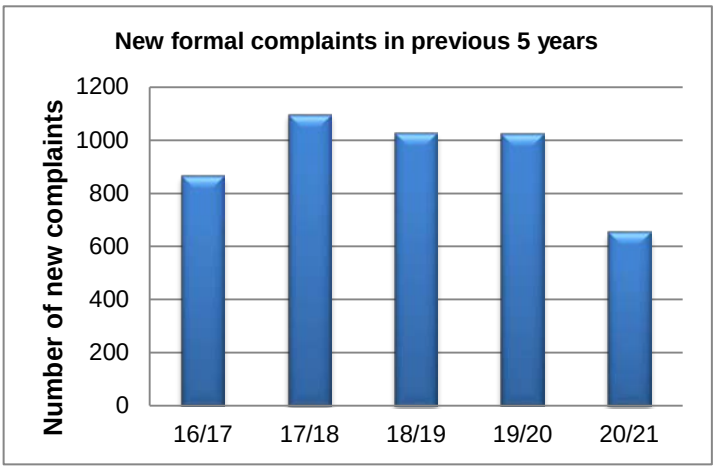
The Patient Advice and Liaison Service (PALS) provide 'on the spot advice and support' with the aim of timely resolution. In the event that this has not been achieved, PALS discuss with patients and relatives how their concerns can be appropriately resolved and where appropriate, provide advice to them on the formal complaints process.

The Trust recognises the value that learning from complaints and concerns brings. It is vital to make the process simple and easily accessible, and leaflets and posters are displayed throughout the hospital to help facilitate patient and carer feedback. During this year the clinical teams have been actively encouraged to share any relevant learning with the complaints team. This is to ensure that it is reflected in the final response so that the patient and/or relative can see the positive actions that have been taken. It also demonstrates first hand our commitment to learning from patient feedback and improving patient experience moving forward.

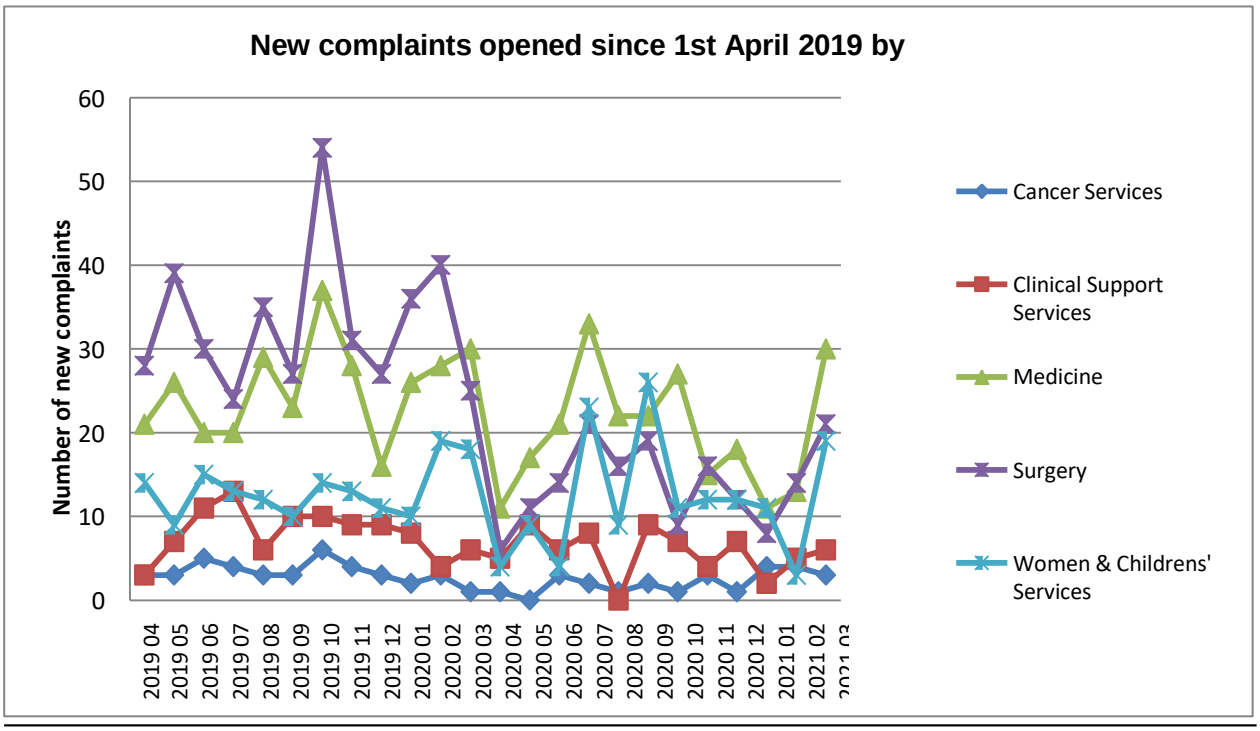
Complaints data assists with measuring the success of learning. The patient experience strategy sets out to reduce complaints relating to treatment/appointments, cancellations of surgery or clinic appointments along with complaints about the quality of treatment provided.

Formal complaints activity

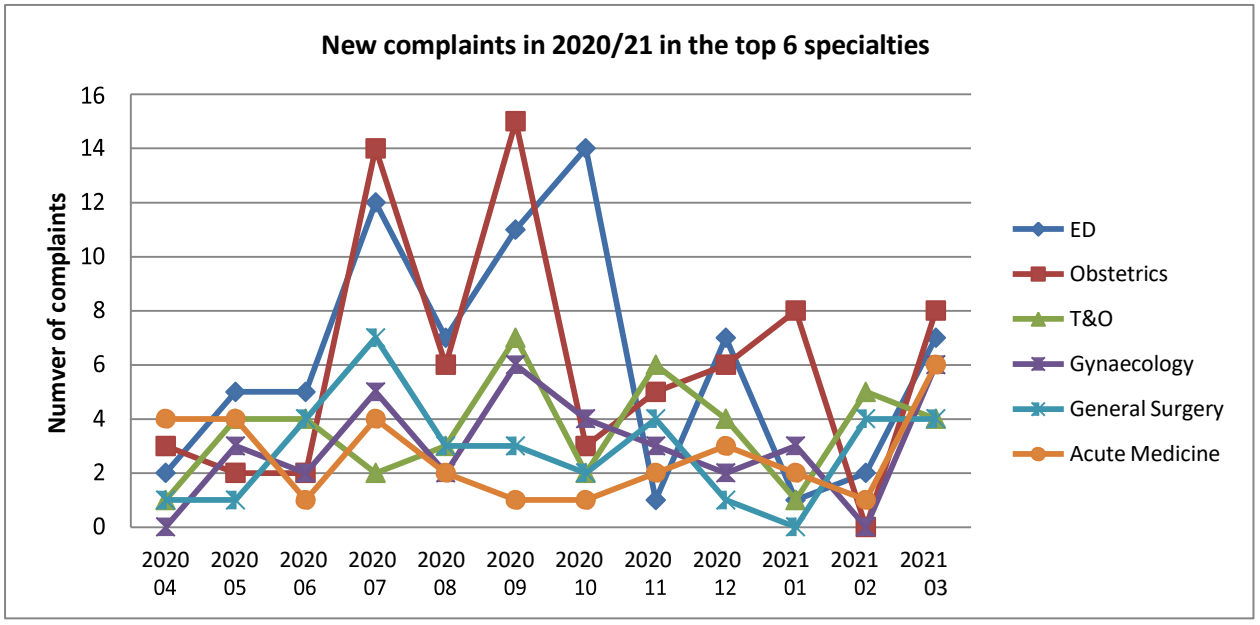
During 2020/21 as a result of the reduction in services, the number of formal complaints opened reduced. The following chart demonstrates the number of new formal complaints opened over the previous five financial years. As shown below, 2020/21 saw a reduction in the number of new complaints received at the Trust, a reduction of 36%. The COVID-19 pandemic began to impact Britain in early 2020 with the country going into national lockdown on 23 March 2020. This of course led to a dramatic reduction in elective activity within the hospital and a change in the nature of the patients we were caring for during the majority of 2020/21.



The graph below demonstrates the complaints opened each month in 2019/20 and 2020/21 within each of the main divisions. It is interesting to note that throughout all of 2019/20, the surgery division received the highest number of formal complaints however since then medicine has consistently received the highest number. This is due to the Trust pausing the majority of elective surgical activity during the COVID-19 pandemic in line with national guidance and the change in the type of patients we were treating. The number of complaints received by the cancer services division has remained relatively stable throughout the period.



The spike in complaints received in Women's and Children's Services seen in July and September 2020 were largely due to the visiting restrictions that the Trust put in place following national guidance that was issued. This pattern was promptly identified, escalated and actioned as detailed later in this report in the section 'learning from complaints'.



