Public Trust Board

Online

06/11/2024 09:30 - 12:00

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For noting				

22. Any Other Business — Trust Chair

For noting

23. Date of Next Meeting — Trust Chair

Wednesday, 15 January 2025 - Mount Vernon Cancer Centre, Rickmansworth Rd, Northwood HA6 2RN

East and North Hertfordshire NHS Trust

Minutes of the Trust Board meeting held at Hertfordshire Community Trust, Abel Smith House, Gunnels Wood Road, Stevenage SG1 2ST on Wednesday, 11 September 2024 at 9.30am.

Present:	Ms Anita Day	Trust Chair
	Dr David Buckle	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Diana Skeete	Non-Executive Director
	Ms Janet Scotcher	Non-Executive Director
	Ms Nina Janda	Associate Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Ms Theresa Murphy	Chief Nurse
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Dr Justin Daniels	Medical Director
	Ms Lucy Davies	Chief Operating Officer
	Mr Kevin Howell	Director of Estates and Facilities
	Mr Kevin O'Hart	Chief Kaizen Officer
	Mr Thomas Pounds	Chief People Officer
	Mr Mark Stanton	Chief Information Officer
	Ms Eilidh Murray	Director of Communications and Engagement
From the Trust:	Ms Amanda Rowley	Director of Midwifery
	Ms Elizabeth Franklin-Jones	Divisional Director of Nursing and Quality for Children & Young People (24/090)
	Ms Eleanor Willis	Roald Dahl Children with Medical Complexity Nurse Specialist (24/090)
	Ms Grace Mardle	Roald Dahl Children with Medical Complexity Nurse Specialist (24/090)
	Mr Stuart Dalton	Head of Corporate Governance
	Mrs Debbie Okutubo	Deputy Company Secretary (Board Secretary - minutes)
Observer	Professor Zoe Aslanpour	Dean, University of Hertfordshire Medical School

No	Item	Action
	The Chair welcomed everyone to the meeting and commented that this was a live streamed meeting of the Trust Board to ensure transparency to patients, staff and the wider community.	
24/088	**DECLARATIONS OF INTEREST** There were no new interests declared.	
24/089	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Mrs Karen McConnell and Mr Richard Oosterom.	

East and North Hertfordshire NHS Trust

24/090 PATIENT STORY

The Chief Nurse introduced the patient's parent in attendance Ms DF, the Roald Dahl Nurses supporting her and informed the Board that the patient story was about CF.

CF is a 17-year-old boy with a life-long, life-limiting condition. The Board were advised that he has a mitochondrial disease that has no cure or treatment. He had a normal birth and development until he was sixteen months old, when he started to experience infantile spasms and developmental regression; as a result of his condition, CF suffers with complex epilepsy and recurrent chest infections.

In December, CF got covid and suffered with a respiratory infection that brought him into resuscitation unit. At the time CF was 16 years old and as he remained under a Paediatric Acute Consultant until his 19th birthday, CF was treated in the Children's Emergency Department. The Paediatric Intensive care unit (PICU) at Addenbrookes Hospital takes children up to the age of 16 years. Therefore, CF was not able to be transferred to Addenbrookes PICU. Discussions were held with the adult ICU at Lister. Initially CF was accepted by the ICU team. CF was treated on the highest pressures of optiflow available and transferred to Bluebell ward. CF's condition deteriorated further and at this point the ICU team then said that they were not happy to accept CF. CF's condition fortunately improved with the treatment that he received on Bluebell ward and he made a full recovery to be discharged home for Christmas.

Following on from this, Paediatric health care professionals from CF's care team, the palliative care consultants from Keech Hospice and Adult ICU consultants met to discuss the pathway of care for CF if an event were to occur in the future that elicited the need for ICU. The outcome of this meeting was that, if in the future CF required further respiratory management, he would have an admission to ICU with a trial of non-invasive ventilation (CPAP) with the proviso that he had a DNAR in place.

CF's parents, and his health professionals met to discuss signing a ReSPECT document outlining the DNR conditions. On reflection, CF's parents feel they were forced to make a decision about their child's care when the adult team did not know or meet CF or his family and they were judging the situation based on what they read about him.

Following the presentation, a discussion ensued. The Board was informed that this area of care was being reviewed and that there were gaps with patients moving from paediatrics to adulthood. It was noted that in the paediatric intensive care units, paediatricians were generalists but there was no equivalent on adult wards as they were mainly specialists.

Members commented that having access to services was usually labelled and this might be one of the reasons Charlie was denied treatments at times as he had complex needs which was difficult to place under a particular heading.

DF was thanked for being open and transparent about CF's experiences. She was assured that the Board could relate to her story.

Action: the Board agreed that there needed to be a transitional service from childhood to adulthood when receiving treatment.

Members commented that 'Respect' was one of our values in the Trust and in all we do we need to respect the views of the patients and their carers.

It was noted that this was discussed at an internal Trust meeting, but it was deemed to be a bigger issue and needed to be reviewed at the ICB system level.

There was a suggestion that we look at wards like Bluebell and have a dedicated ward for 16- to 19-year-olds.

Members commented on the good relationship between the Roald Dahl nurses and children with complex medical needs.

Members asked DF that with the 'do not resuscitate order' in place did she feel that she was supported by the Trust and what lessons needed to be learnt from this.

DF commented that she felt blindsided, and she was not expecting to be given such a condition. As a family they had supported CF to the age of 17 and considering that he was not expected to live this long as a family they were doing a good job with him. The DNR condition was therefore not necessary.

Members also asked the Roald Dahl nurses what could have been done differently. They responded that everything that could be done was being done as CF had an advanced care plan in place. However, the communication with the family could have been better.

DF commented that the impact of words was important therefore, in the conversations taking place with the medical teams, she would have benefitted from more support.

The Chair thanked DF and the Roald Dahl nurses for coming and commented that it was a hard story to tell and equally hard to hear. The Chair also promised DF that actions would be taken to enable us to do better.

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

24/091 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 10 July 2024 were **APPROVED** as an accurate record of the meeting.

East and North Hertfordshire NHS Trust

24/092 ACTION LOG

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

24/093 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

24/094 CHAIR'S REPORT

The Chair welcomed Ms Diana Skeete, Ms Janet Scotcher and Mr Richard Oosterom as the new Board members.

Professor Zoe Aslanpour was also welcomed as an observer at this meeting and members were advised that she would become a non-executive board member once we become a teaching Trust.

The Chair on behalf of the Board said goodbye to Dr Peter Carter as this was his last Board meeting. He was thanked for his contribution during his tenure.

24/095 CHIEF EXECUTIVE'S REPORT

The Chief Executive also thanked Dr Peter Carter on behalf of staff for his contribution over the years in the Trust.

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

Quality

Members were advised that the Trust had been selected as one of the first trusts in England to implement Martha's Rule – a new patient safety initiative to be rolled out in acute hospitals in England this year. It was noted that Martha's Rule expanded on a Trust programme called Call 4 Concern, which was introduced in January 2024.

The Board was informed of the opening of a new designated space in the Lister Children's Assessment Unit (CAU) for families with children and young people (CYP) with a palliative or end-of life condition, which was named the Phoenix Room.

It was noted that the Lister Urgent Treatment Centre (sometimes called the UTC) was now open to children from age 1. This meant that families had more options when their child needed prompt, but non-emergency care.

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

The Board was informed that staff at Mount Vernon Hospital had been shortlisted as finalists in the Health Service Journal 'Medicines, Pharmacy & Prescribing Initiative of the Year' category.

Thriving People
The Chief Executive gave an update on the Trust's application for teaching hospital status which was currently with the Department of Health and Social Care. The Board would be provided with an update once there was some news.

Congratulatory messages were sent to staff members and teams for being shortlisted in the Nursing Times Workforce awards.

During August, 25 student midwives successfully attained qualified status, and of those graduates, the Board were advised that 23 would remain at the Trust in permanent roles.

Seamless service
Board members noted that a priority for the Integrated Care System this year was a focus on patients affected by frailty with a particular focus on preventing avoidable admissions to hospital.

Continuous improvement
The Trust's new online maternity hub aimed at digitalising maternity records – called My Pregnancy Notes – was now live. Appreciation was sent to the digital team and the maternity team for making this happen.

It was noted that leaders in the organisation had begun their ENHPS for Leaders programme – an extensive course which was detailed about leading teams in the new ways of working. Non-executive directors (NEDs) would also be joining in the work. The Chair commented that visits were important on the leader rounds.

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

24/096 WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

The Chief People Officer presented this item. A report seeking to understand trends and patterns of inequality and outlining detailed information about the Trust's Black and Minority Ethnic (BME) staff, covering the period April 2023 to March 2024 was presented. The document reported on progress, continuing work, and actions still to deliver equity in relation to the national NHS Workforce Race Equality Standard (WRES).

It was stated that Black and Minority Ethnic (BME) and White were the agreed language in the Trust.

In recent years, the Trust had recruited a Chair and two non-executive directors from minority ethnic backgrounds improving the minority representation for members at Board level. Progress was also being made with greater proportionate representation at bands 8A and 8B.

The WRES indicators were discussed. It was noted that 41% of staff regarded themselves as BME at the Trust compared to 25% in the East of England region.

The Board was assured that work was ongoing on a number of the indicators including 'WRES 4' which was the likelihood of White staff accessing non-mandatory training and CPD compared to BME staff which was at 0.8%. Members asked if this indicated an issue with access to training for White staff but were assured that the Trust was monitoring the situation carefully and currently thought the data point was a random variation.

There was also more work being done on formal disciplinary of BME staff levels. Work would continue on educating staff and communities on incivility and its impact, whilst also ensuring accountability.

Part of the work undertaken was to identify two Maternity/Neonatal Equity and Inclusion Ambassadors who would work to secure allocated time to focus on EDI matters in Maternity and Neonatal areas.

Key actions to ensure we have an inclusive structure were discussed including devising a new guide on recruitment and selection to be launched by autumn to support managers. The Board advised that the People Team should consider making this training mandatory for all appointing managers.

Board members commented that on WRES, access to non-mandatory training needed to be worked on and there should be parity on the people accessing the training as it needed to be balanced.

There was a question if we were planning to produce the WRES data separately for bank staff as was being piloted elsewhere. In response it was noted that we used an external provider for bank staff and it was not clear if they were currently collecting the data. However, most bank roles were held by BME staff, so tracking this group of staff separately was likely to be significant.

WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

The Board were advised that the challenge was getting people to declare their disabilities as not all disabilities were visible.

During conversation, it was noted that we had started to see the benefit from our refreshed staff network ENHAble. There was also an increase in supporting reasonable adjustments. There were also more inclusion ambassadors.

It was noted that the Trust was working with University partners to improve the offer to staff. The Freedom to speak up guardian was also involved in a lot of improvement work.

In response to a question on the number of people on a disciplinary process, it was noted that it was a relatively small number. It was also suggested that Managers were being supported to manage relationships and performance by having discussions rather than escalating to a formal disciplinary process.

Members asked about BME staff experiencing discrimination and if it was historical and affected patient care. In response it was noted that some

issues were long standing and how we responded was very important but the more we educate ourselves, the better we would get.

On the 90 days challenge, it was noted that a lot of work had happened around this, and we were receiving honest feedback.

The data would be taken to a number of groups and a number of discussions would take place. A lot of work was being done for example in the EDI strategy all this work would feed into the People and Culture Committee.

On the EDI Steering group, the Trust Chair commented that she would be chairing this group initially. Once she felt that she was confident about the group's terms of reference, approach and likely effectiveness, she planned to hand over to a fellow NED.

It was noted that the WDES metrics and performance was showing a lot of progress.

It was mentioned that WDES data was showing improvement but the discrimination metric for bullying and discrimination required more work, therefore we could not lose sight of this.

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

24/097 QUALITY ACCOUNT

The Chief Nurse presented this item. It was noted that there were improvements which was the right direction with the People Strategy linking into the Quality Strategy.

Quality Account was about giving the assurance to external stakeholders.

In response to a question on what flexibility there was in presenting this report, the Head of Corporate Governance commented that it was no longer a function reserved for the Board but as a Trust we were choosing to continue to do this.

Board members commented that we were obliged on a number of matters that we needed to report on under the Health and Social Care Act. It was further observed that a number of staff put a lot of effort into creating these reports.

Board members commented that the quality account told a good story and there was a lot to be proud of. Having the external stakeholder views at the end of the report was a very good touch.

During discussion, it was noted that there was the need to target our audience in producing this report. Some form of a summarised version would be beneficial for the end user.

Action: A summary of the Quality Account to be to be produced for the end user.

The Chair on behalf of the Board congratulated the team for putting the report together.

The Board **APPROVED** the Quality Account.

24/098 COMPLAINTS, PALS AND PATIENT EXPERIENCE ANNUAL REPORT

This item was not considered at this meeting as it was sent prematurely to the Board. It would first be considered by the Quality and Safety Committee prior to it being presented to the Board.

24/099 INTEGRATED PERFORMANCE REPORT

The Executive Directors gave an update on their respective areas.

Quality

The Board was informed that there was an increase in the number of C difficile cases this month compared to the previous month by 57% (4 cases).
On Sepsis, the Team continue to be a visible presence in inpatient settings assisting with recognition and management of sepsis patients. No serious harms were reported in June.
The Board was informed that the study day that took place in the month of July was successful with over fifty participants. The teaching and presentations supported safe practise areas such as aseptic technique and CDI.

Operations

ED monthly attendances were within normal variation; acuity remained high, with increasing trend.
For Urgent and Emergency Care, the monthly attendances saw further increases with the continued presentation of high acuity reducing the performance to 69.73% in July. There was a strong focus and push in August to improve on the performance. There was also reduced ambulance waiting/handover times.
Members asked if there were any safety or quality issues in Audiology. In response, it was noted that the Trust was working with the national team as there was a shortage of Audiologists nationally which had led to there being a significant number of children on the waiting list at this and other trusts. It was reported that the Trust had written to the ICB to suggest suspending new referrals to the service, but the ICB did not support this approach, given the lack of capacity across the whole system. However, the team were monitoring the backlog in audiology and there had been recent recruitment to the team to improve capacity.

Finance

The Board was advised that in June the Trust submitted a surplus plan of £1.0m for 24/25. This plan assumed that both a £33.8m cost improvement programme would be delivered, and ERF performance of 138% would be achieved.
At Month 4, the Trust had reported an actual deficit of £2.1m. This was adverse to plan by £1.1m. The gap related to additional costs and lost income resulting from Industrial Action.
The Board were advised that the Trust could not tolerate the current level of deficit and that mitigation plans and recovery streams had been put in place.

People
The vacancy rate decreased to 9.2% (622 vacancies). There are 107 more staff in post than a year ago.
Grow Together review (GTR) compliance remains low, particularly for staff in bands 6 and below. Reminders continue to be sent to relevant services and leads to encourage staff to comply.

There would be a Leadership live away day in November.

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

24/100 MATERNITY ASSURANCE REPORT

The Director of Midwifery presented the item. The Board was reminded that the Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of ENH maternity services in 2022 with a further unannounced inspection in 2023.

The Board was informed that to exit the MSSP the service would need to demonstrate sustained improvement in response to identified actions from the diagnostic phase of the MSSP. It was noted that several reviews and self-assessments had taken place as part of the Trust's support programme and assurance processes.

Outstanding CQC actions continue to be progressed and monitored via internal governance processes. It should be noted that these actions are part of the overall maternity improvement plan.

The Board noted the workforce structure and sustainability.

In response to a question, it was noted that cultural work in the team was progressing with signs of positive cultural shift in relevant metrics, and that they would be submitting a detailed report to People and Culture Committee meeting later this month. Improvements in turnover and sickness absence was recognised.

The Board was assured that there was support and recognition of readiness to exit the MSSP from regional and national stakeholders, as the service move into the sustainability phase of the programme.

All Board members felt that the management style should be replicated across the Trust.

With regard to earlier challenges around equipment servicing, replacement and repair, The Board were assured that the service was working closely with the newly appointed lead for Electrical and Biomedical Engineering (EBME) to create a service schedule for maternity services resulting in sustained improvements in this area.

The Board was asked to:

- Note the progress made to meet the exit requirements of the maternity safety support programme.
- Support the recommendation that the service is now ready to commence steps required to exit the programme.
- Note that a progress update and the sustainability action plan will be presented for approval at the November Trust Board.

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

24/102 SYSTEM PERFORMANCE REPORT

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

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

BOARD COMMITTEE REPORTS

24/103 AUDIT AND RISK COMMITTEE REPORT TO BOARD

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

24/104 FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and Planning Committee meetings held on 23 July 2024.

24/105 QUALITY AND SAFETY COMMITTEE REPORT TO BOARD

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

24/106 PEOPLE AND CULTURE COMMITTEE REPORT TO BOARD

The Board **RECEIVED** and **NOTED** the summary report from the People and Culture Committee meeting held on 16 July 2024.

24/107 ANNUAL CYCLE

The Board **RECEIVED** and **NOTED** the latest version of the annual cycle. The estate strategy will be coming to the November meeting.

East and North Hertfordshire NHS Trust

24/108 ANY OTHER BUSINESS

The Chair reiterated that this was the final board meeting for Peter Carter He was thanked for his passion for the Trust, patients and staff and was wished well in his future endeavours.

The Chair thanked the Hertfordshire Community Trust for allowing us to use their venue for this Board meeting.

24/109 DATE OF NEXT MEETING

The date of the next meeting is 6 November 2024.

Ms Anita Day
Trust Chair
October 2024

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

Agenda item: 5

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

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
11/9/24	24/090	Transition for children with complex needs is nationally addressed poorly. The trust needs to improve local provision.	The Board to facilitate a transitional service from childhood to adulthood when receiving treatment.	Dedicated nursing team in place. ITU consultant with responsibility for transition to be appointed.	Medical Director	October 24 Completed
11/9/24	24/097	Quality account to target our audience	A summary of the Quality Account to be produced for the end user.	Work is underway with stakeholders to combine an easy read handheld version for the Quality strategy, which will encompass quality account objectives. We anticipate this being completed by quarter four.	Chief Nurse	March 25

East and North Hertfordshire NHS Trust

Chief Executive's Report

November 2024

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

Quality

Winter puts additional pressure on health care systems due to additional urgent and emergency activity, greater acuity of patients and winter illness affecting our own staff. NHS England has sent a letter setting out its plans, together with expectations of ICBs and Trusts. These do not go beyond our normal plans and escalation processes and the board will be updated in line with these expectations. I attach the letter for the Board's information.

As part of our commitment to providing the highest quality care for our patients and families, the Trust has now launched Dementia Friendly plates and cutlery. The plates are lipped and have a padded bottom to encourage independence for our patients, and the adaptive cutlery has a large, grip handle which can be bent to the required position.

A special thanks to our Dementia team and to our catering department for making this possible.

In addition, we have also refurbished the bedrooms in Lister Hospital's neonatal unit meaning parents can stay close to their babies being cared for on the unit.

After more than 18 months of hard work and dedication, our maternity unit has overseen significant improvements and has been assessed as ready to exit the Maternity Safety Support Programme, following a review meeting attended by NHS England, and representatives from the Local Maternity and Neonatal System, as well as the chair of our Lister Maternity and Neonatal Voices Partnership.

The Trust joined the Maternity Safety Support Programme in response to concerns raised by the Care Quality Commission (CQC) following an inspection at the end of 2022 which saw maternity services at Lister Hospital rated as inadequate. The Trust has worked hard and to make positive changes for the benefit of the women, families, staff, and local community who use its maternity services and following a re-inspection in June 2023 improvements were acknowledged and evidenced in a higher rating of requires improvement.

As a result of this substantial progress made by our staff, we are pleased our improvement efforts have been recognised with a positive outcome.

Thriving People

We continue to welcome new colleagues our Trust each month. Since 1 September I have attended 5 Trust Inductions and have had the opportunity to engage with many of our newest colleagues, ensuring they feel supported and welcomed into our Trust.

Our People Team won the Innovation Award at the HMPA conference held on 3 October. It is an award for innovation but also for having a vision, being brave, working as a team and being focused on delivering exemplary services for our customers. Well done to all of the team!

Over the last 2 years, the Trust has been reshaping its management structures to support a clearer accountability framework, enable greater local autonomy, as well as increasing the clinical leadership of our services. Heads of Clinical Service have now been appointed to our Care Groups, completing this process. Alongside the appointment process, a new development programme commenced on 1 October where Care Group and Divisional leads commenced a programme of leadership development to best support them in delivering these important roles.

Faizah Ahmed, a sepsis nurse and member of the critical care outreach team, was recently published by the Nursing Times, who featured her article on sepsis in their latest issue.

Seamless Services

I attended the HWE (Hertfordshire and West Essex) System Chief Executive's strategy day on 18 September 2024. This started a process of working through the necessary deliverables and structures required to deliver the ambitious vision of the ICB, whilst remaining sustainable in a financially challenging landscape. The next session takes place later this month.

During October, Ofsted and the Care Quality Commission (CQC) undertook a Joint Targeted Area Inspection (JTAI) of services for vulnerable children and families who need help in a local authority area. The Trust's Children's Safeguarding Team contributed to this inspection, and we await feedback and any potential areas of learning.

Continuous Improvement

The ENH Production System (ENHPS) work continues with an increasing number of Positive Leader Rounds happening across the Trust. The purpose is for leaders to visit different areas across the Trust and see the improvements that are taking place. They are not about checking up – but supporting improvement and asking about any barriers and challenges.

During the week of 14 – 18 October, we held our second Rapid Process Improvement Workshop (RPIW) at the Trust – this time focusing on Ophthalmology. It was exciting to be present at the report out from this event and sense the energy from the team and hear the changes they have already made. A fuller report is included within the agenda.

On 22 October we formally launched our OneEPR programme, with demonstrations and talks about how we will be bringing together our core clinical systems into one electronic patient record.

We will be moving to a system called Orbis U, which was reviewed and recommended by Trust clinicians before the final decision was made. It's the first implementation of the EPR in the UK, although extensively used across Europe – and as such we have more opportunity to tailor the product to our needs.

The first move over of patient records will happen in June 2025 including inpatients, the Emergency Department, electronic prescribing, outpatients and results management.

The Government, together with NHS England has launched 'Change NHS' - an engagement programme in advance of the development of a 10-year strategy for the NHS. I attach the letter sent to Trust leaders for your information.

Adam Sewell-Jones
Chief Executive

Department of Health & Social Care

NHS England

Dear colleague,

Change NHS: help build a health service fit for the future

We all know there are big challenges facing the NHS**.** Our staff are working harder than ever to get services back on track, to get waiting lists down and consistently deliver the best care. Yet too often we are struggling to provide the right care, in the right place and at the right time. This is no good for patients and it is demoralising for staff.

That is why today we are launching *Change NHS: help build a health service fit for the future:* a national conversation to develop the 10-Year Health Plan.

On 12 September, Lord Darzi published his independent review of the NHS, which was intended to start an open and honest conversation about the state of our health and service and the reforms needed. The review revealed the scale of the challenge we face. Our NHS is under rising pressure; we are diagnosing ill health too late and not doing enough to prevent it in the first place. It is too hard for people to get an appointment, hospitals are overcrowded, NHS workers are overstretched, and costs are escalating.

For decades, there has been broad consensus that to overcome the challenges facing the NHS, we must focus on providing more care in the community, so hospitals are able to treat the sickest patients, make better use of technology, and do more to prevent ill health.

A different approach is needed if we are to make these crucial shifts and deliver an NHS fit for the future. So, today we are launching our national engagement exercise to develop the 10-Year Health Plan. We want the public and staff to be at the centre of reimagining the NHS, as well as experts from across the health and care landscape, like you. The changes we make must be felt in all our day-to-day lives.

CHANGE NHS Get involved now change.nhs.uk

Over the coming months, we want to hear from you to help co-design this Plan. We are committed to providing unprecedented levels of transparency to the policy making process and targeting those whose voices often go unheard.

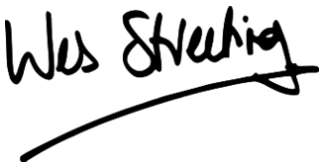
There is a national portal found at **change.nhs.uk** to share your experiences and ideas. There is also a QR code below that we encourage you to share with your stakeholders so that they can feed in their experiences and views.

There will be further opportunities for you and your staff to feed in your views, including a series of face-to-face all-day staff engagement events in the new year across each of the seven regions. We will shortly write out to regional directors and other representative organisations asking for help in nominating participants to attend. Our hope is that these attract a broad representation from across different staff types, care settings and communities, reflecting the diversity of our workforce. We recognise that it is difficult to release staff through this very busy period and are very grateful for your support.

We also want to draw on existing local engagement so that the plan is truly co-produced. In November, we will provide you with a 'workshop in a box' for you to run your own events with the public, staff and stakeholders. This will include a template to capture and share insights back with us to inform the Plan.

This is a once in a generation opportunity to set the NHS on a path for the future. Thank you in advance for your support in shaping the future of healthcare.

Yours ever,



RT HON WES STREETING MP
Secretary of State for Health and Social Care

AMANDA PRITCHARD
Chief Executive, NHS England

Classification: Official

To:
- Integrated care board:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- Integrated care partnership chairs
- All NHS trust and foundation trust:
  - chairs
  - chief executive officers
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
  - chief financial officers
- Regional directors

cc.
- Local authority:
  - chief executive officers

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

16 September 2024

Dear colleagues

Winter and H2 priorities

Further to the meeting with ICB and provider chief executives on 3 September, we are now confirming operating assumptions for the remainder of this financial year.

This letter outlines the steps NHS England is going to take, as well as those ICBs and providers are asked to take, to support the delivery of safe, dignified and high-quality care for patients this winter.

Publication reference: PRN01454

Planning and financial framework

You are all aware of the tight financial environment both across the NHS and for the government more widely; it remains essential in H2 that systems continue their work to return to their agreed 2024/25 plans.

Providing safe care over winter

As set out in our letter of 16 May, we are in the second year of the delivery plan for recovering urgent and emergency care (UECRP).

Colleagues across the country have worked incredibly hard to implement the priority interventions identified in the UECRP. This has delivered improvements in performance on the 4-hour emergency department (ED) and Category 2 ambulance response time ambitions, against an extremely challenging backdrop.

The delivery priorities for this winter remain unchanged from those agreed in system plans.

We all recognise, however, that despite these improvements, far too many patients will face longer waits at certain points in the pathway than are acceptable.

Given demand is running above expected levels across the UEC pathway, ahead of winter we collectively need to ensure all systems are re-confirming that the demand and capacity plans are appropriate and, importantly, are taking all possible steps to maintain and improve patient safety and experience as an overriding priority.

Supporting people to stay well

As a vital part of preventing illness and improving system resilience, it will be important to maximise the winter vaccination campaign.

As well as eligible population groups, it is imperative that employers make every possible effort to maximise uptake in patient-facing staff – for their own health and wellbeing, for the resilience of services, and crucially for the safety of the patients they are caring for.

More detail on eligible flu cohorts is on gov.uk:

- National flu immunisation programme 2024 to 2025
- COVID-19 autumn/winter eligible groups

We confirmed campaign timings for both vaccines in our system letter on 15 August.

This year for the first time, the NHS is offering the RSV vaccine to those aged 75 to 79 and pregnant women. This is a year-round offer but its promotion ahead of winter by health professionals is vital, particularly to those at highest risk.

To support vaccination efforts, NHS England will:

- ensure all relevant organisations receive information as quickly as possible for flu, COVID-19 and RSV
- maintain the National Booking Service, online and through the NHS 119 service for COVID and flu (in community pharmacy settings)
- continue to share communication materials to support local campaigns

ICBs are asked to work with:

- local partners to promote population uptake with a focus on underserved communities and pregnant women
- primary care providers to ensure good levels of access to vaccinations, ensuring that plans reflect the needs of all age groups, including services for children and young people and those who are immunocompromised
- primary care and other providers, including social care, to maximise uptake in eligible health and care staff

NHS trusts are asked to:

- ensure their eligible staff groups have easy access to relevant vaccinations from Thursday 3 October, and are actively encouraged to take them up, particularly by local clinical leaders
- record vaccination events in a timely and accurate way, as in previous campaigns
- monitor staff uptake rates and take action accordingly to improve access and confidence
- ensure staff likely to have contact with eligible members of the public are promoting vaccination uptake routinely

Maintaining patient safety and experience

We recognise this winter is likely to see UEC services come under significant strain, and many patients will face longer waits at certain points in the pathway than acceptable.

It is vital in this context to ensure basic standards are in place in all care settings and patients are treated with kindness, dignity and respect.

This means focusing on ensuring patients are cared for in the safest possible place for them, as quickly as possible, which requires a whole-system approach to managing winter demand and a shared understanding of risk across different health and care settings.

Evidence and experience shows the measures set out in the UECRP are the right ones, and systems and providers should continue to make progress on them in line with their local plans, with assurance by regional teams.

In addition, NHS England will continue to support patient safety and quality of care by:

- standing-up the winter operating function from 1 November:
  - providing capabilities 7 days a week, including situational reporting to respond to pressures in live time
  - this will be supported by a senior national clinical on-call rota to support local escalations
- completing a Getting It Right First Time (GIRFT) data-led review of support needs of all acute sites:
  - across all systems, and deploying improvement resources as appropriate, to support implementation of key actions within the UECRP, with a dedicated focus on ensuring patient safety
- convening risk-focused meetings with systems:
  - to bring together all system partners to share and discuss key risks and work together to agree how these can be mitigated
- expanding the Operational Pressures Escalation Levels (OPEL) framework:
  - to mental health, community and 111, and providing a more comprehensive, system-level understanding of pressures

NHS England will continue to support operational excellence by:

- co-ordinating an exercise to re-confirm capacity plans for this winter, which will be regularly monitored
- running an exercise in September to test the preparedness of system co-ordination centres (SCCs) and clinical oversight for winter, including issuing a new specification to support systems to assess and develop the maturity of SCCs

NHS England will continue to support transformation and improvement by:

- continuing the UEC tiering programme to support those systems struggling most to help them to enact their plans
- reviewing updated maturity scores for UEC high-impact interventions with regions and ICBs, to identify further areas for improvement
- as part of NHS IMPACT, launching a clinical and operational productivity improvement programme in September:
  - this will include materials and data for organisations to use, as well as a set of provider-led learning and improvement networks, to implement and embed a focused set of actions

ICBs are asked to:

- ensure the proactive identification and management of people with complex needs and long-term conditions so care is optimised ahead of winter:
  - primary care and community services should be working with these patients to actively avoid hospital admissions
- provide alternatives to hospital attendance and admission:
  - especially for people with complex needs, frail older people, children and young people and patients with mental health issues, who are better served with a community response outside of a hospital setting
  - this should include ensuring all mental health response vehicles available for use are staffed and on the road ahead of winter
- work with community partners, local government colleagues and social care services to ensure patients can be discharged in a timely manner to support UEC flow
- assure at board level that a robust winter plan is in place:
  - the plan should include surge plans, and co-ordinate action across all system partners in real time, both in and out of hours
  - it should also ensure long patient delays and patient safety issues are reported, including to board level, and actions are taken appropriately, including involving senior clinical decision makers
- make arrangements through SCCs to ensure senior clinical leadership is available to support risk mitigation across the system
- review the 10 high-impact interventions for UEC published last year to ensure progress has been made:
  - systems have been asked to repeat the self-assessment exercise undertaken last year, review the output, consider any further actions required, and report these back through regions

NHS trusts are asked to:

- review general and acute core and escalation bed capacity plans:
  - with board assurance on delivery by the peak winter period
- review and test full capacity plans:
  - this should be in advance of winter
  - in line with our letter of 24 June 2024, this should include ensuring care outside of a normal cubical or ward environment is not normalised; it is only used in periods of elevated pressure; it is always escalated to an appropriate member

of the executive and at system level; and it is used for the minimum amount of time possible

- ensure the fundamental standards of care are in place in all settings at all times:
  - particularly in periods of full capacity when patients might be in the wrong place for their care
  - if caring for patients in temporary escalation spaces, do so in accordance with the principles for providing safe and good quality care in temporary escalation spaces
- ensure appropriate senior clinical decision-makers are able to make decisions in live time to manage flow:
  - including taking risk-based decisions to ensure ED crowding is minimised and ambulances are released in a timely way
- ensure plans are in place to maximise patient flow throughout the hospital, 7 days per week:
  - with appropriate front door streaming, senior decision-making, regular board and ward rounds throughout the day, and timely discharge, regardless of the pathway through which a patient is leaving hospital or a community bedded facility

Next steps

In addition to existing guidance in the UECRP Year 2 letter and elsewhere, we have recently published further evidence-based guidance in the following areas to support further optimisation of winter plans:

- Same day emergency care service specification
- Single Point of Access hubs
- Virtual wards operational framework

As set out above, system risk discussions will follow during September.

We want to thank you and everyone across the NHS for your continued hard work this year.

Together, we are committed to doing everything we can to support the provision of safe and effective care for patients this winter, as well as continuing to improve services for the longer term.

Yours sincerely,

Sarah-Jane Marsh

National Director for Urgent and Emergency Care and Deputy Chief Operating Officer

Dr Emily Lawson DBE

Chief Operating Officer

Professor Sir Stephen Powis

National Medical Director

Duncan Burton

Chief Nursing Officer for England

Classification: Official

Principles for providing safe and good quality care in temporary escalation spaces

Our aim is always to deliver high standards of care for patients in the right place and at the right time.

NHS England believes the delivery of care in temporary escalation spaces (TES) in departments experiencing patient crowding (including beds and chairs) is not acceptable and should not be considered as standard.

A survey and subsequent report by the Royal College of Nursing (RCN) showed the detrimental impact of this care setting on patients and staff and calls for total eradication.

TES do not include spaces that are opened as part of winter pressure planning and refer to care given in any unplanned settings (such as corridors).

However, the current healthcare landscape means that some providers are using temporary escalation spaces more regularly – and this use is no longer 'in extremis'.

The use of TES is never acceptable when caring for children.

These principles have been developed to support point-of-care staff to provide the safest, most effective and highest quality care possible when TES care has been deemed necessary.

The principles should be applied alongside any local standard operating procedures and arrangements governing flow pathways and safe staffing.

Core principles

1. Assessment of risk
2. Escalation
3. Quality of care
4. Raising Concerns and reporting incidents
5. Data collection and measuring harm
6. De-escalation

Publication reference: PRN01560

Classification: Official

1. Assessment of risk

Patients should, where possible, be seen, assessed, and treated within a clinically appropriate bed or chair space. Care given outside of these bed or chair spaces should only be used when all other options have been exhausted.

It is imperative that all healthcare partners across the whole patient pathway, from pre-hospital care to point of discharge, work collaboratively, have clear and open lines of communication and have processes for the escalation of concerns.

Assessments of risk for potential harm and safety for staff and patients that are being considered for care in TES bed and chair spaces must be completed and organisational governance processes and full capacity protocols must be followed. Local patient safety checklists should be used to ensure the patient is safe to be cared for in this setting. This should include an inclusion and exclusion checklist.

Providers should refer to NHS England's Emergency Care Improvement Support Team (ECIST) guidance (FutureNHS login required), which details best practice measures, principles, tools, and evidence. It will support decision making that balances patient and organisational risk across a system in extremis.

The Care Quality Commission's (CQC) fundamental standards should be adhered to.

Consideration should also be given to:

- the clinical, psychological and functional suitability of the patient
  - patients admitted due to mental health should be automatically excluded
- the existence of a clear clinical plan for the patient
  - staff allocated to TES patients must be able to provide ongoing care for the duration of that stay
- appropriate staffing and skillsets that ensure the safe monitoring of patients and the ability to recognise deterioration
- the provision of daily senior nurse quality rounds and safety huddles. The huddles should include a review of the staffing requirements for the additional patients and their individual needs in line with Expectation 3 of the NQB 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' (2016).
- access for staff and equipment to the space and the ability to provide good quality care and emergency response within it
- adherence to local infection control policies

Publication reference: PRN01560

- full environmental assessment (including the assessment of fire hazards and exits)
- the identifiability of the space for staff, ensuring clear visibility of the patient's location for all personnel (patient tracking)
- the ability for patients, families and care partners to easily get staff attention

It is imperative that executive teams and departmental senior accountable clinical staff are visible and support staff caring for these patients and taking decisions in this area.

The level and profile of risks will continually change and will need to be assessed using a dynamic risk assessment (DRA) approach. This assessment should also consider risk across the pathway or system, recognising that increasing a risk in one area may reduce a risk in another part of the pathway, which may be the 'least worse scenario'.

For example, the decision to increase early discharge for 'pathway zero' patients may increase the risk of patient harm, but this may be a lower risk than if the patients were being treated in TES.

A decision to divert ambulances to another provider may increase risks to patient safety due to travelling longer distances but may lead to significantly reduced pressure in the emergency department and reduced need for TES.

Integrated care boards (ICBs) should be supporting providers to manage using a risk-sharing approach.

Providers and systems can use the GIRFT-developed Summary emergency department indicator table (SEDIT) dashboard.

This enables clinicians and managers to evaluate their emergency department's current demand, capacity, flow and outcomes, to understand why problems are occurring and to target the root causes.

2. Escalation

All providers must have working escalation models in place and follow organisational governance and reporting structures.

Local policies on internal escalation should be triggered once a patient's care has been allocated to TES. This should include the senior clinical and management teams (triumvirate) responsible for the department, along with the trust board.

Escalations should adhere to organisational governance processes. Providers should follow any local policies regarding patient flow and safe staffing.

Providers should escalate to system quality groups and use the NHS England Operational pressures escalation levels (OPEL) framework to allow systems to have a clear vision of urgent and emergency care pressures and awareness of the potential risks and harm.

Systems should also consider reporting the number of patients in TES. They should follow their local escalation policies to inform regional teams (including through regional quality groups). Regional teams will be able to escalate to national teams.

3. Quality of care

It is essential to maintain the delivery of high quality care throughout the entire episode of care in TES. The following principles should be followed:

- Patient safety is imperative and patient selection is key. All patients who are being considered for this setting must be reviewed against a safety checklist.
- The care should be person-centred, focussing on the needs of the individual and ensuring that patient's preferences and values guide any clinical decisions made.
- While it is recognised that patient experience will not be optimal, it is important to always maintain privacy and dignity during their episode of care.
- Easy access to bathrooms should be maintained and hourly comfort rounds should be undertaken. Personal hygiene requirements should be identified.
- Patients should have access to nutrition, including hot meals and hydration. Reasonable adjustments should be made for any patients identified as requiring support.
- Patients must be able to get quality sleep.
- Communication with patients, families and care partners is essential. There should be regular conversation informing patients about their treatment plan, condition and any progress to moving to a bed or cubical or to being discharged. Patient confidentiality must be maintained throughout this communication.
- Clinical staff should maintain regular reviews, observations and NEWS2 scoring of patient's conditions to identify early any changes or deterioration that may require the patient to be moved to another area of the emergency department. Medications should be given as per prescription plan and should be monitored.

4. Raising concerns

Staff should have the freedom to speak up (FTSU) and have access to FTSU guardians.

It is imperative that staff delivering care in TES have a voice and feel heard. Staff should be encouraged to raise concerns immediately and these concerns should be dealt with in a timely manner.

Staff should always feel safe to report and raise concerns and be reassured that these are being taken seriously. Staff should not be fearful of raising concerns and reporting complaints.

Senior management teams should promote this and embed it in their organisation's culture.

Staff should have the opportunity to debrief and to discuss areas of concern further.

Staff need to be heard and supported. Areas should have mechanisms to address staff psychological and welfare support (for example, open door policies, drop-in sessions, visible senior staff support and allocated 1-to-1 time). Local staff surveys can also be used.

Patient experience must be monitored, and patients, families or care partners should be given the opportunity to raise concerns and complaints in real time. Local policies on raising concerns and complaints should be followed.

Patient welfare must be measured. This can be done using surveys (such as the Friends and Family Test) or a trust might develop a specific survey about their TES care.

Trusts should consider developing leaflets and information about TES care.

5. Data collection and measuring harm

Trusts need to monitor the risks of potential harm, the actual harm that has occurred and the impact on patients and staff of the use of TES.

This should include, but should not be limited to, complaints, 'duty of candour' incidents and information from external sources such as patient and staff surveys.

Real-time quantitative and qualitative harm data should be visible to senior clinical and management teams and to trust executives. Providers should apply their own processes and incidence reporting systems. These can be used to escalate concerns to system, regional and national colleagues

There must be mechanisms in place to evaluate any harm caused (for example, after-action reviews). These mechanisms should allow learning to be fed back to frontline staff and to trust executives.

The SEDIT dashboard can also support analysis of demand, capacity, estates space and outcomes to evaluate potential harm and realised harm.

6. De-escalation

It is essential that providers and systems have robust models of de-escalation.

De-escalation should mirror escalation plans in reverse and use the dynamic risk assessment approach. The same communication channels used for escalation should be used for de-escalation. Situation reports should be provided for senior teams and trust executives, and system leadership.

The chief executive or board should oversee de-escalation and ensure care is delivered in appropriate areas immediately. The trust board's quality committee should also be sighted, given the risk that the provider is breaching CQC registration in using TES.

There should be a process in place to de-brief staff, identify lessons and review internal standard operating procedures, policies and processes.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board	**Agenda Item**	9
Report title	Estates and Facilities Strategy	**Meeting Date**	6 November 2024
Presenter	Director Estates and Facilities		
Author	Infrastructure Development Programme Manager Programme Director Director of Estates and Facilities		
Responsible Director	Director of Estates and Facilities	**Approval Date**	29 October 2024

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

Report Summary:

Following approval at Trust Management Group (TMG) on 24 October 2024, the Estates and Facilities Team are requesting formal approval via Board for the Estates and Facilities Strategy document.

Impact: tick box if there is any significant impact:

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

Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

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

BAF 1 - Investment

Report previously considered by & date(s):

TMG 24 October 2024.

Recommendation	The Board is asked to review and approve the Estates and Facilities Strategy Document.