The graph above shows the new complaints received in 2020/21 in the top 6 specialties. It is interesting to note that complaints relating to ED and Obstetrics both followed a similar pattern between June and November 2020, albeit an erratic one. Quarter 2 showed significant spikes in the number of ED and Obstetrics complaints with July 2020 demonstrating an increase across all of the top 6 specialties other than T&O. The increase in complaints in July related to quality of care, communication and attitude.

The complaints team adapted their ways of working during the pandemic in recognition of the extreme demands that were already on the clinical teams. They looked to work differently in their investigation of formal complaints which included reviewing medical records and facilitating virtual meetings with staff to discuss what happened. The team have also tried to improve the support that they offer to clinical staff who are involved in complaints investigations as they recognised that these events and incidents also had a great impact on the staff as well as the patients.

Acknowledgement of formal complaints

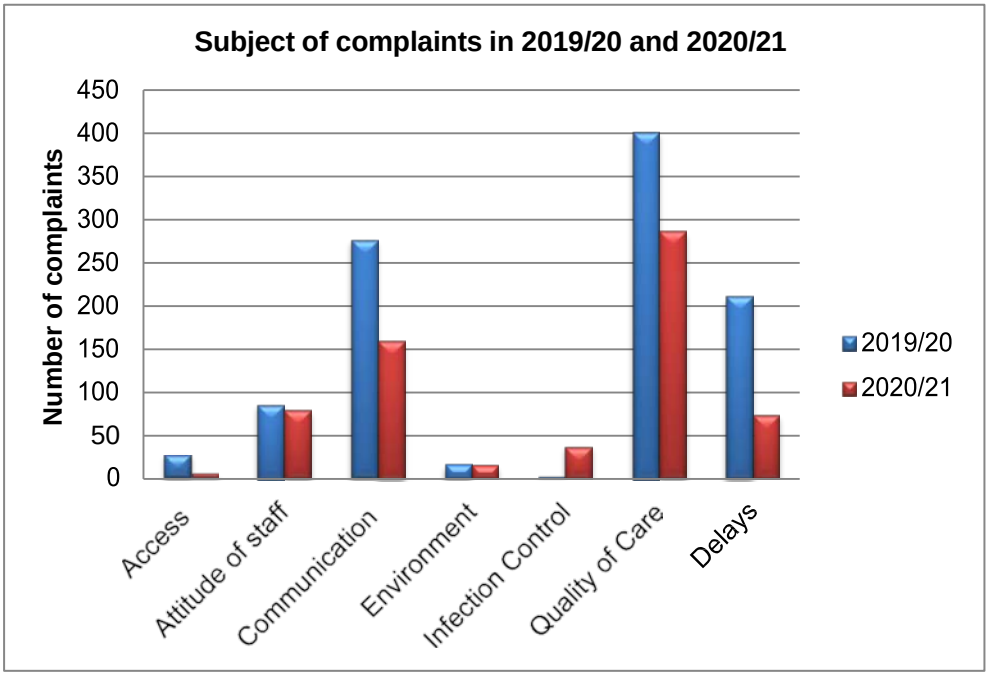
There is a mandatory requirement to acknowledge all formal complaints within three working days of receipt. In 2020/21, 94% of all complaints received were acknowledged within this timeframe.

Subject of formal complaints

The graph below compares the main subject recorded for new complaints received in 2019/20 and 2020/21. As noted above, in 2020/21 there was a 36% reduction in the number of formal complaints received. That reduction is further evident below when looking at the subject of those new complaints.

It is interesting to note that the number of complaints received that relating to the attitude of staff increased from 2019/20 to 2020/21; it accounted for 8% of formal complaints in 2019/20 and then 12% of formal complaints in 2020/21.

Complaints relating to infection control increased in 2020/21 which was to be expected given the COVID-19 pandemic and the associated IPC challenges that brought with it. Within those complaints relating to quality of care, 49% are recorded as relating to medical care and 20% relating to nursing care.



Outcome of formal complaints

During 2020/21, 681 formal complaints were closed. Of those closed, 25% were upheld, 24% partially upheld and 46% were not upheld. At the time of this report 62 remain under investigation.

Learning from complaints and concerns

Analysis of the themes from complaints and concerns is used to identify areas of the Trust that need additional resources or support to improve patient experience. In, addition the information gathered is compared with other patient experience feedback.

At the start of the pandemic all patients and relatives visiting the Trust was restricted in line with government advice. Women attending their antenatal scans were asked to attend alone to adhere to these guidelines unless they had a carer or exceptional circumstances. Once in active labour birthing partners were invited into the Trust to support the mother however they were not permitted to be present until that point. Understandably, this caused distress and upset to both pregnant women and their families. The team recognised the themes of these complaints and escalated appropriately. They maintained close relations with both the clinical teams and the Communications team throughout this time to ensure that we were providing consistent communication to our patients and trying to manage their expectations before they arrived at the hospital. For example further relevant communications were added to the Trust's social media pages and appointment correspondence.

The Trust was tasked with setting up a vaccination hub at Lister Hospital to support the vaccination programme. Initially the focus was to vaccinate front line staff. Then the focus moved to patients who were aged over 80 as these patients were identified at the highest risk of contracting COVID-19. The feedback initially received from patients was that they were having trouble accessing the service and some not familiar with the location and could not find it. These concerns were appropriately escalated and the Communications team and Estates team responded very promptly and within 24 hours there

was new and improved signage. They also introduced ramps to improve the ease of access to the building along with a team volunteers to further support the service. As a result, the feedback received then received very positive feedback from that point on.

The clinical teams are being asked to ensure they inform the complaints team when learning is taken from a complaint so as to ensure this information can be reflected in the final response and also it can be formally recorded on datix. Formally recording the learning is an ongoing area of focus and whilst it has improved, there is still further work to be done and this remains a priority.

Parliamentary and Health Service Ombudsman

The PHSO paused their service at the beginning of the COVID-19 pandemic and resumed investigations in July 2020.

From July 2020 – April 2021 the PHSO reviewed six cases. They confirmed that they would not be investigating four of these but they would be further looking into two. Of those two, one investigation is ongoing and one is already complete with no further action being taken.

Two cases from 2019/20 were also investigated during the reporting period for this report, and as such their outcomes will be included. Both cases were partially upheld on closure from further investigation by the PHSO, with the following actions required:

- **Case 1** – The Trust was required to pay £500 to the family in recognition of distress suffered.
- **Case 2** - The Trust was required to pay £950 to the family. The team have devised a new pathway and the PHSO is content that this will resolve any systemic issues with delay. However the PHSO are recommending that the Trust amend the pathway in line with NICE guidance so that it clearly describes the role of the case co-ordinator in order to remedy any systemic error with communication.

7. Facts and Figures 2020-21

National CQC Adult Inpatient Survey 2019 (published July 2020)

The CQC Adult Inpatient survey asked the views of adults who had stayed overnight as an inpatient in July 2019. 488 patients responded to the ENHT survey, a response rate of 41.4% (compared to 42.4% in the 2018 survey).

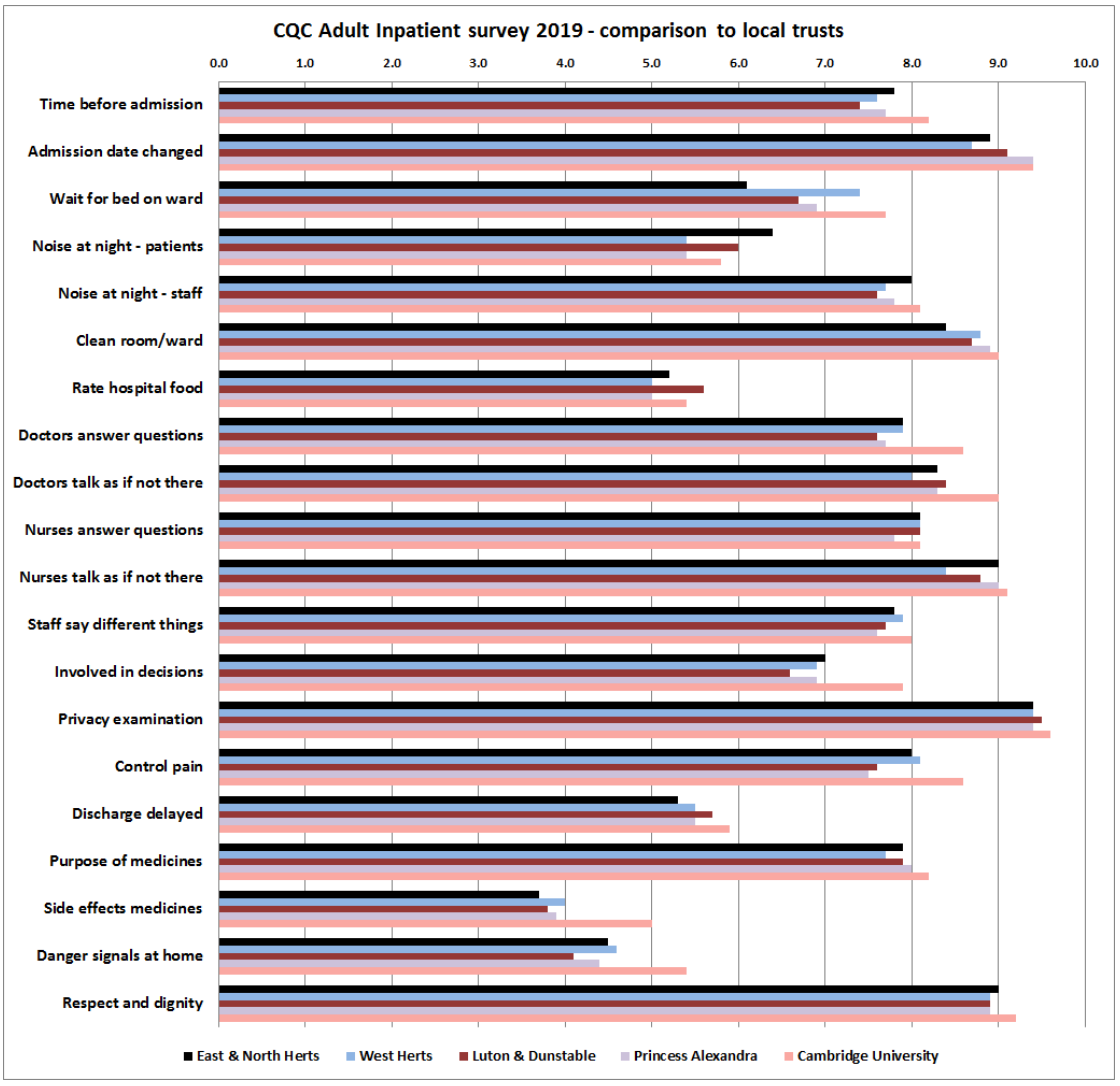
Inpatients were asked what they thought about different aspects of the care and treatment they received. The survey is divided into 11 sections and a score out of ten allocated for each question and section. Each trust is assigned a category showing whether their score is 'better', 'about the same' or 'worse' than most other trusts for each section and question.

Overall Trust Comparison:

The Trust scored 'about the same' as other Trusts for 56 questions in the 2019 inpatient survey and 'worse than other trusts' for the following 7 questions:-

- Operations and procedures: Beforehand, were you told how you could expect to feel after you had the operation or procedure?
- Operations and procedures: After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?
- Leaving hospital: Discharge delayed due to wait for medicines/to see doctor/for ambulance
- Leaving hospital: How long was the delay?
- Leaving hospital: Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?
- Leaving hospital: Did a member of staff tell you about medication side effects to watch for when you went home?
- Feedback on care and research participation: Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

The NHS Outcomes Framework indicator 4b: 'patient experience of hospital care' is measured by scoring the results of a selection of questions from the national Inpatient survey. The table below compares ENHT responses to these questions with local Trusts:



Comparison of ENHT 2018 and 2019 survey results

There are 61 questions that can be directly compared to the 2018 survey. The Trust scored 'significantly higher' for the following question:

- During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?
- The Trust scored 'significantly lower' for the following question:
- From the time that you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

There was 'no significant difference' for the remaining 59 questions.

National Cancer Survey 2019 (published June 2020)

The CQC standard for reporting performance based on 'expected ranges' has been used in this report. This means that Trusts are only flagged as outliers if their scores deviate from the range of scores that would be expected for Trusts of the same size.

The survey was sent to adult patients (aged 16 and over) with a primary diagnosis of cancer discharged from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment in the months of April- June 2019. In ENHT 1,070 patients responded to the survey – a response rate of 58% slightly below the average 61% nationally.

It has been identified that many questions within the survey scored below the national average and some slightly below the Trusts previous year's scores. Further work within the service will be needed to provide assurance on how we will be working towards improving the results in the following year.

ENHT results	2019	2018	2017	2016	2015
No. of question score **above** expected range	0	0	0	1	0
No. of question score **within** expected range	16	9	30	42	35
No. of question score **below** expected range	36	42	22	9	15

Local Patient Surveys

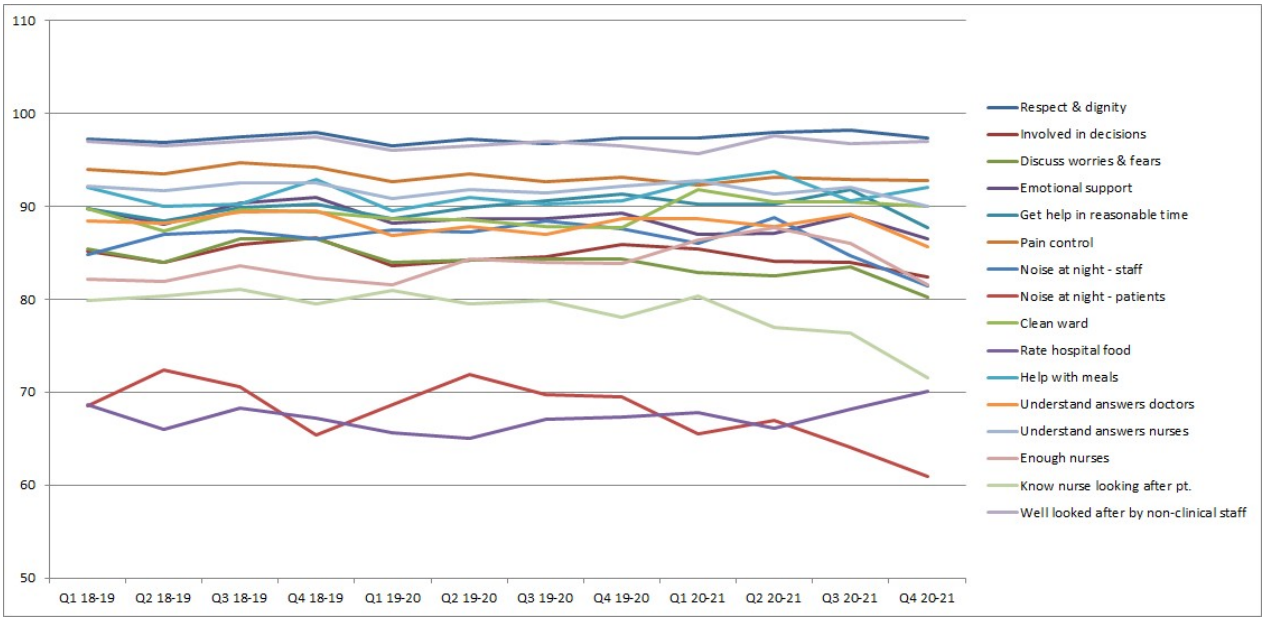
The Trust continually monitors feedback from patients and uses this feedback to make changes and improvements to the services it provides. An electronic patient survey system is in place called 'IQVIA' which enables patients to provide feedback by completing a survey on a simple electronic device (I-Pad) whilst they are in the hospital, or on a paper survey if preferred. Due to ward pressures and the infection control risk during the pandemic in 2020-21, 6937 patients completed one of our surveys (excluding the single question Friends and Family Test survey), a significant decrease from 23,086 surveys completed in 2019-20.