To be trusted to provide consistently outstanding care and exemplary service

October 2024

East and North Hertfordshire NHS Trust

Estates and Facilities Strategy

Developing our care environment between 2024 and 2030

A healthy hospital for a healthy community

Table of Contents

Foreword

Over the years, East and North Hertfordshire NHS Trust has served its population with a commitment and focus on providing the best possible healthcare. We have moved with the times, expanding our estate, adding to our buildings in order to provide care to a growing population and embracing the latest technologies to improve outcomes for our patients. As we think to our future, we have developed this strategy to set out how we can consolidate and maximise our resources to provide the right environment for us to achieve our organisational objectives.

The gradual expansion and adding to our building has meant that there are issues of fragmentation of services and sub-optimal design, which means that we have opportunity, if this is addressed, to improve efficiency and effectiveness through the environment in which we provide care. The team have worked with colleagues from across the organisation to identify these opportunities and they are set out within this strategy.

With patients always at the heart of what we do, we have considered how we can adapt to best meet their needs moving forward and create spaces that will provide us with a longevity to adapt as these needs change. We have also explored how the environment affects our staff, and how we can best support them to continue to provide the excellent care that they strive to, every day.

As a system, Hertfordshire and West Essex will see the re-development of two of its hospitals – Watford General, and The Princess Alexandra, Harlow. This exciting opportunity will result in improvements to acute care for their populations but does mean that as the only other major acute site in the system, we need to think about how we maintain and develop our Lister Hospital site to keep pace and remain a great place to receive care, and to work. We also have new opportunities through digital improvements to think about how we, as a Trust, can use our other hospital sites at Hertford County and New QEII in Welwyn Garden City more effectively, providing joined up care across our whole infrastructure, as well as working differently with primary, community, mental health and social care services to improve broader health and care delivery.

I would like to take this opportunity to thank all colleagues and stakeholders that have contributed to the development of this strategy; a key enabler that will help us to drive this organisation forward for the next five years.

Adam Sewell-Jones, Chief Executive

It is clear from various surveys ranging from patient experience and staff satisfaction reports that a good environment makes everything work better for our patients and staff.

The overriding objective for the estates and facilities team via this strategy is to ensure a safe environment for our patients.

We must ensure that we are ready for every eventuality – from business as usual to future pandemics – and enable our clinical, nursing and support teams to continue their excellent care without distraction from environmental issues.

This strategy is not created to lead a wholesale transformation of the estate, which would be unrealistic and unaffordable, but to support the Trust's business and clinical strategies whilst ensuring that we provide a cost effective and efficient premises of the right size, in the right place and of the right standard to deliver patient care.

We have ensured that this estates and facilities strategy has been led by the requirements of our clinical services and people. We have not allowed any current estate and hospital buildings to restrict the evolving needs of our patients.

We aim to ensure tomorrow's treatments are available for today's patients.

Kevin Howell, Director of Estates and Facilities

1. Trust overview and context

1.1. Trust overview

East and North Hertfordshire NHS Trust provides a wide range of acute and tertiary care services from four hospitals, namely the: Lister in Stevenage; New QEII in Welwyn Garden City; Hertford County Hospital in Hertford; and Mount Vernon Cancer Centre (MVCC) in Northwood, Middlesex.

The area served by the Trust for acute hospital care covers a population of around 600,000 people and includes east and north Hertfordshire, as well as central Bedfordshire. MVCC provides specialist cancer services to some two million people from across Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

Since October 2014, the Lister has been the Trust's main hospital for specialist inpatient and emergency care.

The New QEII hospital opened in June 2015 and provides outpatient, diagnostic and antenatal services, along with a 24/7 urgent treatment centre. Hertford County provides outpatient and diagnostic services. MVCC provides tertiary radiotherapy and local chemotherapy services.

Through the Lister, New QEII and Hertford County hospitals, the Trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including emergency department and maternity care. The Trust offers regional and sub-regional services in renal medicine, urology and plastic surgery. The Trust is also a provider of children's community services.

The Trust is also a leading provider of community-based renal services, with dialysis centres in St Albans, Houghton Regis, Harlow and Bedford.

1.2. Current estates and facilities context

The condition and suitability of our estate directly impacts and influences the care we give our patients and the experience of those who work within our organisation.

Investment into clinical areas on the Lister Hospital site over the past ten years has made improvements in certain aspects of care, however a vast majority of this estate is old and is now not fit for purpose. The current layout of this site, partly driven by incremental developments over time, means that some of our services are fragmented and inefficient. As clinical services have expanded to meet demand, they have had to re-purpose adjacent spaces, and this has resulted in the loss of some of our staff facilities.

Without the opportunity to undertake a significant re-modelling of the Lister site, we need to consider how we use our current space to best effect as part of a long-term plan linking backlog maintenance investment to sustainable improvement.

Hertford County Hospital and the New QEII are more modern buildings and have, overall, better facilities. However, we need to explore how we use all of our estates in a more effective way and further work is required to reorganise our services in order to maximise the use of our three main hospital sites.

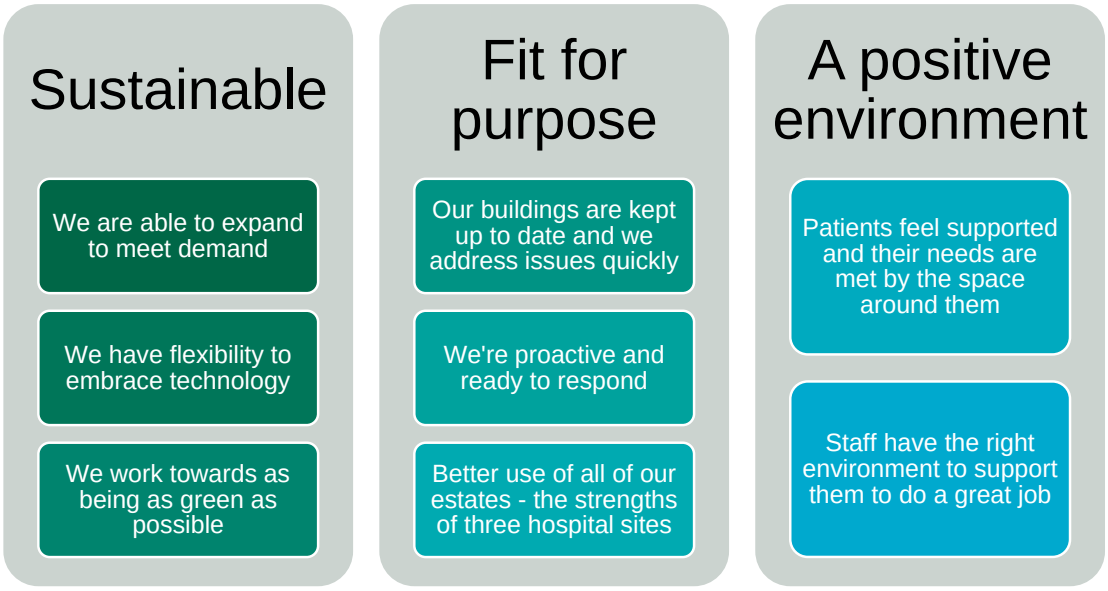
The MVCC estate is no longer fit for purpose and led by NHS England as commissioners of this service, has been subject to a clinical review. The outcome of this review supported the need to relocate the service to a fit-for-purpose facility in addition to transferring delivery of the service to an appropriate tertiary provider. It is anticipated that these plans will shortly be subject to public consultation. Work has and continues to be undertaken on the current site to address the critical infrastructure issues in order to maintain safe delivery of services in the interim.

1.3. Core aims for our estates and facilities

In developing this strategy, we considered the key national and local strategies that influence the context in which we work. This includes national contextual strategy such as the NHS Long Term Plan, the Naylor review and Net Zero strategy, as well as the ICS/ICB strategy, local government strategy and areas for learning. Appendix 1 gives further information on these.

We also undertook engagement sessions with our divisional management teams to explore what is most important to the organisation.

The following aims bring together the key themes highlighted through a review of the relevant strategy, the divisional engagement and the priorities identified by the Estates and Facilities Team to set out how we plan to improve patient experience, improve the skills and satisfaction of our team members and how we will work with the organisation on an ongoing basis to provide the best support we can, within the constraints we have.



Delivery of these aims will underpin the way that we work moving forward.

2. Key assumptions and considerations

The nature of the NHS and the significant ongoing change programmes signalled by the strategies considered and others, means that we have had to make some assumptions to align our priorities and approach to the likely future direction.

2.1. Demand

We are assuming for this strategy that, whilst primary and secondary prevention is a universal ambition across the NHS, there has been limited progress, and demand for services continues to increase. Further planned initiatives will take time to result in significant change.

Unplanned care demand is likely to continue to increase. There are a number of initiatives, particularly in primary care, that have looked to reduce secondary unplanned care demand, but to date, they have not made a significant impact, and so for the purposes of the strategy, we are assuming increased growth in line with previous years.

Cancer screening will continue to increase and as a result, we expect the incidence levels to rise. However, with more cancers identified earlier and the emergence of more targeted treatments we expect, overall, for the current activity levels to remain broadly as is. Our approach to treatments will need to change, with more flexible treatment areas that enable us to keep pace with emerging therapies.

With an aging population, physiotherapy and occupational therapy services are likely to see an increase in demand. Our current facilities for these services are poor, and there's more we could do to the environment to improve patient outcomes and staff satisfaction. We need to consider how rehabilitation facilities can be expanded and improved as part of our planning.

Developments in palliative care options in the community means that more people can spend the last days of their life in their chosen setting of care. However, a significant number of people pass away whilst at the hospital and this is likely to increase with an aging and more complex population. Our mortuary facilities are currently at capacity with little opportunity to expand in the current building footprint. Therefore, we need to consider how we can create more capacity or identify new space to keep up with future demand.

An aging population and an increase in the prevalence in dementia and other age-related mental health issues means that we need to consider how our estates can support these patients well whilst remaining flexible. As we plan our spaces, we need to think about how we align physical and mental health needs, ensuring good accessibility and that research into dementia friendly spaces is incorporated in our design.

The last few years has seen a significant rise in the requirement for bariatric facilities and equipment. However, the recent developments in the treatment of obesity means that we believe that the overall need for bariatric facilities will remain broadly the same, if not, reduce. However, we will continue to monitor the change in trends to ensure that our estates and facilities are accessible to everyone.

2.2. Changes to settings of care

For the purposes of this strategy, we have assumed that there will be no significant changes to the settings of care for patients.

We have estimated that Hospital at Home will increase slightly, but this has not yet been proven to reduce the acute bed base required. We have assumed that the current issues with care and nursing home beds will remain broadly as is.

The realisation of the Hertfordshire and West Essex Surgical Centre in spring 2025 will reduce the number of low-risk elective procedures taking place at local sites, protecting planned activity from factors that can lead to cancellations, and increasing higher acuity capacity at the other hospital sites.

2.3. Technology

Technology continues to develop at a fast pace, and we will work to maximise the opportunities that this brings. The Trust is implementing a new electronic patient record (EPR) system which will help with utilising our estates more flexibly as there will be less reliance on ad-hoc patient records and disconnected workflows. We will also exploit technology to improve our estates utilisation in real time, the planning of equipment maintenance and the management of consumables.

For the purposes of this strategy, we have assumed that there will be an increase in virtual applications for healthcare including how our teams work together and with the broader system. This includes an increase in Hospital at Home, online outpatient reviews, more patient-driven interactions to help people manage their care interventions flexibly, including health status questionnaires. We have also assumed that the options for minimally invasive treatments will continue to increase, including robotic surgery, an increase in day case procedures and, in some cases, a reduced length of stay. However, the increase in patient complexity means that we assume that this will not reduce the overall length of stay we are planning to.

As a principle, we will ensure that our spaces, as they are developed, are technology enabled wherever possible, to support the application of emerging technologies, particularly those that are proven to improve patient care and outcomes.

2.4. Staffing and ways of working

The improvements to the digital infrastructure, including the implementation of the new electronic patient record, will increase opportunities for more home and agile working. We can consider more shared spaces for clinicians to undertake administration, virtual outpatient clinics and multidisciplinary teams (MDTs) which will release clinical space / current admin space adjacent to clinical space to be used more effectively.

Automation and Artificial Intelligence is likely to affect our clinical and non-clinical staffing requirements and the way that we work and will enable us to maximise the skills of our workforce. Better systems of working and the new electronic patient record will lead to an overall reduction in the volume of clinical administration with more documentation such as clinic and referral letters being automated.

In line with a national and ICB strategy of greater integration of healthcare providers, particularly primary, community, secondary and mental health care, there are likely to be more roles that work across organisations. The electronic patient record will help our staff to work in other settings of care, and where appropriate, we can give access to our systems to other providers to target improvements in patient care. Our workforce will be deployed more flexibly to this aim.

In the context of neighbouring acute providers currently in line for new hospital builds on their principal sites, and our close proximity to London, we need to make sure that we are an attractive place to work. This includes ensuring that our estates and facilities are conducive to the primary aim of our workforce to provide safe, effective and efficient patient care. We need to ensure that our staff areas and other facilities such as accommodation are of a good standard and a pleasant place to spend time as this has a significant impact on staff wellbeing and retention.

Maximising opportunities for research and innovation will help us to attract a high-quality specialist workforce. To this end, we will look to collaborate with external partners in research and technology to ensure that we also have an attractive, fit for purpose space which supports creativity and innovation, with the digital infrastructure in place to support this across the site.

3. Capital constraints

The NHS has been grappling with significant capital funding constraints in recent years, which have impacted its ability to modernise infrastructure and improve services. A major issue has been the historical underinvestment in capital projects, particularly between 2014 and 2019, when funds were diverted from capital budgets to meet day-to-day operational needs. This underinvestment has led to aging facilities, outdated equipment, and a growing backlog of repairs, with the NHS facing an estimated £11 billion in essential maintenance work.

Although the last government increased capital allocations in recent spending reviews, with an average of £8 billion per annum allocated for capital investment between 2022 and 2025, these increases have been eroded by high inflation, making it difficult for NHS trusts to deliver projects within budget. Many projects are being delayed or scaled back as costs spiral. Furthermore, the end of public-private partnerships (since 2018) has reduced access to alternative financing for large infrastructure projects.

Hertfordshire and West Essex ICS received a base system capital allocation of £62m during 23/24. The Trust received a capital distribution of c£15m from this pot. This was used to support backlog maintenance and medical equipment replacement requirements as well as to provide support to progress digital and other transformation and strategic investments. This is a low level of annual investment relative to both the size of the Trust’s asset base and the age and condition of its estate. The system allocation was supplemented by access to some further central funding to progressive specific projects.

Hertfordshire and West Essex ICS and its constituent organisations remain committed to seeking to identify opportunities to use a greater proportion of its capital resources to help to deliver transformation programmes that can help to address the systems underlying financial sustainability challenges. However, this is difficult given the current need to commit the overwhelming majority of capital resources to maintain safe services and equipment across providers.

Since the outcome of the UK General Election in 2024, the new government have been considering how they apportion funding (both capital and revenue) to best address the current shortcomings across public sector departments. Alongside the Budget on 30 October 2024, the Chancellor will confirm final spending totals for 2024–25, set detailed departmental allocations for 2025–26 and will likely set an overall path for public spending for the subsequent years. This may have a significant impact on our organisational priorities and approach, particularly around seeking new funding for initiatives, and the move of the Mount Vernon Cancer Centre. The outcome of the spending review may change the risk profile for capital availability and may result in opportunities to progress priority initiatives set out in section 6.

4. Trust vision and clinical priorities to 2030

The Trust's vision is:

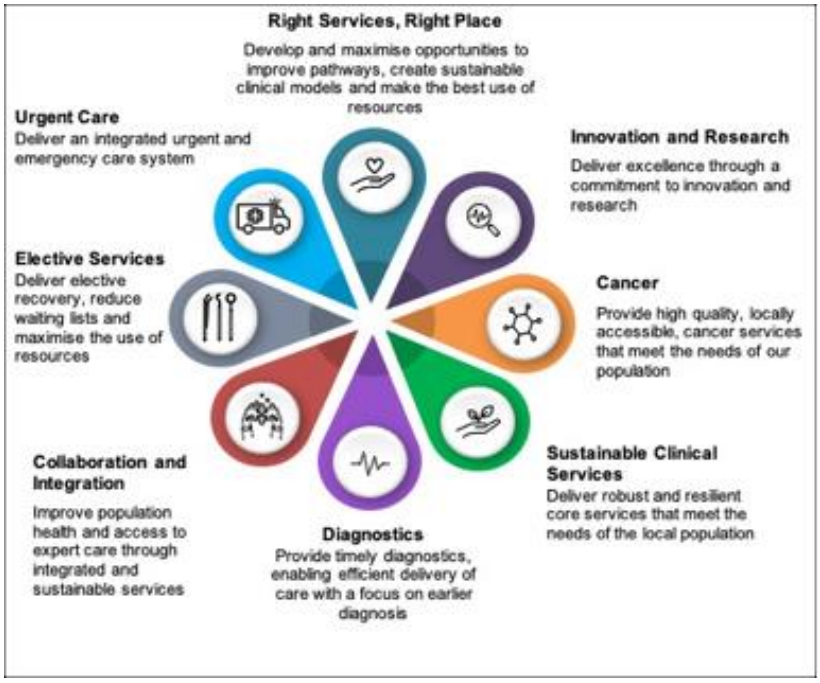
To be trusted to provide consistently outstanding care and exemplary service

To be trusted:	To be consistent:	To provide exemplary service:
That the manner and outcomes of our services means our communities trust us with their care.	No matter where, when or how people access our services, their experience should be of consistently outstanding care.	Ensuring that our patients and communities receive a high standard of service in addition to their clinical care – from the first contact to the last.

We deliver our vision by focusing on our strategic themes:

- **Quality** – consistently deliver quality standards, targeting health inequalities, and involving patients in their care.
- **Thriving people** – support our people to thrive by recruiting and retaining the best and creating an environment of learning autonomy and accountability.
- **Seamless services** – deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners.
- **Continuous improvement** – continuously improve services by adopting good practice, maximising efficiency and productivity, and exploring transformation opportunities.

In 2021 a strategy engagement process took place, working through the Trust's ambitions and confirmed that, whilst we will continue to build on those clinical areas in which we excel, we will aim to be a consistently high-performing, high-quality district general hospital. The following clinical priorities were identified as part of this process:



4.1. Delivering our vision through our estates and facilities

There are several key developments that have been led by the Estates and Facilities team to enable progress to be made against the Trust vision. They include the following schemes.

4.1.1. Ward reconfiguration

This scheme develops a collaborative estate, operational and clinical ward moves programme that will address risks identified in relation to the Strathmore building and paediatric ward, as well as considering how we best utilise the ward space that we have available. This programme includes:

- Re-mapping of all wards on Lister site to develop a plan to move non-ambulatory services out of Strathmore and re-locate in suitable alternative accommodation due to fire compliance issues.
- Placement of suitable ambulatory services into the Strathmore building, after completed works, that meet fire safety regulations.
- Clinical and speciality engagement forums to support design process.

4.1.2. Vascular theatre development

The HWE ICS is one of the only remaining systems nationally without a compliant vascular surgery network. Specialised commissioners have a requirement to only commission services which meet the national specification, and this requires a network model.

The three Trusts (West Hertfordshire Teaching Hospital, East and North Hertfordshire and The Princess Alexandra) all deliver a good vascular service individually but fail to meet several national standards which are associated with better outcomes. Through a series of

workshops and assessments a decision was jointly made to support a single arterial vascular centre at Lister Hospital, supported by Princess Alexandra Hospital and West Hertfordshire Teaching Hospital as non-arterial centres.

The hybrid vascular theatre, completed in September 2024, will facilitate endovascular and combined open / endovascular procedures on behalf of the network. The Trust have already delivered assets in support of this project including a dedicated vascular ward and refurbishment of the Interventional Radiology (IR) unit.

4.1.3. Home dialysis

Home dialysis is an NHS priority highlighted in the 2021 NHS Getting It Right First Time (GIRFT) report in which a key recommendation was to expand access to home dialysis. The report recommended the promotion of home dialysis therapy to ensure it is offered to all suitable patients, reaching a minimum target rate of 20% of dialysis patients in every renal centre.

The GIRFT report has highlighted seven key actions which includes home dialysis therapies rates. All renal providers to ensure adequate training facilities for home haemodialysis (HD) and peritoneal dialysis (PD) to deliver the 20% rate and all renal providers to ensure that shared care dialysis becomes a feature of all dialysis facilities in the NHS to improve transition of patients to home dialysis.

The objective of the renal replacement therapy team is to provide a “home from home” feel training facility, with capacity for which 8 HD and 4 PD training stations (12 in total), at the Lister to support the North Hertfordshire patient population. This facility would be further supported by clinical consultation rooms (supporting Consultant and Nurse Led clinics), family multi-user training and education room, clinical administration space, clinical consumable storage, technician workshop, staff change and washroom facilities (separate staff and patients). The training facility will also provide flexibility to be able to provide isolation in the event of future pandemics. We are anticipating that this facility will be operational by the end of 2025.

4.1.4. Origin Housing

Approximately one third of the Lister hospital site is set aside for accommodation. This stems from an arrangement between the Trust and St Pancras Housing Association in 1998 for a period of 99 years. The accommodation comprises of self-contained flats, blocks of flats built originally as nursing accommodation and a training facility known as the Old School of Nursing. The contract was passed to Origin Housing at the time when St. Pancras housing association was merged.

There has been a subsequent lack of investment and the number of the houses and flats have become dilapidated with serious backlog maintenance issues both in terms of fabric and infrastructure. This culminated in a review being undertaken by the Trust Estates and Facilities Team into the compliance issues affecting hospital and university staff.

In 2023 the Trust and Origin Housing started discussions around the short, medium, and long-term proposals for the site.

Proposals for an interim arrangement of investment and stabilisation commenced in 2023. Approximately £5.7 million has been set aside by Origin Housing to bring the environment and the existing stock up to an acceptable standard over a two to three year period, and the physical work commenced in August 2024.

Requirements of a modern hospital and the face of accommodation in the NHS has changed dramatically over the last 20 years. There is no longer the substantial call for nurses' accommodation that there once was and the additional need from overseas nurses has now reduced. The Old School of Nursing and some additional blocks has therefore been utilised as office accommodation for our clinical and non-clinical teams, however the issues with their condition remain.

Origin Housing merged with Places for People in April 2024, the UK's leading social enterprise. In considering how we might redevelop this site; we are reaching out to our other partners both in the local council and local Universities. The Trust has identified its accommodation and support requirements appropriate for a modern acute hospital, which includes:

- Training facilities both for our Universities and the Trust
- Modern residential facilities for staff on an interim basis and on call staff
- Staff support services
- Support for patient families
- Commercial opportunities
- Support for other healthcare facilities and partners in the local health economy

The existing site is low rise, low density, and the plan is to enhance the utilisation of this footprint, something welcomed by the local planning department of the council at a recent informal discussion meeting. Delivery of this will need to be realised through investment by Origin Housing, with the Trust retaining ownership of the land.

A high-level business proposal will be built up over quarters 3 and 4 of 2024/25 which will be consulted on with Trust staff and partners to ensure that we are planning for a long-term solution that will address pressures that exist and maximise the opportunity to enhance our position as an employer of choice both locally and in the southeast.

4.1.5. Solar Panels / LED Lighting Installation

The NHS National Energy Efficiency Fund (NEEF), which aims to reduce NHS estate operating costs by investing in selected energy efficiency projects and then reinvesting any savings back into frontline care, awarded a grant of £780,000 to install 900 roof-mounted solar panels at the Lister hospital site. The panels will generate approximately 326,000 kWh of clean electricity a year with an expected reduction in carbon emissions of 62 tonnes, a reduction in the use of grid electricity and associated cost savings. In quarter 3 in 2024 the panels will be installed on the roof spaces of the maternity building, endoscopy building and treatment centre at Lister hospital.

Dr Justin Daniels, Medical Director and Chair of the Trust's Sustainability Board, said:

"*Introducing solar technology at our Lister site will make a huge difference as part of our wider sustainability programme to become more energy efficient. We've also nearly completed a project to install LED lighting across the Lister site with an expected cost saving of £1 million a year."*

The Trust is committed to reducing their carbon footprint with sustainability projects such as heat decarbonisation which will move the Trust to electric heating; a plan to extend the electric vehicle charging scheme for staff and to switch some of their internal vehicle fleet to electric. There have also been major changes in the types of anaesthetic gases used and

the way they are used. The Trust is also prioritising the use of inhalers that have a decreased impact on global warming.

4.1.6. Heat decarbonisation plan

The Trust is working in partnership with Veolia Energy to develop a heat decarbonisation plan. Once the proposal is finalised, a funding application will be submitted for Phase 4 funding of the Public Sector Decarbonisation Scheme, applications for which open mid-October 2024.

4.1.7. Lister main entrance and office accommodation

Lister Hospital was built in 1972 and has undergone significant clinical development and transformation within the last 10 years but whilst these developments have contributed to overall improvement in patient outcomes; the environment has not kept up pace with regards to user experience.

Unlike New QEII and Hertford County Hospital, Lister has no formal, modern, welcoming civic main entrance and there is a lack of dining and retail provision. It fails to deliver commercial benefits that other NHS organisations generate through retail capacity.

In addition to this, staff administration workspace is limited on site, resulting in a cohort of the Trusts workforce having to be located off site at Wiltron House and Avnet House, creating a significant cost pressure to the Trust through additional rent. In addition to this for those cohorts of staff who are based on site, there are concerns over the appropriateness of location with regards to service needs or personal wellbeing.

To help address this, a proposal was developed for a newly designed civic main entrance and office accommodation solution. The application for Permitted Development has been approved by Stevenage Borough Council in 2024.

5. Our current strengths, weaknesses, opportunities and threats

Whilst significant progress has been made against our Trust vision and associated clinical priorities, the context has evolved. With our neighbouring Trusts looking to replace their core clinical facilities, they will have an opportunity to address the challenges that the physical environment has had on patient flow and efficiency. Without the chance of any significant re-build, we will need to make sure that we use the estates that we have more efficiently, whether this is through smaller developments to address specific issues, or thinking differently about how we provide services across our three main sites.

Whilst these major developments take place in our neighbouring Trusts, there will be a level of disruption to services that we will not see on our sites, so this gives us an opportunity to support ICB delivery in a different way. We would also like to explore how we partner more effectively with universities with a view to moving towards becoming a Teaching Hospital, and how we can explore different avenues to capital funding, as the current routes are, and likely to remain, constrained. The following diagram sets out our estates strengths, weaknesses, opportunities and threats.

Strengths	• Stability – no significant developments planned that risk interruptions to care delivery where our neighbouring Trusts may experience some issues • Hertford County and New QEII sites are relatively new and fit for purpose • Well established backlog maintenance programme addressing existing issues • Good reputation as a provider of innovative healthcare (eg robotics) and tertiary services (eg renal) • Track record of delivery – hybrid theatre, home dialysis, ward reconfiguration, new front door	• Lister site is landlocked meaning limited scope to expand • Some existing areas of Lister Hospital are dated and require significant investment • Existing estates limit effective patient flow and care environments fall short of patient expectation • Some services, such as diagnostics, are fragmented across sites leading to inefficiency and staff dis-satisfaction • We don't currently have a clear picture of estates utilisation and therefore can't ensure that they are maximised	Weaknesses
Opportunities	• Close working with University of Hertfordshire and move towards Teaching Hospital status • Three main sites giving estate flexibility, two of which are currently underutilised • Hertford County transfers to ENHT ownership in 2033 and will unlock opportunities to be more flexible • Developments in treatment and research including robotics and novel therapies may encourage commercial organisations to partner with the Trust • Embedding of the HWE Surgical Centre, releasing some space and resource • Ability to assist neighbouring Trusts with service continuity during major developments	• Availability of capital to make improvements needed • Ability to keep providing services on the MVCC site without considerable investment if there is further delay to the transition programme / new MVCC build • Neighbouring Trusts have an opportunity to significantly improve their flow and care environments through re-development and we risk being an efficiency outlier as a result • Availability of capital and revenue to innovate	Threats

6. The priorities for our capital spend on our estates and facilities

Given the constraints around capital, we need to make sure that our allocation is used to best effect to develop and deliver our core services. We need to increasingly explore taking an entrepreneurial approach and look for opportunities to partner with commercial and other public sector organisations to access more capital or alternative capital.

In considering how we prioritise investment, we have identified four categories into which we will map our initiatives.

- **Priority for existing funds** - Those priorities that can't not happen need funding from our capital allocation.
- **Proactively seek funds (NHS / external / commercial)** - High priorities that aren't affordable within our existing funds, but are mission critical and warrant investment of time and effort to seek the funding.

- **Prepare to act -** Those priorities that, were funding to become available, we have part-developed plans that we could readily finalise to exploit opportunities as they arise.

- **Hold -** Those priorities that don't meet the criteria to warrant time to develop plans, but might be good to explore in the future.

In our work to identify the priorities, we undertook workshops with each of the Divisional management teams. The workshops identified a number of concerns and areas to address the challenges that the Trust is facing, both now and in the future. Appendix 2 sets out the summaries of these sessions.

The following table sets out some examples of how our current strategic priorities might map against this framework:

	Examples of priorities
Priority for existing funds	• One stop clinics and diagnostics • Redesigned / rebuilt theatre complex • Better child and young people spaces • Better facilities for women including separate spaces for fertility, pregnancy loss, other gynae patients • Ward and tower reconfiguration (and more side rooms) • Backlog maintenance • Equipment renewal • Fire compliance • Digital transformation
Proactively seek funds (NHS / external / commercial)	• Technology and innovation centre incl. education facility and research facility • Increased robotic theatres • Diagnostics hub incl. readiness for emerging diagnostics and AI • Therapy services rehab and gym off-site facilities • Updating of renal units
Prepare to act	• Dedicated haematology and oncology ward and day unit • MVCC maintenance and transition • Permanent location for PET CT • Redesign of emergency department (ED) – open plan 'triage' • Fewer postnatal and antenatal beds per bay • Increased assessment beds for medicine and surgery
Hold	• Inpatient renal hub at Lister • Private patient facilities and specialty expansion incl. gynae • Elderly inpatient wards

This list will be further considered and refined once the outcome of the Budget and Spending Review is completed and at which point, we expect to have a clearer picture of the capital availability and capital limits for forthcoming financial years.

We will then establish the resources required to action each category, as there will be a need to work up proposals to the required level of detail.

7. Principles of how we will approach development

The principles that will drive our approach to development on our sites are outlined below.

These principles will need to be considered for any scheme and the proposals developed will need to set out how they are to be delivered and evidenced.

The principles will be underpinned by the development of core design outlines for each space purpose – clinical, administrative and staff rest, which focusses on creating flexible, effective environments that can be used for a range of purposes to maximise utilisation options. This will mean that, whilst a major redevelopment of our main sites is not a viable option, individual initiatives and schemes will be less piecemeal and will contribute towards better consistency in terms of quality of environment and bring the currently fragmented estate more in line.

8. Estates and Facilities technical priorities

8.1. Backlog maintenance

All NHS estate must be accurately assessed and maintained to ensure it is fit for purpose, conducive to the activities taking place and safe for patients and staff.

The Trust bases the management of assets on the following guidance:

- ‘A risk-based methodology for establishing and managing backlog’. dh.gsi.gov.uk
- ‘Developing an estate strategy’, NHS Estates
- ‘Estatecode’, NHS Estates 2003
- Estates Return Information Collection (http://www.efm.nhsestates.gov.uk)

The process of establishing and managing backlog has a direct link with other systems of governance and a risk management process is already in place.

A critical infrastructure risk register (CIR) has been developed as part of our estates engineering, capital and facilities management function. The CIR is monitored as part of the estates and facilities compliance meetings and presented at the capital review group for assurance on allocation for backlog maintenance capital spend. The CIR is compiled using the corporate risk register, the 6-facet survey, asset information, incidents and complaints.

The purpose of backlog maintenance is to bring the estate and associated assets that are below acceptable standards, in terms of their physical condition or do not comply with mandatory fire safety requirements and statutory safety legislation (as they apply to the built environment), up to an acceptable condition. To establish the current condition of the estate and associated assets, a 6-facet survey should be undertaken every five years and reviewed annually, which assess all buildings that are in use to support or deliver healthcare.

Our last 6 facet survey focussed on the Lister Hospital site and was undertaken by Rider, Levett, Bucknall in May 2023. This survey was undertaken utilising the Risk Based Methodology for Establishing and Managing Backlog Maintenance and the HTM 00-08 standard. The ‘facets’ against which the estate is assessed are as follows:

- physical condition
- functional suitability
- space utilisation
- quality
- compliance (fire and health & safety requirements)
- environmental management

Following completion of the survey, a ‘building condition’ is allocated in line with the table below:

A	as new (that is, built within the past two years) and can be expected to perform adequately over its expected shelf life
B	sound, operationally safe and exhibits only minor deterioration
C	operational but major repair or replacement will be needed soon, that is, within three years for building elements and one year for engineering elements
D	runs a serious risk of imminent breakdown
X	supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice (that is, improvements are either impractical or too expensive to be tenable).

The survey for Lister Hospital concluded that for overall ‘physical condition’ we were scored C and for ‘statutory compliance’ a B.

The risk rating, which looks at how much of the estate is ranked below B was significant. The definitions are set out in the table below:

Risk Rating	Description
Low risk	Can be addressed through agreed maintenance programmes or included in the later years of your estate strategy.
Moderate risk	Should be addressed by close control and monitoring. They can be effectively managed in the medium term so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety. These items require expenditure planning for the medium term.
Significant risk	Require expenditure in the short term but should be effectively managed as a priority so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.
High risk	Must be addressed as an urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.

When considering costs and cost forecasting for backlog maintenance, there are several elements considered:

- Condition survey: to appraise the physical condition of your estate, including compliance with mandatory fire safety requirements and statutory safety legislation.
- Establishment of costs: assessing the cost to bring sub-standard assets up to an acceptable condition (backlog maintenance costs).
- Risk assessment: to determine the risk of failing to take the appropriate action to replace or repair sub-standard assets to prioritise action and spending.
- Estate investment planning: short- and long-term investment planning to maintain asset availability.

The May 2023 report for Lister Hospital set out a backlog maintenance cost pressure of between £70 and £75 million with a 10% optimism bias across its estate.

5 year backlog maintenance cost projection

Scheme Name	25/26 Total (£000)	26/27 Total (£000)	27/28 Total (£000)	28/29 Total (£000)
Electrical infrastructure	200	500	700	450
Nurse call system	280	100	175	150
Ventilation	1500	800	450	1200
Heating and hot water	670	670	800	670
Roof/external works	230	550	550	800
Medical gas	360	250	550	250
Lifts	500	500	500	200
External works	1100	1100	1100	1100
Internal fabric	1600	1600	1200	1200
Fire safety	780	780	780	1500
Asbestos removal/encapsulation	190	75	150	190
Plumbing/water	860	860	750	1200
Grand Total	**8,270**	**7,785**	**7,705**	**8,910**

This is only reflective of the Lister hospital site as 6 facet surveys are the responsibility of the building owners who hold the investment portfolio for any capital works or lifecycle costing.

8.2. PFI, LIFT and leases

ENHT has a number of strategic and significant clinical and non-clinical sites which are funded through Private Finance Initiatives (PFI) and Local Investment Finance Trusts (LIFT), and similar commercial third-party arrangements which are from past investment cycles.

Managing and monitoring the regular investment in these assets is integral to maintaining their utilisation and suitability for current and future health needs.

Current agreements are several years into their arrangement and a substantial number are either at or past their mid-point or coming to an end.

There is a tangible and urgent need for foresight in the management and where appropriate, planning the return of these assets alongside core NHS estate. Understanding the investment in and management of assets within these sites remains integral to minimising any effects from significant cost pressures and asset replacement requirements in the future.

8.2.1. Hertford County Hospital

The Trust is focusing on the monitoring and management the Hertford County Hospital (HCH) agreement as this Site has the earliest expiry date of May 2033. The intention is that all PFI (or similar) arrangements will be reviewed over a planned period.

The Trust operates services in Hertford County Hospital (HCH), under a Private Finance Initiative (PFI) Project Agreement. The Hospital was re-developed under a PFI arrangement in 2003 and the new hospital building opened in November 2004.

The privately financed £8.5 million facility opened its doors to patients in November 2004. It has a Gross Internal Area of 5,073m2. The Project Agreement is between the Trust (as the Tenant) and Project Co (as the Landlord). The Facilities Management services are also provided by Project Co.

The Trust currently provides a wide range of outpatients, antenatal, postnatal, diagnostic and therapeutic services to the people of south-east Hertfordshire along with a number of NHS tenants.

The Trust is currently actively working with the Landlord of Hertford County Hospital to improve the overall site condition.

Photograph of Hertford County Hospital

8.2.2. New QEII Hospital

The Trust operates services in the New QEII under the terms of a sublease with Hertfordshire and West Essex Integrated Care Board (formerly East and North Hertfordshire CCG). The ICB hold the head lease as a public private partnership under an NHS LIFT arrangement.

The £30 million New QEII Hospital in Welwyn Garden City opened to patients on 15th June 2015. The facility was developed by Community Health Partnerships and a private sector partner.

The lease is a LIFT standard lease plus and expires after 25 years, i.e., in 2040. The Trust pays a charge for the use of c.80% of the facilities which it uses within the building through an Under Lease Plus Agreement (ULPA) with the CCG.

Under the terms of the LIFT project agreement, the private sector partner is responsible for maintaining the building to at least condition category B (the minimum acceptable condition that must be achieved to avoid backlog costs) as defined in the NHS Estate Strategy guidance.

The Site offers a range of different services with NHS tenants who include the Trust and Hertfordshire Community NHS Trust. GP Out of Hours services are also provided from the Site.

Photograph of New QEII Hospital

8.2.3. Other rented properties

We rent space in a number of other properties including, Wiltron House and Avnet House, and their compliance is considered as part of the lease arrangements with the landlords and owners.

8.3. Our Green Plan

In response to The Greener NHS pledges set out in Delivering a Net Zero Health Service published in October 2020, the Trust developed its Green Plan. It sets out the organisation's plans to approach the two net zero targets within. They are:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040 (with an ambition to reach an 80% reduction by 2028 to 2032)

- For the emissions we can influence (out NHS Carbon Footprint Plus), we will reach net zero by 2045 (with an ambition to reach an 80% reduction by 2036 to 2039)

Our Green Plan (2021 – 2024) outlines the aims, objectives and delivery plans for sustainable development and the targets that we would work towards. The delivery is monitored through a Green Plan Programme which looks at progress against the following work streams:

Corporate approach
- Embed sustainability throughout the Trust in process and policy

Our people
- Supporting and empowering staff

Green space and biodiversity
- Enhance the quality of our green spaces and reduce biodiversity loss

Procurement
- Supply chain controls and ethical purchasing
- Social value

Sustainable care models
- Whole system approach to deliver best quality care

Estates and facilities
- Reduce resource consumption
- Improve energy and water efficiency
- New build and refurbishment to follow sustainable design

Climate adaption
- Preparedness to deal with effects of climate chage / extreme weather events and changing disease prevalence

Travel and logistics
- Minimise the environmental and health impacts - encourage sustainable and active travel

The Trust Board receives regular updates on progress, and whilst some progress has been made, the Green Plan is currently being refreshed to reflect on learning and the challenges to delivery. Developments set out within this strategy will embed the ambitions of the Green Plan as a key strategic driver.

8.4. Electro-Bio Medical Equipment

Electro-Bio Medical Engineering (EBME) covers the maintenance, repair and management of medical equipment. It has been an area of weakness for the Trust and following issues highlighted during a CQC inspection, we have undertaken steps to significantly strengthen our approach to EMBE management. They include:

- Transfer of responsibility for EBME from Planned Care to Estates and Facilities in April 2023
- Improvements in our managerial capacity and capability
- Improvements to our processes
- Audits of equipment by external medical device specialist

- Medical devices group re-established and strengthened with the Medical Director as chair
- Appointment of a qualified and experienced EMBE manager to drive the improvement programme
- Upskilling staff
- Implementation of an equipment register to track and proactively manage maintenance.

The department has focused on improving the Trusts equipment records, where it is located and maintenance status. In the first instance, all high risk, highly technical equipment has been identified and checked with external manufacturers and maintenance suppliers, providing external oversight and assurance.

A new tracking system has been purchased and is being rolled out as part of the ongoing survey of equipment that will keep a track on equipment to ensure clinical and nursing staff have the best equipment at hand to reduce delays, but also will identify timetable for servicing and validation to maintain compliance. This should substantially reduce the capital investment need through improved efficiency, avoiding duplication.

Once we have a clear picture on the equipment required, in situ and what requires maintenance, we will be able to review the existing contracts we have with suppliers and maintenance contractors to drive up value for money for the trust by utilising our purchasing power in line with our standing financial instructions.

Our processes will continue to be informed by good practice which we will replicate across our sites. Additionally, we will look for opportunities to share this learning with our partner organisations to explore opportunities for system-level efficiency.

The Sterile Services Department has also recently joined the Estates and Facilities team and the lessons learned through the EBME process is also driving improvements. Bringing these teams into the Estates and Facilities ensure technical expertise and engineering excellence across the Trust, in what historically have been seen as operationally, separate functions. Whilst there is more progress to be made, we have seen substantial improvements, and we aim to report significant gains in assurance to the Trust Board within the next 12 months through good management and investment.

8.5. Other technical considerations

Much of the monitoring of our estates and facilities is driven nationally, but we also consider what our patients tell us directly about how the environment is affecting their care. Appendix 3 sets these mechanisms and feedback out in more detail.

9. Estates and Facilities Team development

9.1. About the team

The Estates and Facilities Team is responsible for ensuring that the environments in which the Trust provides its services are fit for purpose and that patients have everything that they need whilst they’re at the Trust.