IQVIA Local Patient Experience Surveys	No. completed 2016-17	No. completed 2017-18	No. completed 2018-19	No. completed 2019-20	No. completed 2020-21
Inpatient	11,954	12,239	12,311	11,587	3597
Maternity	3,031	2,625	1,820	1,341	829
Day Case	3,679	2,091	760	706	210
Outpatients	2,123	5,447	5,969	5,814	757
Renal Dialysis Unit	1,278	1,101	1,453	1,352	1134
Discharge	739	583	677	731	112
Emergency Department/ UCC	372	321	279	157	49
Assessment	528	832	652	697	3
Neonatal Unit	121	139	154	182	81
Critical Care	51	107	200	245	63
Community Respiratory	45	221	275	214	3
Experience of End of Life Care		16	52	50	15
Bramble Safeguarding		3	1	0	0
Renal Tele-clinic		41	25	10	0
TOTAL	**23,921**	**25,766**	**24,628**	**23,086**	**6937**

Historically around 1,000 patients completed the inpatient survey whilst on the ward. This number dropped significantly during COVID, but the number of participants is now increasing. The data collected from this survey enables the Trust to monitor feedback month by month and address any areas of concern. The questions asked within the inpatient survey cover a wide range of topics such as:

- Respect and Dignity
- Medication
- Environment
- Support
- Staffing

The following chart shows a comparison of the inpatient survey results between 2018-19 to 2020-21:

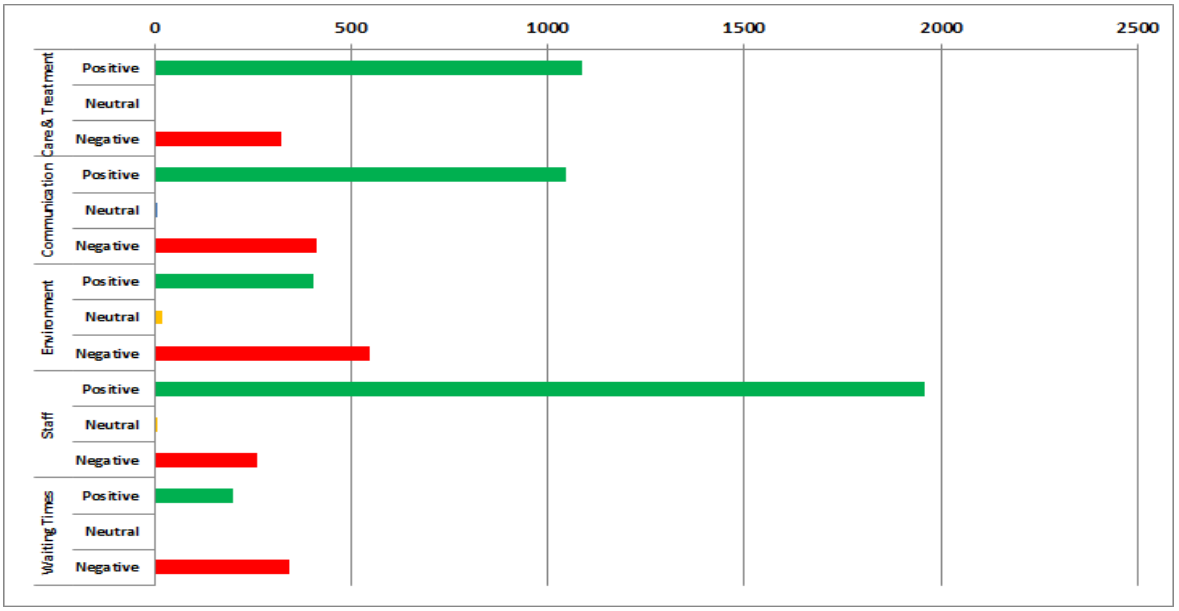


Comments sentiment trends

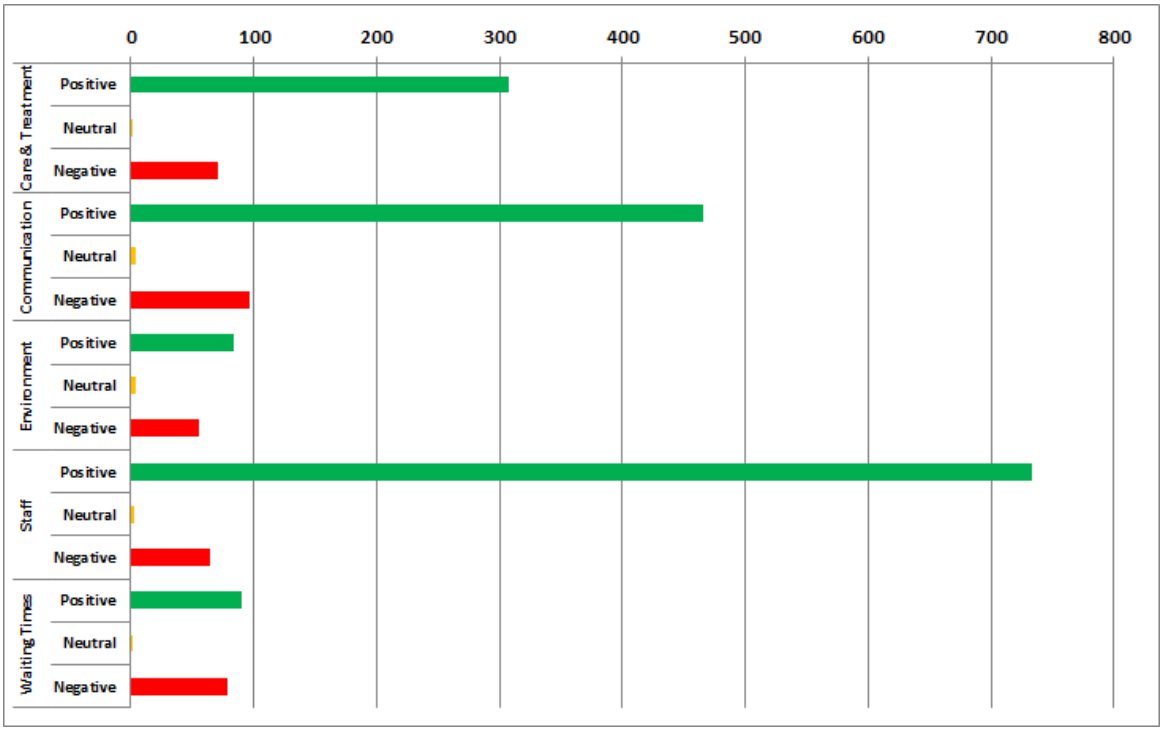
The IQVIA patient experience survey system automatically allocates a positive, neutral or negative rating to patient comments, theming them against the following five categories: Care and treatment, Communication, Environment, Staff, Waiting. This system has been set up using a 'word bank' against each of these categories.

The graphs below summarise the number of positive, negative and neutral comments against each category for 2020-21 for the Inpatient surveys and Outpatient surveys:

8. Inpatient Survey



Outpatient Survey



Friends and Family Test

The Friends and Family Test (FFT) asks **'Overall, how was your experience of our service?'** There are six response options ranging from 'very good' to 'very poor'.

In March 2020, NHS England/Improvement ceased the national FFT reporting requirements to enable staff resources to be diverted towards more immediate priorities during the Covid-19 pandemic. FFT data submission for acute settings resumed in January 2021 with trusts submitting their December 2020 data.

We have continued to collect feedback from patients during the Covid-19 pandemic although the response numbers are increasing they are still reduced in comparison to the pre-Covid period. Access to the Trust's surveys continues to be promoted to patients via the Trust website and the quick link www.tellusmore.or.uk – posters with this link and a QR code are widely displayed throughout the Trust. We also carry out post-discharge telephone calls to patients to ask for feedback regarding their experience of their most recent visit to hospital.

An easy read version of the FFT survey is offered to people (with appropriate support if needed) who have dementia, learning disability, are profoundly deaf, deafblind, blind/vision loss, have little or no English or low levels of literacy. Guidance is available for staff offering the FFT survey to patients with dementia or a learning disability. The FFT survey is also available on the Trust's intranet and website as a short video clip translated into British Sign Language and translated into different languages.

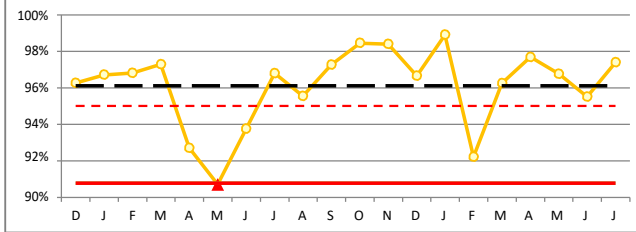
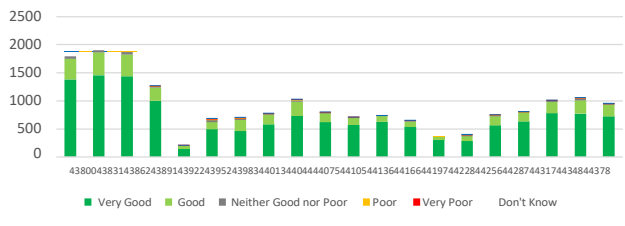
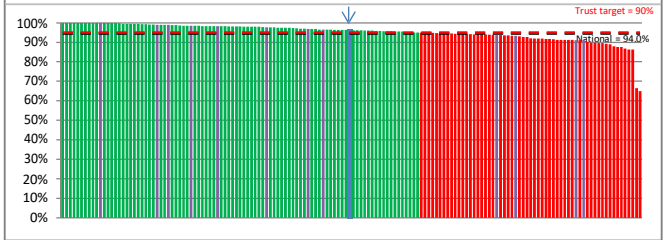
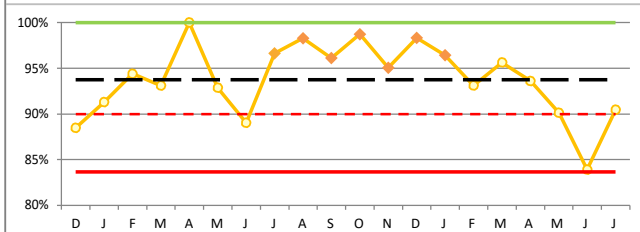
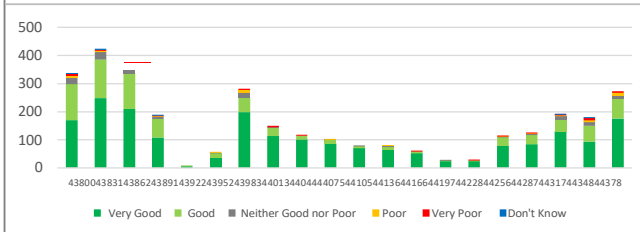
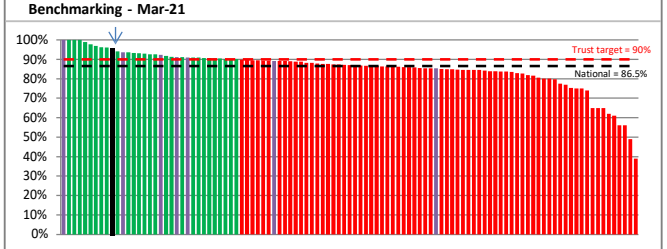
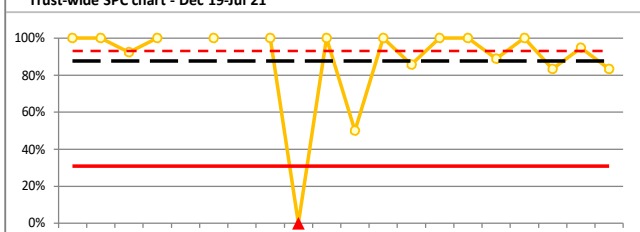
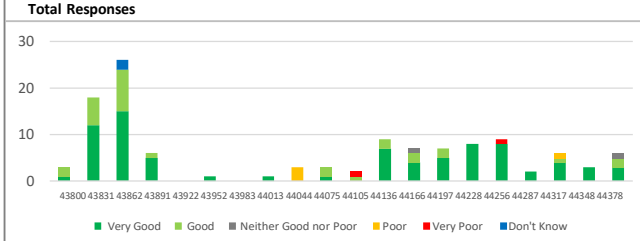
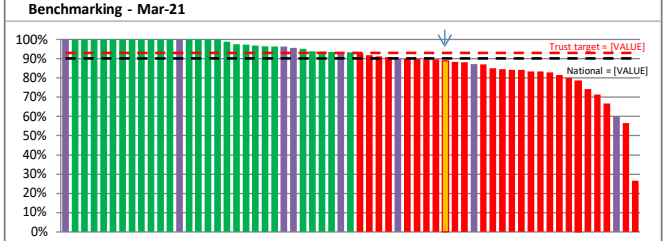
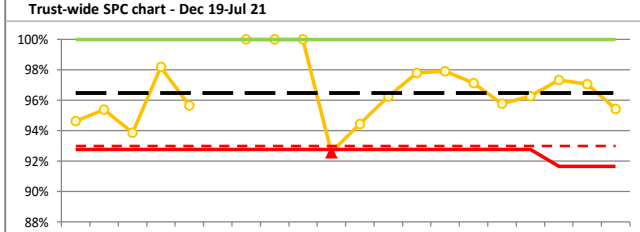
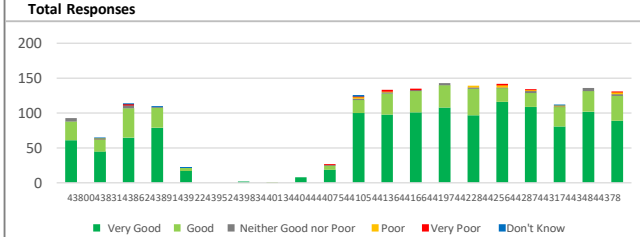
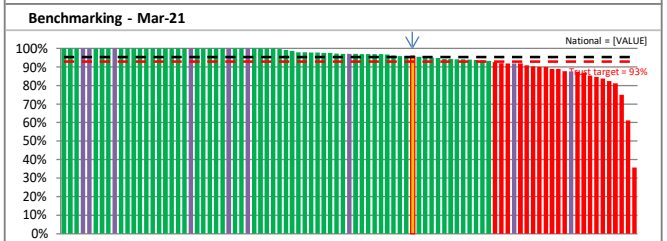
Summary of Trust FFT results and response rates (2020-21):

In 2020-21 14,533 patients responded to the Friends and Family Test question (compared to 65,035 in 2019-20).

The following charts show the number of positive responses, total responses and benchmarking data.

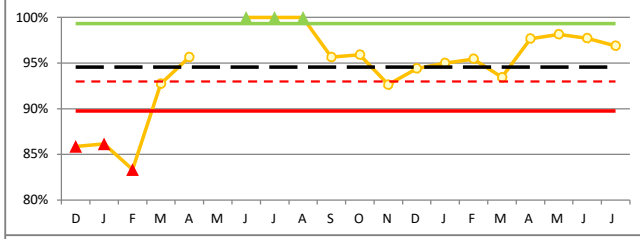
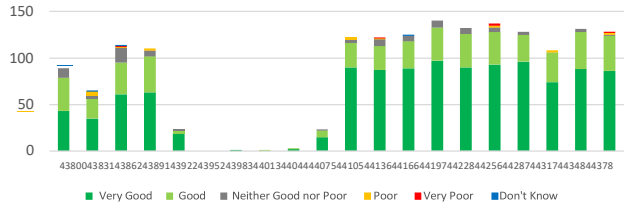
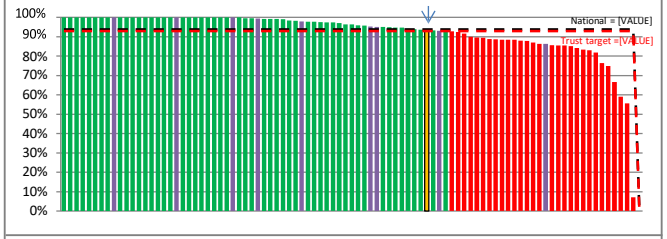
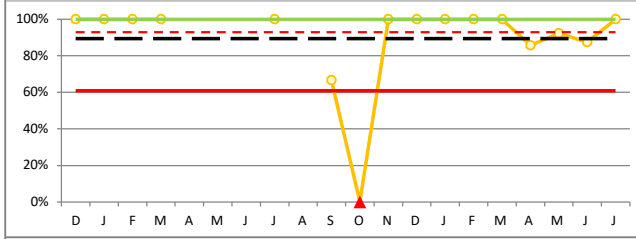
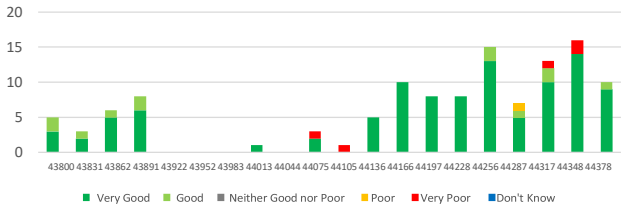
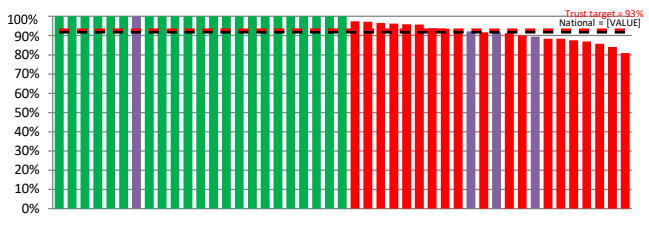
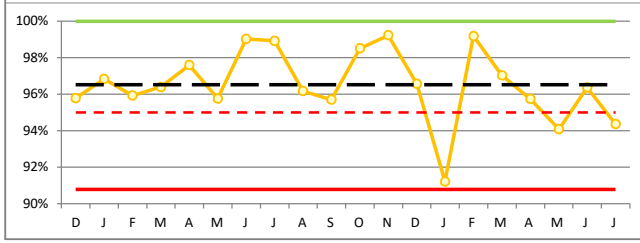
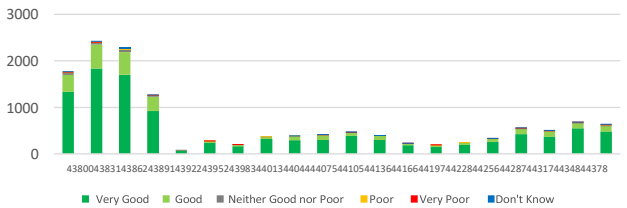
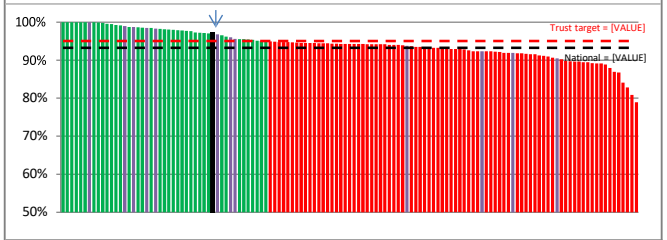
Friends and Family Test