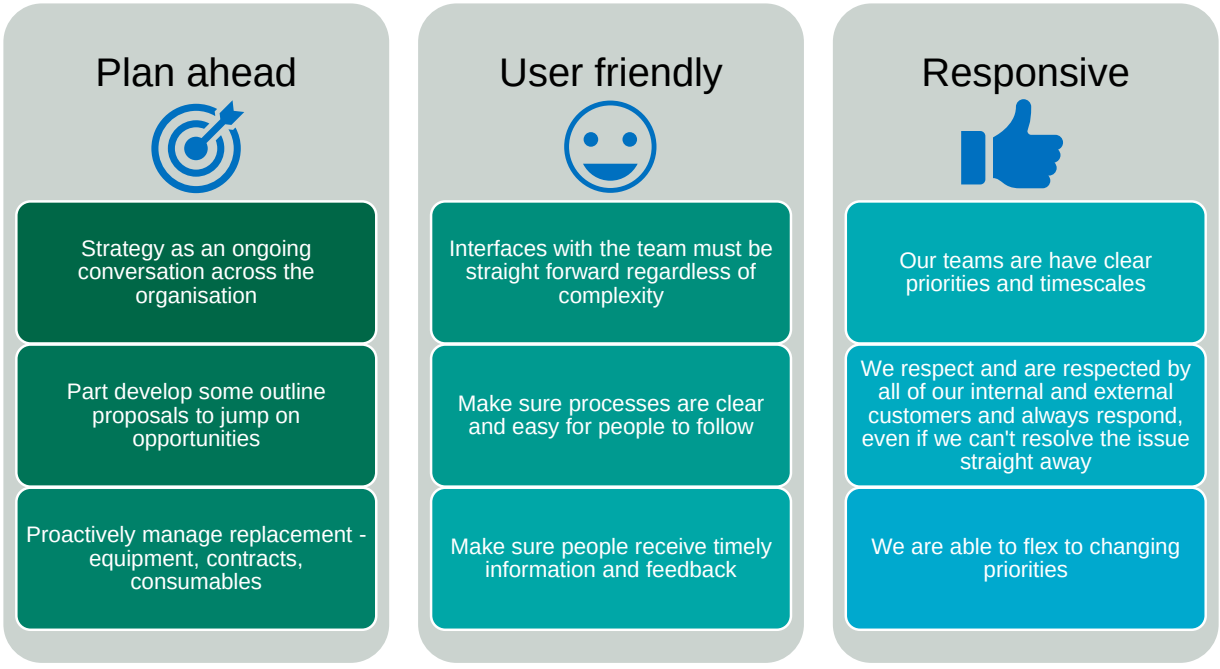
The remit includes different technical elements, bringing together a diverse group of individuals with specialist skills, as well as some more generalist functions.

Engineering	Mechanical	Decontamination	Water and plumbing	Electrical
Compliance	Capital programmes	Sustainability and energy	Fire safety	Security
Waste	Health and safety	Catering	Facilities contracts	Linen and uniforms
Portering	Non clincial transport	Car parking	Scheme design	Strategic & commercial developments

The Team fulfils a sometimes-invisible support function, and as part of this strategy we have given some thought to how we ensure sustainability and innovation within the team to enable us to continue to deliver a robust and trusted service to the rest of the organisation.

9.2. Improving the way that we work

We need to balance good process with being adaptable and responsive to issues as they arise. We have therefore developed the following principles for the way that we will work and the processes that we will establish.



9.2.1. Plan ahead

Whilst this strategy puts us in a good position to move forward, we need to ensure that the conversation and high level of engagement continues with colleagues from across the organisation, and that the Team is empowered and has protected time to look forward and plan. We need to consciously make time to work collectively and individually to horizon scan, innovate, discuss to make more sustainable, effective decisions.

As part of this, we need to identify those priority schemes that, should some capital become available, we would want to target. By part developing some outline proposals that can be easily finalised with up-to-date context and costings, we can ensure that we are able to respond in the most effective way within tight timeframes and maximise our potential opportunities. We will also develop some outline proposals to share with commercial organisations to explore potential for external / partnership funding.

To respond to feedback from colleagues on the impact of failing equipment, we will make sure we improve our processes around the maintenance and replacement of equipment. We will develop a robust database, making sure we have forward plans with all our suppliers and engineering / testing teams. This will also help us to better plan our capital expenditure and minimise the impact to clinical efficiency. We will use this same approach with contracts, consumables and other time-limited processes so that we're always as proactive as possible.

9.2.2. User friendly

As a provider of services to our internal customers, an indicator of success is that they can contact us swiftly, easily and the experience feel straight forward, even if the issue is complex for us to resolve. We are very much there to enable our clinical colleagues to provide effective and seamless services, and we recognise that this means that we need to own problems and find a way to put them right as swiftly as possible.

Our processes need to be clear and easy to follow. We should enable colleagues to help us to develop our systems and processes so that they can be well understood by all, not just us, and be as effective and efficient for our customers as part of that.

This includes making sure that we provide proactive, timely information about planned or unplanned maintenance or disruption to our normal services, and where colleagues come to us to report issues or identify improvements, we make sure we close the loop with effective feedback.

9.2.3. Responsive

As a team, we need to balance those planned activities and routine tasks with being available to respond at short notice to the needs of the organisation, especially where issues arise that are impacting our ability to deliver care. Therefore, we identify those priority areas for action that need to progress regardless of ad-hoc requirements and are working to clear timescales. To deliver this, we work flexibly as a team and use the skills and experience of our team members to their fullest.

As a facilitative resource and a team of highly skilled and knowledgeable specialists, we understand how we fit in terms of needing to provide a service and respect all our internal and external customers. In the same way, our colleagues understand the part that we play behind the scenes and are respectful of the value that we bring. Even where there are

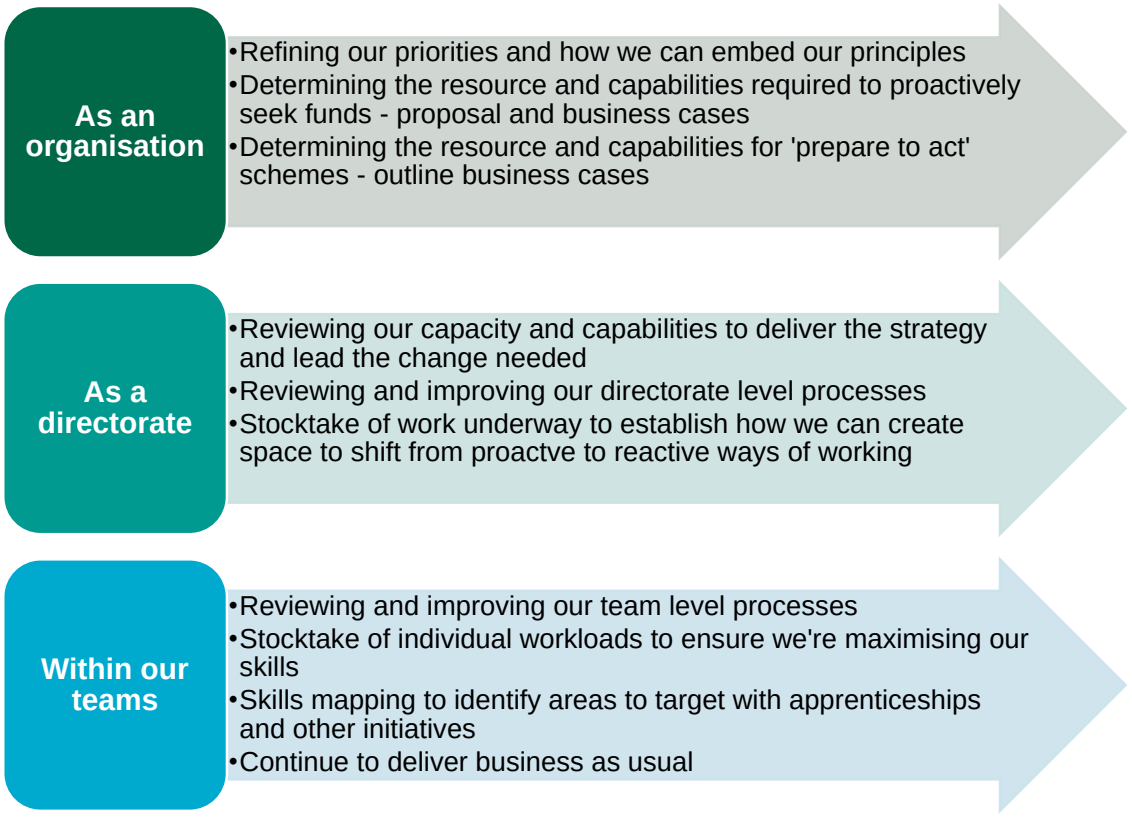
issues that we can't resolve straight away, we continue to hold the skills of our team and others in high regard and foster a culture of mutual respect.

9.3. Developing our team for the future

Appendix 4 contains more information about the team and how we plan to learn from our successes and challenges and develop our team for the future.

10. How this strategy will drive our workplan

The successful delivery of this strategy will require input from across the organisation. We will be continuing to engage with colleagues on how we shape our resulting workplan during the remainder of 2024/25. The initial workplan for 2025/26 will be important to ensure that we are addressing our priorities and maximising opportunities to work differently. The key elements of this will be:



October 2024

East and North Hertfordshire NHS Trust

Estates and Facilities Strategy

Developing our care environment between 2024 and 2030

APPENDICES

Appendix 1: Strategic drivers informing our approach

1. NHS Long Term Plan

To make the NHS fit for the future and to ensure value, the NHS Long Term Plan was published January 2019.

The plan sets out how the NHS will overcome challenges by:

- Doing things differently
- Preventing illness and tackling health inequalities
- Backing the workforce
- Making better use of data and digital technology
- Getting the most out of the taxpayer's investment in the NHS

Within the plan are Estates focused ambitions; "The NHS will improve the way it uses its land, buildings and equipment. This will mean we improve quality and productivity, energy efficiency and dispose of unnecessary land to enable reinvestment while supporting the government's target to build new homes for NHS staff".

Some specific key expectations are outlined:

- Reduce the amount of non-clinical space by a further 5%, freeing up over one million square metres of space for clinical or other activity.
- Reduce the NHS carbon footprint by a 1/3 from 2007 levels including improving energy efficiency
- Improved management of the estate
- Modernise and standardise ambulance fleet to help reduce emissions and improve air quality.
- Improve utilisation of estate
- Ensure build and maintenance is sustainable

These expectations are reflected in the Trust priorities.

2. Naylor Review

The Naylor Review was published in 2017, examining how the NHS could best use its estate to support the delivery of NHS England's five year forward view.

The report highlights opportunities to support sustainability, transformation and optimisation of NHS land and buildings. The report outlined individual recommendations relevant to both national and local NHS organisations, and these have been considered in the development of our priorities.

3. Delivering Net Zero

In 2020, the NHS published the 'Delivering a Net-Zero National Health Service' in response to the health emergency of climate change setting out two clear targets for NHS organisations to meet:

1. Emissions **we control** directly (the NHS Carbon Footprint) we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 – 2032.

2. Emissions **we can influence** (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

The Trust has reflected this in its work on decarbonisation and moving towards net zero.

4. ICS/ICP Strategy

The Hertfordshire and West Essex Integrated Care System (ICS) is one of 42 ICSs in England and works to deliver health and social care services to those living in Hertfordshire and Essex, in 13 district and borough council areas, supporting a population of approximately 1.6 million.

The population in which it serves is diverse and continually growing, however the area is home to some of the healthiest in the country but in stark contrast, also supports high levels of deprivation and poor health.

Partners within the ICS have come together for form the Hertfordshire and West Essex Integrated Care Partnership (ICP). This is a joint statutory committee, established by the Hertfordshire and West Essex Integrated Care Board, Essex County Council and Hertfordshire County Council.

The ICP provides a forum for system partners to agreed shared objectives and collaborate on joint challenges to improve the health and wellbeing of our population.

The Hertfordshire and West Essex ICS Strategy contains six priorities which are:

1. Give every child the best start in life
2. Support our community and places to be health and sustainable
3. Support our residents to maintain healthy lifestyles
4. Enable our residents to age well and support people living with dementia
5. Improve support for people living with life-long conditions, long-term health conditions, physical disabilities, and their families
6. Improve our resident's mental health and outcome for those with learning disabilities and autism.

These six priorities are underpinned by a set of guiding principles, which are to:

- Plan and deliver services in a joined-up way
- Help people to stay healthy and well

- Act quickly when they need help or support
- Tackle the inequalities which lead to physical or mental ill health
- Involve the people who use services in designing them.

The ICS is currently developing its estates and facilities strategy, looking at how the system can work together within its combined assets to deliver improved care and outcomes for the population. The Trust has been engaged with the work to develop the strategy, and the priorities outlined in this strategy are reflected within the emerging system-wide strategy.

5. Health Infrastructure Plan

The Department of Health and Social Care launched the Health Infrastructure Plan in 2019 which sets out a rolling five-year programme of investment in modernising health infrastructure.

The plan provides capital to:

- Modernise the primary care estate
- Build new hospitals
- Improve mental health facilities
- Investment into new diagnostics and technology
- Eradicate critical safety issues

At the core of this plan was the 2020 commitment to a New Hospital Programme which committed to build 40 new hospitals by the end of the decade (2030).

The first phase of investment saw two of our neighbouring hospitals, Princess Alexandra Hospital NHS Trust, Harlow and West Hertfordshire Hospitals NHS Trust, Watford receive a capital boost which has enabled them to build new health facilities such as operating theatres and procedure rooms. Subsequently, both Trusts have had plans approved for new hospital builds which will radically update their core care environments. However, following the General Election in July 2024, the new government has asked for this scheme to be reviewed, and this may change the current plans in terms of investment and timelines.

6. Sustainable Hertfordshire Strategy

The Sustainable Hertfordshire Strategy, published in 2020, articulated a vision “To create a cleaner, greener and more environmentally sustainable county”.

Outlined in this document are ambitions to enable and inspire sustainability, including:

- Net zero greenhouse gas county before 2050
- Improved wildlife and water by 20% by 2050
- Clear air by 2030
- Preparedness for future climate
- Resource efficiency

This aligns with our net zero strategies.

7. Stevenage Borough Council Strategy

Stevenage Borough Council, as part of their sustainable Transport plan are focusing on:

- Green Travel Plan – setting targets for various sustainable transport modes
- Seasonal public transport ticket loan
- Cycle to work scheme to get a bike tax free
- Pool bikes for commuting between offices/sites
- Green mileage allowance for business travel via Smartgo Stevenage
- Considering an Ultra Low Emissions Car Salary Sacrifice scheme

8. Climate Change

The Trust relies on the Emergency Prevention, Preparedness and Response Framework and Business Continuity Plan to guide the local response to the impacts of climate change via the completion of a climate adaptation risk assessment. The main climate related risks for the Trust are over-heating due to heatwaves and localised flooding due to severe weather events.

Our ICS will build long-term adaptation planning into their Green Plans by 2025.

The climate related financial disclosure report identifies environmental risks that could impact the NHS, and the outline steps being taken to build resilience. The following progress has been made against this:

- All climate related risks are identified and added to the Trust's risk register
- Risks are reviewed monthly via the Trust Risk Management Group Meeting and reported up to the Trust Quality and Safety Committee
- Both climate-related risks and strategy are reported and monitored on a bi-annual basis at the Trust Sustainability Board and reported up to the Trust Finance, Planning and Performance Committee

The Trust is currently refreshing its Green Plan, which is due to be submitted to the ICS Working Group in January 2025. The refresh will incorporate updated strategic direction and key actions, along with revised metrics and local targets to achieve the net-zero targets 2040 (direct) and 2045 (indirect).

9. Learning from COVID-19

The pandemic has fundamentally changed how healthcare is managed.

The way in which the estate has had to adapt to support social distancing, increase sanitation and quickly implement new models of working was vital in maintaining staff and patient health and wellbeing.

The need for enhanced digital transformation to enable virtual and remote working highlighted possibilities and opportunities, freeing up prime estate as a result.

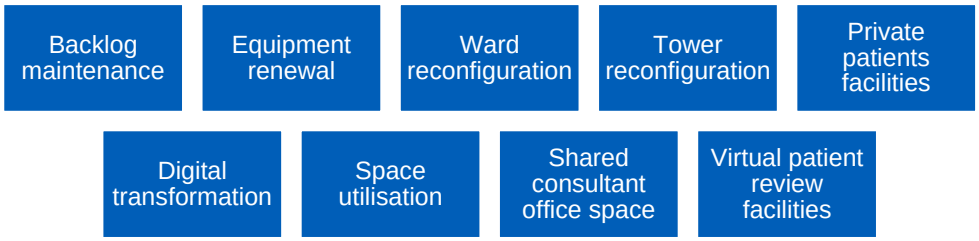
We have been forced to think and work differently, offering opportunities to use our estate in a more efficient and smarter way. However, to do this, there needs to be a joined up, collaborative approach before any significant and irreversible changes are made to the estate.

Appendix 2: Summary of divisional engagement sessions

The following sections set out the feedback received through our engagement sessions with the divisional leadership teams over summer 2024.

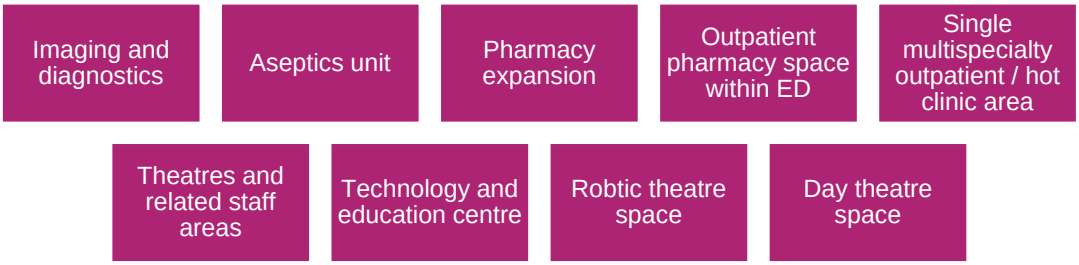
1. Cross-divisional priorities

There are some priorities that span all divisions and these are the common themes:



2. Planned Care

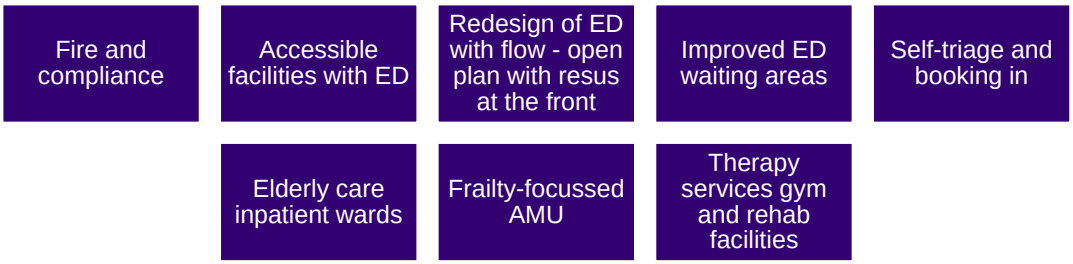
The Planned Care division outlined the pressures that their current services are under and how the fragmentation of the estate leads to inefficiencies in service delivery and the impact on patient experience. The team identified where any investment could best be targeted to address these issues:



3. Unplanned Care

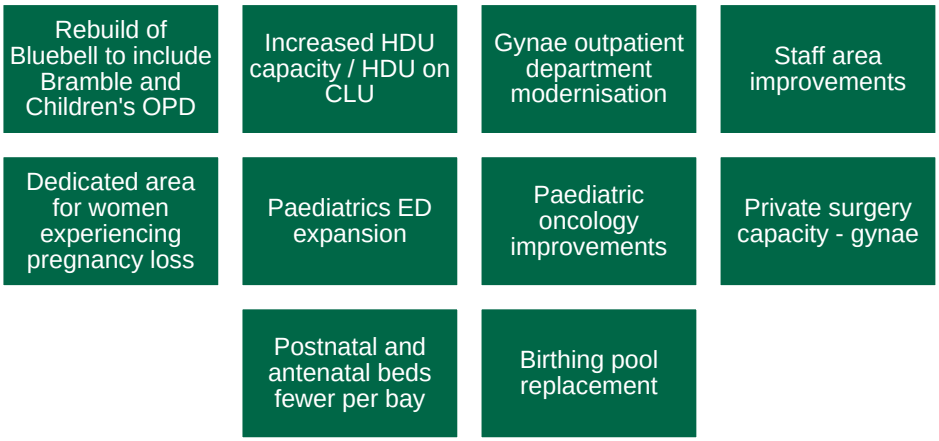
The Unplanned Care division discussed their challenges, including capacity and effective use of the space available to them. There have been a number of reactive changes to the space to increase capacity to match demand, including the addition of an Urgent Treatment Centre to see patients with lower acuity needs, and adaptations required for the Covid-19 pandemic.

Despite the system working on a range of initiatives to better support patients outside of the ED environment, the scope to slow the increase in patient numbers is limited, and therefore we have predicated our themes on targeting increased patient numbers, a continuing acuity range and increased numbers of older people with complex needs.



4. Women and Children

The current care environment has challenges in relation to the age of the fabric of the buildings, their suitability and their scope for adaptation to accommodate the requirements of services. There are also some limitations to implementing best practice in relation to providing separate accommodation for women experiencing pregnancy loss or requiring gynae procedures that is currently co-located with maternity services.



5. Cancer services

Cancer services are currently provided on two sites – Lister hospital and the Mount Vernon Cancer Centre.

Mount Vernon Cancer Centre services are, following a review led by NHS England, planned to relocate to the Watford General Hospital site under the management of University College London Hospitals (UCLH). The programme has so far spanned several years, and the relocation and transition are still reliant on securing adequate capital and revenue funding.

The fabric of the estate at the current Mount Vernon Cancer Centre is poor, and the site, owned by Hillingdon Hospital, has significantly depleted its clinical delivery. A number of improvements have been made to the site to enable continuation of delivery of the cancer services, however, more investment will be needed to keep the site operational for years to come. We are currently collating the improvements that would be required to keep the site operational and safe in the meantime for the coming 2-3 years.

If capital were to be identified soon for the relocation programme, it would still take some years for the new facility to be built and ready to accept patients. Ensuring sustainability on

the current site will require a continued Fabric Improvement Programme, and negotiation with UCLH around the point that the ownership of the service transfers.

The future arrangements for MVCC relocation are subject to public consultation towards the end of the 2024 calendar year.

The cancer services that will continue to be delivered by ENHT on the Lister site have been the main consideration in our discussions with the divisional leadership team.

Depending on the outcome of the MVCC consultation and reprovision programme, there may be a requirement for a satellite radiotherapy site to be located on the Lister hospital site, but this has not yet been considered within plans.

Appendix 3: Technical monitoring and patient feedback

1. Premises Assurance Model (PAM)

The NHS Premises Assurance Model (PAM) has been developed to provide a nationally consistent basis for assurance for trust boards, on regulatory and statutory requirements relating to their estate and related services, and this NHS constitution right - “To be cared for in a clean, safe, secure and suitable environment”.

The NHS PAM self-assessment questions (SAQs) are grouped into five ‘domains’, with a separate section for helipads, FM Standard Maturity Framework and Contacts:

- Safety (hard and soft)
- Patient experience
- Efficiency
- Effectiveness
- Organisational governance

The first four domains cover the main areas where estates and facilities impact on safety and efficiency.

The organisational governance domain acts as an overview.

The SAQs cover all the major areas where NHS estates and facilities impact on safety and clinical services.

1.1. Summary of PAM assessment outcomes 2021/2022 and 2022/2023

The **2021/2022** overall assessment results were:

- 0.6% has been assessed as Inadequate
- 53% as Requiring Moderate Improvement
- 21% as Requiring Minimal Improvement
- 17% as Good
- 0% as Outstanding

The **2022/2023** overall assessment results were:

- 1.0% has been assessed as Inadequate
- 19% as Requiring Moderate Improvement
- 37% as Requiring Minimal Improvement
- 43% as Good
- 0% as Outstanding

This return identified 3 SAQs as inadequate, these were:

Domain: Effectiveness E1: With regards to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following and is this in-line with the ICS infrastructure strategy?	5. Strategy Understood - **inadequate** Staff know and understand the strategy and their role in achieving it? 6. Progress - **inadequate** Progress against delivering the strategy is monitored and reviewed?

Domain: Safety Hard SH15: With regards to Medical Devices and Equipment can the organisation evidence the following?	4: Maintenance - **inadequate** Are assets, equipment and plant adequately maintained?

1.2. PAM assessment outcome 2023/2024

The **2023/2024** overall assessment results were:

- 1.0% has been assessed as Inadequate
- 35% as Requiring Moderate Improvement
- 29% as Requiring Minimal Improvement
- 35% as Good
- 0% as Outstanding

This return identified 2 SAQs as inadequate, these were:

Domain: Effectiveness E1: With regards to having a clear vision and a credible strategy to deliver good quality Estates and Facilities services can the organisation evidence the following and is this in-line with the ICS infrastructure strategy?	5. Strategy Understood - **inadequate** Staff know and understand the strategy and their role in achieving it? 6. Progress - **inadequate** Progress against delivering the strategy is monitored and reviewed?

This year's assessment has shown slightly reduced assurance ratings and increased levels of improvement required.

Electrical and Biomedical Engineering (EBME) and Sterile Services Department (SSD) have now transferred over from Planned Care Division to the Estates and Facilities Directorate. A previously failing service area is in the process of undergoing complete service transformation following an extensive review by the newly appointed Head of Clinical Engineering and SSD.

In summary the key areas that need improvement at the current time, and included within action plans are:

- *Policies and procedures;* Majority are available; however some are outdated and in need of review, these include Medical Management Policy, Transport Policy, and Pressure System Policy.

- *Roles and responsibilities;* limited number of Authorised Persons (AP's) for the size of the estate, this has also been identified in our Authorised Engineers (AE's) annual audits – in particular for Electrical Safety, Lifts & LOER, Decontamination and Ventilation. Improvement is also needed with the Safe Management of Contractors on site, again this has been identified via AE's Annual Audit.

- *Maintenance:* Moderate improvement required with progressing PPM (planned preventative maintenance) programme across range of disciplines including medical devices and equipment, window restrictors and fire risk assessments (FRA's).

This strategy has been developed in line with the ICS infrastructure strategy, and the team have been engaged in its development. Further engagement will follow with all teams to ensure clarity in relation to roles to deliver the strategy.

2. ERIC

Estates Return Information Collection (ERIC) is a mandatory collection for all NHS trusts including Ambulance trusts. It comprises information relating to the costs of providing and maintaining the NHS Estate including buildings, maintaining and equipping hospitals, the provision of services e.g. laundry and food, and the costs and consumption of utilities.

In recent years, ERIC has become more detailed, allowing for in-depth analysis of core estate, and has expanded its scope, with data on fire safety and carbon reduction now included.

On 8th October 2024, NHS England published "*Delivering productivity through the NHS estate"*. The report looks at estate costs and performance in 2022/23 compared to those observed by Lord Carter in 2014/15. It is based on NHS trusts' annual ERIC submissions.

At a national level, it has identified the following trends:

- Over the past 9 years, the cost of occupancy – the total expenses associated with occupying and operating buildings – across NHS secondary care has fallen by £0.24 billion, from £12.2 billion in 2014/15 to £11.9 billion in 2022/23 (in 2022/23 values).
- The number of patients using these facilities each year has increased by 13.8 million, from 123.9 million in 2014/15 to 137.7 million in 2022/23.
- The non-clinical occupied floor area has dropped from 44% to 33% of the total estate, below Lord Carter's 35% target. With the integration of new technologies and modern working methods, trusts are aiming to further reduce non-clinical space to below 30%.
- The amount of floor area used for each patient attendance has decreased by 7% in the same period, contributing to the lower overall occupancy costs.
- Under-utilised occupied floor area has dropped to 1.9% from 4.4% in 2014/15.
- More than 1,850 energy efficiency schemes have been implemented since 2018/19. 81 new combined heat and power (CHP) units have been installed and 47% of the estate is now using LED lighting.
- Estates and facilities management teams have reduced the ongoing cost of their services by 17% (£2.24 billion or £16 per attendance).

The national estates team is shifting its focus to how the estates and facilities management community can boost productivity by investing in failing infrastructure and supporting more effective operating models. It is therefore imperative that we ensure that our ERIC returns are accurate to inform comparative analysis and benchmarking and our returns to date have informed our investment priorities.

3. Modern Methods of Construction

Modern methods of construction (MMC) is a core government and NHS policy when developing modern infrastructure and there is a requirement that MMC will be utilised as the default on all construction projects. There is a national NHS target that any scheme over £25m will look to achieve MMC at 70% for new builds and 50% for refurbishments. Where there are exceptions and targets cannot be achieved, a full and complete explanation and justification must be provided including of options explored to attain the required target.

4. RAAC

There have recently been a number of high-profile examples of the use of Reinforced autoclaved aerated concrete (RAAC) in public sector buildings and a national programme of investigation was launched to identify buildings at risk. It is a lightweight material that has been used predominantly in flat roofing but also used for walls and floors between the 1950s and 1990s. It was used as it was a cheaper alternative to concrete and easier to install. However, it is less durable than concrete and only has an expected lifespan of 30 years. It is more susceptible to structural failure if exposed to moisture.

In July 2023 and external survey by chartered surveyors was conducted across each of the Trust's three sites and no RAAC material was identified. Therefore, no further action is required.

5. Feedback from our patients

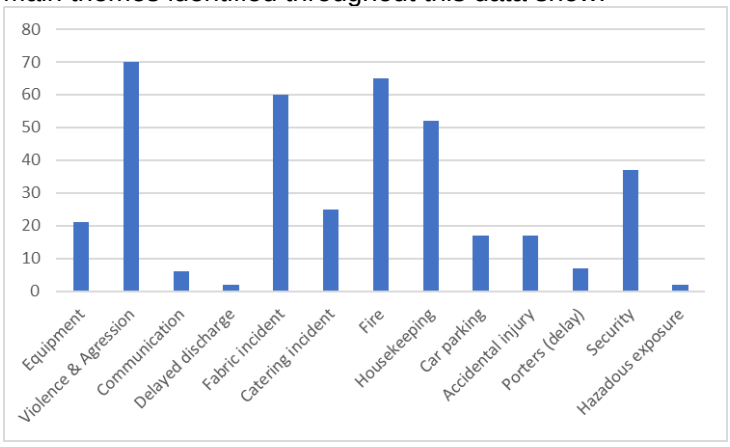
It is important that staff and service user feedback is acknowledged and used to help understand needs, identify issues and ultimately support improvements the environment and services we provide to both our workforce, patients and visitors.

We can utilise this important information to make better decisions, making changes where necessary.

To capture feedback, the Trust has the Patient Liaison Service (PALS) and an internal system, Enhance, to log any issues formally. Furthermore, the Trust actively encourage patient representation in relevant forums/groups to help drive improvements and developments.

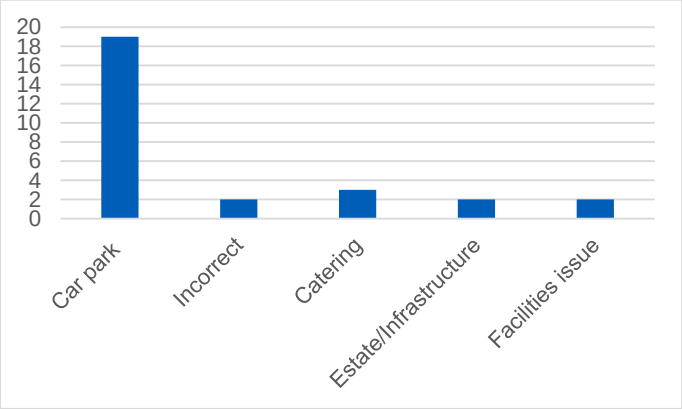
Data extracted from the Trusts Enhance system between January 2023 and December 2023 indicates that out of 15,312 issues logged 3% (449) relate directly to Estates and Facilities. It was noted that a few issues logged were incorrectly linked to Estates and Facilities and needed to be re-assigned to the correct managing department.

Main themes identified throughout this data show:



The main themes were violence and aggression linked to security, fire and fabric incidents. This is in keeping with previous years.

PALS data obtained for issues logged in 2024 showed 28 formal patient logged complaints linked to Estates and Facilities.



Results show that a significant number of complaints were related to the car park with regards to access and staff behaviours.

It is noted that there were two complaints incorrectly linked to Estates and Facilities.

We get regular verbal feedback from visitors to the Lister hospital site regarding the front of the hospital and its main entrance. Visitors have been raising concerns that the front desk is unmanned, and that signage is unclear. Patients are often having to find staff members to ask directions, and on occasions, entering clinical treatment areas to do so, which is increasing the risk of infection for vulnerable users. As often a first impression, this creates a negative impression and perception of the Trust by its users and this needs to be addressed as part of the Trusts estate developments, particularly the Lister Civic Main Entrance programme, but clear signage and wayfinding should be worked through as part of all developments.

6. Feedback from our patients through PLACE assessments

Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account.

Patient-Led Assessments of the Care Environment (PLACE) assessments will provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

The assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment can support the care of those with dementia or with a disability. PLACE assessments focus exclusively on the environment in which care is delivered and do not cover clinical care provision or how well staff are doing their job.

Recruitment and training of patient assessors is the responsibility of those organisations undertaking assessments. The assessments take place every year, and results are published to help drive improvements in the care environment. The results show how hospitals are performing both nationally and in relation to other hospitals providing similar services.

The Trust scored positive improvements for the food domain, but the overall PLACE position does not present a positive representation of the Trust.

Scores compared against local organisations who participated within the East of England Commissioning region Bedfordshire Hospital, Milton Keynes, Cambridge University Hospital (Addenbrookes), West Hertfordshire Teaching Hospital (Watford), Princess Alexandra Hospital, cannot be fully compared as East and North Hertfordshire is the only Trust categorised as an acute large Trust.

The disability and dementia category showed the largest variance against the national average. Examples of areas where points were lost in the disability category include lack of handrails in some corridors, signs not at the recommended height to make viewing easy, picture and text not used on all toilet/bathroom/shower rooms and a range of seating not provided for patient's needs. To improve the score in this category funding would be required to invest in furniture and fixings across the site.

Other areas where scores could be increased with little or no investment include supporting our patients during mealtimes to sit up in bed or sit out, packaged foods to be opened for those patients identified with having difficulty opening packages, hearing loop signage to be visible and not covered.

The dementia category would require significant work and funding to become fully compliant in this area to further improve our future position. Examples of areas where points were lost include flooring being inconsistent and inappropriate, all toilet/bathroom/shower room doors not in a single distinctive colour, and the lighting would need to be possible to be adjusted by the patient by using a dimmer switch or one on/one off system.

Other areas where scores can be increased with little or no investment include the installation of a dementia clock – date and time to be correct, and the installation of artwork/points of interest on the walls.

The Trust would need to invest significantly to become fully compliant across the six domains, but it has been identified scoring can be increased by improving engagement and awareness clinically and non-clinically across the Trust, which we will be striving towards during 2024.

We will ensure that the feedback gathered through the PLACE process will continue to inform and shape our priority developments, especially the development of our core design outlines.

Appendix 4: Developing our Estates and Facilities Team

1. The Estates and Facilities departmental vision

A healthy hospital for a healthy community

The departmental vision is underpinned by our Estates and Facilities guiding principles:

- Patient centered
- Safe
- Sustainable
- Flexible
- Affordable
- Collaborative
- Accessible
- We know our estate

These key principles have shaped our Estates and Facilities directorate strategic objectives:

Putting the patient experience first:

- Provide a safe and fit for purpose environment
- Listening to user feedback and continue to strive for improvement
- Ensure equitable access to care to meet the needs of the community

Delivering safety, efficiency and compliance:

- Reduce estates and facilities running costs through effective management and robust measurements
- Clear framework and management for capital investment planning
- Clear governance and control processes in place to manage risk and compliance.
- Robust communication and strive for collaboration with subject matter experts to deliver a safe environment.

Maintaining our estate sustainably

- Ensure all new builds and improvements are compliant and align with Net Zero standards
- Reduce waste

Supporting a flexible, digital estate

- Utilising digital technology and systems to support and streamline services, resources and efficiency

Supporting a diverse and flexible estates and facilities workforce

- Empowering our workforce to work autonomously
- Recognise the potential of individuals to develop
- Supporting a flexible workforce to improve health and wellbeing
- Improving the estate to support training, education and research.

Working in partnership

- External partnership collaboration to enable system working and learning.
- Robust management of external commercial contracts to ensure longevity of the estate.

2. Successes and team stories

The Team is rightly very proud of what they do, and the impact that it has. Below are some recent key successes highlighted by the Team:

- ✓ We now recycle all staff uniforms through Shredall SDS, which contributes to the Trusts recycling rate. In April we recycled 27 bags, a total of 437kg of uniforms, that nearly half a tonne and in May we recycled 18 bags, a total of 275kg.
- ✓ Providing a supportive and safe working environment where our team feels included, listened to, and respected by other team members and Trust staff, enabling them to thrive at work.
- ✓ In September of 2023 a new Peabody's coffee shop was opened which utilised some existing space, cost neutral to the Trust, and has resulted in income generation through rent.
- ✓ Contracts software scoping, procurement and roll out, due to be completed in December 2024 including training to staff across the Trust and contracts database review and update nearly complete.
- ✓ Successfully over delivering for the 2023-2024 CIP programme including supporting with the EBME contracts deep dive, identifying and delivering savings.
- ✓ PET CT scanner in the Lister Plaza opened in March 2024.
- ✓ The Trust awarded £1.1million from National Energy Efficiency Fund (NEEF) for LED roll-out Lister site. Full installation due completion mid-August. Upon completion 762 C02 tonnes saved per year, predicted 64% energy reduction to annual savings of £1.005,355 on electricity.
- ✓ The Trust was awarded a government grant of £750,000 to install 14,000 roof-mounted solar panels at Lister Hospital. The panels will generate approximately 326,000 kWh of renewable electricity a year with an expected reduction in carbon emissions of 62 tonnes, a reduction in the use of grid electricity and associated cost savings. Once installed predicted 108 CO^2 tonnes save per year.
- ✓ 9 x electrical vehicle charging points have gone-live in 2024 at Lister, locations include maternity, estates and Treatment Centre.
- ✓ The Trust was awarded £100,000 from Low Carbon Salix Fund to support development of ENHT Heat Decarbonisation Plan (HDP) – in partnership with Veolia Energy. Bid in preparation for Salix Phase 4 portal opening in October 2024. If funding secured will enable the Trust to start the first phase of the decarbonisation of the Lister.
- ✓ Upgrade to the hospitals building management system (BMS) was completed in 2024. The building management system monitors the status & performance of critical engineering systems throughout the Lister site. The new system enables remote access and allows engineers to make checks on systems from any location via secure internet access.
- ✓ In 2023 the estates team facilitated the replacement of the Trust's five endoscope washer machines with 8 new machines capable of processing more advanced

scopes, more reliably, faster and to the highest standards. This work has enhanced the capability of the sterile services department to meet the ever-greater demand for reprocessing of increasingly more advanced devices.

- ✓ As part of the 2023-24 Backlog Maintenance Programme the estates team replaced the water treatment plant that provides purified water for the reprocessing of reusable surgical instruments. The new plant is both more resilient and more efficient, significantly reducing the volume of wastewater produced.

- ✓ In February 2024, we opened our first Changing Places, a specialist disabled toilet and changing facility. This facility allows disabled people to be changed in a modern, purpose-built room, fully equipped with a changing bed and hoist.
  This is an amazing achievement which the trust is very proud of and further demonstrates the trust's commitment to constantly improving the patient experience.

- ✓ The Security team were nominated for the VIP award in August 2024. The team feel valued, they feel empowered to do their jobs without micro-management. Staff have had a personal email and card from a young mental health patient who they supported for weeks in Bluebell Ward - as well as an email from her mother and grandmother commending the team.

- ✓ The Portering Team won Team of the Year in 2021 for improving patient movement response times and have led on the introduction, assembly and training of Redirooms, the instant patient isolation rooms, which supports reducing the spread of infection.

- ✓ The Non-Clinical Transport Team introduced a route planning tool to support improvements for deriver and vehicle efficiency and utilisation.

- ✓ The Catering Team have worked to improve menus, implemented smart fridges to support 24/7 food accessibility and extended restaurant opening times for user convenience. Furthermore, they have removed the use of single plastic to support sustainability. The Catering Team scored above the national average for food in PLACE assessments and have been nominated for two awards at the most recent Trust Staff Awards.

- ✓ The Catering Team are working to reduce food waste, improve the retail food offerings and introducing seasonal menus. They are also working to implement finger food menus to support patients with dementia.

We also asked the staff working within the teams for their feedback on what they do.

"The linen room team is small but very hard working. I am very proud of the job that we do." – Ben, Linen Assistant

"I absolutely love my job. My role is to deliver the linen when someone from our team is absent or on leave. The job is very rewarding, to have satisfaction that delivering clean linen is helping the patients to feel better and recover quickly." – Taj, Linen and Uniform Assistant

"Clean linen is an important part of healthcare. It must be cleaned correctly and delivered to the ward in the same manner to reduce the spread of infection" – Joey, Linen and Uniform Supervisor

"I am proud to be part of such an integral team within the Trust. Every day brings a new challenge, lots of variety and knowing my contribution helps towards making the hospital safer and clean" – Seb, contract monitoring team

"The Capital Projects Team has been established for around 18 months and have successfully delivered a number of legacy projects whilst broadening our project involvement across design, cost management and programming" – John, Head of Capital Projects

"Since January 2024, I have received more than 20 emails commending the security teams regarding the help, care and professionalism whilst carrying out their roles" – Dan, Health, Safety and Security Lead

3. Learning from our successes and challenges

In addition to the successes, we have a number of areas in which we need to develop our skills and learn from our challenges. In developing this strategy, we will be looking for ways to embed the following learning:

- We must remember to take time to review our successes and identify learning to be shared with other teams in the directorate and more broadly to spread good practice and positivity.
- We are often reactive and have little time to plan forward. We must find time, individually and collectively to be more proactive whilst maintaining the ability to be responsive.
- We need to be careful to manage expectations to avoid over-promising and under-delivering. We need to develop clear terms of engagement and be happy to be held to account for delivery.
- We need to communicate better whilst maintaining our boundaries, making ensure that we engage staff, colleagues and patients on an ongoing basis, but making clear what the limitations are of our roles or the relevant compliance frameworks that we work within.
- A strengthened business case process will help us to maximise our pool of suppliers and drive best use of capital investment.
- On the occasions where appropriate, our team members need to be empowered to say no, where saying yes would impact them doing a great job. This includes things like challenging the expectation that porters have time to take patients out for air or to smoke, or security managing the behaviour of patients with mental health needs. Being able to do this will improve response times and help the Trust to deliver better flow and patient care.

4. Developing our team for the future

Delivering safe, fit for purpose clinical environments requires an engaged and empowered Estates and Facilities workforce. Developing people and addressing the skills gap is a core element of NHS England's Action Plan.

These are the following significant areas identified by NHSE for future skills development:

1. Digital and technology: for example, exploring AI applications and digital twins present exciting opportunities. Getting the data together to help make people and systems safer.

2. Net Zero and the Green agenda: developing the skills to adapt and operate the estate and help the NHS reach Net Zero by 2040.

3. Data analytics: one of the key skills required within the EFM workforce – the ability to look at data, understand it, gain insights from it and communicate it to the relevant people.

In addition, the need to maintain some of the critical skills the NHS already has. Several systems will continue to be used for years to come, so retaining and transferring that knowledge will be crucial as a transition to new technology occurs.

The Estates and Facilities directorate has a comparatively older workforce when compared to the rest of our organisation, with 68.75% aged over 45 years, compared to 41.26% for ENHT workforce overall. We therefore need to develop a strong pipeline to ensure that we have the skills needed to reduce this average age, maintain a sustainable workforce and develop the new skills we will need for the future.

We have some teams that are outsourced to service delivery partners, and contract management arrangements monitor availability of workforce and their development pipeline.

To develop our directly employed workforce of the future, we need to recognise and address some of the issues we have in attracting the right people. The physical nature of some roles, such as healthcare cleaning can be off-putting, particularly given that candidates would be able to earn a similar wage in less physically demanding jobs in a sector such as retail. We therefore need to work with our People Team partners to set out the benefits of working as part the NHS and make sure that this is widely publicised alongside the breadth of options in terms of the roles available.

The key actions for us to undertake as a team, with support from the People Team, are:

- Complete a full Estates and Facilities workforce skills audit
- Develop a skills action plan and correspondent training programmes to develop our social technical and digital skills for examples Net Zero Carbon Skills
- Develop a technical career pathway that rewards continued technical skill development for all Estates and Facilities staff
- Ensure all the Estates and Facilities workforce have formally approved succession plans
- Coordinate, standardise and streamline the recruitment process from advertising to hiring to secure the highest quality talent and meet diversity targets
- Establish a comprehensive and diverse set of job routes into Estates and Facilities, including a robust apprenticeship and young person's recruitment programme
- Undertake work to identify and remove unconscious bias from the recruitment processes

4.1. National Estates and Facilities Workforce Action Plan

The Estates and Facilities Management (EFM) workforce is one of the NHS' greatest assets however, it also presents one of its most significant challenges. An aging workforce, a lack of diversity and the need to develop future-proofed skills all present pressing issues, as well as significant opportunities.

The NHS Estates and Facilities Workforce Action Plan was published in June 2022 and sets out how EFM leaders can meet the ambitions of the NHS People Plan and People Promise and develop a robust and resilient team aligned to the future needs of the NHS. The plan is focused on the areas which can make the biggest impact and is split into four key strands:

4.2. Creating new career pathways

Career progression within Estates and Facilities has traditionally had a focus on technical expertise and experience, rather than broader consideration such as managerial and leadership competencies. We need to address this to ensure a well-rounded, balanced workforce for the future.

We also need to set out new career pathways which clearly show career progression and knowledge mobility. This will support staff to shape their own careers and improve retention. It will also provide prospective employees with a clear articulation of career progression and mobility within and across the NHS and align the NHS with candidates' expectations in a competitive job market.

There are members of the EFM workforce that currently have membership of a professional body, and that's within the context of a relatively technical area of work. By strengthening our relationship with key professional bodies and ensuring equity of access for all, we can improve the focus on continuous professional development.

The Estates and Facilities team have set out the following actions to undertake in the year 2025/26 in partnership with our People Team to prepare the workforce to 2030 and beyond:

- Develop career pathways for every Estates and Facilities role type, showing career mobility within the division.
- Develop policies which provide people with the opportunity to work in other areas of the organisation and geographies.
- Enhance the utilisation of apprenticeships in line with the national Workforce Action Plan in partnership with local technical colleges and schools.
- Promote career pathways locally and regionally, engaging with local colleges, career fairs and events.

4.3. Working with local education and developing our workforce for the future

We will, with our People Team partners, explore how we can work more closely with local, further education providers to maximise opportunities to bring young people into Estates and Facilities roles.

Many of the roles within the team lend themselves to apprenticeships, being of a hands-on, practical nature. We will establish an apprenticeship programme, as well as streamline the recruitment process to make sure that we are able to identify people with the right skills or promise that we can train up.

5. Management succession planning

Leadership skills are important to any team, and strong management enables teams to deliver to their potential. As many of the career pathways in Estates and Facilities are grounded in a predominantly technical skillset, it is important that we equip our teams with the right skillsets to enable strong management succession planning. This includes managing people, leadership styles, developing strategies and facilitating change within teams including challenging and changing cultures.

As well as clarifying career progression opportunities, we need to equip our first and middle managers (bands 5-7) with basic leadership and management skills, and further support our more senior managers (band 8a and above) to lead the culture changes that are needed across the Estates and Facilities workforce. We will also consider how our senior management team can work together to create a strong multi-disciplinary team, making space for the development of strategy and tactical response.

We need to create a learning environment that is not in place currently, embracing opportunities for job shadowing, feedback, learning, self-reflection, personal development, and coaching. This will lead to a more empowered, balanced workforce, with effective leadership at all levels.

6. Improving efficiency

6.1. Contract management and maximisation

A core element of improving our efficiency is to maximise the effectiveness of our contract management, and by providing specialist skills on management of a range of private finance initiatives (PFI) and similar third-party commercial contract arrangements. This will include contract specifications and associated performance monitoring reports, auditing, surveys, along with operational manuals and similar that are designed and utilised in line with best practice to provide suitable evidence against internal and external regulatory inspections such as PAM and CQC and achieve alignment with Trust SFIs, governance and Procurement Policy. We are seeking to do this by working in partnership with our tenants, suppliers, contractors etc.

Hertford County site – There are several opportunities to utilise this space more effectively and reduce our running costs, however, this is reliant on clinical agreement to decentralise services away from Lister, and improved strategic management of the site. We also need to explore the commercial opportunities of the site.

New QEII site – There are significant opportunities to further utilise the space at this site, however, further development requires explicit agreement from the landlord.

Operational contract management - Ongoing business as usual (BAU) contract management that ensures that CHP delivers services in line with contractual obligations and that operational services are provided to the required performance specifications.

To achieve this, we will undertake the following:

- The creation of a centralised repository with standardised documents, procedure and workflows, and where contract information is available and easily managed through expanding the skills and expertise of the existing team to deliver a high-quality service.

- Operational contract management - Ongoing business as usual (BAU) contract management that ensures that PFI assets are management by the PFI Co in line with contractual obligations and that operational services are provided to the required performance specifications.

- PFI contract expiry and transition – Forward- focused project activity that the current contractual relationships are ended efficiently, contractual obligations relating to expiry and hand back are fulfilled, and a smooth transition is achieved.

- Initiative-taking services delivery – Wider activity that establishes the arrangements, including procurement activity, for delivering and managing assets and services following PFI contract expiry.

Our Contracts Management Team will ensure that the directorate adopts a common approach to utilising the contract monitoring system. This will enable us to produce reports on progress, and we will work towards involving other relevant Trust divisions in the use of the contract monitoring system maximise its impact. As a part of this, we will manage the contracts software, from roll out to full management, including building of the contacts repository and training sessions for relevant staff.

In addition to this, the Team will deliver against the following key activities:

- Create, manage and monitor a legal register of properties to ensure best value for money for commercial enterprises. Support in the negotiations, preparations, adoptions and extensions.
- Implement substantive contract management for the PFI and LiftCo building, HCH and New QEII. Ensure that performance targets are maintained, and contractual obligations are imposed.
- Prepare and implement an exit strategy for HCH in readiness for May 2033
- Support the directorate on the delivery of the overall CIP programme, ensuring targets are realistic and ensure governance i.e. PID completion, risks to delivery identified etc.
- Support with the delivering of national policies implementation such as the new food and drinks standards.
- Support divisional contract managers with the lifecycle of their contracts including support during tendering, planning for milestones, CIP scoping etc.
- Build a practical reporting mechanism for Estates and Facilities contracts, suitable for board reporting requirements and including:
  - Contract life value tracking
  - Annual increases
  - Service delivery status
  - Improvement planning
- Promote a collaborative relationship with our procurement teams, advancing a combined approach and supportive team work to ensure:
  - Processes are compliant
  - Value for money is achieved
  - Framework, tendering and market testing is explored
  - All necessary stakeholders or colleagues are involved and informed of changes

6.2. Cost Improvement Programme (CIP)

The Estates and Facilities Team have made a significant contribution to Trust CIPs and have delivered against, and in some cases, exceeded their targets. We are mindful that we have a role in supporting the financial position whilst ensuring compliance, safety and control. Improving contract and performance management with our providers through the application of key performance indicators has helped us to increase value for money with our partners, and we are continually looking for other innovative ways to improve efficiency and cost effectiveness.

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	10
Report title	Green Strategy	**Meeting Date**	6 November 2024
Presenter	Director of Estates and Facilities		
Author	Estates and Facilities Manager		
Responsible Director	Director of Estates and Facilities	**Approval Date**	21.10.24

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

Report Summary:

In January 2022 East and North Hertfordshire NHS Trust formally adopted its Green Plan (2021- 2024), a live strategy outlining aims, objectives, and delivery plans for sustainable development.

This paper is to inform the Trust Board on the Trust Green Plan and its supporting delivery programme comprised of 8 related but separate work streams.

Impact: tick box if there is any significant impact:

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

The Greener NHS has defined 2 net zero targets.

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040.
- For emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045.

The Green Plan sets out the Trusts' carbon emission and resource use reduction targets in mandated policy and statute.

Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:

Quality Standards	☐	**Thriving People**	☐	**Seamless services**	☐	**Continuous Improvement**	☐

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

Strategic Risk 1- Investment (capital, system allocation and no growth)

Report previously considered by & date(s):

Recommendation	Included in the paper under section 8.0 Recommendations.

To be trusted to provide consistently outstanding care and exemplary service

1.0 Purpose

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

2.0 Background

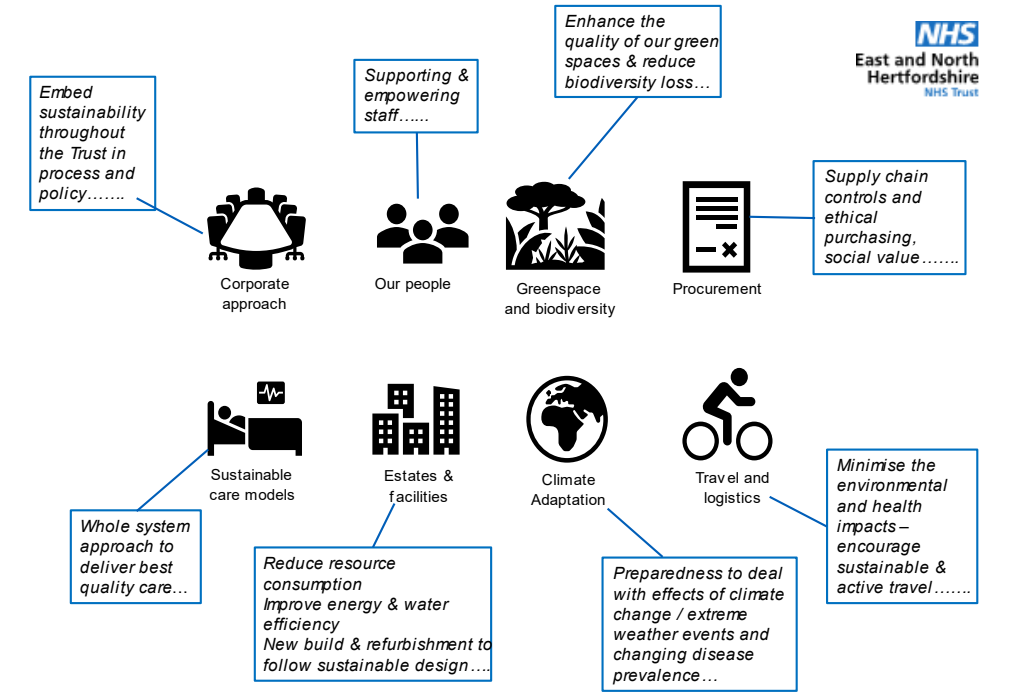
Programme outcomes – the Greener NHS has defined two net zero targets:

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

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

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

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



Two years on the Trust continues to work towards the NHS Long Term plan of achieving Net Zero by 2040, through embedding sustainability at the heart of decision making across the Trust. A key project within this work has been the Trust Decarbonisation Strategy completed in October 2023. The decarbonisation strategy outlines a roadmap for the Trust to follow and ultimately operate a Net Zero estate through structural fabric improvements, installing low carbon heating sources and explore future carbon offset initiatives.

In addition to the decarbonisation strategy, work continues to progress, albeit at varying rates. The eight key areas within the plan remain the same and continue to progress through individual and now consolidated workstreams. Corporate Approach and Our People workstreams have merged to form The Green Ambassadors Network.

The remaining workstreams apart from Climate Adaptation and Procurement, have dedicated leads supported by small task and finish groups. Climate Adaptation and Procurement workstreams are being led by the Integrated Care Board (ICB), however remain in early stages of development.

Workstream updates are monitored via the bi-annual Trust Sustainability Board and at the Finance, People and Performance Committee on a quarterly basis. Justin Daniels (Trust Medical Director) chairs the Sustainability Board, with Karen McConnell (Non-executive Director) acting as deputy chair.

The complexity of attempting to deliver a 16-year multi-work stream, unfunded programme underpinned by a short-term strategy (the Green Plan) remains a significant challenge for the Trust. Net Carbon Zero is the most significant non-clinical policy agenda in the NHS, and the policy and protocols are developing and evolving alongside expected delivery.

The Trust current Green Plan ‘expired’ in January 2024; however, the expectation is for the Trust to produce a revised version in January 2025 which will feed into the Integrated Care System’s (ICS’s) overarching Green Strategy. It should be noted that revised government guidance is pending and due for release end of October. Within the revised guidance there will be a section updating on reporting requirements, this aspect remains one of the most challenging areas in how Trusts monitor progress against the Net Zero target.

3.0 Trust Green Plan update

3.1 Decarbonising the Estate

The ENHT estate within direct control of the Trust is limited to the Lister Hospital at Stevenage. The Lister site is ageing, and has amassed significant backlog maintenance of £68m, with at least 50% of this considered critical infrastructure risk. Replacement of the majority of the estate is unfeasible due to costs, and as such a ‘“fabric-first’’ approach is being developed to enable the existing estate to perform better and deliver against sustainability objectives.

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

The Trust understands why decarbonisation is important. The key to the emerging decarbonisation plan is to assist in discussions in how to move from ambition to action and develop a clear roadmap to decarbonising the site.

With the Trust-wide decarbonisation strategy now published, work is underway collaborating with our Energy Centre partner Veolia Energy to develop a supporting action plan, however, limited funding opportunities and competing financial priorities will impact delivery.

Investment in low-carbon technology and renewable generation is also required as ENHT’s largest emitters are related to the consumption of gas and electricity. The Trust has been extremely fortunate to be awarded £1.3million for LED rollout at Lister (completion date mid-November) and £750,000 for solar panel installation across 3 buildings (completion date mid-November). A further £95,000 has been awarded to develop a Heat Decarbonisation Plan (HDP) which will form the baseline of a further funding application bid - the Salix 4 funding round. At the time of reporting, the Salix 4 portal is open for submissions with a closing date of 24 November.

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3.3. Carbon footprint data collection

Climate change poses a major threat to our health as well as our planet. A number of influencing factors contribute towards our overall footprint. A key impact over the last five years has been the general increase in clinical activity with both emergency attendances and patient admissions. This has an impact throughout the Trust increasing the use of utilities, equipment, and travel. As previously mentioned, the Trust has taken a major step towards acting against climate change with the development of our decarbonisation strategy.

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

- NHS Estates Net Zero Carbon Delivery Plan
- Net Zero travel and transport strategy
- Greener NHS Data Collection

Other than Green Plan guidance, the following documents set out sustainability reporting requirements for NHS bodies:

- The NHS standard contract for NHS providers
- The Group Accounting Manual for DHSC bodies

There are currently no requirements for NHS Trusts or ICBs to develop and publish their own ***carbon footprints.***

"*The time and resources spent on foot printing needs to be proportionate and should not distract from acting. Organisations that have the capacity and skills may choose to focus on foot printing their organisation, while other organisations may need to focus resources on taking action to reduce emissions".*

"All Trusts should be annually reporting on progress towards delivering against their Green Plans, as set out in the Green Plan guidance. From 2023/24 NHS England will report annual emissions estimates for the whole NHS via the NHSE annual report and accounts".

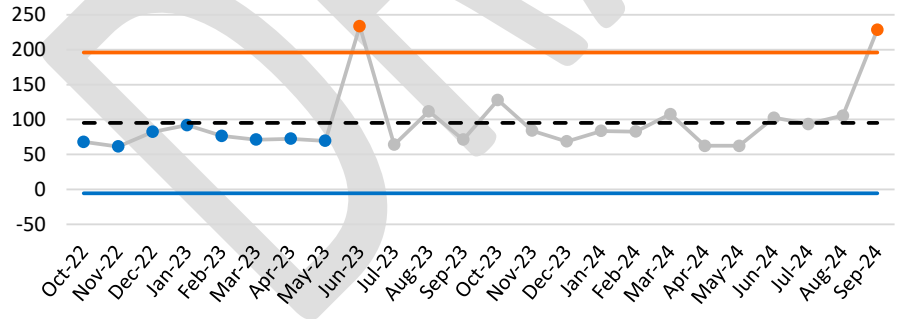
(National Greener NHS Team (NHS England) February 2024.)

The essential focus for Trusts is to achieve key actions outlined in the 'Should do' and 'Could do' checklist, which underpins the Green Plan guidance to achieving Net Zero. Our Trust has progressed extremely well against this checklist as highlighted below against the respective workstreams.

Internal monitoring.

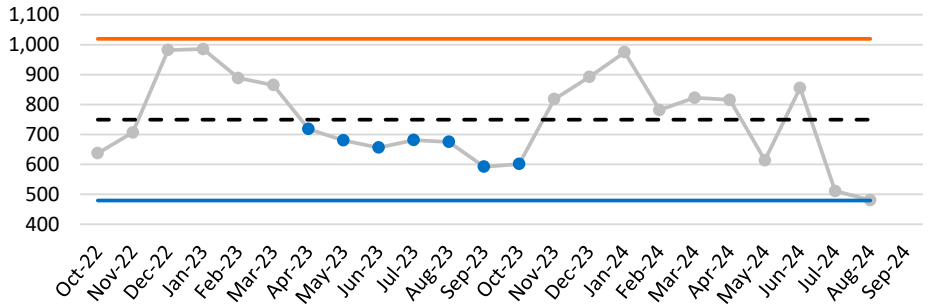
The Trust has developed a methodology for data collection that can be used to calculate its annual carbon footprint, based on monitoring emissions from electrical and gas **ONLY**. These data flows are continually analysed to identify trends and provide the Trust with the ability to create bespoke action plans to mitigate against potential inconsistencies.

CO2 emissions from electricity



<u>*CO2 emissions from electricity*</u> *(graph 1.)*
Peak in emissions June-July and August-September due to Energy Centre down-time, resulting in increased reliance from main-grid.

CO2 emissions from gas



C02 emissions from gas (graph 2.)
Shows seasonal variation, higher usage over winter months. The spike in June 2024 has been contributed to estimated metre reading error.

4.0 What we have achieved to date.

Green Ambassadors Network (*combined Our People and Corporate Approach*).

- GA Network established (30 members)
- Established Sustainability Board (bi-annual meet) with Chair and Deputy Chair.
- Trust Green Plan features on Trust Corporate Induction Programme
- Ongoing communications led promotion of green initiatives (national and local)
- Refresh of Sustainability Awareness Training in progress.

Sustainable care models

- Glove Reduction Campaign
- Piped Nitrous Oxide outlets caped, removal of manifold pending.
- Desflurane anaesthetic gas removed from both Lister and Mount Vernon sites.
- Hospital at Home modelling and assessment made using the Sustainability in Quality Improvement (SusQI) framework. Opportunities identified show reduced carbon impact and cost savings.

Travel and logistics.

- 9 x electric vehicle charging points gone-live, locations including Maternity, Estates Office, and Treatment Centre.
- EV charging workplace scheme established for all staff.
- 5 Electric vehicles (fleet) lease signed, pending finance sign-off.
- Stream (track and trace logistics software) installed for fleet vehicles – next step to map travel routes – aim to reduce emissions related to business travel.

Estates and Facilities

- Decarbonisation Strategy completed.
- Trust awarded circa £95,000 to develop Heat Decarbonisation Plan (HDP), Veolia Energy are developing the plan in partnership with the Trust. The HDP will enable the Trust to submit a further application to Salix Phase 4 (Nov

2024) to secure funding to start the first phase of the decarbonisation of the Lister site.

- Trust awarded £1.3million from National Energy Efficiency Fund (NEEF) for LED rollout Lister-site. Upon completion (delayed till mid-November) – 762 C02 tonnes will be saved per year, *predicted* 64% energy reduction equating to annual savings of £1,005,355 on electricity.
- Trust awarded £750,000 (NEEF) for solar panel installation, 14,000 panels installation progressing - Endoscopy, Maternity, Treatment Centre, and Strathmore Wing. Once fully installed 108 C02 tonnes saved per year. Go-live mid-November.
- Building Management System (BMS) platform upgrade onto IQ-Vision, enabling improved controllability of mechanical and electrical equipment.
- Reusable Sharps System site-wide roll-out completed.

Green space and biodiversity

- Hertfordshire County Council and the Trust supported the Green Space and Biodiversity think tank, hosted by the Trust. A key focus is progressing a clean air initiative trial in 2024.
- The Trust mapped the Green Space across the Lister Hospital to create a 'Green Space' baseline so further creation can be recorded and help improve our external spaces for staff.

Procurement

- This is at the early stages of development, being led by the Integrated Care Board (ICB).

Climate Adaptation

- This is at the early stages of development, being led by the Integrated Care Board (ICB).

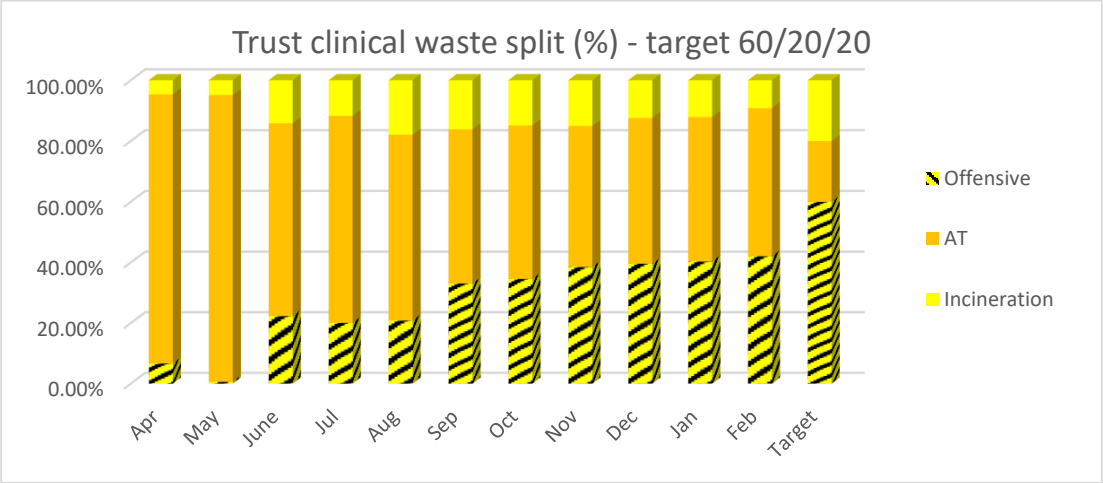
4.1 Waste management

2023/2024 has seen several changes within the waste disposal service throughout the Trust. Service improvement, efficiency, cost-effectiveness, and sustainability have been the key drivers for this year's activities.

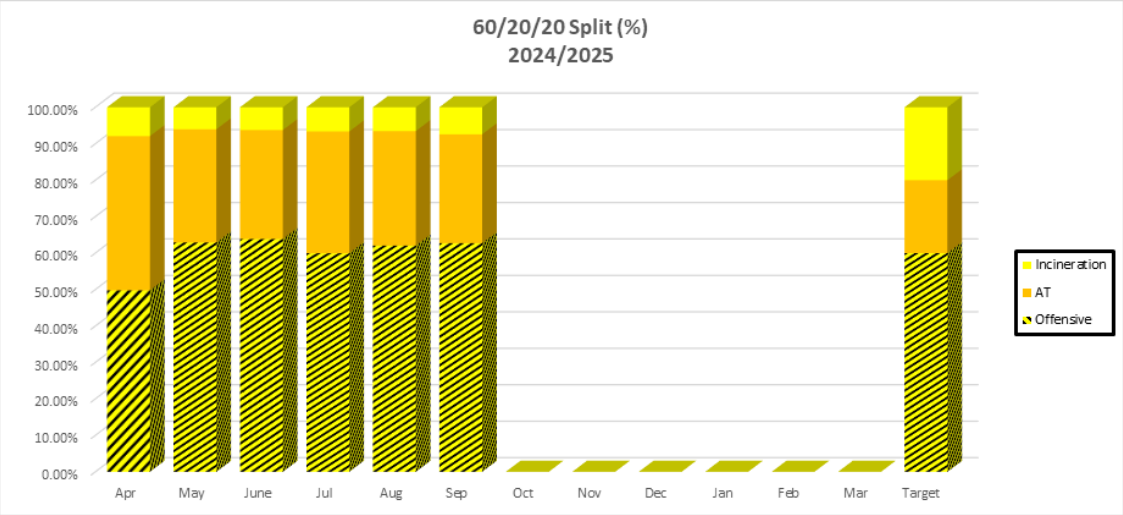
The mobilisation of the Sharpsmart Total Waste Management Contract on 1 June 2023 has seen considerable progress toward and achievement of some of the key national targets.

National targets	**Trust achievement**
To achieve 0% waste to landfill across all waste streams by end 2023.	This target was achieved ahead of schedule - 1 June 2023 and continues to be maintained. This includes both clinical and non-clinical waste streams.
To achieve the clinical waste segregation targets set in the NHS England Clinical Waste strategy (20% incineration waste;	National target was achieved in May 2024 (graph 3 and 4 below), instrumental in reaching this target has been the embedding

20% AT/Infectious waste;60% offensive waste.)*	of a Total Waste Management Contract across the Trust – provided by Sharpsmart.
To ensure full compliance with Healthcare Technical Memorandum 07-01 – Safe and Sustainable Management of Healthcare Waste.	Work continues to ensure all service areas have appropriate waste disposal signage, bin labels and guidance materials in place to simplify waste segregation / ensure compliance. Ongoing programme of technical/trend audits to measure compliance and provide feedback to ward and department teams, providing guidance and training where necessary.



Graph 3. Trust clinical waste split against national target (%) April 2023 – February 2024.



Graph 4. As above, national clinical waste target achieved in May 2024.

4.2 Sharpsmart reusable sharps containers installation.

The aim of this service development is to contribute to the Trust's aim to eliminate single use plastics and to reduce the quantity of clinical waste requiring high temperature incineration (HTI). Single use sharps containers and their contents are subject to destruction via HTI. The installation of this system at Lister Hospital, Lister Treatment Centre, Hertford County Hospital, New QEII Hospital and Chiltern Kidney Centre was completed at the end of February 2024.

4.1 NHS Standard Contract 2023/2024 sustainability requirements

ENHT current progress against NHS Standard Contract sustainability requirements.

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

5.0 Governance

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

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

This summary below is based upon a detailed assessment of each of the 8 Green Plan work streams. The maturity rating was developed using other comparable NHS England national standards and adjusting the level criteria to reflect sustainability programme characteristics.

The criteria provided is an indication of the level of maturity of a selection of factors considered including resourcing, funding and progress to date. This has recently been updated to reflect maturity matrix status as at July 2024.

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

Workstream	Status	Workstream lead	Rating
Corporate approach	launched	Workstream merged – Green Ambassadors. Debbie Cockcroft	Level 3
Our people	launched	Workstream merged – Green Ambassadors. Debbie Cockcroft	Level 3
Travel and logistics	launched	Sam Woods	Level 3
Estates and facilities	launched	Helen O'Keefe / Ali Morris	Level 3
Sustainable care models	launched	Phil Smith	Level 2
Green space and biodiversity	launched	Bridget Sanders	Level 2
Procurement	Not launched	TBC	Level 1
Climate adaptation	Not launched	TBC	Level 1

6.0 Sustainability Impact Assessments

The Green Plan has not yet embedded sustainability across all the Trust enabling strategies and operations. This became apparent in an assessment of clinical strategies deployed in 2022.

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

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

- Reduced air quality damage from reduced patient journeys to site

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

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

When assessing the Hospital at Home service (chosen at random for demonstration purposes), no further assessment was made to capture impact and benefit linked to sustainability. There is currently no defined Trust process where business or policies are assessed through a sustainability impact assessment. To date there has only been one example of robust in-depth sustainability impact analysis being undertaken. The Hospital at Home strategy was assessed using the Sustainability in Quality Improvement (SusQI) framework.

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

It should be noted sustainability assessment of HAH was undertaken by an external company who are trained and specialise in using the SusQI framework. This comes at a cost to the Trust and is not financially sustainable to continue with this approach. Either a team within the Trust are identified and trained in using the in-depth evaluation tool or a simpler sustainability impact assessment is developed and embedded as part of business as usual – for example included in all Project Initiation Documentation and Business Case templates.

7.0 Risk and mitigation

Risk	Mitigation
Gaps in leadership, to drive forward Green Plan agenda, risk of programme fatigue	Non-executive Director Karen McConnell and Medical Director Justin Daniels
Delay launches of procurement / climate adaptation workstream	Monitoring direction / support from Integrated Care System Sustainability Working Group
Limited available funding / competing priorities (critical infrastructure) to invest to decarbonise the estate	Seek national / local funding opportunities, cross reference with critical infrastructure and backlog maintenance funding
Not achieving net zero targets due to lack of funding to recruit staffing resource to drive and progress Green Plan programme.	Reliant on good will and free time of staff to lead workstreams and progress green plan agenda.

8.0 Recommendations

- The Trust should prioritise a reoccurring budget to fund essential aspects of the Green Plan including the staffing requirements as defined within **‘’**Delivering a ‘Net Zero’ National Health Service’’.
- The Trust should explore all external funding opportunities, have business cases developed in advance to ensure timely submissions.
- Sustainability Impact Assessments, much like Equality Impact Assessments, should be captured as part of good governance when business cases and strategies are proposed and approved.
- New Clinical Strategies should be assessed for sustainability impact as part of the approvals process.

9.0 Conclusion

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

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

END OF REPORT

Helen O’Keefe (Head of Compliance and Sustainability)

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	11
Report title	OneEPR programme update	**Meeting Date**	6 November 2024
Presenter	Chief Information Officer		
Author	Chief Information Officer		
Responsible Director	Chief Information Officer	**Approval Date**	23 October 2024

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

Report Summary:

Given the scale of the programme, it has been branded as OneEPR which was the underlying theme of the Business case, this branding will be used in addition to the standard ENH branding.

The Trust programme governance/delivery model has been agreed with a focus on clinical leadership, Our CCIO Roxana (Consultant surgeon) has 50% of her job plan dedicated to OneEPR with a team of 5 Consultants with dedicated time. Our CNIO Shella is 100% dedicated with a team of 3 fulltime Nurses. The clinical Digital team are leading engagement with Clinical colleagues along with chairing the design workshops which have Clinical, Digital and Dedalus representation.

The programme is halfway through the 12-week Future state design which is progressing well and has good engagement across the Clinical workforce.

The OneEPR launch event in October 2024 was well attended with good feedback, ENH and Dedalus Executives talked about joint commitments to the programme and experts were on hand to demonstrate the product to staff.

Impact: tick box if there is any significant impact:

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

If you have ticked any of the boxes, succinctly explain why. This section enables the reader to understand from the start particularly significant implications/impact envisaged. This can be both positive benefits and disbenefits that are crucial to inform robust decision-making or assurance. [See note 10]

Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

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

Strategic Risk 8 - Improving performance and flow
Strategic Risk 10 – Digital Transformation

Report previously considered by & date(s):	
[See note 12]	
Recommendation	The Board/Committee is asked to note the update.

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OneEPR

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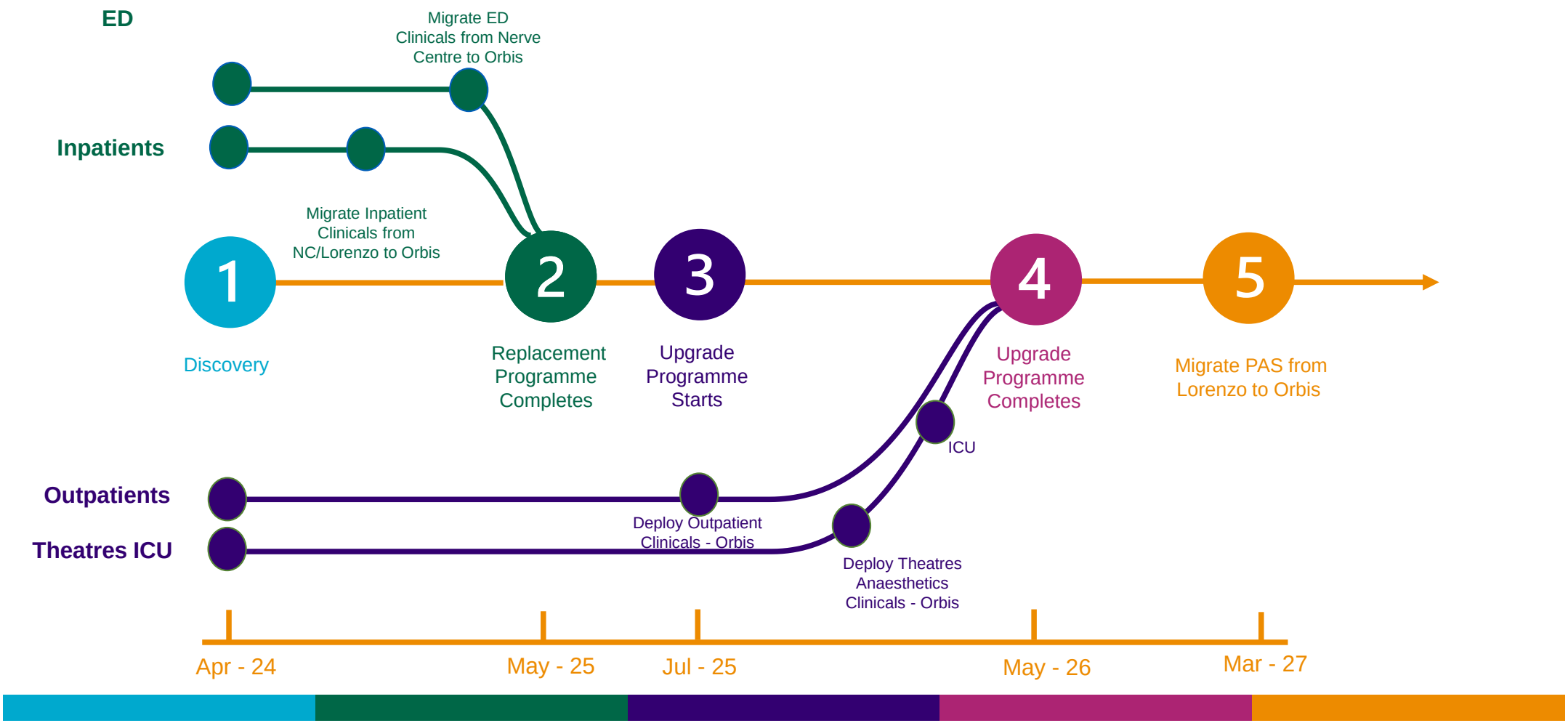
Update - November 2024

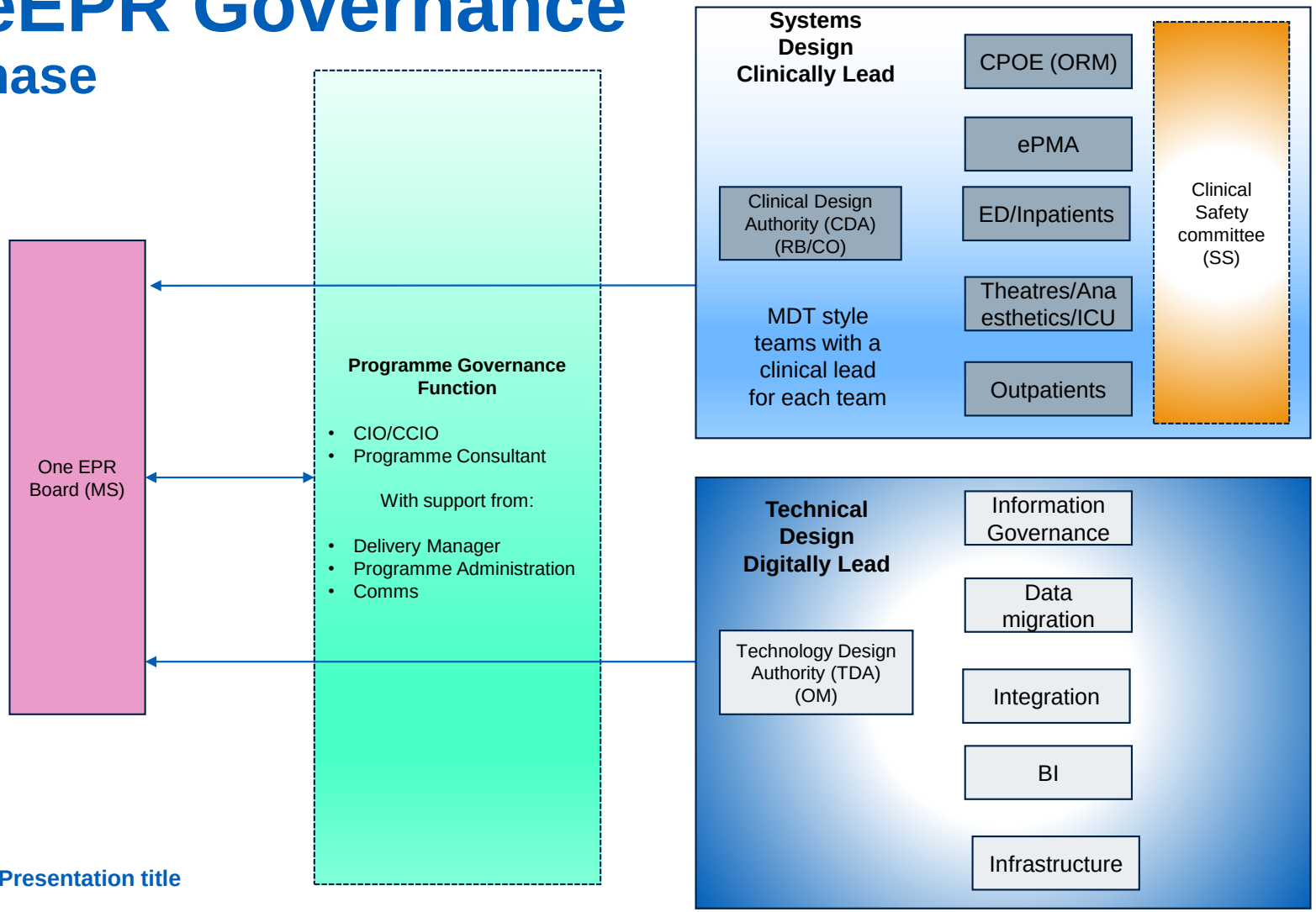
OneEPR Timescales



OneEPR Governance

1st phase

East and North Hertfordshire NHS Trust



Board

East and North Hertfordshire NHS Trust

Meeting	Trust Public Board	**Agenda Item**	12
Report title	ENHPS Delivery Plan Update	**Meeting Date**	6 November 2024
Presenter	Chief Kaizen Officer		
Author	Chief Kaizen Officer		
Responsible Director	Chief Kaizen Officer	**Approval Date**	24 October 2024

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

Report Summary:

The Board is asked to discuss and note progress and achievements following the roll-out of our new improvement method – the ENH Production System. Following initial training and certification of staff from our recently established Kaizen Promotion Office (KPO), we have delivered our new 'Introduction to ENHPS' session to over 450 staff. We have also commenced 60 senior leaders on our 'ENHPS for Leaders' programme, a more intensive course that coaches' leaders in both the method and a new way of leadership and behaviours that help embed and sustain continuous improvement into day-to-day work.
The report also captures a range of additional supporting improvement activity that has occurred over recent months which will increase in scale as we move forward.

Impact: tick box if there is any significant impact:

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

ENHPS supports our vision and strategic goals providing a unified way of thinking and acting through a set of philosophies and practices that focus on sustaining high levels of quality, safety, satisfaction and morale by aligning the entire workforce around a consistent improvement method, supported by a new approach to leadership.

Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:

Quality Standards	☐	**Thriving People**	☒	**Seamless services**	☐	**Continuous Improvement**	☒

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

ENHPS mitigates BAF Risk 11 VMI – getting what the Trust needs, BAF Risk 5 Culture, leadership and engagement and BAF Risk 12 Clinical engagement and change.

Report previously considered by & date(s):

Trust Guiding Team 24 October 2024

Recommendation	The Board/Committee is asked to discuss and note the report.

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ENHPS Delivery Plan Update
Public Board
6 November 2024

Kevin O'Hart, Chief Kaizen Officer

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ENH Production System

ProudToBeENHT

ENH Production System (ENHPS)

East and North Hertfordshire NHS Trust

In 2023 we started the next phase in our improvement journey and adopted the Virginia Mason Production System® (VMPS), a lean management methodology based on the principles of the Toyota Production System (TPS). We realised early on in our transformation journey that our current improvement approach was not nimble enough to keep up with the changing and challenging health care environment, and we knew we needed a method to achieve our imperative of putting the patient first, leading with quality and remaining an economically viable organisation. To help us accelerate our journey we have partnered with the Virginia Mason Institute (VMI), a globally recognised leader in improvement and a not-for-profit US healthcare system who has 15 years' experience working with the NHS.

Lean in healthcare is about creating value and reducing burdens that patients and staff experience every day. So rather than focusing on saving money, lean organisations focus on sustaining high levels of quality, safety, satisfaction and morale. They do this by aligning the entire workforce around a consistent improvement method and use that approach to promote, test and implement process improvements on an ongoing basis.

We call our new method the ENH Production System (ENHPS) , this approach provides a unified way of thinking and acting through a set of philosophies and practices that have been tested for more than half a century. It is built on an underlying philosophy that embraces:

•Patient First
•Focus on Highest Quality and Safety
•Engage All Employees
•Strive for Highest Satisfaction
•Respect for People

ENHPS is not a short-term strategy, or a set of tools, it is a long-term philosophy involving a complex socio-technical system that will shape our culture to one relentlessly focused on consistently delivering outstanding care and exemplary service.

Organisational Readiness Assessment

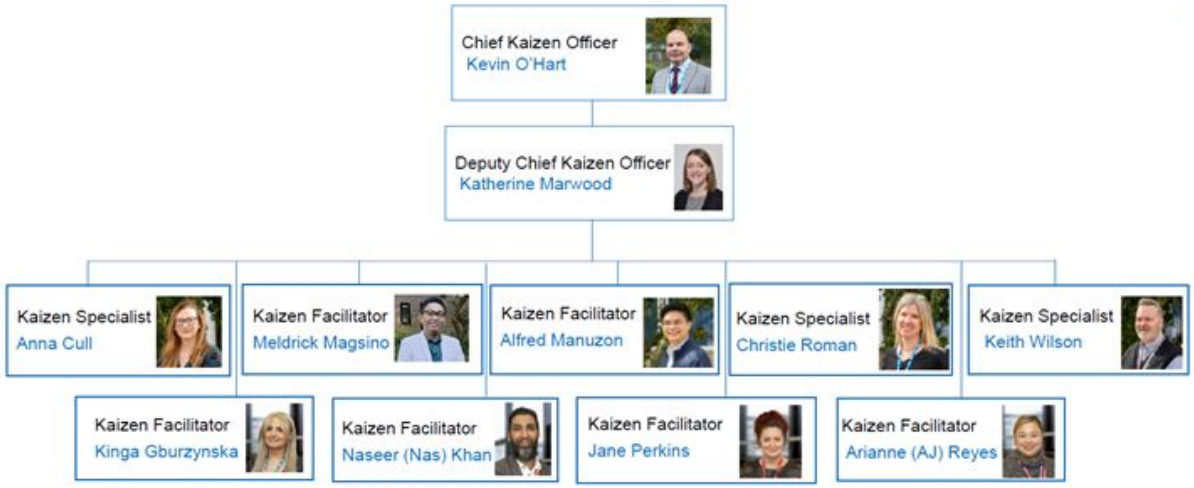
East and North Hertfordshire NHS Trust

In October 2023 we invited VMI to undertake an organisational readiness assessment before we embarked on our transformational journey, a two-week process that captured feedback from over six hundred staff through a variety of interviews, focus groups, surveys and observations. This process emphasised a single, shared improvement method would bring focus and alignment to our strategic vision which alongside modern leadership approaches, would inspire teams to feel more trusting, open, curious and help to innovate and solve problems together. As an organisation and Board our ambition and commitment is reflected below -

- We will create a safe environment where curiosity and experimentation flourishes and frontline staff are empowered so improvement is led by those that do the work, where the work is done
- Leaders will show respect by stepping away from the role of problem-solver and instead take on the role of problem-framer, engaging and coaching frontline teams to act and improve services and process every day
- Our improvement method will provide the structure and culture that staff need to embed and sustain quality and safety as part of their daily work

Kaizen Promotion Office

East and North Hertfordshire NHS Trust



- We established a new Kaizen Promotion Office (KPO) in January 2024. Kaizen is a combination of two Japanese terms (kai = change and zen = good) which is commonly interpreted today as meaning continuous improvement. The KPO role is to:

  - Promote the method
  - Deliver ENHPS training and education
  -Facilitate a range of kaizen events
  - Provide coaching in the method
  -Maintain the method

- There is an intense three-part certification process for every KPO staff member with teaching and coaching provided by experienced VMI staff and a rigorous sign-off process prior to accreditation. This ensures the organisation builds the required ongoing internal capability, resilience and expertise. VMI highlight the pace and development of our KPO and delivery plan as one of the most successful they have supported.

‘Intro to ENHPS’ Training – Value, Waste and 5S

East and North Hertfordshire NHS Trust

Value

Waste

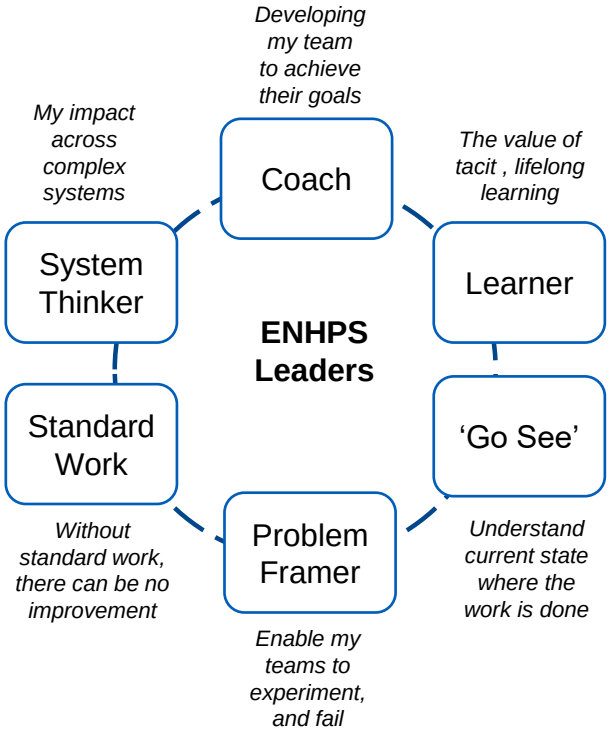
Waste Walk

5S

- Imagine a healthcare organisation where staff are equipped with the training and tools to be successful at their jobs, people understand and are set-up to successfully manage their workload in an environment where high quality care and exemplary service is standard, there is a place for everything and everything is in its place, supported by supplies and resources provided just in time for when they will be needed.
- Our new ‘Intro to ENHPS’ training session introduces staff to the concepts of value, waste and 5S, the foundations of the ENHPS method. It provides staff with a simple, meaningful and effective approaches to safely manage and organise their work environment. Staff are shown how to identify waste or tasks/ items that do not add value from the perspective of the patient. People often feel uncomfortable referring to waste, so it is important to remember it is not a judgment on people, it is about the process. 5S is then taught as a strategy for waste reduction through a simple process of sort, simplify, sweep, standardise and self-discipline (and root cause analysis).
- The KPO have delivered 45 training sessions to over 450 staff since we launched the programme in late June. This has involved all staff groups, all staff levels across all sites.
- Staff are encouraged to then apply their learning in practice alongside their teams and undertake a waste walk and 5S exercise with feedback and learning shared at a celebration event that KPO facilitate six weeks later.

‘ENHPS for Leaders’ Training Programme

East and North Hertfordshire NHS Trust



- In August we launched three cohorts of our new ‘ENHPS for Leaders’ programme with each cohort involving 20 senior leaders from across the organisation, including the executive team. This training consists of five study days held six weeks apart, with learning applied on the genba through fieldwork. This course teaches senior leaders' knowledge of the method, and coaches for the new leadership approach required.
- Session one is based on understanding lean culture and whilst introducing people to value, waste and 5S, considers how leaders can approach and manage change with their teams, whilst maintaining respect for people.
- Session two teaches standard operations, this refers to the tools in the method that help people understand how time drives resource, and how to understand and analyse processes through direct observation.
- Session three focuses on promoting innovation through understanding tools and concepts that help mistake proof processes which reduce future defects and errors.
- Sessions four and five introduce the concept of daily management, an approach that embeds daily huddles, production boards and standard work into how teams and leaders know, run and improve their services each day.
- As more leaders undertake this training, they will role model their learning on the genba, alongside teams who are simultaneously learning value, waste and 5S.

Rapid Process Improvement Workshops

East and North Hertfordshire NHS Trust

- A rapid process improvement workshop (RPIW) is a KPO facilitated five-day workshop, focused on a particular process in which the people who do the work are bought together in an intensive improvement event to improve that specific process or a problem area.
- These events are designed around a Plan-Do-Study-Act (PDSA) method and include a six-week planning process where detailed observations involving the process or problem area is studied ahead of the event, so the problem is clearly defined and understood.
- Kaizen events such as an RPIW empower and engage staff to improve their processes and services and include training so teams can generate their own ideas and co-design potential solutions using PDSA tests of change to inform a 30, 60 and 90 day implementation plan. As part of standard work, the RPIW process will always involve patient and carer involvement and co-production.
- Our first RPIW in March 2024 involved our resourcing team who wanted to improve the time taken between when a new vacancy was identified, to the date the new recruit was boarded on day one. Improvements made since this event include an average 11 day reduction in the cycle time between time of conditional offer to completion of pre-employment checks. Not only do these improvements impact on direct clinical care as we fill our vacancies quicker, the resourcing team are applying their learning in every aspect of their work with significant knock-on impact on team morale and health and well-being.
- Our second RPIW occurred in October and involved members from our ophthalmology team who wanted to improve the patient injection pathway for age related macular degeneration. The week generated over 62 ideas and a series of PDSAs that were then tested on the genba evidenced patient's physical steps in the process were reduced from 282 to 104 following a redesign of flow in the environment. In addition, PDSAs involving the value stream evidenced a reduction in time for each individual attendance from 46 mins to 24mins for patients requiring pressure checks, and from 34mins to 13mins for patients not requiring pressure checks. There were also savings in excess of £17k per annum identified from a reduction in medicines waste.

Basic Daily Management and Positive Leader Rounds

East and North Hertfordshire NHS Trust

Production Boards

A simple quick and visual display regarding the status of the team's work, linked to actions if abnormal conditions are observed

Daily Huddles

Brief and focused daily huddles by the production board to review the work ahead and discuss and agree the plan

Standard Work for Leaders

Visible leader standard work that includes purposeful genba walks to coach frontline staff with focus on identifying waste and empowering teams to test ideas and make improvements

- Basic daily management is a structured system and lean strategy that helps teams and departments ensure their day-to-day operations run smoothly and improve continuously, whilst also embedding accountability. This approach will help embed and sustain the ENHPS method.
- Daily management is leadership standard work with emphasis on leaders being present where the work is done (genba) – teaching, guiding and coaching frontline staff to improve their daily work by reducing waste.
- Many of the concepts (i.e. production boards) involve visual management, these are visual cues that drive action so people can know at a glance the status of the team's daily work or can see when to take action and what action to take if abnormal conditions are observed.
- Positive Leader Rounds (PLR) involve senior leaders visiting the genba to role model and establish new standard work. It allows leaders to test the health of local processes, engage staff and create curiosity in ENHPS and encourage positive action. PLRs are intentional; that is to say they use structured prompts to guide and coach teams to think about daily management and kaizen.
- PLRs involve all members of the executive team and we are currently increasing the number of visits we conduct, so they become part of business as usual.

Strategic Goal Deployment

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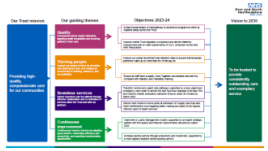
- Strategic goal deployment cascades the organisation's vision and strategic goals down into the organisation and shows the way for every team, every individual in the organisation, at every level.
- Strategic alignment links these organisational goals to departmental/ team annual objectives and individual Grow Together conversations, with ENHPS the method for improvement for how we deliver them.
- Whilst this remains work in progress, the long-term aim of strategic alignment is to harness the energy, creativity and ideas of all 6,000 staff to drive the organisation forward.

Long-Term Vision

Strategic Direction (multi-year)

Strategic Goals



Divisional / Care Group Objectives

Kaizen Plans

ENH PS Events

Daily Management Plans

Grow Together Goals

Multi-Year

Annual

9 | ENHPS

Next Steps

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- KPO certification processes will accelerate following recent recruitment with more staff completions increasing the internal capacity and resource that can be deployed for training programmes, kaizen events and coaching.
- We will continue to expand the availability of ‘Intro to ENHPS’ courses, thereby increasing number of staff who develop awareness of the method. At the same time we will also increase the number of places within our ‘ENHPS for Leaders’ programme, allowing more and more leaders to learn the method and be coached as new leaders.
- As the coverage of staff involved in ENHPS training grows, we will see increased application of the method and we will share these insights and learning to play back kaizen stories to the organisation and build momentum.
- We will reflect and learn from our 24/25 delivery plan, before developing and agreeing prioritisation for our 25/26 delivery plan. This will then be signed-off via the Trust Guiding Team, the organisation’s delivery oversight governance meeting.

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	13
Report title	**Board Assurance Framework (BAF) Risks**			**Meeting Date**	6 November 2024
Presenter	Head of Corporate Governance				
Author	Head of Corporate Governance				
Responsible Director	Deputy CEO			**Approval Date**	
Purpose	**For information only**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

Revised BAF format

Changes to the BAF format were agreed by the Board in July and are presented for the first time. The changes are to help Board and its committees understand the level of assurance and traction on actions are included for the first time. The changes most significantly introduce assurance ratings for all controls and new columns for action leads and timescales to help ensure these are clear and included.

Due to the large number of changes involved it has not been possible to show these as tracked changes in the usual way. But tracked changes will be reverted to for future updates.

Board spotlight on two BAF risks

The Board in July also agreed to spotlight scrutinise two BAF risks at each Board meeting going forward. The first two spotlighted BAFs are BAFs 1 (Investment) and 2 (Health Inequalities):

Spotlight BAF Risk 1 - *Martin Armstrong*

- The context is this is a new risk added to the BAF in 2024/25 with a 12 risk score.
- Some of the challenges are more 'wicked', needing system solutions such as needing transformational solutions to address the system financial gap.
- Positive actions identified include: establish a monthly 'Investment Review Group; a Space Utilisation survey; The system has invested in a Population Health Management system that can generate data to support analysis of the distribution of system resources.
- The controls with the lowest assurance scores relate to the Estates Strategy; the Productivity Framework; and Trust Long-Term Financial Model and Medium-Term Financial Plan. The Estates Strategy assurance score should improve once the strategy is reviewed and approved by November Board.
- There are a significant range of identified mitigation actions. The question for the Board is whether if all these are carried out, the Investment risk will be mitigated to a tolerated level.

Spotlight BAF Risk 2 *(Health inequalities) – Justin Daniels*

- The Medical Director has dedicated significant time on developing this risk with the Head of Corporate Governance and the health inequalities risk has been virtually re-written as a result. A range of previous controls have been removed after concluding

these were not significant controls. Whilst applying the new assurance methodology has identified significant gap areas that were not previously captured on the Gaps/Action section (see below).

- Carrying out the assurance mapping helped identify new gaps such as the need for an ICS delivery plan for its Patient Equality, Diversity and Inclusion Strategy; the lack of a dedicated resource for health inequalities in comparison to staff inequalities that has a dedicated lead, which in turn has meant a dedicated health inequalities workplan has not been produced. These are significant gaps given Health Inequalities is one of the top 12 risks the Board identified and Quality & Safety Committee (QSC) discussion on 23 October agreed warranted Board discussion.
- The Medical Director has also proposed the risk description is amended slightly to include the wording emboldened and in red which QSC supports: *If we do not address health inequalities nor meet the expectations of patients and other stakeholders Then population/stakeholder outcomes will suffer* ***Resulting in poorer public health****, loss of trust, loss of funding opportunities and regulatory censure.* Board agreement for the change is sought.
- There is no proposed change to risk score of 12.

Key other updates:

Risk 7 *(System inertia) Adam Sewell-Jones*

- It is proposed for the risk score to reduce from 16 to 12 with a reduced 3 likelihood to reflect a significant gap has been mitigated: The gap 'Ability for the Trust and Board to be able to influence and inform system development and thinking' has been addressed by the Chief Executive attending ICB Board, co-chairing the HCP and the increasing focus of work at HCP level.

Impact: tick box if there is any significant impact (positive or negative):

Equality (patients or staff)	☒	**Patients**	☒	**Finance/ Resourcing**	☒	**System/ Partners**	☒	**Legal/ Regulatory**	☒	**Green/ Sustain-ability**	☐

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

Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

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

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

Report previously considered by & date(s):

July Board. Lead committees have reviewed the BAF risks they are responsible for during September and October.

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

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East and North Hertfordshire NHS Trust

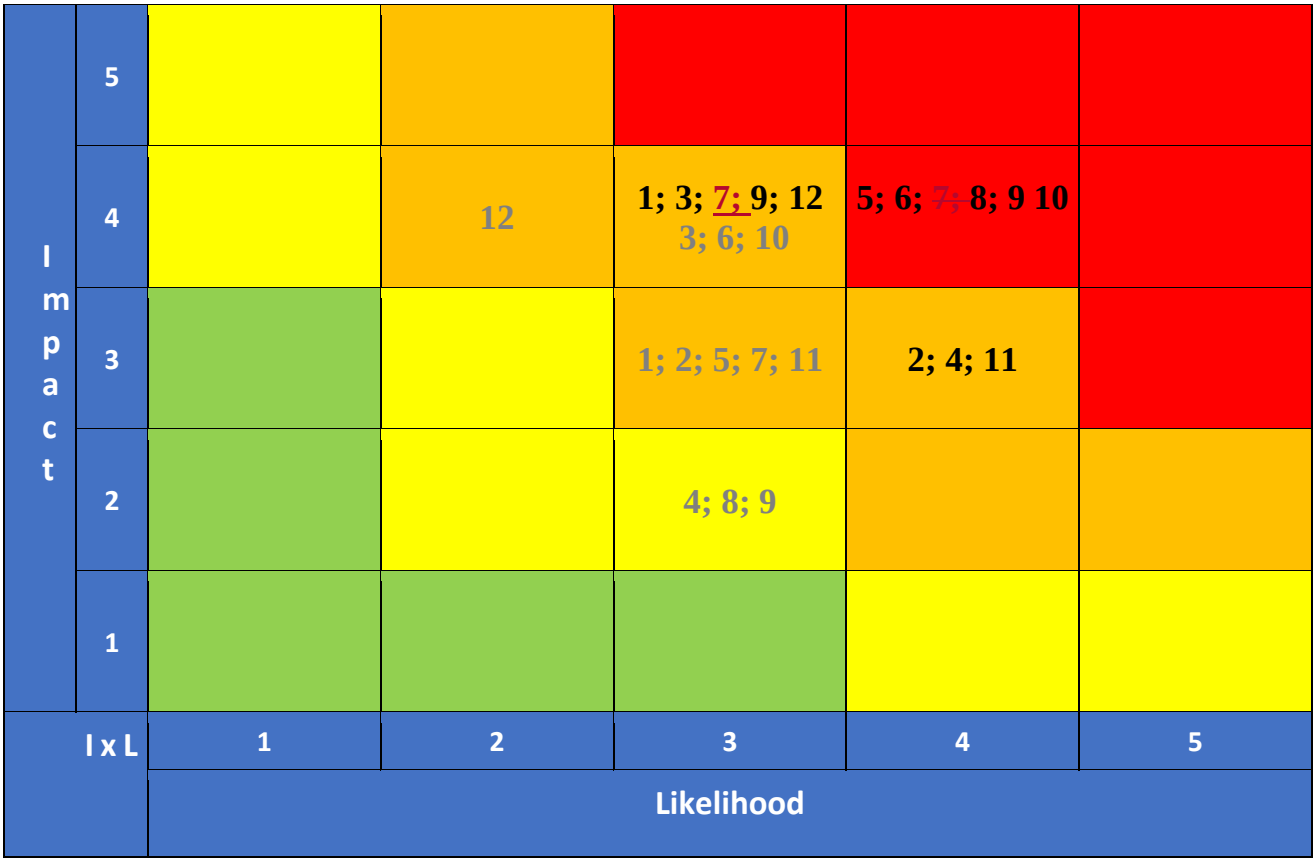
BOARD ASSURANCE FRAMEWORK REPORT

Section 1 - Summary

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

Section 2 Strategic Risk Heat Map

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



Section 3 Risk Appetite

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

Section 4 Risk Scoring Guide

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

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

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

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

Section 5 Assurance Scoring Guide

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

NHS East and North Hertfordshire NHS Trust

Our Trust mission

Providing high-quality, compassionate care for our communities

Our guiding themes

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

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

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

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

Annual goals 2024-25

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

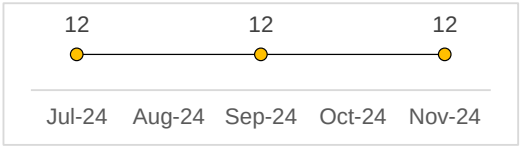
Vision to 2030

To be trusted to provide consistently outstanding care and exemplary service

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

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

Risk Trend



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

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

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

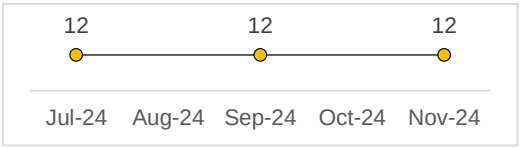
Current Performance – Highlights from the Integrated Performance Report:
• The Trust workforce has expanded significantly since COVID. This represents a significant financial investment, although activity delivery and productivity has declined. • Underlying in year financial performance is at significant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

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

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

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

Risk Trend



Risk Lead	Chief Medical Officer	Assurance committee	Quality & Safety Committee

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

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

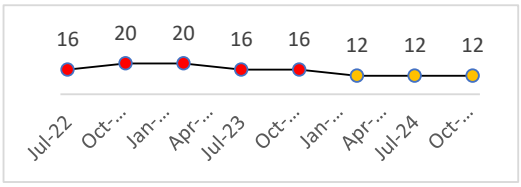
			Risk Register
• Childrens wellbeing bill • Tobacco and vape bill • Mental health bill	• Implement actions once legislation enacted	MD	2025
• Workforce health strategy – no evidence of impact being collected	• Decision not to seek data at present (gap tolerated)	MD	To close if Board accept no action
•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

Current Performance – Highlights from the Integrated Performance Report:
• ED 4 hour standard • 28 day faster diagnosis standards • DMO1 – audiology • 65 week waits for community paediatrics

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

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

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



Risk Lead	Chief Financial Officer	Assurance committee	FPPC

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

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

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

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

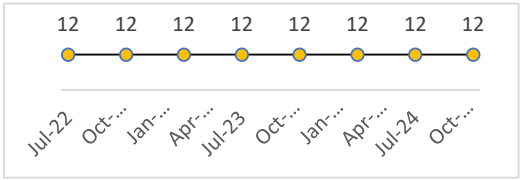
Current Performance – Highlights from the Integrated Performance Report:
• The Trust reports a YTD deficit of £1.3m, this is adverse to plan by £0.7m • As at Month 6 the Trust ERF plans are significantly behind plan. Significant pay and non pay hotspots have emerged. • The utilisation of significant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

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

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

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

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People and Culture Committee

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

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

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

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

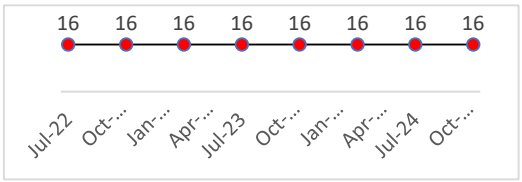
Current Performance – Highlights from the Integrated Performance Report:
• Successful recruitment drive for newly qualified nurses trained in the UK with increased attraction from outside of region and for key areas such as Emergency Department • Significant numbers of Care Support Worker applicants with a renewed focus on assessment standards to ensure skills correctly align with role • Developing inclusive recruitment practices to broaden attraction and increase diversity

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

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

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

Risk Trend



Risk Lead	Chief People Officer	Assurance committee	People Committee

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

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

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

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

Current Performance – Highlights from the Integrated Performance Report:
• Updated 2023 staff survey results are being issued with local cascade and progression of actions and renewed focus • A suite of leadership and culture development work is underway for use in the short and medium term • Time to resolve disciplinary cases has improved and is being sustained to improve employee relations • More work is underway to seek to resolve grievances informally and encourage early resolution.

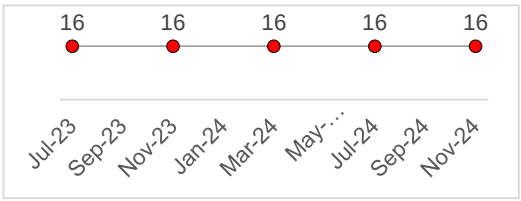
Associated Risks on the Corporate Risk Register		
Risk no.	Description	Current score
	N/A	

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

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

Assurance

Risk Trend



Risk Lead	Thom Pounds, CPO	Assurance committee	People

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

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

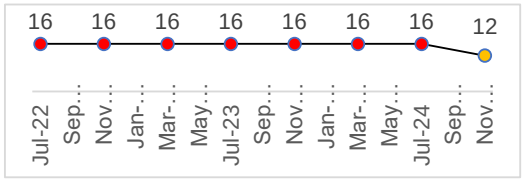
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Lower tiers operational & clinical restructure – operating model change	• Consultation concluded and new Care Group structure in place • Review of the full organisation chart taking place to ensure clear lines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

Current Performance – Highlights from the Integrated Performance Report:
• Care group structure becoming more embedded with final posts being filled • Launched development session for new care groups with phased approach to address learning and development requirements • Positive Leadership round now embedding with better structure • ENHPS for leaders has started for 3 cohorts • Latest RPIW completed for Opthalmology

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

Strategic Aim: **Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners**		**Risk score** ~~16~~12
Strategic Risk No.7: **System inertia**		
If effective system working does not develop at pace	***Then*** the issues the Trust needs system solutions to resolve will perpetuate	***Resulting in*** in enduring areas of sub-optimal health services and patient outcomes and costs.

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



Risk Lead	~~Deputy~~ Chief Executive	Assurance committee	FPPC

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

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

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

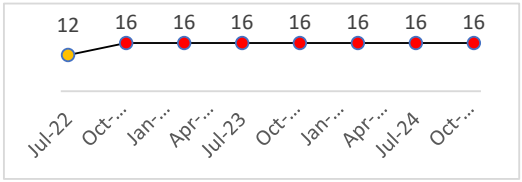
Current Performance – Highlights from the Integrated Performance Report:
• The over-arching system financial plan targets achievement of £30m deficit in 24/25. • Output of HCP effectiveness review • CQC assessment of ICB • HCP performance dashboard metrics tracking progress against HCP priorities

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

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

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

Risk Trend



Risk Lead	Chief Operating Officer	Assurance committee	FPPC

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

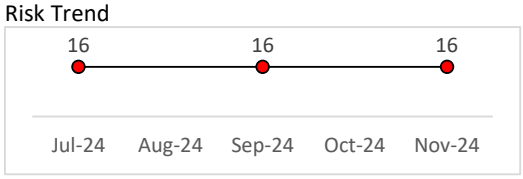
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Agreed Opel Status and Escalation Pathways for ED	• Local triggers and escalation for triage and WTBS • Regular safety huddles in ED led by EPIC and duty matron • Optimise SDEC pathway • Optimise frailty pathway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

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

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

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

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

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

Risk Lead	Chief Operating Officer	Assurance committee	QSC

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

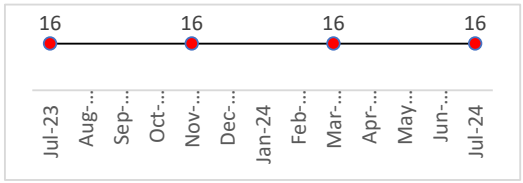
Gaps in Controls and Assurances	Actions and mitigations to address gaps	Lead	Target date
• Clear ownership and roles and responsibilities for making decisions on the future of the current service and ENHT's role in this • Fragmented decision-making between ICB and NHSE which could make	• Add to agenda/ensure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

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

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

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

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

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

Risk Lead	Chief Information Officer	Assurance committee	FPPC

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

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

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

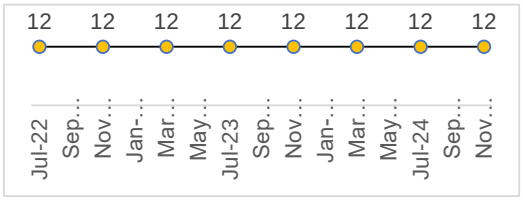
Current Performance – Highlights from the Integrated Performance Report:
• A successful recruitment campaign in Digital has secured a number of Substantive roles ahead of the EPR enhancement programme. • Digital Roadmap presented to FPPC January 2024 • Digital programme commenced April 2024

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

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

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

Risk Trend



Risk Lead	Chief Kaizen Officer	Assurance committee	People

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

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

concerns raised by staff (i.e. Freedom to Speak Up framework)	• Identified as a key priority in response to the staff survey therefore included as part of the 'team talk' discussions where actions are being developed and delivered locally. • Freedom to speak up training included in required learning for all staff on ENH Academy. • Reciprocal mentoring programme in place to develop greater appreciation and understanding of colleagues from different personal and professional background.	• TP • TP • TP	• Dec 24 • Sept 24 • Mar 25
• Variation in ward to Board quality governance structures and operational procedures	• Embed new Divisional model and deliver developmental training programme for leadership teams. • Implement daily management via the ENH PS for Leaders programme. • Roll-out weekly Positive Leader Rounds initiative. • Introduction of leader standard work.	• LD • KOH • KOH • KOH	• Sep 24 • Dec 24 • Sept 24 • Dec 24
• Evaluation of ENH Production	• Annual transformation continuum assessment	• KOH	• Mar 25
• Prioritisation of finite KPO resource in the context of multiple competing legitimate demands and the importance of strategic alignment (relates to Executive Value Stream Guiding Teams)	• Kaizen event • Development of Executive values streams • KPO members going through certification process, which takes time	• KOH • KOH • KOH	• Aug 25 • Feb 25 • Jan 25

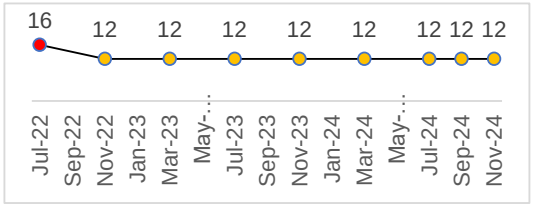
Current Performance – Highlights from the Integrated Performance Report:
• KPO team successfully achieved Advanced Process Improvement Training certification via VMI in May. Due to turnover six new KPO staff commenced APIT 20 cohort in August. • Intro to ENHPS course focusing on waste and 5S launched via ENH Academy across all main sites from June with over 30o staff already attended.. • First Rapid Process Improvement Workshop (RPIW) for Recruitment completed March and standard work planning for second RPIW focusing in ophthalmology scheduled for October. • Executive Masterclass in Standard Leader Work facilitated by VMI delivered April. • PDSA for new Positive leader Rounds commenced June. • Phase 1 LEIPA 360 questionnaires and feedback sessions completed. • Nominations and programme confirmed for three ENHPS for Leaders cohorts commenced in August. • Kaizen event focusing on triage and prioritisation process with TGT for KPO resource completed with 30-day implementation plan agreed in August. • New kaizen clinic model for frontline staff to access KPO coaching support started as PDSA in August.

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

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

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

Risk Trend



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

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

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

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

Current Performance – Highlights from the Integrated Performance Report:
• Staff survey • GMC survey • R&D annual report performance information – number of clinical studies and patients recruited • Sustained improvement in mortality outcomes

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

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	14
Report title	Summary Learning from Deaths Report	**Meeting Date**	6 November 2024
Presenter	Medical Director		
Author	Mortality Improvement Lead		
Responsible Director	Associate Medical Director for Reducing Unwarranted Variation	**Approval Date**	11 September 2024

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

Report Summary:

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

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

Impact: tick box if there is any significant impact:

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

Equality:

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

Patients' benefit/detriment:

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

Legal/Regulatory:

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

Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:

Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

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

Strategic Risk 5 - Culture, leadership and engagement

Report previously considered by & date(s):

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

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

To be trusted to provide consistently outstanding care and exemplary service

1. Executive Summary

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

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

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

1.2.2 Compliance with Learning from Deaths NQB Guidance
The national Learning from Deaths guidance states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This paper provides this information for Q1 2024-25. An in-depth Learning from Deaths Report covering the same period was provided to both the Quality and Safety Committee, and Mortality Surveillance Committee in June 2024.

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

Figure 1: Learning from deaths and CQC domains of care

1.3 Risks

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

Table 1: Current risks

Risks	Rating
Cardiology: recurrent HSMR and SHMI alerts (especially AMI) Following recurrent MI mortality alerts and a report by the Cardiology Clinical Director, a joint initiative between Cardiology and Coding was agreed. This work remains ongoing. The latest update to the Mortality Surveillance Committee in April indicated there are still mis-matches between clinical activity and coding in a significant percentage of cases. The update also looked at heart failure and reported a significant mis-recording of HF among patients admitted under General Medicine. A further update was agreed for September. To date the improvement work has not found evidence of clinical concerns.	
Ovarian Cancer SACT 30 Day Mortality: External review findings In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. Following completion of the review of patient care, a formal SI report has been completed. Associated actions are scheduled to continue to the end of the year. Until confirmation is received that these have been concluded this risk will be maintained.	
SJRPlus review tool Following transfer of the SJRPlus review tool from NHSE to Aqua, it took some time to gain the data protection assurances required by our Executive. An element of risk has remained, as to date AGEM has not conducted a Pen Test, on the basis that the App has moved from one part of the Azure platform to another. Our Chief Information Officer approved our use of the tool, on the basis that we logged this as a tolerated risk on the Risk Register. As this issue took time to resolve, the conduct of reviews was suspended for more than two months. To mitigate the risk, during the downtime, where prompt review was considered important, cases were allocated to Divisions/Specialties via ENHance. The number of Q1 deaths reviewed to date is suboptimal from a learning perspective but was deemed necessary for the sake of good governance/IT risk management.	
Implementation of the Patient Safety Incident Response Framework (PSIRF) Work remains ongoing to ensure cohesion between our SJR process and the new patient safety framework. We continue to work closely with the PSIRF implementation Lead, checking that relevant policies and procedures align. While new PSIRF processes become embedded across the Trust, it will remain important to check for alignment with our learning from deaths process.	

	Low risk		Medium risk		High risk

2. Context

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

2.1 Headline mortality metrics

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

Table 2: Key mortality metrics

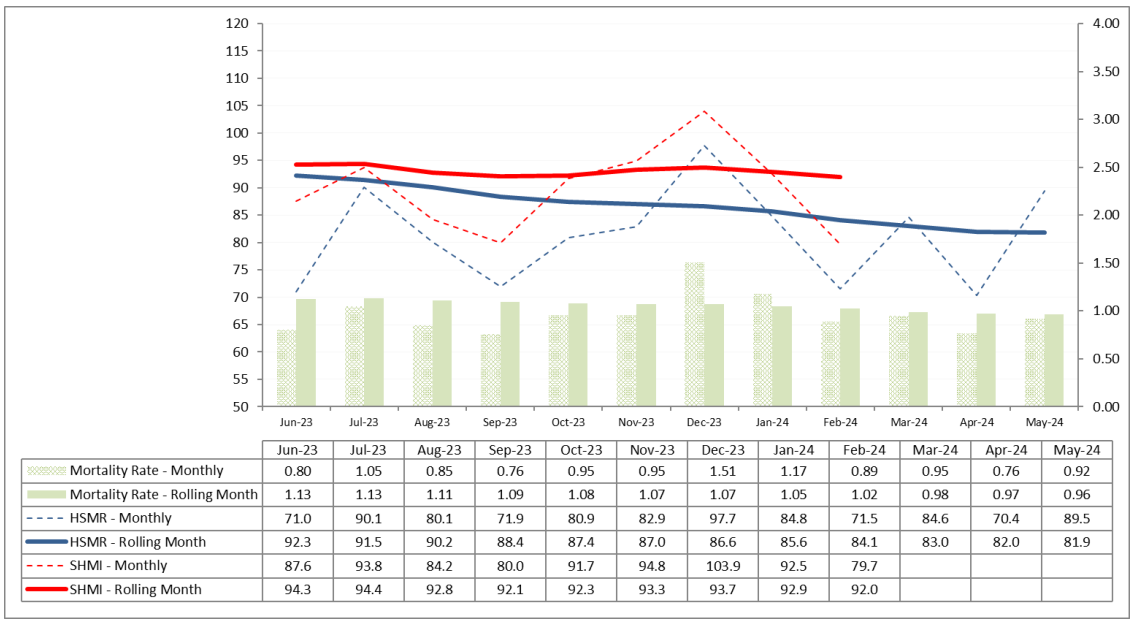
Metric	Headline detail
Crude mortality	Crude mortality is 0.93% for the 12-month period to Jul 2024 compared to 1.08% for the latest 3 years.
HSMR: (data period Jun23 – May24)	HSMR for the 12-month period is **81.85, 'First quartile'.**
SHMI: (data period Apr23 – Mar24)	SHMI for the 12-month period is **91.41, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 2nd (of 11) within the Model Hospital list* of peers.

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

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

Rolling 12-month SHMI reported by CHKS stands at 92.0 to February 2024. This represents a decrease from the last reported 94.12 for the 12 months to December 2023.

Figure 2: Trust key mortality metrics: Latest position



	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Mortality Rate - Monthly	0.80	1.05	0.85	0.76	0.95	0.95	1.51	1.17	0.89	0.95	0.76	0.92
Mortality Rate - Rolling Month	1.13	1.13	1.11	1.09	1.08	1.07	1.07	1.05	1.02	0.98	0.97	0.96
HSMR - Monthly	71.0	90.1	80.1	71.9	80.9	82.9	97.7	84.8	71.5	84.6	70.4	89.5
HSMR - Rolling Month	92.3	91.5	90.2	88.4	87.4	87.0	86.6	85.6	84.1	83.0	82.0	81.9
SHMI - Monthly	87.6	93.8	84.2	80.0	91.7	94.8	103.9	92.5	79.7			
SHMI - Rolling Month	94.3	94.4	92.8	92.1	92.3	93.3	93.7	92.9	92.0			

2.2 Mortality alerts

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

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

2.2.3 SHMI CUSUM alerts

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

Table 3: SHMI Outlier Alerts March 2023 to February 2024

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths	Included Spells
101 - 159: Urinary tract infections	136.94	91	66	25	1228
79 - 131: Respiratory failure; insufficiency; arrest (adult)	193.35	42	22	20	80
100 - 156, 158: Nephritis; nephrosis; renal sclerosis, Chronic renal failure	415.20	25	6	19	323
35 - 50: Diabetes mellitus with complications	232.12	24	10	14	291
108 - 198, 199, 200: Skin disorders	189.78	23	12	11	331
90 - 146, 147: Digestive, anal and rectal conditions	289.26	15	5	10	441
81 - 56, 133: Cystic fibrosis, Other lower respiratory disease	198.54	19	10	9	153
58 - 101: Coronary atherosclerosis and other heart disease	284.31	10	4	7	245

As a thorough review of UTI was recently undertaken, no further action is currently proposed. Following an update by Coding, who have monitored the skin disorders group, their findings are to be shared with the Community, but no further internal work is planned. Both the nephritis group and coronary atherosclerosis are under scrutiny with collaborative work ongoing between Coding and the Clinical Leads involved. On the back of recurrent alerts for Diabetes, Respiratory failure, cystic fibrosis, other lower respiratory diseases and the Digestive, anal and rectal conditions, further review and monitoring between Coding and the relevant services has been requested by the Mortality Surveillance Committee.

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

2.2.5 Key Learning from Deaths Data

2.2.5.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q1 2024-25.

Table 4: Q1 2024-25: Learning from deaths data

	Apr-24	May-24	Jun-24
Total in-hospital deaths (ED & inpatient)	100	119	97
Deaths with SJR completed to date (at 01.08.24)	8	3	1
Patient safety incident escalation from SJR (by month of death) (at 01.08.24)	1	3	1
SJR outcome: Deaths more likely than not due to problem in care (≥50%)	1	1	0
Learning disability deaths	1	2	0
Mental illness deaths	1	1	1

Stillbirths	1	0	1
Child deaths (including neonats/CED**)	0	0	1
Maternity deaths	0	0	0
PSIIs declared regarding deceased patient	0	0	0
SIs approved regarding deceased patient	1	2	0
Complaints received in month regarding deceased patient	4	3	1
Requests received in month for a Report to the Coroner	19	21	15
Regulation 28 (Prevention of Future Deaths)	0	0	0

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

2.2.5.2 Learning from deaths dashboard

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. During the transition from our old in-house mortality review tool to using the SJR*Plus* tool and approach, the dashboard was not used, as the data aligned differently. The dashboard has now been reintroduced and is provided at Appendix 1.