NHS East and North Hertfordshire NHS Trust

Measure	Trust-wide SPC chart - Dec19 - Jul 21	Total Responses	Benchmarking - Mar-21
Inpatient Positive feedback			
A&E Positive feedback			
MAT - Antenatal Positive feedback			
MAT - Birth Positive feedback			

Friends and Family Test

East and North Hertfordshire NHS Trust

Measure	Trust-wide SPC chart - Dec 19-Jul 21	Total Responses	Benchmarking - Mar-21
MAT - Postnatal Positive feedback			
MAT - Community Positive feedback			
Outpatient Positive feedback			

East and North Hertfordshire NHS Trust

Agenda Item: 17.3

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022
EQUALITY & INCLUSION COMMITTEE – MEETING HELD ON 7 DECEMBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present the report from the Equality and Inclusion Committee meeting on 7 December 2021 to the Board.		
Action required: For information		
Previously considered by: **N/A**		
Director: **Chair of Equality & Inclusion Committee**	**Presented by:** **Chair of Equality & Inclusion Committee**	**Author:** **Corporate Governance Officer**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) The discussions at the meeting reflect the BAF risks assigned to the Equality and Inclusion Committee.
Any other risk issues (quality, safety, financial, HR, legal, equality): N/A

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

East and North Hertfordshire NHS Trust

Agenda Item:17.4

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022

STRATEGY COMMITTEE – 17 NOVEMBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board the summary report from the Strategy Committee meeting held on 17 November 2021. The report includes details of any decisions made by the Strategy Committee under delegated authority.		
Action required: For discussion		
Previously considered by: N/A		
Director: Chair of Strategy Committee	**Presented by:** Chair of Strategy Committee	**Author:** Corporate Governance Officer

Trust priorities to which the issue relates:	**Tick applicable boxes**
Quality: To deliver high quality, compassionate services, consistently across all our sites.	☒
People: To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.	☒
Pathways: To develop pathways across care boundaries, where this delivers best patient care.	☒
Ease of Use: To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff.	☒
Sustainability: To provide a portfolio of services that is financially and clinically sustainable in the long term.	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) The discussions at the meetings reflect the BAF risks assigned to the Strategy Committee.
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

STRATEGY COMMITTEE – 17 NOVEMBER 2021

EXECUTIVE SUMMARY REPORT TO TRUST BOARD

The following Non-executive Directors were present:
Karen McConnell (Strategy Committee Chair), Biraj Parmar (Associate Non-Executive Director) and Ellen Schroder (Trust Chair).

The following core attendees were present:
Martin Armstrong (Director of Finance and Deputy CEO), Julie Smith (Chief Operating Officer), Michael Chilvers (Medical Director), Rachael Corser (Chief Nurse), Kevin O'Hart (Director of Improvement), Mark Stanton (Chief Information Officer), Thomas Pounds (Chief People Officer), Mary Hartley (Deputy Director of Strategy).

MATTERS TO BE REFERRED TO THE BOARD
No specific issues were referred to the Board.

MATTERS CONSIDERED BY THE COMMITTEE:

STRATEGIC REFRESH:
STRATEGIC PLANNING FRAMEWORK
The Committee received an update on the progress with the strategic planning framework which reflected progress on the vision and strategic objectives to date and considerations in relation to service prioritisation. Work had commenced on the development of baseline models including the finalisation of a Do Nothing scenario model. A series of transformation roadmaps were being developed in alignment with digital and estates roadmaps. An Integrated Business Plan was being prepared and would be reviewed at the relevant Trust Committees and the Trust Board in early 2022.

The Committee welcomed the update and noted the progress to date and future plans.

TRANSFORMATION PORTFOLIO UPDATE
The Committee received an update on the wider transformation portfolio and discussions were held around projects on admission avoidance and discharge improvement. Further key areas where there was a need for focus on transformation would be discussed at the February Strategy Committee meeting.

DISCHARGE IMPROVEMENT PROPOSAL
The Committee received an update on the discharge improvement process. It was noted that work was being undertaken to simplify the discharge process and to create a single vision where everyone was clear on the process to follow for discharge from the front door. This would be a long term project for improvement and discussions were being held on how to work collaboratively with system partners.

ENABLING STRATEGIES:
DIGITAL STRATEGY
The Strategy Committee received and noted an update on the digital strategy. The Committee heard that the Trust was selected as one of 10 digital aspirants in 2021. This was a levelling up exercise which included funding and support from NHS Digital in order for

the Trust to achieve a good level of digital maturity. There was a specific process that the Trust needed to go through to form a strategy and then submit a case for funding.

UPDATED GREEN PLAN

The Committee was presented with a high level overview of the Green plan and sustainability agenda and the steps towards the transformation to a net zero NHS. Key actions that could be taken over which the Trust had control were noted including actions on the estate as part of the decarbonisation process.

The next steps in delivering against the Green plan would encompass two significant programmes of work:

- Creation of the Green plan delivery programme which was a 25 year programme.
- Commissioning of a site-wide energy strategy and decarbonisation plan that would run until 2045.

The Committee noted that one of the challenges for the Green plan and the Trust's sustainability journey would be conflicting policy agendas with various other NHS policies.

The Green plan was approved by the Committee for submission to Board for final appoval.

STRATEGIC PROJECTS:

ICS PATHOLOGY PROCUREMENT

The Committee noted the update regarding the ICS Pathology Procurement and was informed that the project had not yet proceeded to Best and Final offer (BAFO). The full business case was yet to be approved and signed off by all six organisations involved.

MVCC SERVICE RE-PROVISION AND NETWORKED RADIOTHERAPY UPDATE

The Strategy Committee noted the overview provided regarding the MVCC Service re-provision and the development of the proposal for networked radiology. The overall status report rating was currently amber. Feedback was awaited following the UCLH Expression of Interest in the Department of Health and Social Care's new hospital programme.

SYSTEM COLLABORATION

This item had been discussed at the Public Trust Board meeting held on 3 November. The Committee noted the outputs from the five task and finish groups that had been put in place.

BOARD ASSURANCE FRAMEWORK

The Strategy Committee received the latest version of the Board Assurance Framework and the risks that had been assigned to the Committee. Discussion was held during the meeting against all areas over which the Committee had oversight and there was assurance on how the risks would be mitigated.

Karen McConnell
Strategy Committee Chair

January 2022

East and North Hertfordshire NHS Trust

Agenda Item:17.5

TRUST BOARD – 12 JANUARY 2022
CHARITY TRUSTEE COMMITTEE – MEETING HELD 13 DECEMBER 2021
EXECUTIVE SUMMARY REPORT

Purpose of report and executive summary (250 words max): To present to the Trust Board **in its capacity as Corporate Trustee** the summary report from the Charity Trustee Committee (CTC) meeting held on 13 December 2021.		
Action required: For information		
Previously considered by: N/A		
Director: Chair of CTC	**Presented by:** Chair of CTC	**Author:** Corporate Governance Officer

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality: our sites	To deliver high quality, compassionate services, consistently across all	☒
People: develops an	To create an environment which retains staff, recruits the best and engaged, flexible and skilled workforce	☒
Pathways: patient	To develop pathways across care boundaries, where this delivers best care	☒
Ease of Use: simple and staff	To redesign and invest in our systems and processes to provide a reliable experience for our patients, their referrers, and our	☒
Sustainability: clinically sustainable in	To provide a portfolio of services that is financially and the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) N/A
Any other risk issues (quality, safety, financial, HR, legal, equality):

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CHARITY TRUSTEE COMMITTEE MEETING HELD 13 SEPTEMBER 2021

SUMMARY REPORT TO BOARD

The following members were present: Bob Niven (CTC Chair), Val Moore (Non-Executive Director) and David Buckle (Non-Executive Director)

Key decisions made under delegated authority:
The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its Terms of Reference:

Approval for expenditure over £5,000
The Committee discussed the following applications for expenditure over £5,000:

Proposal	Cost	Outcome
Cancer: To purchase rehabilitation equipment for new rehab and wellbeing gym.	£26,000	Approved with a request for confirmation on the usage and what would happen if the service was not fully used.
Maternity: To provide counselling to parents who have experienced baby loss at the Trust.	£18,900 for 12 months	Approval to support short-term funding, with the possibility of extending it to the 12 months. This was conditional on discussions taking place for further non-Charity funding.
Cancer: To provide specialist cancer hair care services for patients with hair loss.	£13,440	Approved.
Unplanned Care: To replace 16 TVs in the Acute Medical Unit.	Approx. £8,320	Approved.
Palliative Care: To extend the Butterfly Coordinator role for a further year.	£14,151	Approved.