3.0 Scrutiny to SJR

3.1 Medical Examiner Scrutiny

Table 5: Medical Examiner scrutiny data: Q1 2024-25

Scrutiny detail	Apr	May	Jun	Q1 Total
Total in-hospital deaths	100	119	97	316
Number of ENHT deaths scrutinised by ME	91	103	96	290
Number of MCCDs not completed within 3 calendar days of death	8	15	2	25
Number of ME referrals to Coroner	19	21	15	55
Number of deaths where significant concern re quality of care raised by bereaved families/carers	1	1	0	3
Number of patient safety incidents notified by ME office as a result of scrutiny	0	1	1	3
Number of ME referrals for SJR	27	22	25	74

3.2 Structured Judgement Reviews

3.2.1 SJR process and methodology

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

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

While it took some time to gain the data protection assurances required by our Executive, a three-year contract was signed on 9 July. This meant that the conduct of reviews was suspended for more than two months. Although suboptimal from a learning perspective, this was deemed vital for governance purposes. To mitigate the risk, during the downtime, where prompt review was considered important, cases were allocated to Divisions/Specialties via ENHance.

Unfortunately, this does mean that very few Q1 death reviews have been completed at the time of writing this report.

3.2.2 SJR and deaths YTD headline data

Table 6: Headline Year to date SJR and deaths data

Data count	Apr-24	May-24	Jun-24	Total
Total in-patient deaths	89	112	85	286
Total ED deaths	11	7	12	30
SJRs completed on in-month deaths (at 01.08.24)	8	3	1	12

The above table shows that to date, only 4% of hospital deaths have received a formal structured judgement review. This means that significant effort will need to be made in the remaining three quarters of the year in order to review the 15-20% suggested by the Better Tomorrow team (now part of Aqua) as being needed to provide robust learning/assurance.

3.2.3 Learning beyond SJR
3.2.3.1 SJR patient safety incident escalations

Table 7: Year to end of Q1 Patient Safety Incidents reported following SJR

Escalations for deaths in month (at 01.08.24)	Apr	May	Jun	Total
Patient Safety Incident Escalations from SJRs	1	3	1	5

For deaths in the current year which have been subject to an SJR, 5 cases have been escalated as a patient safety incident. When we adopted the SJR format and revisited our internal quality and governance processes, it was agreed with our patient safety team, that there are three triggers in the SJR which should result in the case being logged and investigated as a patient safety incident.

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

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

15 cases have been concluded and discussed at Mortality Surveillance during Q1 using the new process. Summary detail is provided below:

Table 8: Q1 2024-25: Concluded Escalated Cases Summary

SJR/SI	Death Preventability (Final MSC decision)	Incident category	Learning themes
SI	Definitely not preventable	Suboptimal management nutritional needs	Nutrition Fundamentals of Care Delirium Training/Awareness MCA/DOLS
SI/SJR	Definitely not preventable	Anaphlayxis	Readmission Medication/IV fluids/Electrolytes/Oxygen

			Treatment/Management Plan Resuscitation Allergic Reaction
SI	Definitely not preventable	Delay in medical review	Assessment, investigation or diagnosis Clinical Monitoring/Obs/planning Weekend/Out of Hours
SI	Definitely not preventable	Development of pressure sores	Fundamentals of Care
SI	Definitely not preventable	Hospital-Hospital Transfer	Assessment, investigation or diagnosis Treatment/Management Plan Infection Control Operation/Invasive Procedure
SI/SJR	Slight evidence for preventability	Fall/Delay in medical review	Assessment, investigation or diagnosis Medication/IV fluids/Electrolytes/Oxygen Treatment/Management Plan Clinical Monitoring/Obs/planning
SI	Possibly preventable, less than 50-50	Missed diagnosis	Assessment, investigation or diagnosis Documentation
SJR	Possibly preventable, less than 50-50	Missed diagnosis	Readmission Assessment, investigation or diagnosis
SI	Possibly preventable, less than 50-50	VTE	Assessment, investigation or diagnosis Clinical Monitoring/Obs/planning
SJR	Possibly preventable, less than 50-50	HDU Staffing levels	Clinical Monitoring/Obs/planning
SI	Possibly preventable, less than 50-50	Dislodged femoral line	Assessment, investigation or diagnosis Communication with patient, relatives and carers MCA
SI	Possibly preventable, more than 50-50	Delay in Reporting Radiology Result	Assessment, investigation or diagnosis System Error/outsourced
SJR	Possibly preventable, more than 50-50	Delay in referral	Assessment, investigation or diagnosis
SI	Strong evidence of preventability	suboptimal monitoring of a deteriorating patient	Weekend/Out of Hours Fundamentals of Care Fluid Balance Deteriorating Patient
SI/SJR	Strong evidence of preventability	Failure to repeat blood tests and delays	Assessment, investigation or diagnosis Medication/IV fluids/Electrolytes/Oxygen Deteriorating Patient INR not checked and no CT for 2 days

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

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

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

A quarterly ‘Food for Thought’ presentation is now created, each iteration focussing on a particular aspect of SJR outputs. These presentations are shared in forums such as Mortality Surveillance Committee, Divisional Quality and Safety meetings and with the ICB. The latest looked at End-of-Life SJR data for the 2023-24 year.

4.0 Improvement activity

4.1 Focus areas for improvement/monitoring

Table 9: Focus Areas for Improvement

Diagnosis group	Summary update
Ovarian Cancer	In the 2017-20 national Systemic Anti-Cancer Therapy (SACT) audit, the Trust was identified as an outlier for 30 Day Mortality. Following discussion at Mortality Surveillance an external peer review was commissioned. This identified a lack of integrated care at MVCC. With completion of the assurance work, a final SI report has now been completed, with associated actions scheduled to continue to the end of the year. The Mortality Surveillance Committee will continue to monitor ongoing work until all actions on the remedial action plan have been completed.
Cardiology diagnoses	Following recurrent MI mortality alerts and a report by the Cardiology Clinical Director, Cardiology committed to a joint initiative with Coding to review all cases with an admitting diagnosis, or cause of death, of acute MI, to identify and exclude 'coding error' cases and ensure appropriate learning. This work remains ongoing with regular updates provided to the Mortality Surveillance Committee. Critically, to date the improvement work has not found evidence of clinical concerns.
Sepsis	While HSMR performance relative to national peer remains extremely well placed, achievement of sepsis targets remains variable. The sepsis team continues to develop multiple initiatives aimed at improving compliance.
Stroke	The Trust has maintained a SSNAP rating of B for the period January-March 2024. After a long delay, SSNAP finally provided an updated risk adjusted mortality report covering the 2-year period April 2021 to March 2023. While this indicated that the Trust was not an outlier for mortality, it also showed no improvement since the last reported risk adjusted metric for 2019-20. At the same time HSMR and SHMI have both showed significant improvements since the April 2021-March 2023 period. It is likely to be some time before we can see whether the SSNAP metric follows a similar trajectory. As our SSNAP risk adjusted mortality is not well placed versus our national peers, mortality performance will continue to be monitored, with a further update to Mortality Surveillance Committee by the service, scheduled for October. The recent focus has been on working with the national team on the Thrombolysis in Acute Stroke Collaborative (TASC) project which is a national programme to work with selected Trusts to improve their Thrombolysis rates. Collaborative working at a regional level with the East of England Integrated Stroke Delivery Network (ISDN) remains ongoing. This continues to focus on the National Optimal Stroke Imaging pathway (NOSIP) and Trust team members from nursing, medical and radiology teams recently attended a regional event focussing on CT perfusion scanning.
Emergency Laparotomy	In the recently published NELA year 9 Report our mortality has reduced to single digits, standing at 8.4% risk adjusted which is below the national average. It has been a long journey to achieve this, and it has only been possible with the multi-disciplinary work established in our Trust Emergency Laparotomy Pathway since 2019. While focussed improvement work continues, case ascertainment remains a challenge. To meet the Best Practice Tariff, we need a case ascertainment above 90%. Good news includes the fact that the service considers we are well placed to achieve the new BPT requirement of completion of risk documentation and geriatric input for 40% patients, indicating that in this regard we are amongst the top performing Trusts. The long-anticipated re-establishment of the Surgical Assessment Unit commenced from mid-January 2024 and has improved emergency surgical patient flow, thereby significantly improving the care for NELA patients. Collaborative deaths review work is also ongoing with the Coding department, aimed at improving the quality of coding and thereby improving the accuracy of submitted HES data, which forms the basis of mortality indicators. The benefits from this work will take time to

	show in published metrics. From April 2024 the NoLap Audit has been introduced. This is a national mandatory audit which will include cases meeting NELA criteria, but which were not included in NELA as the patient was too high risk to be operated on. For the first year the two main inclusion criteria are bowel perforation and ischaemia.

5.0 Preventable deaths

Currently we are here referring to those deaths that have been judged more likely than not to have been preventable on the basis of an SJR. It must be remembered that the question of the preventability of a death is the subjective assessment of an individual reviewer on the basis of a SJR desktop review. While not definitive, the assessment by them that the death was more likely than not due to a problem in healthcare (more than 50:50% preventable) provides an invaluable, powerful indication that further in-depth investigation of the case is required using the Trust's Patient Safety Incident processes.

The table below provides year to end of Q1 deaths/SJR/Preventability data (detailing SJRs conducted up to 1 August 2024). The outcome of investigations and actions relating to deaths judged more than 50:50 preventable will be discussed by the Mortality Surveillance Committee.

The preventability of death data provided in this report is taken from mortality reviewers assessment in their structured judgement reviews. As indicated in 3.3.2.1, where cases are escalated for further patient safety review/investigation, the additional rigour employed may bring to light detail which results in a downgrading (or increase) to the level of harm deemed to have been caused. The results of these more in-depth reviews are taken into consideration when estimating the number of deaths judged to be more likely than not due to a problem in healthcare reported in the annual Quality Account.

Table 10: 2024-25 SJR preventable deaths data Year to the end of Q1

Data count (at 01.08.24)	Apr-24	May 24	Jun 24	**Total**
Hospital deaths (ED & inpatient)	100	119	97	316
SJRs completed on in-month deaths	8	3	1	12
% of deaths subject to SJR to date	8%	2.5%	1%	4%
Deaths judged more likely than not to be due to a problem in healthcare	1	1	0	2
% SJRs assessed ≥50:50 preventable	12%	33%	0%	8%

6.0 Options/recommendations

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

Appendix 1: Learning from Deaths Dashboard

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

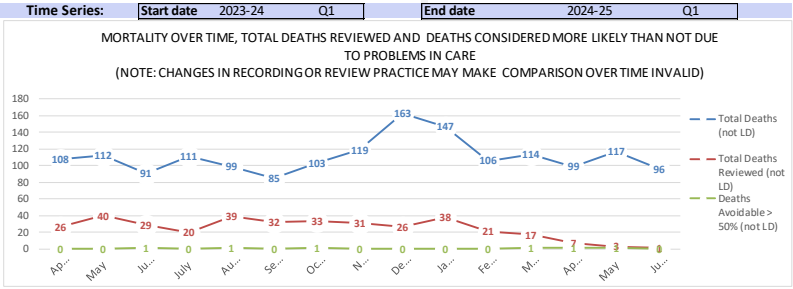
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
96	117	1	3	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
312	367	11	76	2	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
312	1358	11	352	2	4

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



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

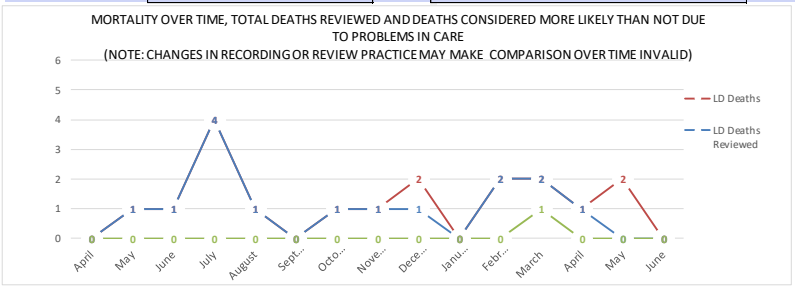
Score 1 Definitely preventable			Score 2 Strong evidence of preventability			Score 3 Probablypreventable (more than 50:50)			Score 4 Probably preventable but not very likely			Score 5 Slight evidence of preventability			Score 6 Definitely not preventable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	18.2%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	9.1%	This Quarter (QTD	8	72.7%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	18.2%	This Year (YTD)	0	0.0%	This Year (YTD)	1	9.1%	This Year (YTD)	8	72.7%

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

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

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

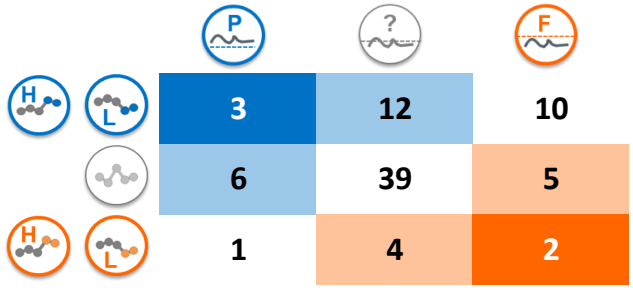
Time Series: Start date 2023-24 Q1 End date 2024-25 Q1



NHS
East and North Hertfordshire
NHS Trust

Integrated Performance Report

Month 06 | 2024-25



Data correct as at 23/10/2024

Performance Highlights

East and North Hertfordshire NHS Trust

Quality

- *C difficile (C diff.)* - There has been an increase in the number of cases this month (9) compared to the previous month (4 cases). Although this remains above the monthly threshold.
- MRSA BSI - There were zero MRSA BSI in the month of September'24 with an annual threshold of 0.
- Friends and Family Test (FFT) - Positive feedback on the Trust's inpatient facilities is consistently passing the target; Emergency and Outpatient department remains mixed.
- Proportion of complaints acknowledged within three working days is consistently passing the target.
- The rolling 12-month crude mortality rate continued to decrease in Sep-24, HSMR remained below 100 and SHMI has seen a increase in their latest respective publications.

Operations

- Urgent and Emergency Care - The monthly attendances saw an increase from previous month but the performance has improved to 73.50% in September.
- Cancer Waiting Times - The Trust achieved the 28-day Faster Diagnosis and 31-day decision to treat to treatment in Aug-24, but not the 62-day referral to treatment standards. All three are statistically likely to have mixed performance (passing and failing) from month to month.
- Referral To Treatment (RTT) 18 weeks - Numbers of patients waiting over 65, 78 and 104 weeks for treatment (excluding Community Paediatrics) continued to show Improving trends in-month.
- Diagnostics - The proportion of patients waiting more than six weeks for diagnostic tests remains higher than the target, and has started to increase in the recent months.

Finance

- The Trust approved a surplus plan of £1.0m for 24/25. This plan assumes that both a £33.8m cost improvement programme will be delivered, and ERF performance of 138% will be achieved.
- At Month 6, the Trust has reported an actual deficit of £1.3m. This is adverse to plan by £0.7m. This gaps relates to lost income resulting from Industrial Action earlier in the year.
- ERF delivery was behind plan in month due to delays in recruitment to new posts and lower activity than run rate for Orthopaedics and Urology.
- Pay was £0.6m adverse to plan in month, excluding non recurrent reserves. High levels of Waiting list initiative payments, high locum usage for medical staff within the ED and Paediatric department and high midwifery usage continue to be the main pay hotspots and actions are being undertaken to mitigate in future months.

People

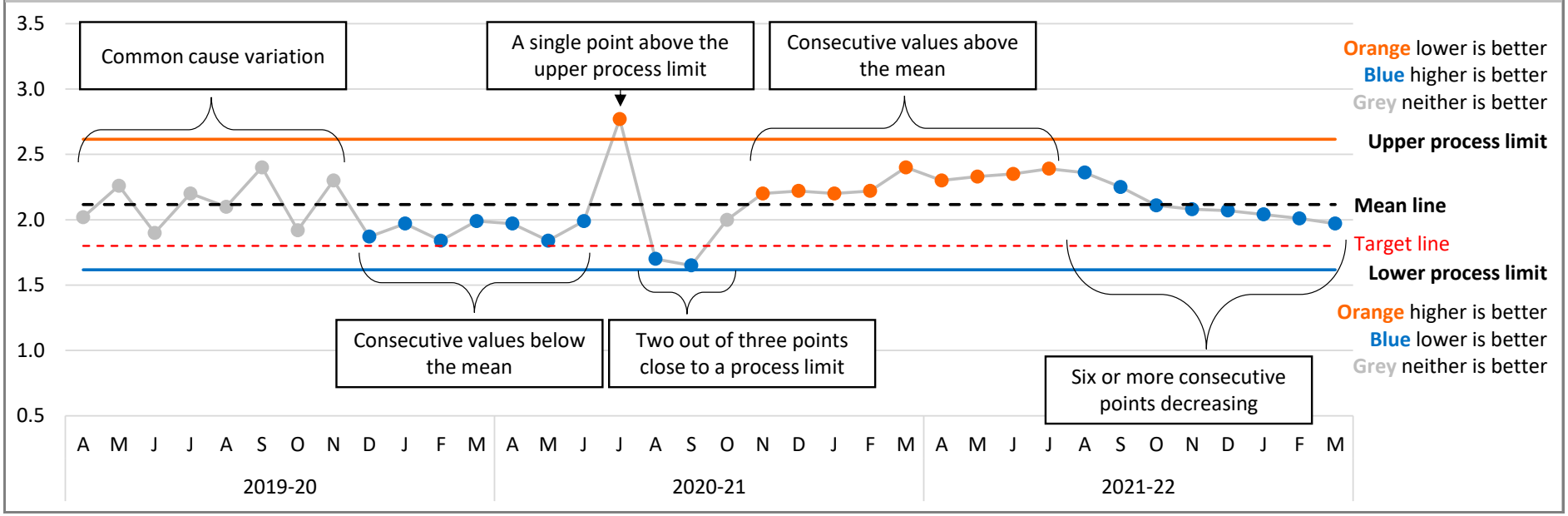
- The vacancy rate decreased to 9.2% (628 vacancies). Recruitable establishment decreased by 23.5 WTE. There are 142 more staff in post than a year ago.
- Work is underway to explore simplification of the GROW Together appraisal system and appraisal compliance stands at 85.05% showing 770 outstanding appraisals - Corporate divisions are the worst performing with 207 listed as 'not done' of which 87 are Estates & Facilities, 64 IT and 24 Nursing & Quality
- Statutory training in M06 shows as 88.9% a slight dip of 1% whereas mandatory training increased by 1.9% and stands at 82.72%.
- Targeted work to support leaders to prevent and manage sickness absence continues, with coaching for managers, occupational health advice and sickness absence case review meetings.

Month 06 | 2024-25

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

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

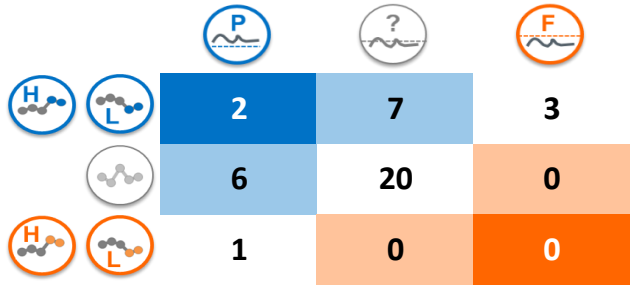
Assurance

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

East and North Hertfordshire NHS Trust

Quality

Month 06 | 2024-25



Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Sep-24	n/a	1,320			Common cause variation No target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Sep-24	0	0	L	?	10 points below the mean Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Sep-24	0	9		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Sep-24	0	4		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Sep-24	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Sep-24	0	4		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Sep-24	0	1		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Sep-24	0	0	L	?	24 points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Sep-24	80%	95.3%	H	P	1 point above the upper process limit Metric will consistently pass the target
Safer Staffing	Overall fill rate	Sep-24	n/a	84.9%	H		9 points above the mean No target
	Staff shortage incidents	Sep-24	n/a	31			Common cause variation No target

Month 06 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Sep-24	n/a	0.55			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Sep-24	n/a	0.33			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Sep-24	95%	95.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Sep-24	95%	47.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Sep-24	95%	83.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Sep-24	95%	72.7%	H	F	8 points above the mean Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Sep-24	85%	87.3%	H	F	7 points above the upper process limit Metric will consistently fail the target
HATs	Number of HAT RCAs in progress	Sep-24	n/a	120	H		10 points above the mean No target
	Number of HAT RCAs completed	Sep-24	n/a	15			Common cause variation No target
	HATs confirmed potentially preventable	Sep-24	n/a	3			Common cause variation No target
PU	Pressure ulcers All category ≥2	Sep-24	0	6		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Sep-24	n/a	5.3			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Sep-24	n/a	1.1%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Jun-24	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Feb-23	6.0%	5.8%			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	Sep-24	95%	96.7%		P	Common cause variation Metric will consistently pass the target
	A&E positive feedback	Sep-24	90%	85.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Sep-24	93%	92.5%	H	?	8 points above the upper process limit Metric will inconsistently pass and fail the target
	Maternity Birth positive feedback	Sep-24	93%	100.0%	H	?	5 points above the upper process limit Metric will inconsistently pass and fail the target
	Maternity Postnatal positive feedback	Sep-24	93%	98.5%	H	?	13 points above the upper process limit Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Sep-24	93%	93.3%	H	F	13 points above the upper process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	Sep-24	95.0%	96.4%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Sep-24	n/a	419	H	-	9 points above the mean No target

Month 06 | 2024-25

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Sep-24	n/a	64		-	Common cause variation No target
	Number of complaints closed in-month	Sep-24	n/a	80		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Sep-24	75%	98.6%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Sep-24	80%	60.3%		?	Common cause variation Metric will inconsistently pass and fail the target
Maternity Safety Metrics	Caesarean section rate Total rate from Robson Groups 1, 2 and 5 combined	Jul-24	60 - 70%	70.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Sep-24	3.3%	4.7%	H	P	2 points above the upper process limit Metric will consistenly pass the target
	3rd and 4th degree tear vaginal	Sep-24	2.5%	0.0%	L	?	2 points below the lower process limit Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Sep-24	4.5%	0.8%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear instrumental	Sep-24	6.3%	2.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Sep-24	6.0%	4.9%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Sep-24	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Sep-24	12.5%	4.7%		P	Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Sep-24	2.3%	3.7%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bookings completed by 9+6 weeks gestation	Sep-24	50.5%	71.9%		P	Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Sep-24	72.7%	76.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Number of serious incidents	Sep-24	0.5	0	L	?	11 points below the mean Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Sep-24	12.8	7.7	L	?	8 points below the mean Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Sep-24	12.8	9.1			Rolling 12-months - unsuitable for SPC
	HSMR In-month	Jul-24	100	89.1		?	Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	Jul-24	100	82.0			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Apr-24	100	93.6		?	Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Apr-24	100	91.7			Rolling 12-months - unsuitable for SPC

Month 06 | 2024-25

Quality

Summary

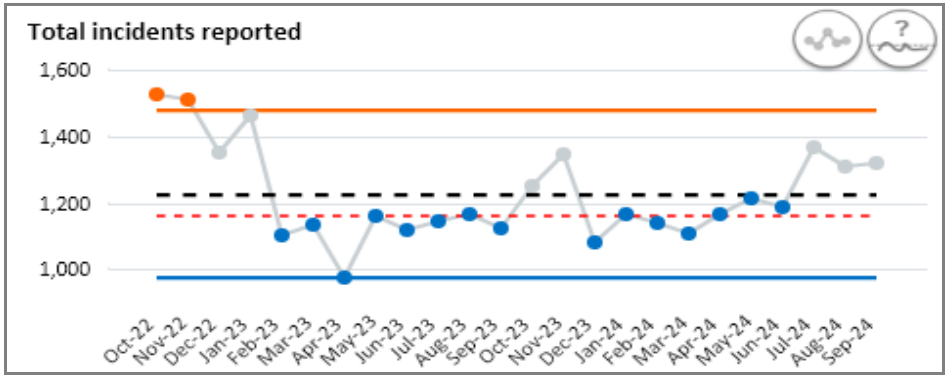
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	Jul-24	n/a	809			1 point above the upper process limit No target
	Rate of emergency re-admissions within 30 days of discharge	Jul-24	9.0%	6.6%			Common cause variation Metric will consistently pass the target
Length of Stay	Average elective length of stay	Sep-24	2.8	2.2			7 points below the mean Metric will consistently pass the target
	Average non-elective length of stay	Sep-24	4.6	4.0			1 point below the lower process limit Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Sep-24	n/a	92.4%			Common cause variation No target
	Individualised care pathways	Sep-24	n/a	24			Common cause variation No target

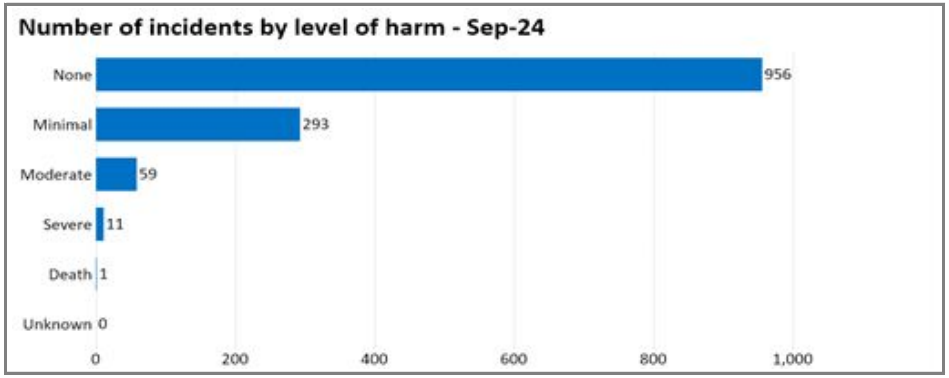
Month 06 | 2024-25

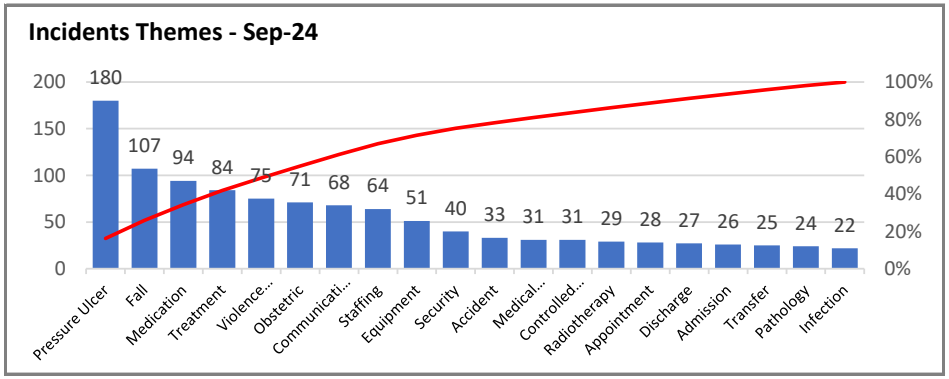
Quality

Patient Safety Incidents

East and North Hertfordshire NHS Trust

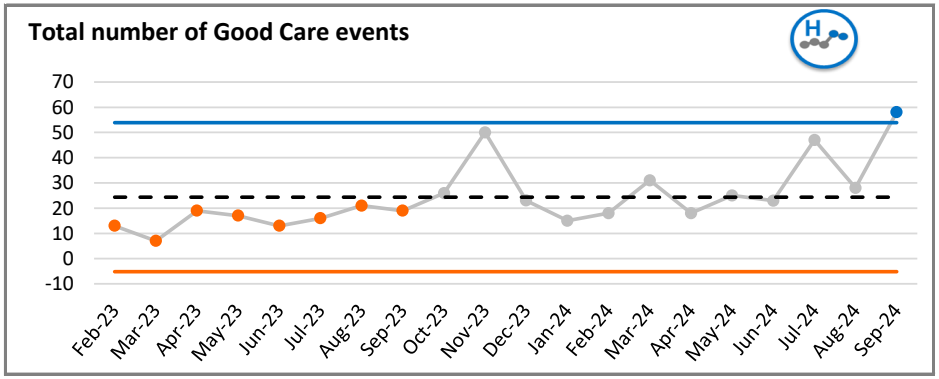






Key Issues and Executive Response

- Normal variation in incident reporting. Noted increase in falls over summer months across the Trust with 1 resulting in fracture. This aligns with high number of challenging patients in the Trust who require support from ENCT with limited resources. Falls lead doing targeted support with ward 10B and working with ward managers to collate learning points and review how wards can be supported.
- The number of accumulated open incidents remains an improvement priority across Divisions. Significant positive improvement noted across Planned Care. Unplanned Care remains area of priority with highest reported rate of incidents and highest proportion of open incidents.
- Daily incident huddles in place in Womens services, Planned Care and Care Group 3.
- Special cause variation in good care events reported with 57% reported by W&C division. Noted 2 events of early recognition of unwell patient with appropriate escalation at Mount Vernon also good teamwork and leadership within main theatres.
- Four serious incidents remain open, all relate to Paediatric Audiology.
- 1 PSII completed in September and signed off by Trust Board (wrong site injection in Ophthalmology). Ongoing Trust wide learning regarding LocSSIPS to seek further assurance.

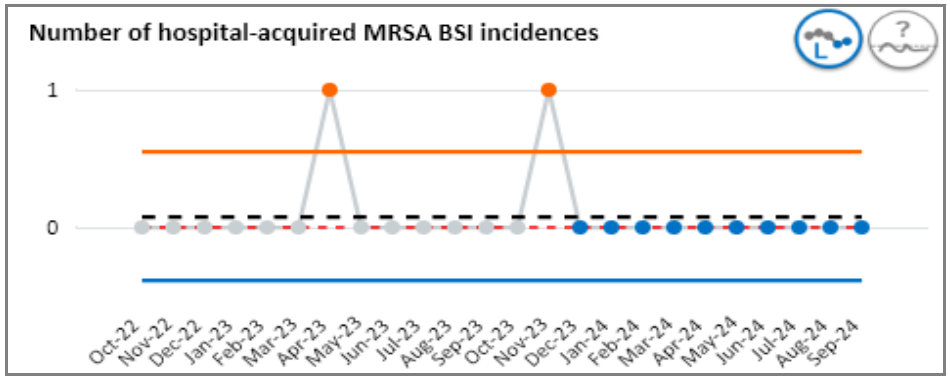


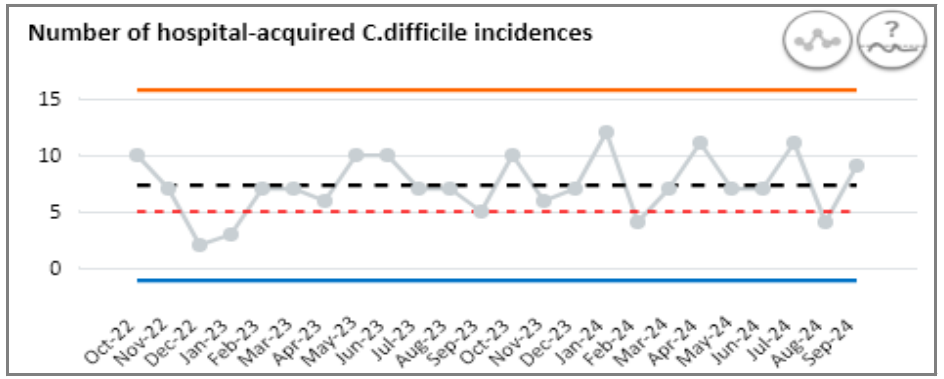
Month 06 | 2024-25

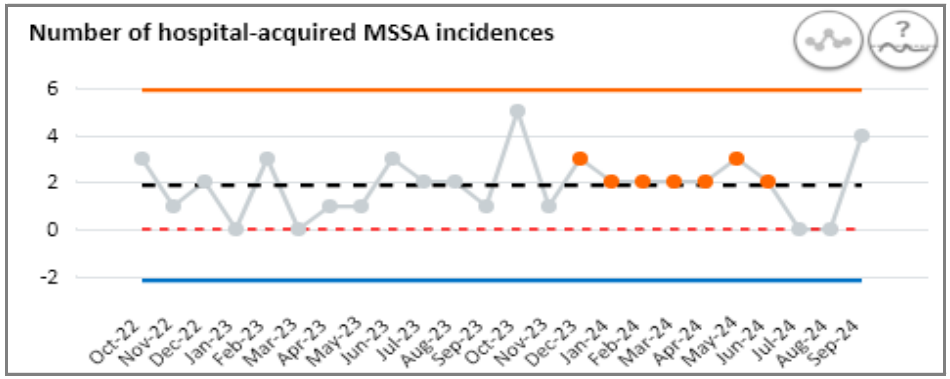
Quality

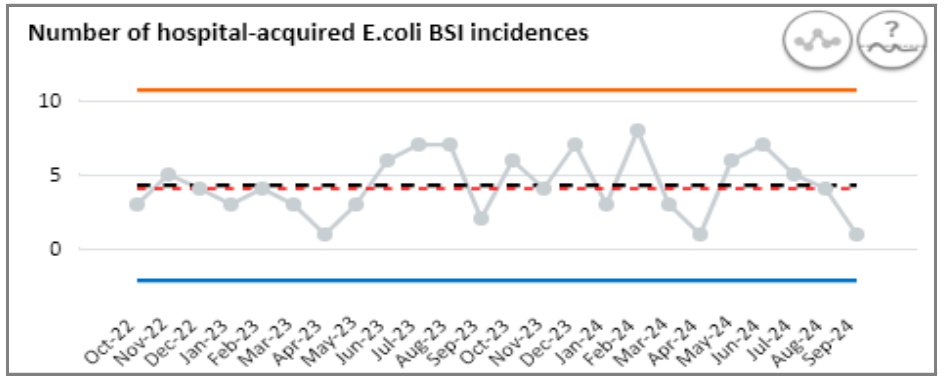
Infection Prevention and Control

East and North Hertfordshire NHS Trust









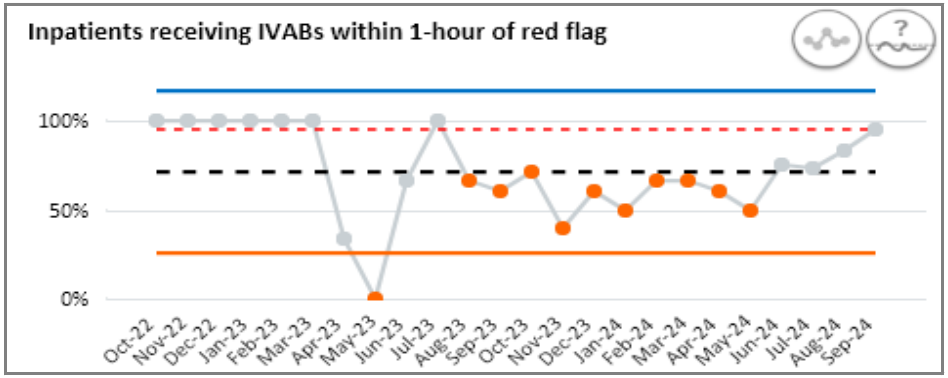
- *C difficile (C diff.)* infection (CDI) - there has been an increase in the number of CDI cases for the month of September 2024 compared to the previous month. Six cases within the Unplanned Care division whilst three, were within Planned Care. All of these cases were discussed in the weekly multidisciplinary team (MDT) meetings, where all found unavoidable incidents. The patients involved in these cases all received appropriate and timely treatment and care. The MDT continued to emphasise the learning identified at the weekly MDT meetings, such as, prompt isolation, timely testing and sending of samples, alongside appropriate review of antibiotics, including the use of proton pump inhibitors (PPI). Year to date (YTD), there are 49 cases against a threshold of 92, slightly above trajectory.
- MRSA BSI - there were zero MRSA BSI YTD.
- MSSA BSI - there were four MSSA BSI cases in September 2024. This is recognised as a significant increase as there were zero cases in the previous two months. The cases are being reviewed by the IPC team and any learning will be fed back to the relevant teams. YTD 11, one case above at this period in the previous financial year (0 threshold).
- *E.coli BSI* - there was one healthcare-associated infection in September 2024. This is a significant reduction in *E.coli BSIs* from the previous months of this financial year. YTD 23 (threshold of 55).

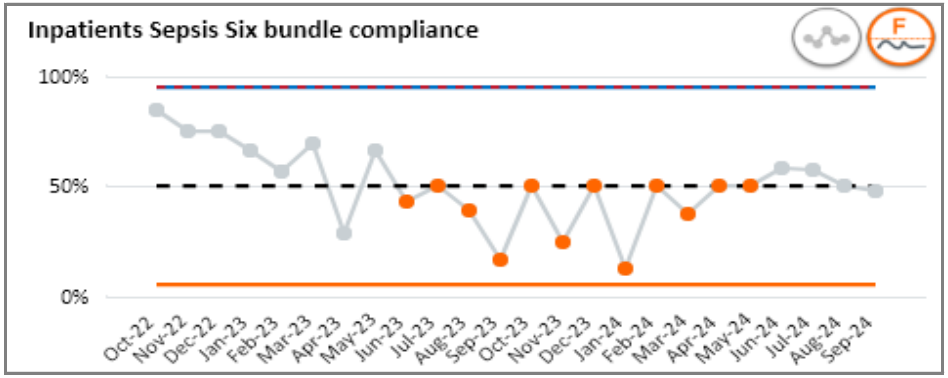
Month 06 | 2024-25

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust





Themes

Sepsis IP	2023-24						2024-25					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	83%	75%	78%	57%	100%	63%	78%	88%	75%	95%	65%	67%
IV antibiotics	71%	60%	60%	50%	75%	67%	60%	50%	75%	74%	83%	95%
IV fluids	56%	71%	83%	57%	100%	100%	67%	71%	67%	77%	83%	80%
Lactate	83%	57%	60%	25%	86%	63%	89%	100%	75%	89%	59%	81%
Urine measure	83%	71%	60%	50%	57%	75%	89%	88%	92%	74%	94%	76%

Key Issues and Executive Response

Themes

- Sepsis six bundle compliance sits at 48% which is a natural variation from August. There has been improvements in lactate collection from 59% to 81% and IVABX has improved to 95% compliance reaching Trust targets in September with 20 out of 21 patients receiving within the hour standard.
- Urine measurement has declined to 76% from 94% highlighting the need for continued hard work to drive compliance up.
- Compliance for oxygen administration remains at 100%.
- All other aspects of the sepsis six show normal variation.
- 5/11 IP fails occurred out of hours, highlighting the pressures of the on call teams, impacting prompt assessment and implementation of sepsis treatment.

Response

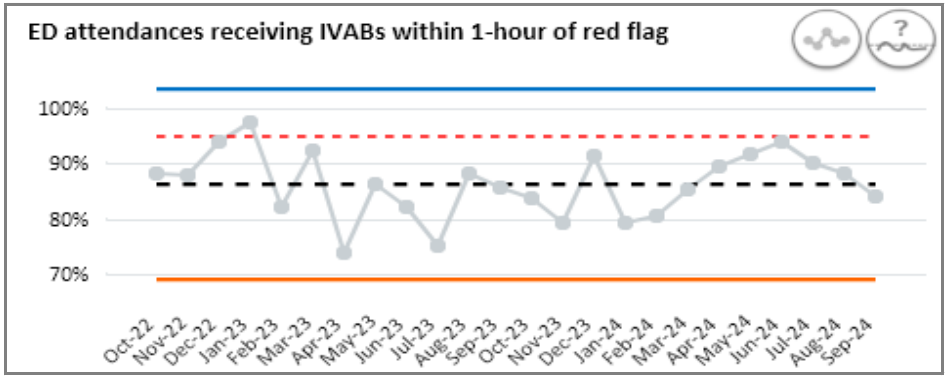
- A delay in antibiotic administration was found to be due to a failure to prescribe of antibiotics by the night medical staff which was then addressed at ward round. It has been reported as a safety incident and shared with the teams and anti-microbial pharmacist for local learning. There was no patient harm associated with this delay.
- Lactate information has been circulated including how to take and where the POC machines are located.
- World Sepsis Day - highlighted management with all clinical teams including adequate blood culture volumes, the use of the Sepsis Screening Tool and appropriate fluid balance measurement.
- Sepsis Grab boxes have started to be rolled out and as of the end of September are in place across the majority of inpatient areas. Roll out of these boxes will continue throughout the coming month.
- The Sepsis Team are starting Train the trainer bitesize sessions to link nurses with an emphasis on appropriate fluid balance and usage of the Screening Tool.

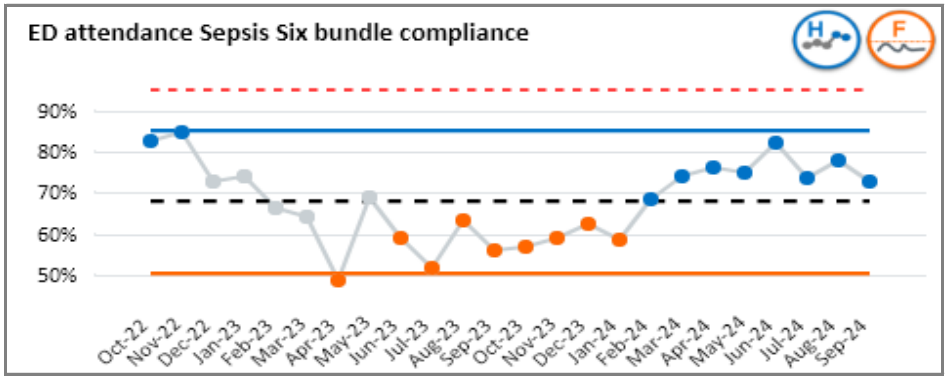
Month 06 | 2024-25

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust





Themes

Sepsis ED	2023-24						2024-25					
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Oxygen	98%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%
Blood cultures	87%	93%	91%	92%	100%	97%	97%	91%	100%	99%	93%	97%
IV antibiotics	84%	79%	91%	79%	80%	85%	89%	92%	94%	90%	88%	84%
IV fluids	88%	87%	92%	82%	85%	84%	91%	92%	94%	92%	90%	87%
Lactate	97%	93%	95%	98%	100%	98%	100%	100%	100%	100%	96%	98%
Urine measure	63%	64%	67%	66%	78%	86%	79%	83%	86%	74%	79%	81%

Key Issues and Executive Response

Themes

- 50% of the Sepsis Six has exceeded Trust targets within September. This includes oxygen, blood cultures and lactate collection.
- Urine output measurement has steadily increased throughout the quarter from 74% at the start up to 81% at the end of the quarter.
- IV fluid and antibiotic compliance shows natural variations with end of quarter compliance sitting at 89% and 87% respectively.
- Antibiotic delays were associated with delay in senior decision making perhaps due to diagnostic uncertainty on initial arrival to ED.
- ED has been consistent throughout Q2.

Response

- No serious harms were reported in September.
- The Sepsis Team continue to provide bedside education to staff, often attending patients in ED and going through the Sepsis Screening Tool in real time.
- ENHance reports are submitted to ED matrons for non-compliance to be reviewed and set a plan for continuous improvement.
- ED resus project to create a sepsis drawer is in progress.
- Mandatory e-learning is being updated to include a detailed video showing how to use the digital screening tool.
- World Sepsis Day: focused on sepsis recognition, management and awareness. Urine output measurement on NerveCentre and documentation were highlighted in particular for ED.
- The team has started collaborating with antimicrobial pharmacist to provide teaching to nursing staff regarding appropriate and timely antimicrobial use in septic patients.

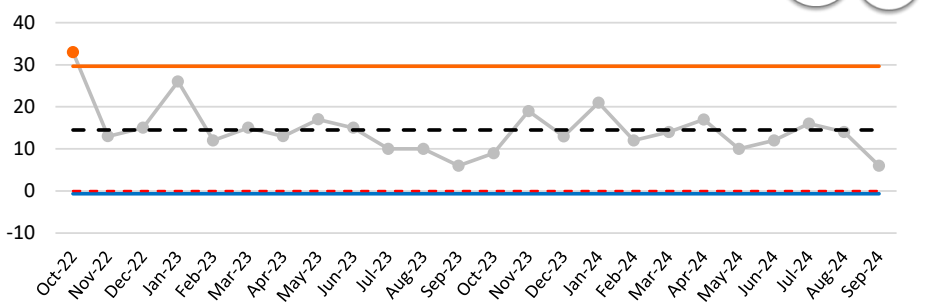
Month 06 | 2024-25

Quality

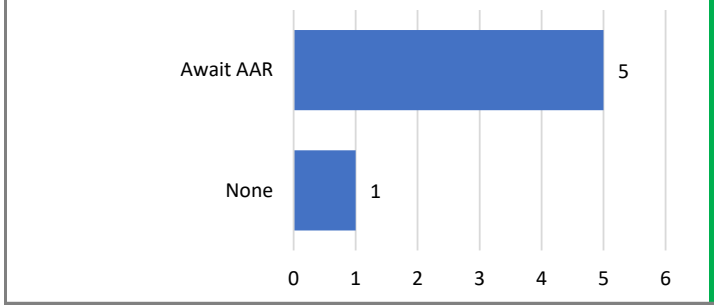
Pressure Ulcers | VTE

East and North Hertfordshire NHS Trust

Number of hospital-acquired pressure ulcers



Themes - Sep-24

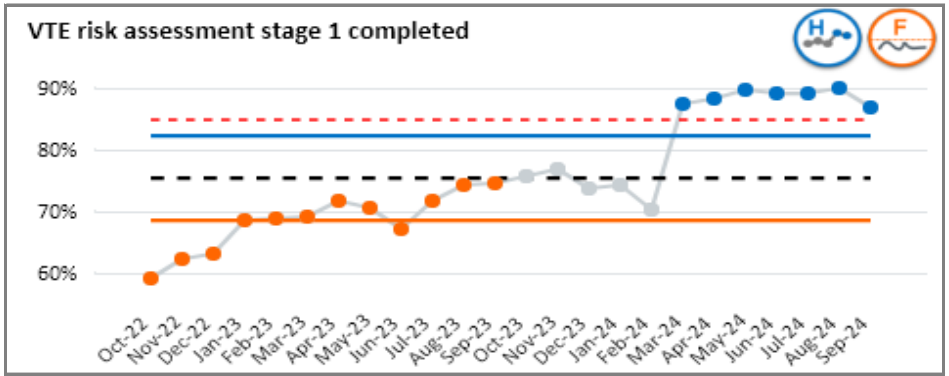


459

days since last category 4

as at 16/10/2024

VTE risk assessment stage 1 completed



Key Issues and Executive Response

Pressure Ulcers

- Annual Link Nurse Study day held on 1st of July had good turnout. Link Nurses have agreed to continue with PU Audits in line with CQUIN just ended National audit, aiming to increase our compliance to 85%.
- Heel PUs continue to lead the PU numbers. Some of the new Care Groups are focusing on reducing these, ensuring ward managers are ordering enough supply of Heel protection equipment.
- There are plans to convert to PURPOSE-T when the new digital system goes live next year. This will align our Trust with the ICS/ICB and NWCSP recommendations for PU prevention
- New categorisation as per NWCSP is now embedded in our Trust and service. Ongoing teaching and support is provided by the Tissue Viability team.
- As part of response to PSIRF the Tissue Viability service has amalgamated the Pressure Ulcer report among the Divisions to encourage Local and trust wide shared learning.
- TVT Actions FOR 2023/24: Risk assessment and pressure ulcer prevention care planning improvement project within CDU in ED; (Paused as requiring more support)

VTE

- Improved compliance since February with adjustments implemented to mimic VTE Exemplar Centres
- Continue sustained improvement in local QI projects with ongoing speciality involvement, AMU to join QI project shortly
- Reports are continuously being analysed to provide focused data-driven quality improvement projects in specific areas and teams.
- Quarterly VTE and Anticoagulation Newsletter distributed in August to feedback ward and specialist data.
- Ongoing pilot of digital 'welcome pack' in certain areas to improve patient awareness of VTE, VTE risk assessments and VTE prevention.

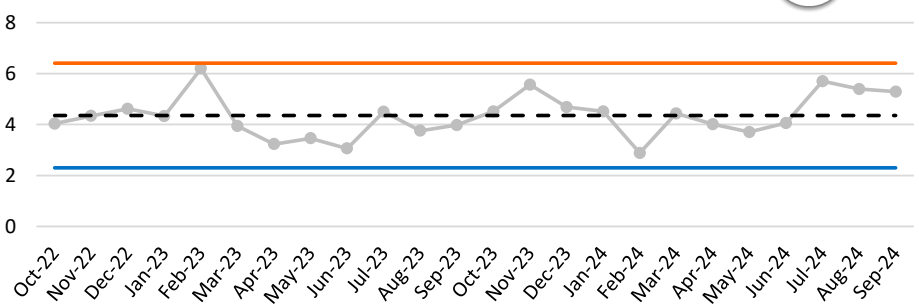
Month 06 | 2024-25

Quality

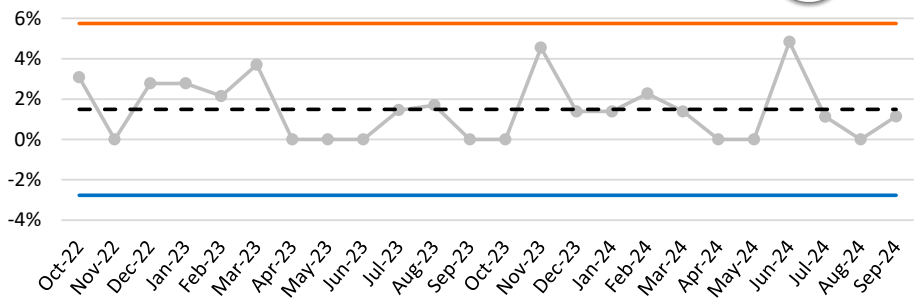
Patient Falls

East and North Hertfordshire NHS Trust

Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm



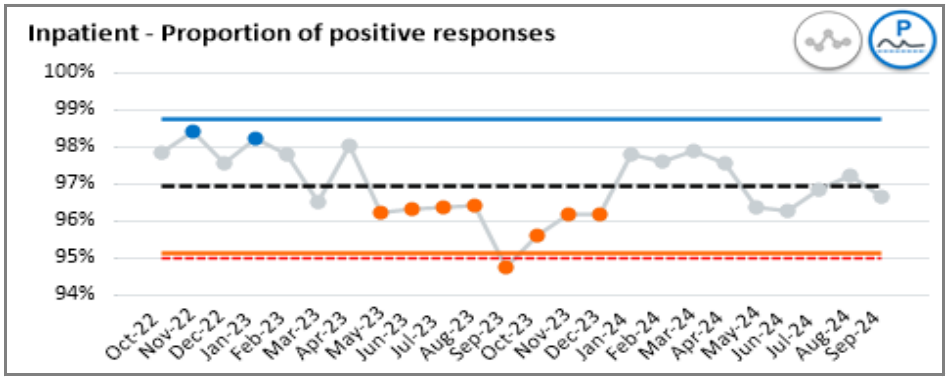
Key Issues and Executive Response

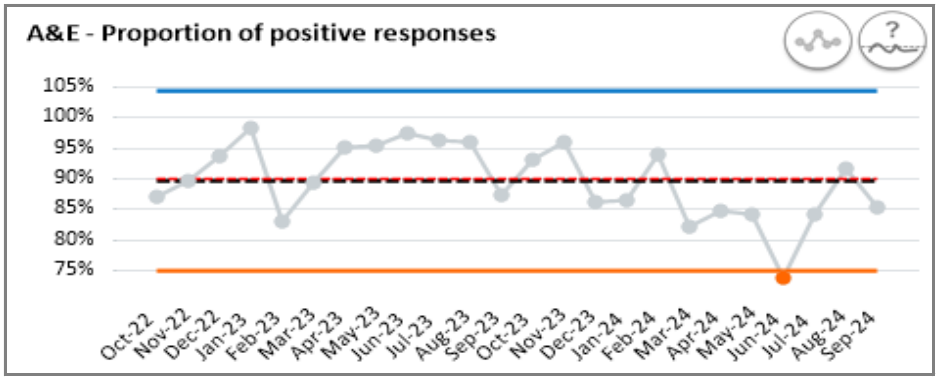
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- We have seen an increase of inpatient falls over the last 3 months. Areas of focus are 11A, 9A, 7B, 6B, ED, AMU1, & Barley where there's an increase of falls incidence over the last 3 months. Falls lead will present the data on ward manager's meeting to understand the challenges and how to best support the team. Working closely with the roster team to see if short term sickness which could lead to poor skill mix and short staffing might have contributed to this.
- Violence and Aggression incident increased month on month from July compared to the previous months (June). This is an increase of 36% in September compared to June data. Falls Lead to Liaise with the security manager to identify learnings and support for staffs and patients.
- 1 inpatient fall with serious harm recorded for the month of September. This is awaiting to be presented to Divisional Incident Safety Huddle (DISH) in unplanned care to identify shortfall of care/unpick learnings.

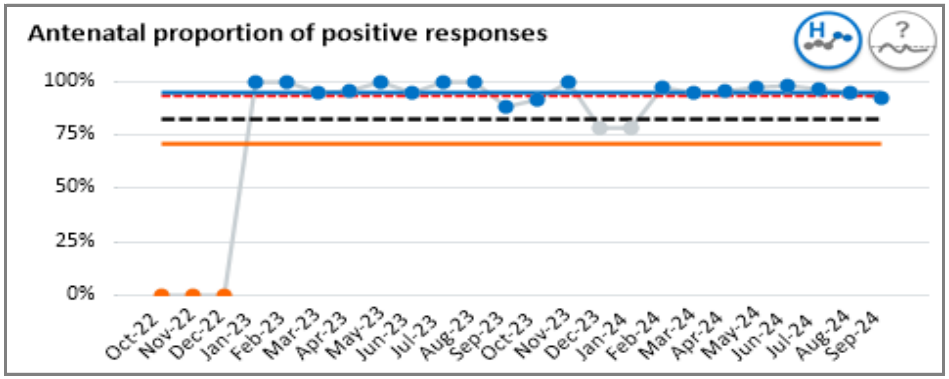
Quality

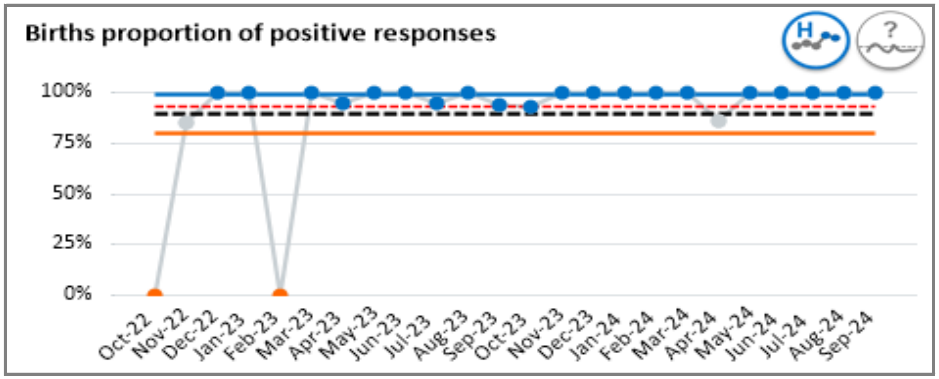
Friends and Family Test

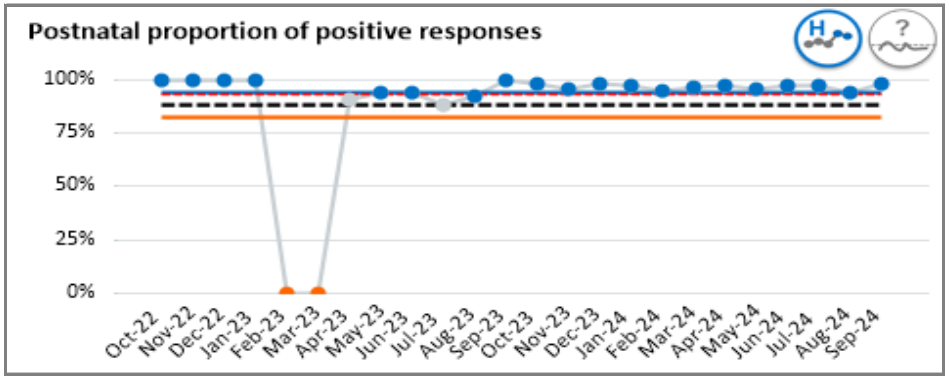
East and North Hertfordshire NHS Trust

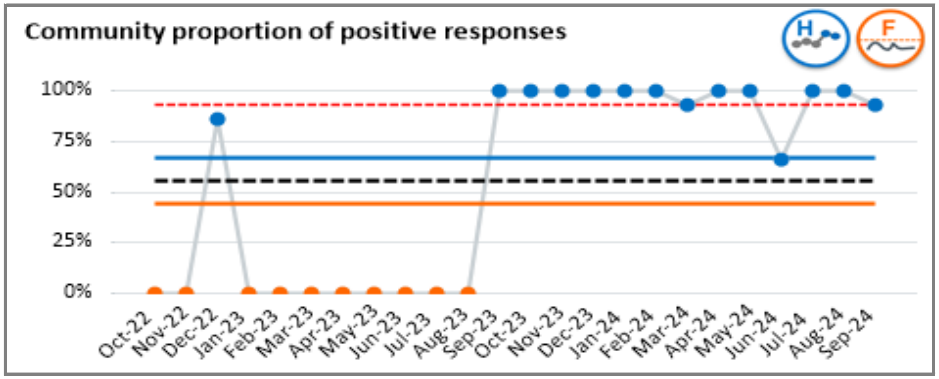










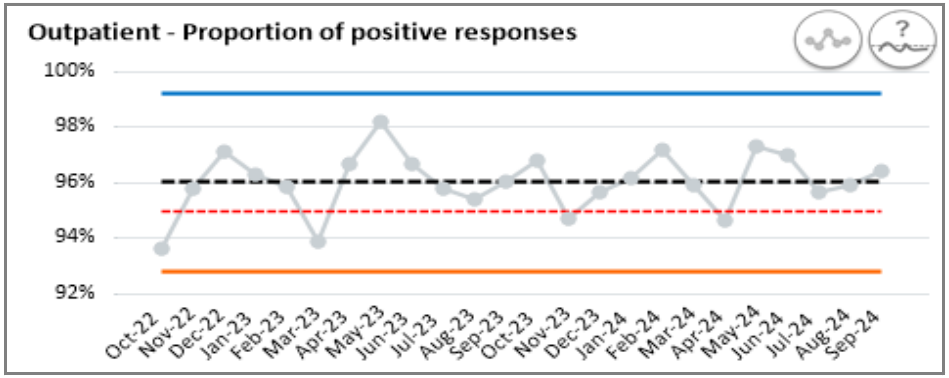


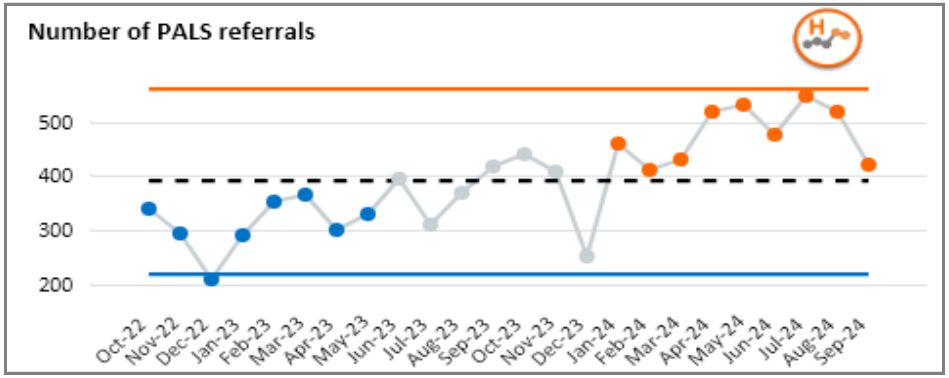
Month 06 | 2024-25

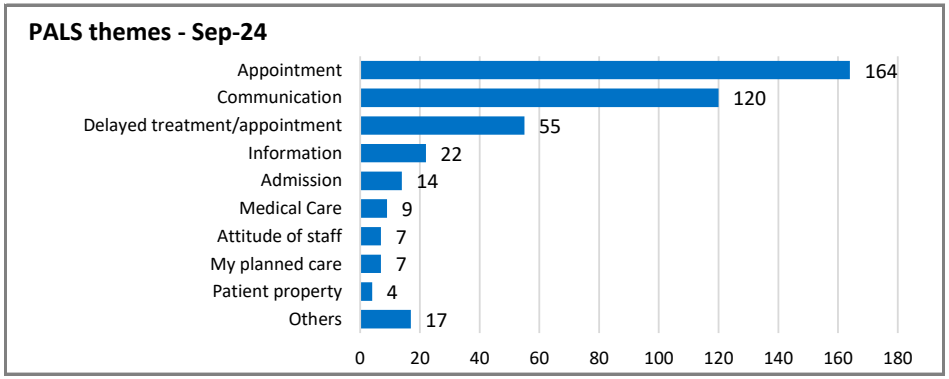
Quality

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

- Slight dip in ED and outpatient satisfaction and a slight reduction on the number of responses for September Trust wide compared to the previous 2 months. Themes within the comments remain consistent related to waiting times, lack of information regarding waiting times, lack of communication, and staff attitudes. These comments have all been highlighted to the senior divisional nursing teams. A full update of FFT themes and actions from the divisions will be brought to November PACE.

Patient Advice Liaison Service

- PALS continues to receive a high volume of emails and phone calls. Despite considerable efforts and a reduction in the turnaround time for enquiries to within a 6 week response timeframe, the team inbox is sitting around 160 emails due to the number of enquiries coming in each week.
- There has been a reduction in the amount of concerns raised, which we hope will have a positive effect to trying to close cases.
- All enquires are screened each day so those of priority receive a quicker response.
- Trauma and Orthopaedics, Radiology and ENT continue to be the services with the highest amount of concerns raised in September.

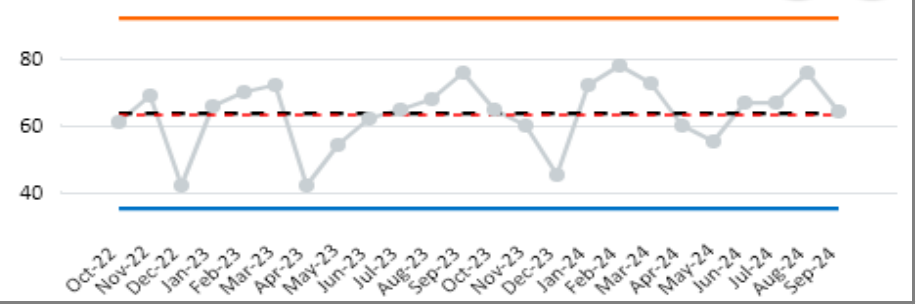
Month 06 | 2024-25

Quality

Complaints

East and North Hertfordshire NHS Trust

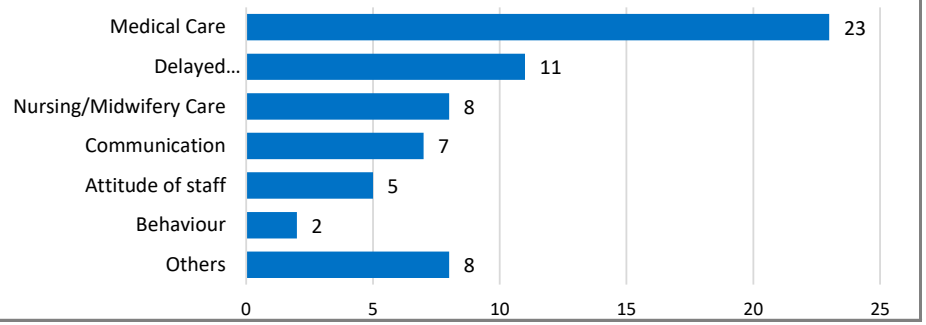
Number of written complaints received



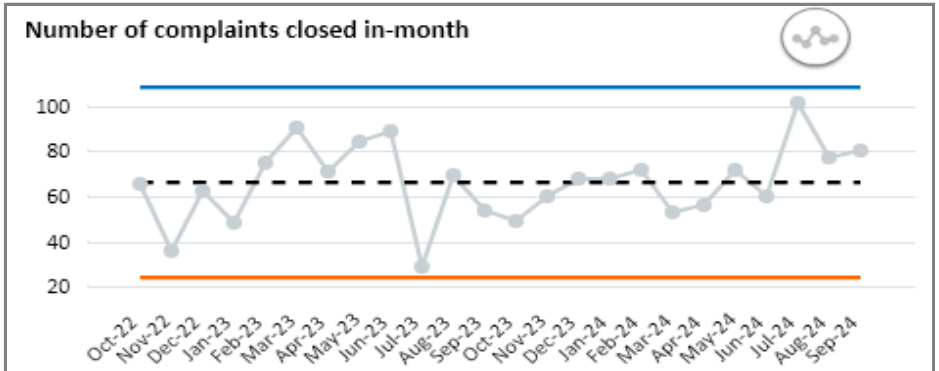
Key Issues and Executive Response

- At the time of writing, the Trust has 126 open complaints, with 20 complaints awaiting for scope confirmation.
- There has been a reduction in the amount of complaints received which has allowed the team additional time to draft complaint responses.
- Emergency medicine (11) followed by Acute Medicine (7) T&O (5) are the top 3 directorate's to receive complaints in September.
- Acknowledgement was 100% compliant within 3 working days.

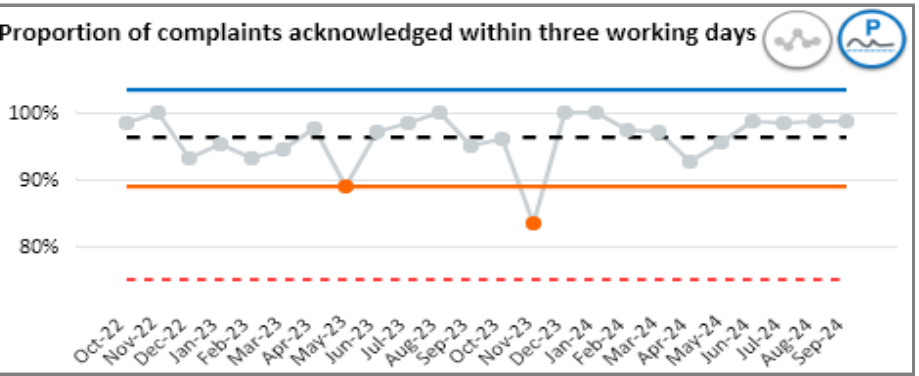
Complaints themes - Sep-24



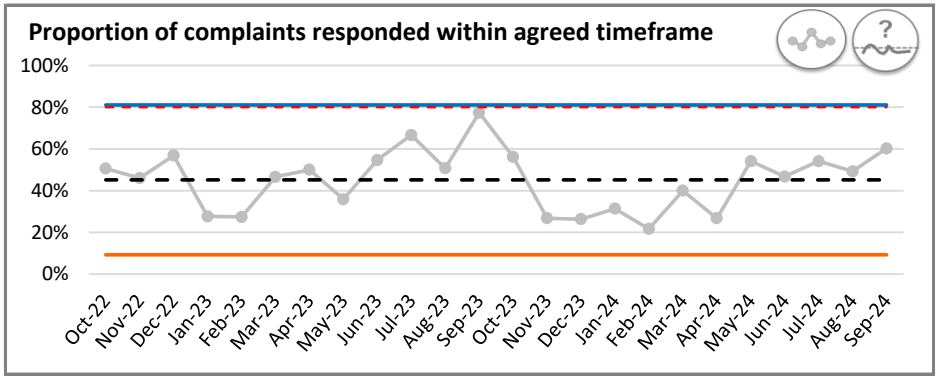
Number of complaints closed in-month



Proportion of complaints acknowledged within three working days



Proportion of complaints responded within agreed timeframe

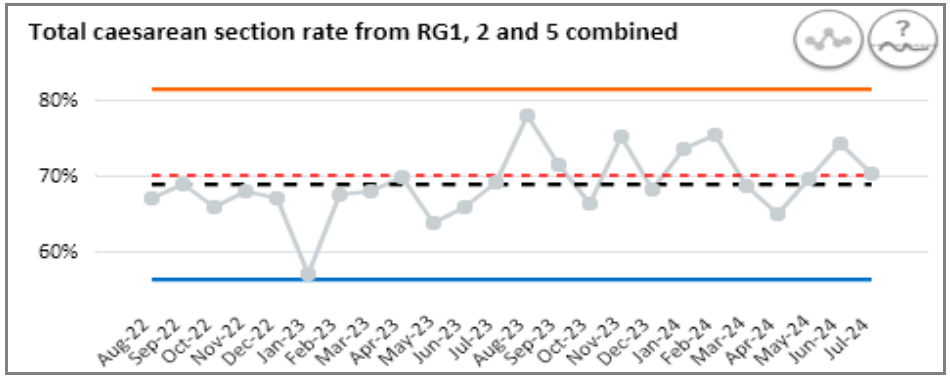


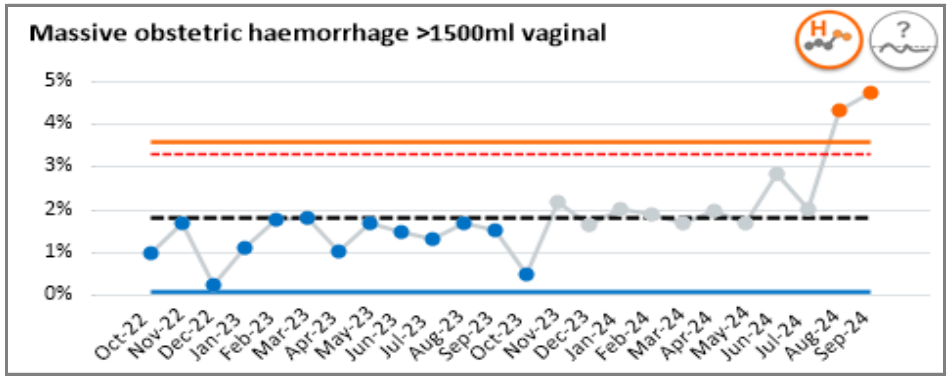
Month 06 | 2024-25

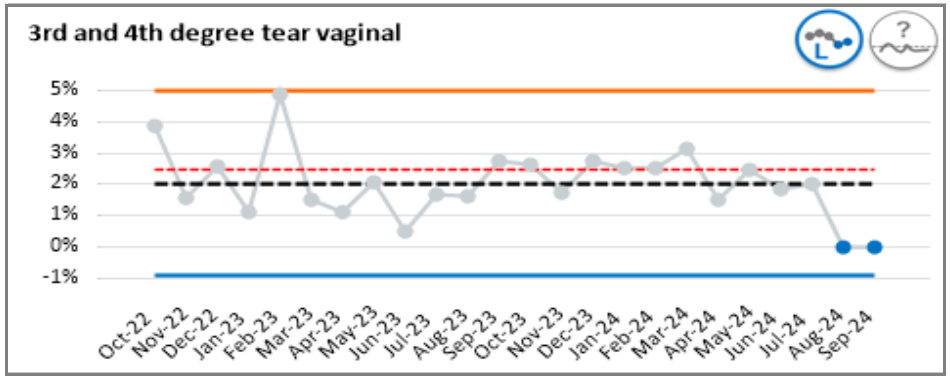
Quality

Maternity | Safety Metrics

East and North Hertfordshire NHS Trust







Key issues and executive response

- No PSII declared or cases meeting criteria for referral to MNSI during September 2024. Learning from Q4 & 1 presented at PSERP & Trust Women's Neonatal Safety and Quality Committee (TWNSQC).
- 3rd/4th degree tears at vaginal births rates remain low and below national expectation. Increased rate at instrumental deliveries in August 2024 (6 cases) seen as an anomaly and returned within normal parameters for September 2024. Obstetric risk lead review and audit continues to investigate themes. Working party to implement the OASI2 care bundle in line with national recommendation. Training package produced for launch Autumn 2024.
- Normal variation for MOH ≥ 1500mls at LSCS and no correlation seen with known increased caesarean section rates. Active use of carbetocin in conjunction with other uterotonics proving to have good effect on MOH rates, financial cost and LOS in obstetric theatres and recovery. Rate of MOH > 2000mls remains significantly low. Increased rates for MOH ≥ 1500mls at vaginal deliveries. 26 cases of MOH data entry omission since EPR launch, meaning actual rates may be lower. however, data reflects triangulation with ENHance incident reporting. Thematic review for themes and trends presented at RHD, with actions including proforma adaptations and early administration of tranexamic acid. Good care reporting reflective of implementation of changes.
- Breast Feeding initiation and discharge rates show normal variation consistent with previous months.
- ATAIN rates are well below goal limits (<6%). Weekly ATAIN reviews continue. No avoidable cases for either obstetric or neonatal care reasons in September 2024.
- Unable to provide Robson Group criteria reports due to incomplete K2 data entry by clinicians regarding denominators including onset of labour (n=151). Total caesarean section rates for September 2024:
- Total LSCS= 167 (43.6%)

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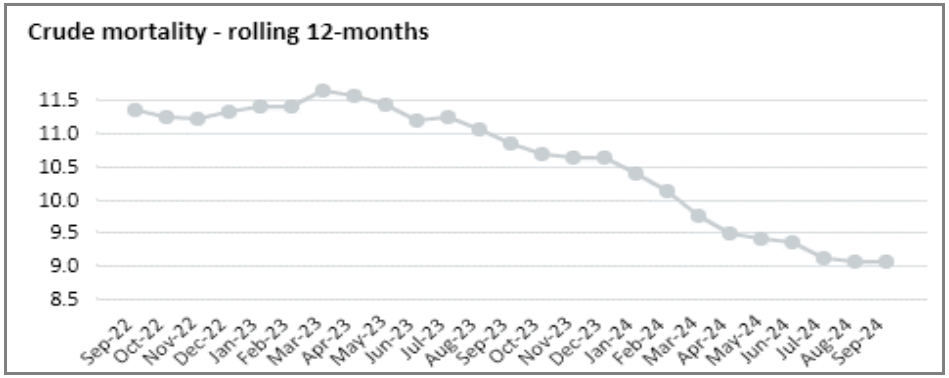
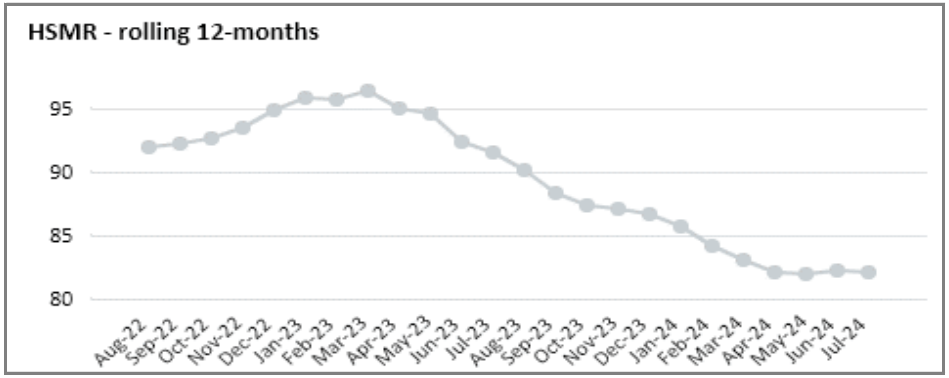
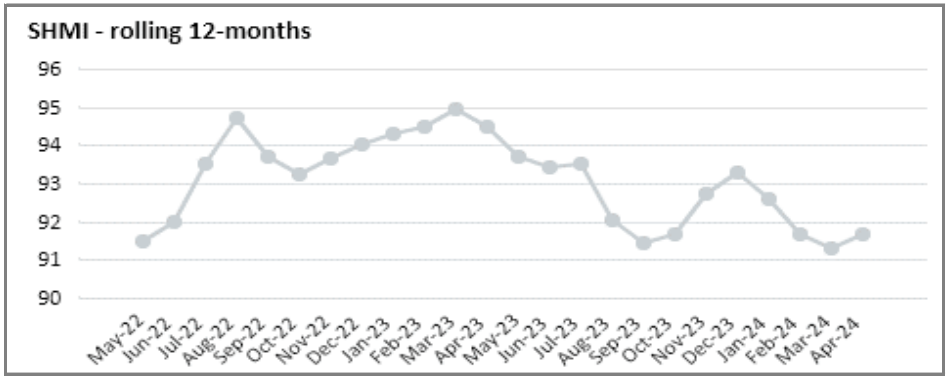
Quality

Mortality

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

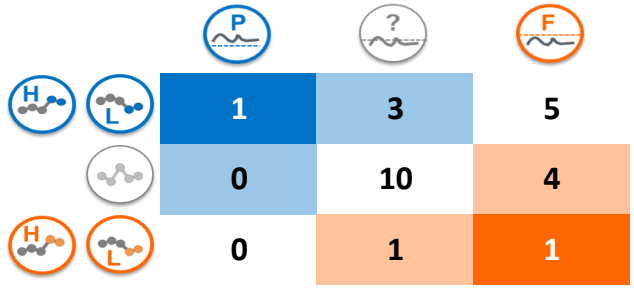
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception was during the COVID pandemic, when the usual correlation was weakened by the partial exclusion of COVID-19 patients from the HSMR metric. This partial exclusion continues.
- The general improvements in mortality (excluding the COVID-19 period) have resulted from corporate level initiatives such as the learning from deaths process and focussed clinical improvement work. Of particular importance has been the continued drive to maintain a high standard of clinical coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average.
- Following a six month gradual upward trend in rolling 12-month HSMR, it has now been on a downward trend since March 2023.
- The latest rolling 12-month HSMR to Jul-24, reported by CHKS, stands at 82.0. While this positions us in the first quartile of trusts nationally, it should also be noted that national peer currently stands well below 100 at 90.6. CHKS has confirmed that a rebase of their HSMR is due imminently.
- There are currently no 3SD outlier diagnosis groups.
- Latest NHSD published rolling 12-month SHMI available to May 2024, shows a slight increase from 91.65 to 92.71. This positions us in the first quartile of trusts nationally and well below the national average.
- Following the Dec-23 in-month spike of 103.1, the latest in-month figure provided by CHKS for Apr-24 stands at 93.6, below the national average.
- For the period to Apr-24, CHKS reported 6 3SD outlier alerts.

Month 06 | 2024-25

East and North Hertfordshire NHS Trust

Operations

Month 06 | 2024-25



Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Sep-24	95%	73.5%			2 points above the upper process limit Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Sep-24	2%	5.0%			4 points below the lower process limit Metric will consistently fail the target
	Percentage of ambulance handovers within 15-minutes	Sep-24	65%	17.8%			9 points above the mean Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Sep-24	80%	57.8%			2 points close to upper process limit Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Sep-24	240	178.0			2 points below the lower process limit Metric will inconsistently pass and fail the target
	Average (mean) time in department - admitted patients	Sep-24	tbc	456.0			2 points below the lower process limit No target
	Average minutes from clinically ready to proceed to departure	Sep-24	tbc	205			15 points below the mean No target
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Sep-24	92%	54.2%			7 points above the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Sep-24	0%	59.1%			1 point above the upper process limit Metric will consistently fail the target

Month 06 | 2024-25

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	62-day referral to treatment standard	Aug-24	85%	87.5%		?	Common cause variation Metric will inconsistently pass and fail the target
	31-day decision to treat to treatment standard	Aug-24	96%	97.5%	H	?	13 points above the mean Metric will inconsistently pass and fail the target
	28-day Faster Diagnosis standard	Aug-24	75%	77.0%	H	?	11 points above the mean Metric will inconsistently pass and fail the target
	Proportion of cancer PTL waiting more than 62 days	Aug-24	7%	16.6%		F	Common cause variation Metric will consistently fail the target
	Number of cancer PTL waiting more than 104 days	Aug-24	16	116		F	Common cause variation Metric will inconsistently pass and fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Aug-24	0	9		?	Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for suspected cancer	Aug-24	93%	85.2%	L	?	1 point below the lower process limit Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Aug-24	93%	90.5%		?	Common cause variation Metric will inconsistently pass and fail the target

Month 06 | 2024-25

Urgent and Emergency Care

Summary

East and North Hertfordshire NHS Trust

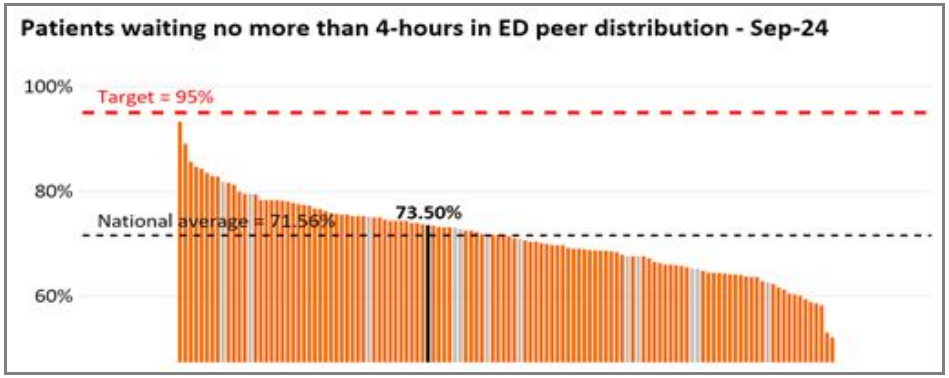
Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q2 2024-25	A	B			
	4-hours direct to Stroke unit from ED	Sep-24	63%	34.0%		F	Common cause variation Metric will consistently fail the target
	% of patients discharged with a diagnosis of Atrial Fibrillation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

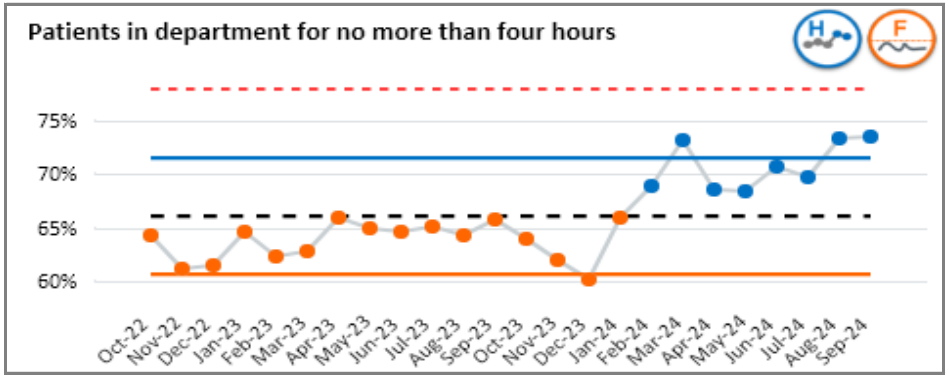
Month 06 | 2024-25

Operations

Urgent and Emergency Care

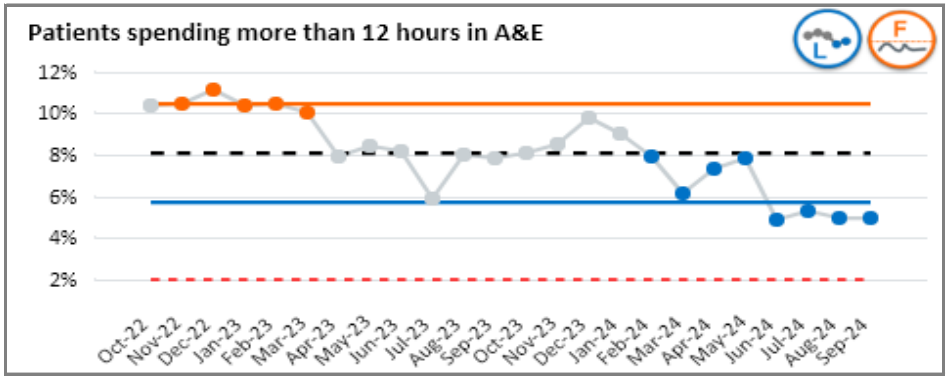
East and North Hertfordshire NHS Trust

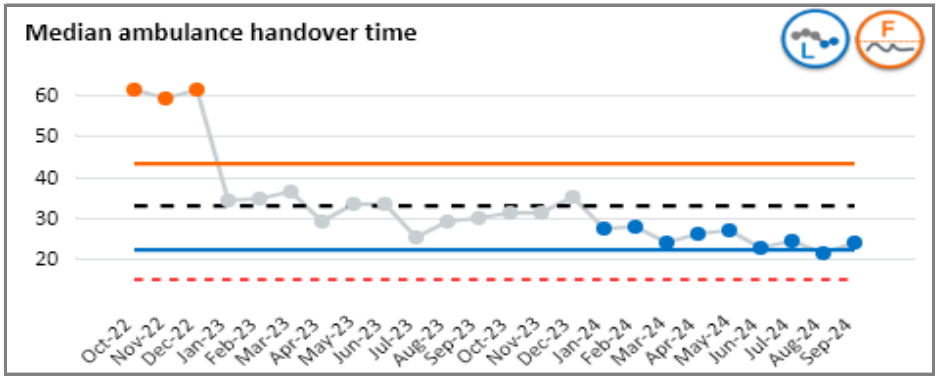




Key Issues and Executive Response

- 4HR performance improved in September to 73.5%, ahead of the Trust's internal trajectory of 73%. September performance was supported by MADE week with system partners; performance for MADE week reached 79.95%. Most MADE actions remain in place internally; and some key system partner actions also remain in place.
- Acuity continues to track upwards vs H1 last year - 3.4% up - appears to be a sustained shift.
- Non elective IP spells have shifted up by 17% vs H1 last year and LOS for these patients has shifted down approx. 20%.
- Ambulance arrivals have shifted up vs H1 last year
- Ongoing work focused on boosting Medical SDEC activity through extended working hours and specialty pathway redesign.
- Continuous improvements have been achieved across all KPIs in the Emergency Department (ED), including Triage, Wait Time Between Stages (WTBS), the transition from ED Doctor to specialty referral, specialty to DTA, and the overall duration of stay in the ED for both admitted and non-admitted patients.