Other outcomes:

Investment Portfolio Update

The CTC received a report on the Charity's investment portfolio and factors affecting its performance from Rathbones (who were not present at the meeting). The Trust's Charity portfolio return since 31 August 2021 was -2.1% which was behind the benchmark. The Chair of CTC undertook to make contact with Rathbones to explore the underperformance.

Charity Highlight Report

The CTC received the Charity Highlight Report. The Committee was informed that activities were being scheduled to generate income for the Charity. The Charity had enjoyed excellent press coverage since September with 12 press releases sent out resulting in 72 articles published. The Charity was also successful in a bid to be featured in the Sun Christmas Campaign. The Committee noted that compared to historic fundraised income, lower levels of income generated were being seen as a consequence of the pandemic and the ability to hold events although legacy income had increased.

Charity Governance and Approvals

A report was presented to the Committee, noting that there was a need to ensure that CTC meetings operated effectively and efficiently and that the Committee had the time and information needed to ensure sound governance and assurance for the larger, more expensive and complex bids, whilst operating with the Trust's Standing Financial Instructions (SFIs).

The Committee approved option 2, maintaining the current levels of approvals and a number of changes to create efficiency including sending out a 'Projects for Approval' paper in advance with full project details, applicants to be available for questions only and decisions to be taken in the order of highest value first. The process would be continually reviewed.

Major Projects Update

The Committee was informed of the latest developments around the Sunshine Appeal and noted that a new location had been found with the space being better suited for the project. Pledges had been received to support the project and a match funding campaign was being considered.

The Committee also received an update on how funds had been spent in relation to the #HereForEachOther campaign.

Charity Finance Report and Reforecast

The Committee received the Finance Report and was informed that as at 31 October 2021 the year to date income was £685k against a budget of £669k (excluding Gifts in Kind). The year to date legacy income was £320k against a budget of £34k (this surplus compensated for the adverse variance in 'all other income'). It was noted that fundraising income was suffering as a direct result of COVID and it was felt that this would continue for the foreseeable future. Expenditure was slightly higher than anticipated. To assist with managing the Charity's income position, a reforecast was brought to meeting and an income reforecast was proposed from £1.52m to £1.28m. This reforecast was approved by the Committee.

Charity Strategy Update

The Committee was informed that a meeting had taken place with the Non-Executive Directors and others in order to discuss a framework for the Charity strategy. The aim was to produce a strategy to steer activity by April 2022.

Charity Annual Report and Accounts (Final)

The Committee received and approved the final version of the East and North Hertfordshire Hospitals' Charity Annual Report and Accounts 2020/21 which had been considered and approved by the Audit Committee at its meeting on 19 October and Trust Board on 3 November.

External Auditor's Report

The Committee received the East and North Hertfordshire NHS Trust Charitable Fund Final Audit Completion Report for the year ended 31 March 2021. There had been no significant changes to the figures brought to the CTC in September, however a classification error was noted which had subsequently been amended in the accounts. The audit was now complete and the Letter of Representation had been approved and the auditors would now issue their opinion. The Final Charity Annual Report and Accounts 2021-22 and External Auditor's Report are included on the Trust Board (as Corporate Trustee) agenda for noting.

Any Other Business

The Committee noted that this was Mr Niven's last meeting as CTC Chair and thanked him for his support, assistance and leadership. Dr Buckle was confirmed as the next CTC Chair.

Bob Niven
Chair of the Charity Trustee Committee
January 2022

East and North Hertfordshire NHS Trust

Agenda Item: 17.5.1

TRUST BOARD - PUBLIC SESSION – 12 JANUARY 2022

CHARITY ANNUAL REPORT AND ACCOUNTS 2020/21

Purpose of report and executive summary (250 words max): For information, to present the East and North Hertfordshire Hospitals' Charity Annual Report and Accounts 2020/21 as audited by BDO.		
Action required: For information		
Previously considered by: **The annual report and accounts and auditor's report was considered and approved by the Audit Committee at its meeting on 19 October and Trust Board on 3 November and was approved by CTC on 13 December.**		
Director: **Chief People Officer**	**Presented by:** **Charity Director / Financial Controller**	**Author:** **Charity Director**

Trust priorities to which the issue relates:		**Tick applicable boxes**
Quality:	To deliver high quality, compassionate services, consistently across all our sites	☒
People:	To create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce	☒
Pathways:	To develop pathways across care boundaries, where this delivers best patient care	☒
Ease of Use:	To redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff	☒
Sustainability:	To provide a portfolio of services that is financially and clinically sustainable in the long term	☒

Does the issue relate to a risk recorded on the Board Assurance Framework? (If yes, please specify which risk) N/A
Any other risk issues (quality, safety, financial, HR, legal, equality):

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

Draft Board Annual Cycle 2021-22

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	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework		X		X		X		X		X		X
Data Pack		X		X		X		X		X		X
Patient Testimony (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Operational and People Recovery		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X				X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and People Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
Strategy Committee		X		X				X		X		
Inclusion Committee				X		X		X		X		X
Strategy												
Annual Operating Plan and objectives *(subject to change as dependent on national timeline)TBC*				X								

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
System Working (ICS and ICP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update		X		X		X		X		X		X
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report								X				
Freedom to Speak Up								X *Deferred to Jan*		*Deferred to Mar*		X
Review of Trust Standing Orders and Standing Financial Instructions								X				
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review								X *Deferred to Jan*		*Deferred to Mar*		
Finance, Performance and People Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report								X				

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Equality and Diversity Annual Report and WRES *Note – Likely to move to Inclusion Committee*						X						
Gender Pay Gap Report *Note – Likely to move to Inclusion Committee*												X
Market Strategy Review - *TBC*												
Quality and Safety Committee												
Complaints, PALS and Patient Experience Report		X *See April QSC*				X		X *Deferred to Jan*		X		
Safeguarding and L.D. Annual Report (Adult and Children)				X								
Staff Survey Results												X
Learning from Deaths		X		X				X		X		
Nursing Establishment Review				X						X		
Responsible Officer Annual Review								X				
Patient Safety and Incident Report (Part 2)		X		X				X				X
University Status Annual Report				X *Deferred to Sept*		X						
QSC TOR and Annual Review								X				
Strategy Committee												
Digital Strategy Update				X *Deferred*				X *Covered at Oct Board Dev.*				X
Strategy Committee TOR and Annual Review								X *Deferred to Jan*		*Deferred to Mar*		

Draft Board Annual Cycle 2021-22

Items	April 2021	5 May 2021	June 2021	7 Jul 2021	Aug 2021	1 Sept 2021	Oct 2021	3 Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
Shareholder / Formal Contracts												
ENH Pharma (Part 2)				**X** *Received and discussed at 2 June Board Developme nt meeting*								

DATA PACK

Contents

1. Performance Data:

CQC Registration and recent Care Quality Commission Inspection

2. Friends and Family Test Report

Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission inspected eight of the core services provided by East and North Hertfordshire NHS Trust across Lister Hospital, the New Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 23 - 25 & 30 – 31 July 2019. The well led inspection took place from 10 – 11 September 2019. The Use of Resources inspection, which is led by NHS Improvement took place on 6 August 2019.

The inspectors focused on **Safety, Effectiveness, Responsiveness, Care and how well led services are** in eight core service lines:

At **Lister Hospital** CQC inspected:

- Surgery
- Critical Care
- Children's and young people
- End of life care
- Outpatient

At the **New QEII Hospital** CQC inspected:

- Urgent Care Centre
- Outpatients

At the **Mount Vernon Cancer Centre** CQC inspected:

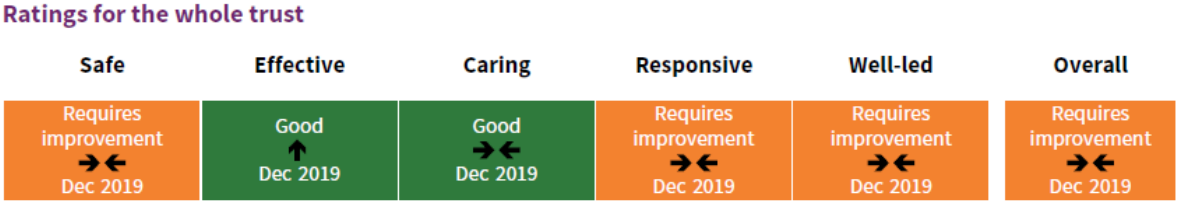
- Medicine (MVCC)
- Radiotherapy (MVCC)
- Outpatients

At the July 2019 inspection, these core services were rated either as requires improvement or good.

Summary of the Trust's Ratings

Our rating of the Trust stayed the same -**requires improvement**.
We were rated as **good** for caring and effective and **requires improvement** for and safe, responsive and well led.

We were rated as **requires improvement** for use of resources



	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
Queen Elizabeth II Hospital	Requires improvement ↑ Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement ↓ Dec 2019	Requires improvement ↑ Dec 2019	Requires improvement ↑ Dec 2019
Mount Vernon Cancer Centre	Requires improvement → ← Dec 2019	Good → ← Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
Hertford County Hospital	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement → ← Dec 2019	Good ↑ Dec 2019	Good → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019	Requires improvement → ← Dec 2019
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

The CQC have issued a number of requirement notices and set out a number of areas for improvement - “Must Do’s” and “Should Do’s”.

The requirement notices are:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

An action plan was been developed against all of these and was submitted to CQC on 22 January 2020. This was monitored by the Quality Improvement Group, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. Regular updates have been provided to the CQC and the action plan was formally closed in 2021. A programme of internal and external inspections remain in place to test and evidence progress and that the actions are embedded across the organisation.

During 2021 we have participated in a number of virtual assurance assessments with CQC on well led, medicine management, infection prevention and control and across our core pathways. These have all been positive but are not rated.

Site Ratings

East and North Hertfordshire NHS Trust

Lister Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Good July 2018	Good July 2018	Good July 2018	Good July 2018	Good July 2018		Good July 2018
Medical care (including older people's care)	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Surgery	Inadequate December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Critical care	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Maternity	Requires Improvement July 2018	Good July 2018	Good July 2018	Good July 2018	Good July 2018		Good July 2018
Services for children and young people	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
End of life care	Good December 2019	Requires Improvement December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients	Good December 2019	Good December 2019	Good December 2019	Good December 2019	Good December 2019		Good December 2019
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019

New QEII

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Urgent and emergency services	Requires Improvement December 2019	Good December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019		Requires Improvement December 2019
Outpatients and diagnostic imaging	Requires Improvement December 2019	N/A	Good December 2019	Requires Improvement December 2019	Good December 2019		Requires Improvement July 2018
Overall	Requires Improvement December 2019	Good December 2019	Good December 2019	Requires Improvement December 2019	Requires Improvement December 2019		Requires Improvement December 2019

Hertford County Hospital

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Outpatients	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Good March 2016	Good March 2016	Good March 2016		Good March 2016

Mount Vernon Cancer Centre

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Medical care (including older people's care)	Requires Improvement December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 → ←		Requires Improvement December 2019 → ←
End of life care	Requires Improvement July 2018	Good July 2018	Good July 2018	Inadequate July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Outpatients	Good December 2019 → ←	N/A	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 ↓		Requires Improvement December 2019 ↓
Chemotherapy	Requires Improvement July 2018	Good July 2018	Good July 2018	Requires Improvement July 2018	Requires Improvement July 2018		Requires Improvement July 2018
Radiotherapy	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←		Good December 2019 → ←
Overall	Requires Improvement December 2019 → ←	Good December 2019 → ←	Good December 2019 → ←	Requires Improvement December 2019 → ←	Requires Improvement December 2019 → ←		Requires Improvement December 2019 → ←

Community Health Services for Children, Young People and Families

	Safe	Effective	Caring	Responsive	Well-Led		Overall
Community health services for children and young people	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016		Good March 2016
Overall	Good March 2016	Good March 2016	Outstanding March 2016	Good March 2016	Good March 2016		Good March 2016

Friends and Family Test - November 2021

APPENDIX 1

Inpatients & Day Case	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No of Patients eligible to respond
5A	85.71	0.00	5	1	1	0	0	0	7	167
5B	66.67	0.00	0	2	1	0	0	0	3	29
6A	100.00	0.00	7	8	0	0	0	0	15	37
6B	88.89	0.00	7	9	2	0	0	0	18	58
7A	95.83	0.00	19	4	1	0	0	0	24	119
7B	96.30	0.00	13	13	1	0	0	0	27	157
8A	100.00	0.00	2	15	0	0	0	0	17	67
8B	100.00	0.00	1	0	0	0	0	0	1	29
9A	100.00	0.00	6	4	0	0	0	0	10	43
9B	96.43	0.00	11	16	1	0	0	0	28	29
10A	100.00	0.00	5	3	0	0	0	0	8	23
10B	66.67	0.00	2	0	1	0	0	0	3	46
11A + 11B/RSU	93.18	0.00	24	17	2	0	0	1	44	77
ICU1	100.00	0.00	2	0	0	0	0	0	2	10
SSU	94.44	0.00	24	10	2	0	0	0	36	79
ACU	97.67	0.00	33	9	0	0	0	1	43	81
AMU2	97.37	0.00	24	13	1	0	0	0	38	83
Ashwell	90.91	0.00	12	8	2	0	0	0	22	24
Barley	100.00	0.00	7	5	0	0	0	0	12	34
Pirton	100.00	0.00	24	13	0	0	0	0	37	47
Swift	92.73	1.82	40	11	3	1	0	0	55	164
Day Surgery Centre, Lister	100.00	0.00	4	0	0	0	0	0	4	402
Day Surgery Treatment Centre	100.00	0.00	61	6	0	0	0	0	67	354
Endoscopy, Lister	98.84	1.16	78	7	0	1	0	0	86	819
Endoscopy, QEII	100.00	0.00	48	4	0	0	0	0	52	202
Cardiac Suite	100.00	0.00	52	1	0	0	0	0	53	111
MEDICINE/SURGERY TOTAL	96.91	0.28	**511**	**179**	**18**	**2**	**0**	**2**	**712**	**3291**
Bluebell ward	100.00	0.00	15	7	0	0	0	0	22	143
Bluebell day case	NP	NP							0	19
Neonatal Unit	100.00	0.00	24	4	0	0	0	0	28	68
WOMEN'S/CHILDREN TOTAL	100.00	0.00	**39**	**11**	**0**	**0**	**0**	**0**	**50**	**230**
MVCC 10 & 11	100.00	0.00	3	0	0	0	0	0	3	131
CANCER TOTAL	100.00	0.00	**3**	**0**	**0**	**0**	**0**	**0**	**3**	**131**
TOTAL TRUST	97.12	0.26	**553**	**190**	**18**	**2**	**0**	**2**	**765**	**3652**

Continued over ....

Inpatients/Day by site	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister	96.90	0.28	502	186	18	2	0	2	710	3319
QEII	100.00	0.00	48	4	0	0	0	0	52	202
Mount Vernon	100.00	0.00	3	0	0	0	0	0	3	131
TOTAL TRUST	97.12	0.26	**553**	**190**	**18**	**2**	**0**	**2**	**765**	**3652**

Accident & Emergency	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. of Discharges
Lister A&E/Assessment	72.60	16.44	29	24	5	5	7	3	73	11892
QEII UCC	93.02	4.65	30	10	0	2	0	1	43	6077
A&E TOTAL	80.17	12.07	**59**	**34**	**5**	**7**	**7**	**4**	**116**	**17969**

Maternity	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses	No. eligible to respond
Antenatal	0.00	75.00	0	0	1	1	2	0	4	411
Birth	98.08	0.96	74	28	1	0	1	0	104	452
Postnatal	97.09	0.97	70	30	2	0	1	0	103	452
Community Midwifery	100.00	0.00	3	0	0	0	0	0	3	559
MATERNITY TOTAL	95.79	2.34	**147**	**58**	**4**	**1**	**4**	**0**	**214**	**1874**

Outpatients	% Very good/good	% Poor/very poor	Very good	Good	Neither good nor poor	Poor	Very poor	Don't Know	Total responses
Lister	96.59	0.00	128	42	4	0	0	2	176
QEII	93.33	3.33	40	16	1	1	1	1	60
Hertford County	95.88	1.03	68	25	1	1	0	2	97
Mount Vernon CC	93.27	2.88	168	26	7	0	6	1	208
Satellite Dialysis	96.92	0.00	51	12	2	0	0	0	65
OUTPATIENTS TOTAL	95.05	1.49	**455**	**121**	**15**	**2**	**7**	**6**	**606**

Trust Targets	% Would recommend
Inpatients/Day Case	96%>
A&E	90%>
Maternity (combined)	93%>
Outpatients	95%>
NP = Not provided	