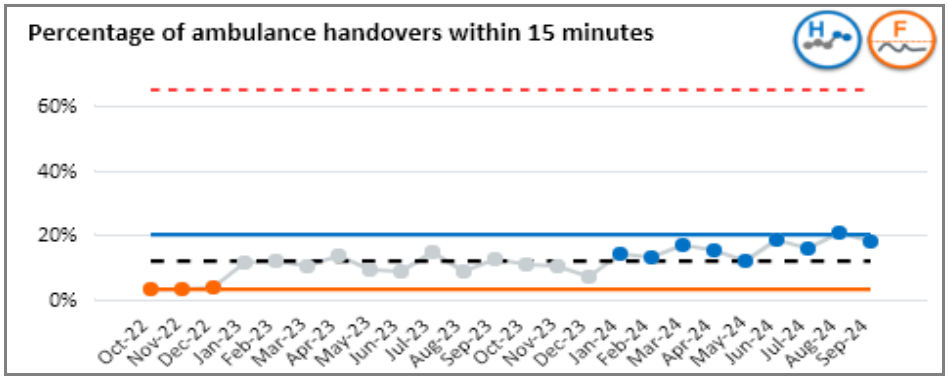


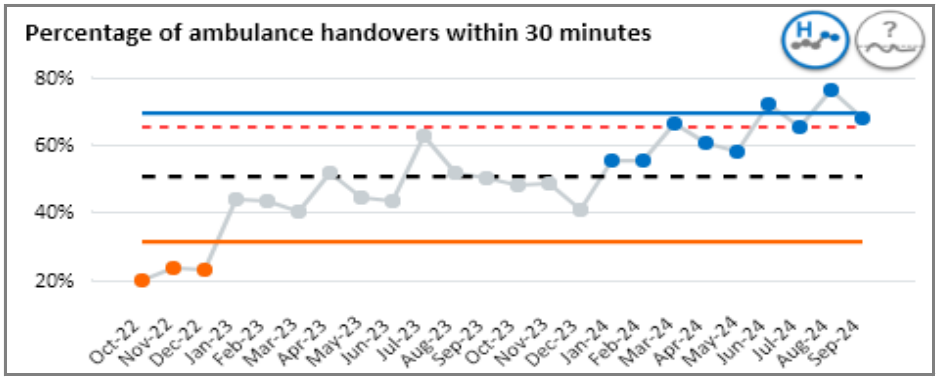
Month 06 | 2024-25

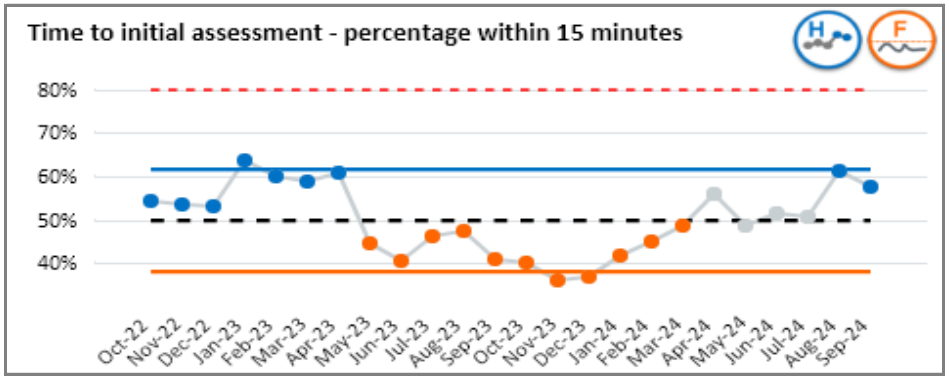
Operations

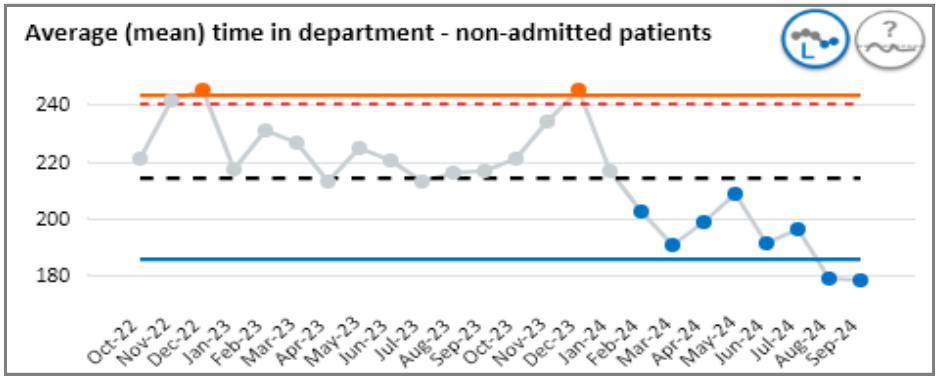
Urgent and Emergency Care New Standards

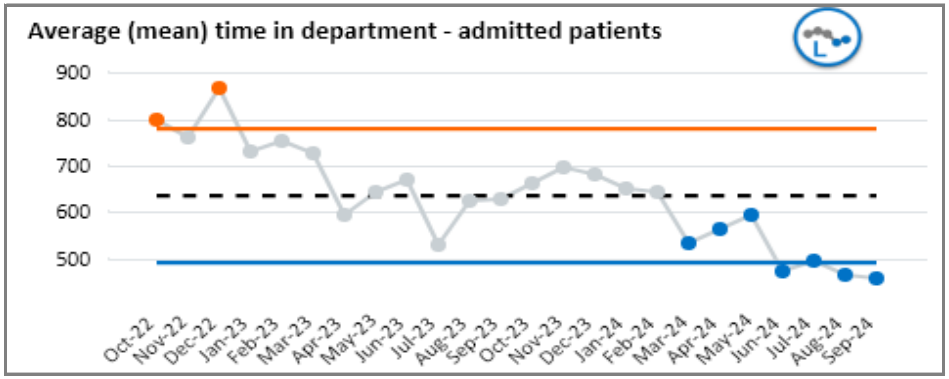
East and North Hertfordshire NHS Trust

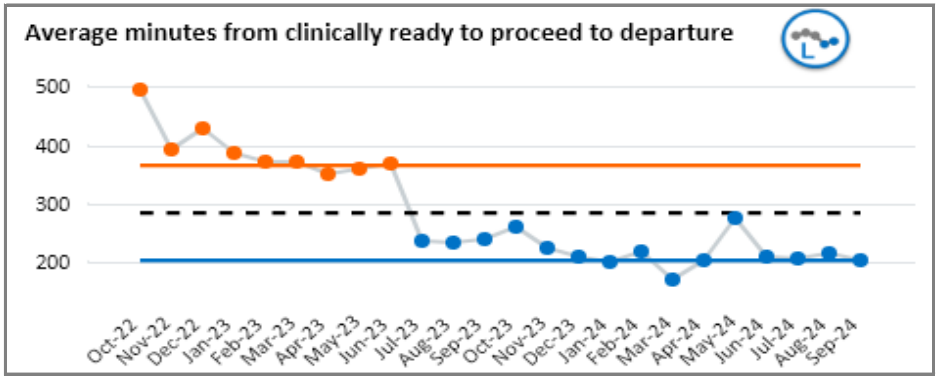










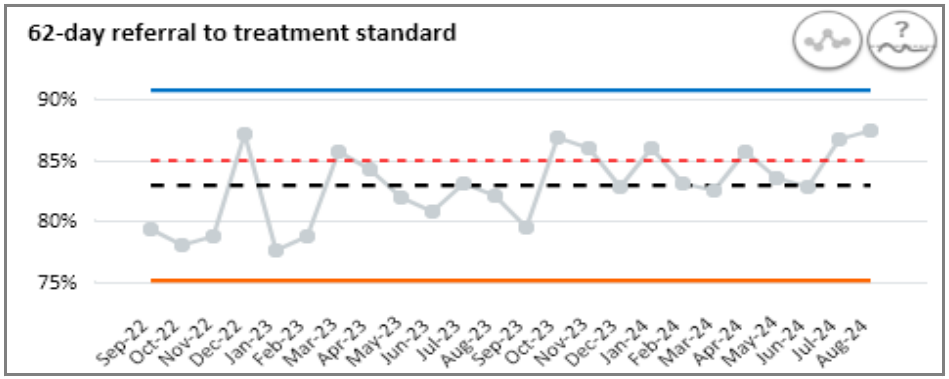


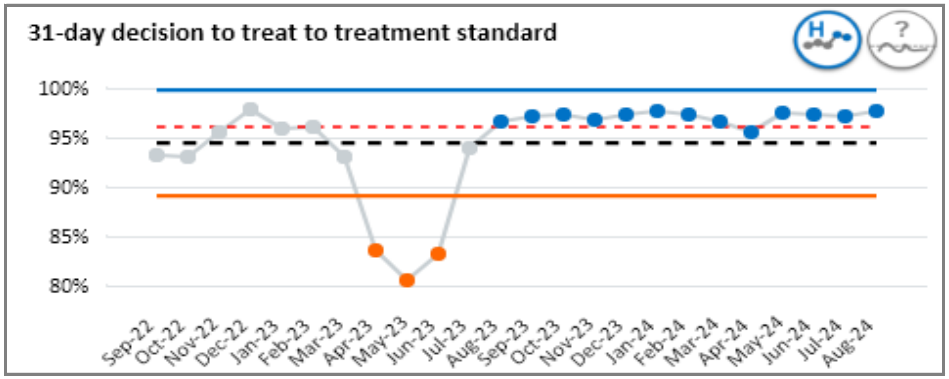
Month 06 | 2024-25

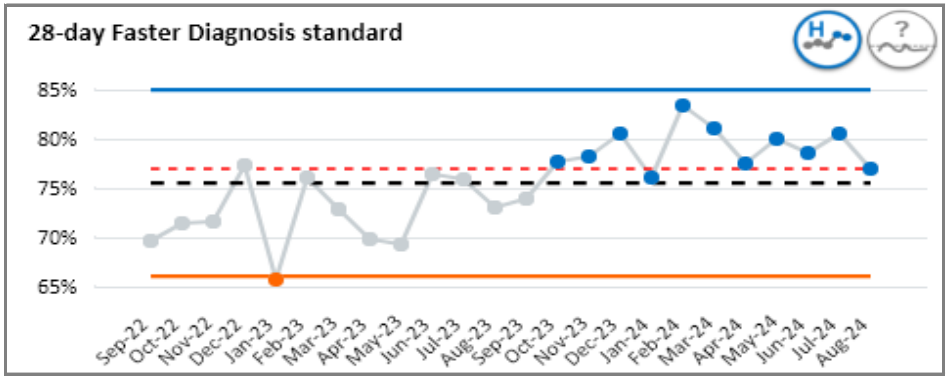
Operations

Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- We achieved all 3 of the national targets in August 24 with compliance in the 28 General Faster Diagnosis Standard (FDS), 31-Day General treatment standard, and compliance in the 62-Day general treatment standard - one of few trusts to achieve this nationally.
- Work continues with the operational teams to sustain and improve CWT performance for the Trust with more focus on the Lower GI colonoscopy capacity (partly mitigated with WLI and use of private sector colonoscopy), MRI capacity (mitigated with mobile MRI at Lister), breast radiology delays (partly mitigated with WLI and locum radiologist) and radiology reporting (partly mitigated with WLI and prioritising cancer patients).
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning.
- The Trust has reported on the new CWT standards but still monitors the previous 9 standards.

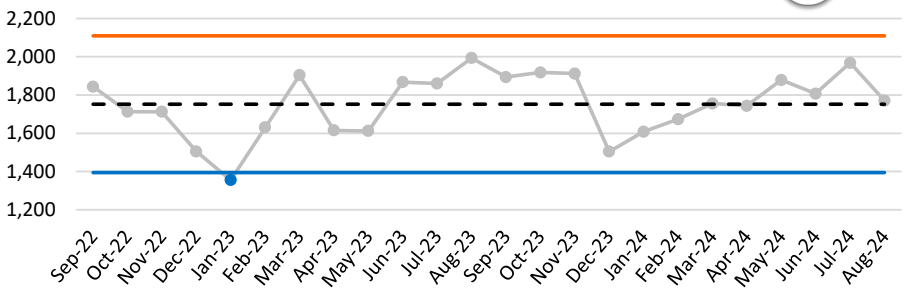
Month 06 | 2024-25

Operations

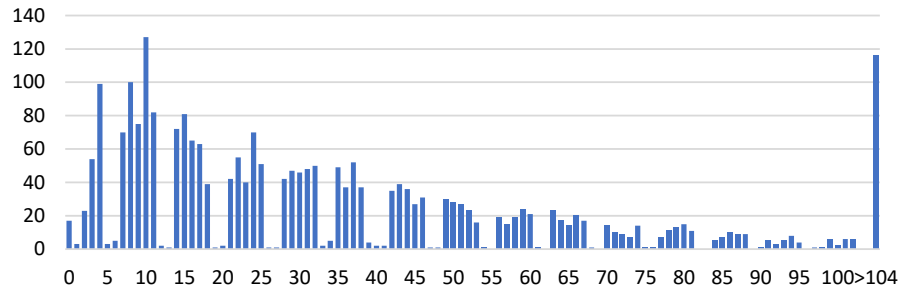
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

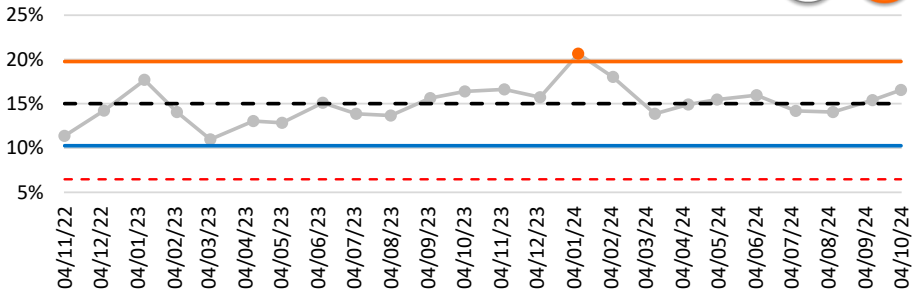
Suspected cancer referrals



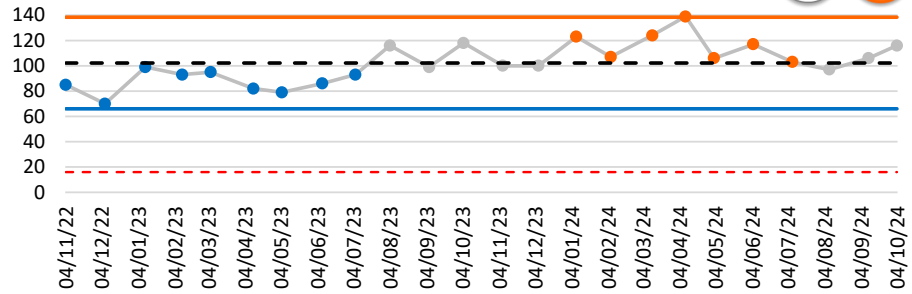
62-day PTL as at 04/10/2024



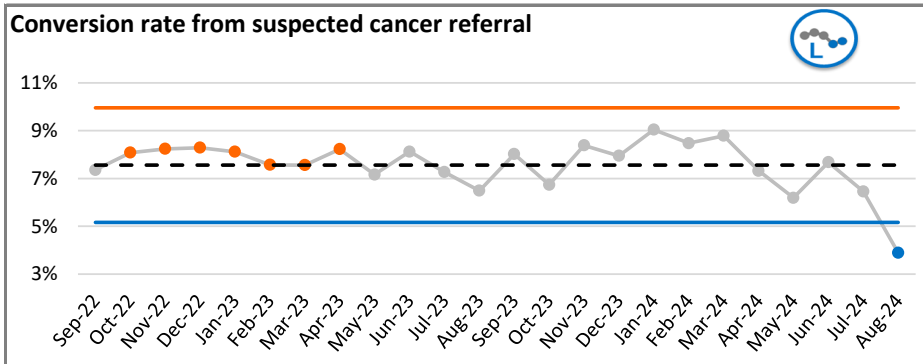
Proportion of cancer PTL waiting more than 62 days



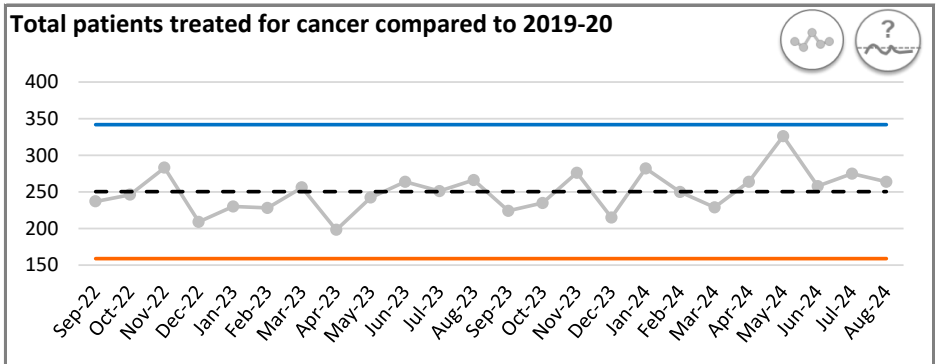
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



Total patients treated for cancer compared to 2019-20

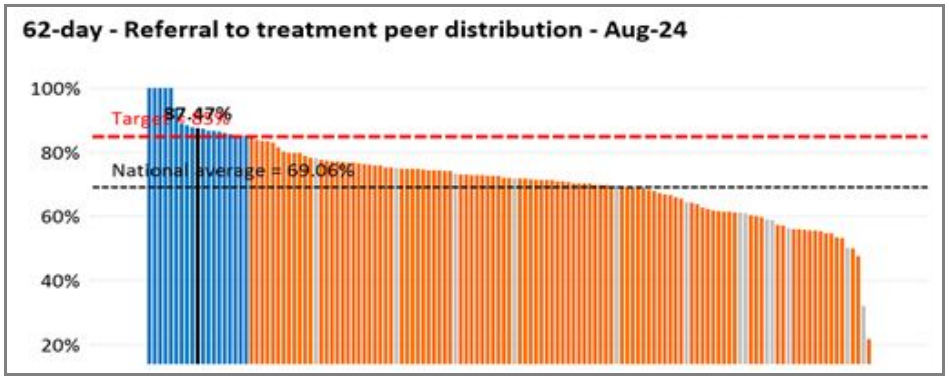


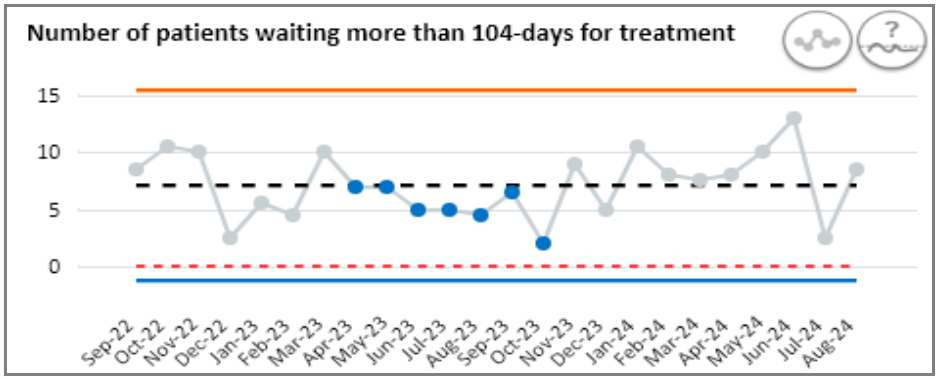
Month 06 | 2024-25

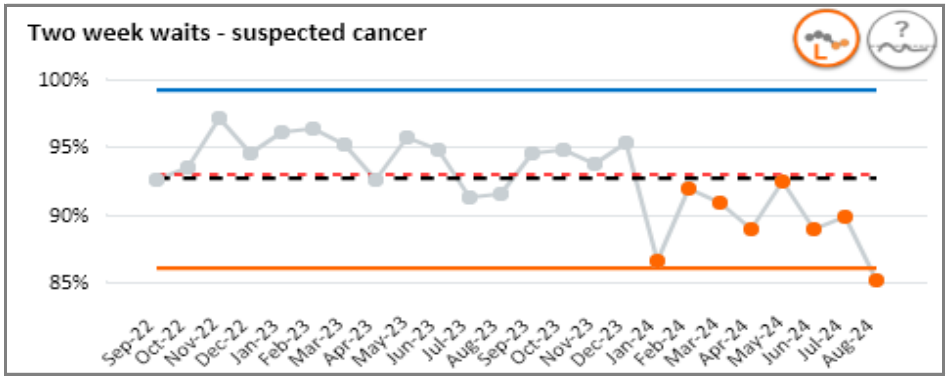
Operations

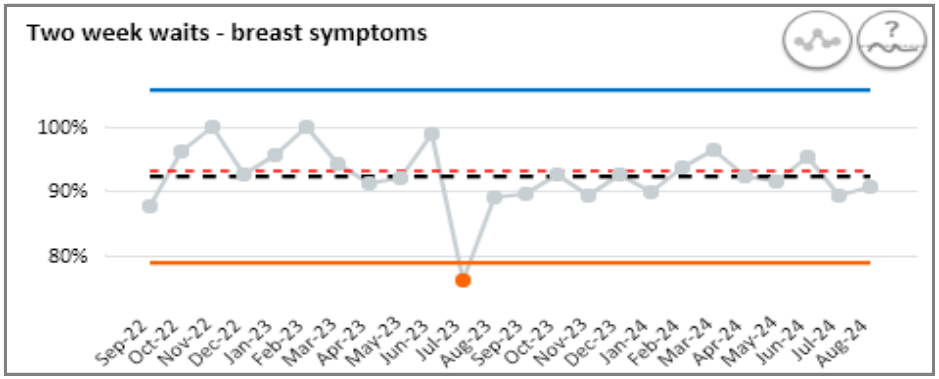
Cancer Waiting Times | Supporting Metrics

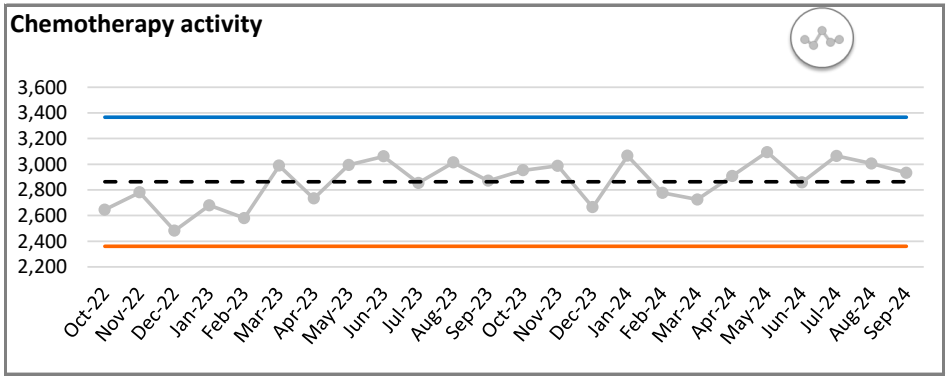
East and North Hertfordshire NHS Trust

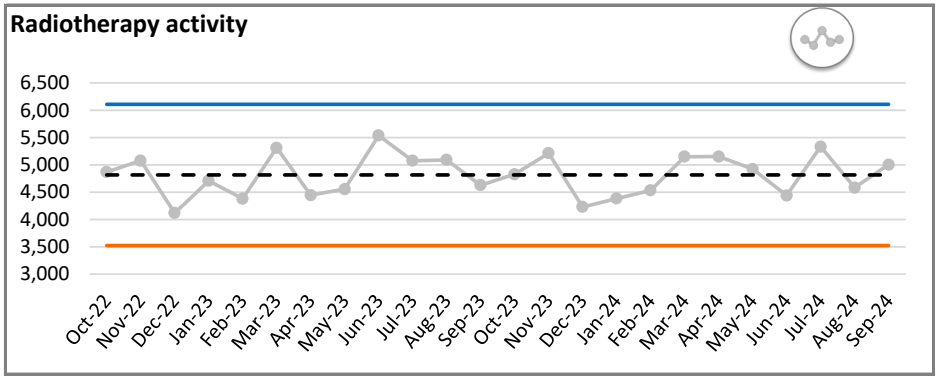










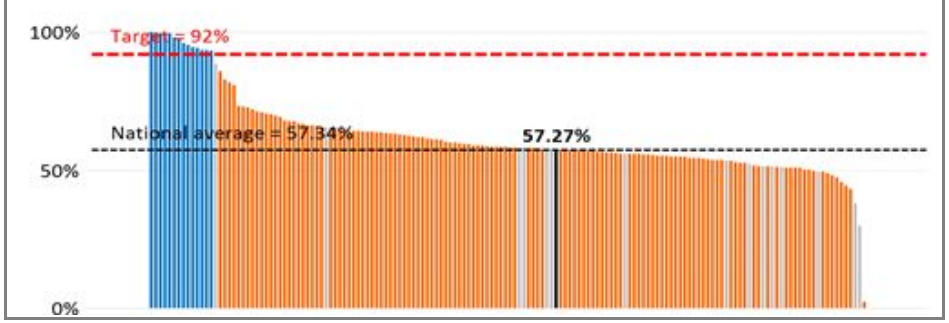


Month 06 | 2024-25

Operations

RTT 18 Weeks

East and North Hertfordshire NHS Trust



Key Issues and Executive Response

Community Paediatrics

- Community Paediatrics is now reported via the Community Data Set.
- The waiting list continues to increase, driven by referrals for neuro diversity which is reflected in the increase in over 18 week wait.
- Transformation work is ongoing to change pathways both internal to E&N Herts and as part of HWE system transformation work.
- This includes a standardised system-wide referral form and a single point of administrative triage. Improved reporting through developing a Community Services reporting and coding dashboard.
- **104 Weeks** - There were 988 Community Paediatric patients waiting over 104 weeks at the end of September.
- **78 Weeks** - There were 2,288 patients waiting over 78 weeks at the end of September, compared to 2,116 the previous month, an increase of 189 patients.
- **65 Weeks** - There were 2,989 patients waiting over 65 weeks.

Key Issues and Executive Response

Excluding Community Paediatrics

- The Trust reported a performance of 58.3% of patients treated within 18 weeks in September, which is above last month's national average.
- **65 Weeks** - The Trust delivered against our forecast of 70 patients waiting more than 65 weeks at the end of September 2024. This was 2.2% of East of England's 3,200 breaches, with only one third (23) due to capacity issues.
- End of October forecast of 40 patients waiting over 65 weeks with the main risks in T&O, Gastro, and Pain capacity. Focused management at patient level to mitigate is in place. No breaches beyond November are anticipated.
- Most trust services are already 52 week compliant.
- Revised demand and capacity modelling is being finalised to ensure optimum opportunity to deliver 52 weeks across all services by end March 2025.
- Daily outpatient drumbeats have been set up to support the utilisation of capacity for 52 week delivery, with a focus on non-admitted pathways for T&O and Gastro.
- A weekly 6-4-2 meeting has been set up to identify potential additional Outpatient clinic room capacity to maximise utilisation.

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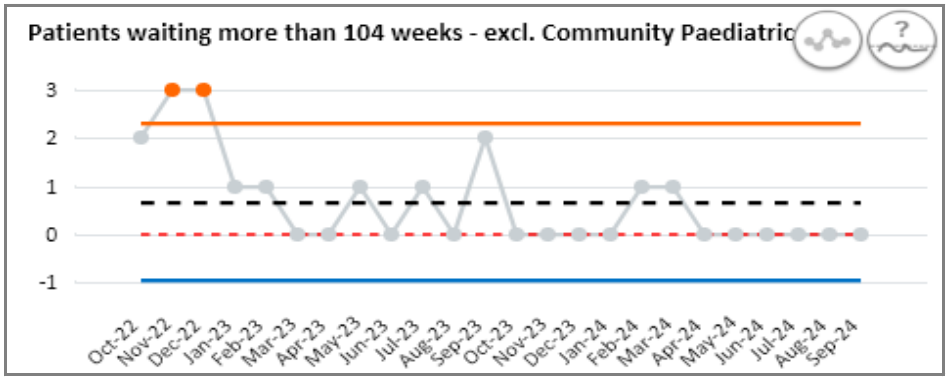
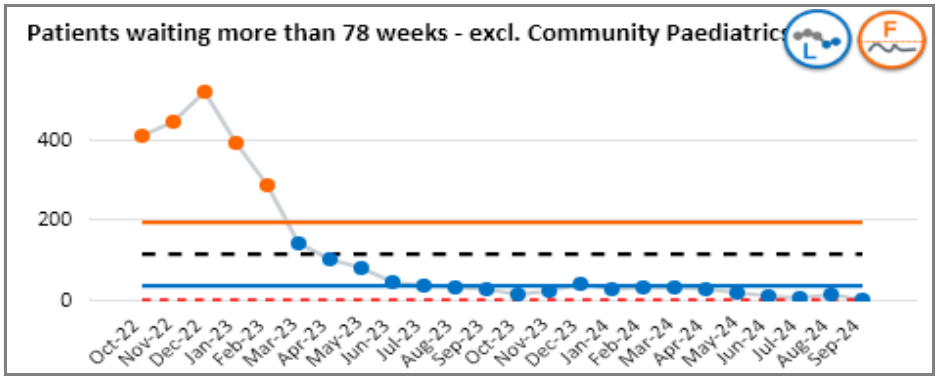
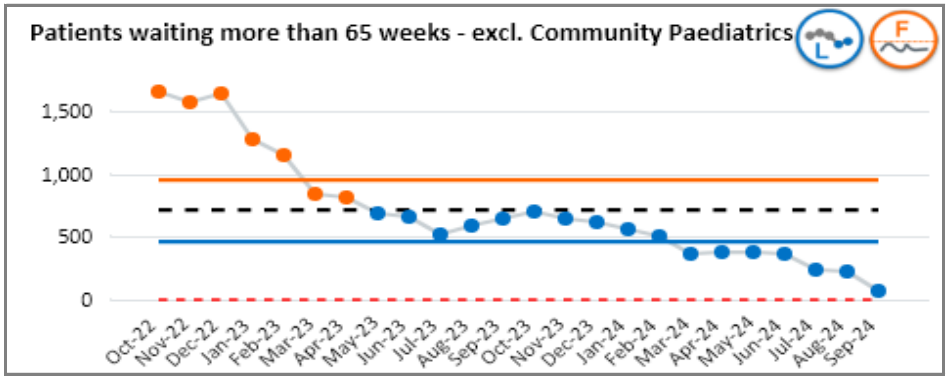
Operations

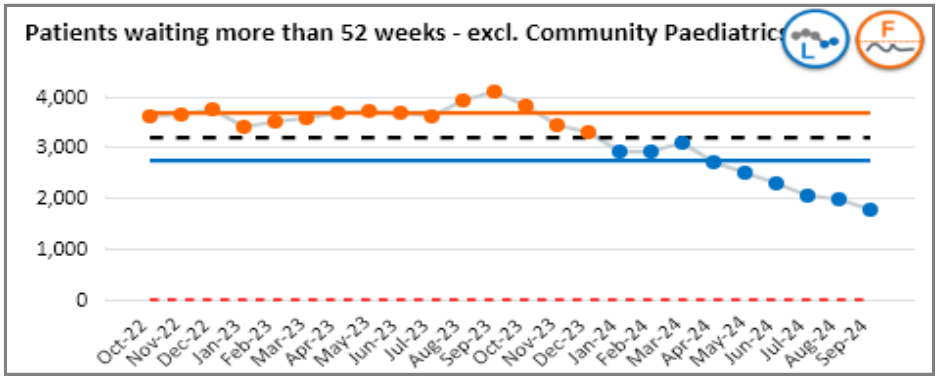
RTT 18 Weeks

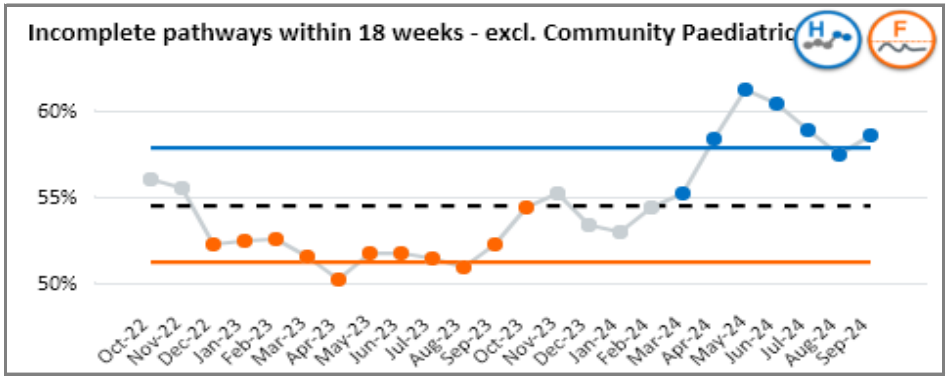
East and North Hertfordshire NHS Trust

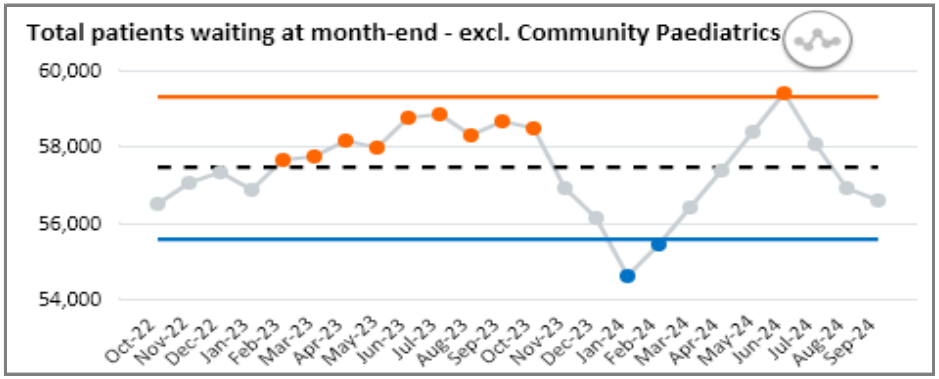












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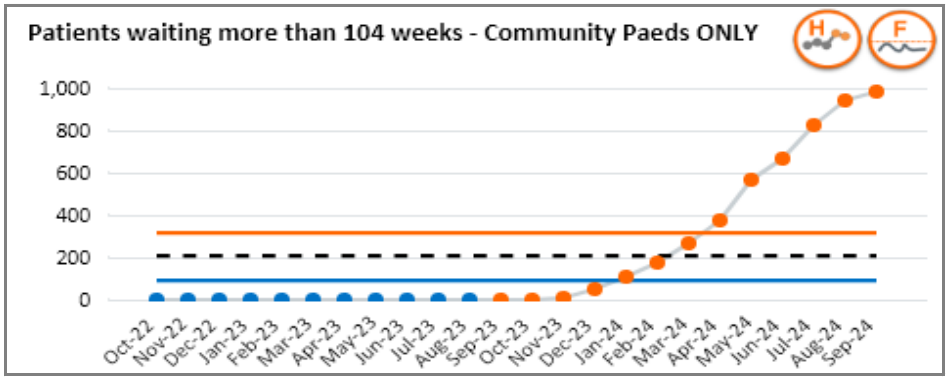
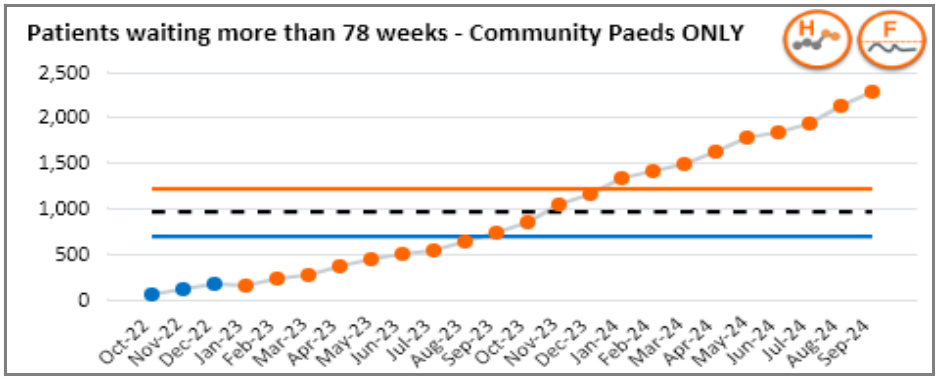
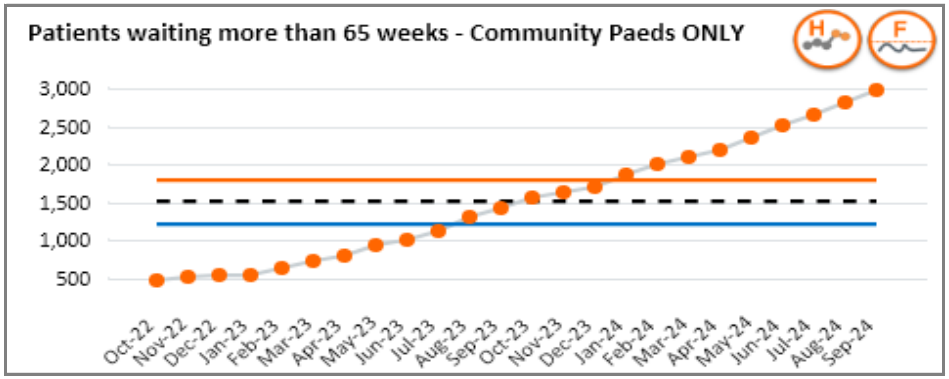
Operations

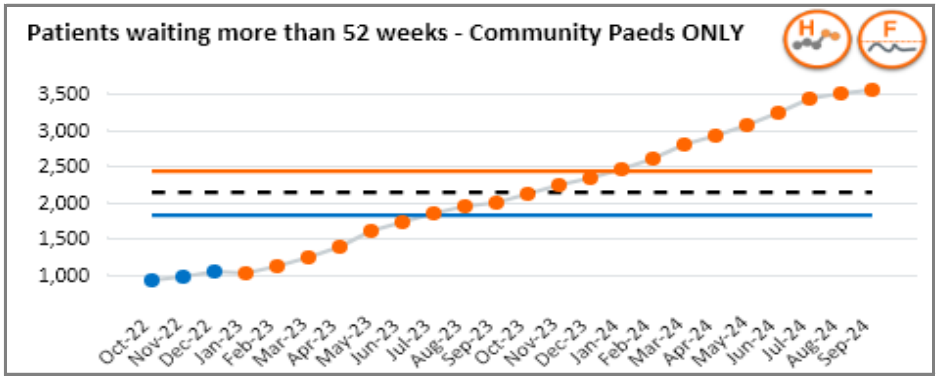
RTT 18 Weeks

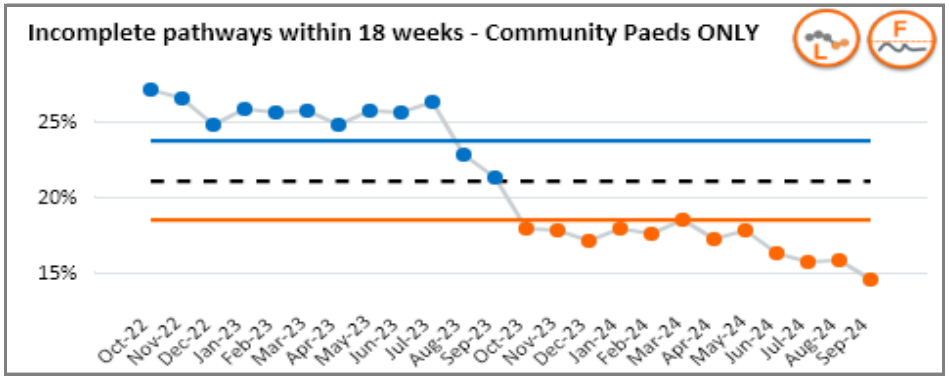
East and North Hertfordshire NHS Trust

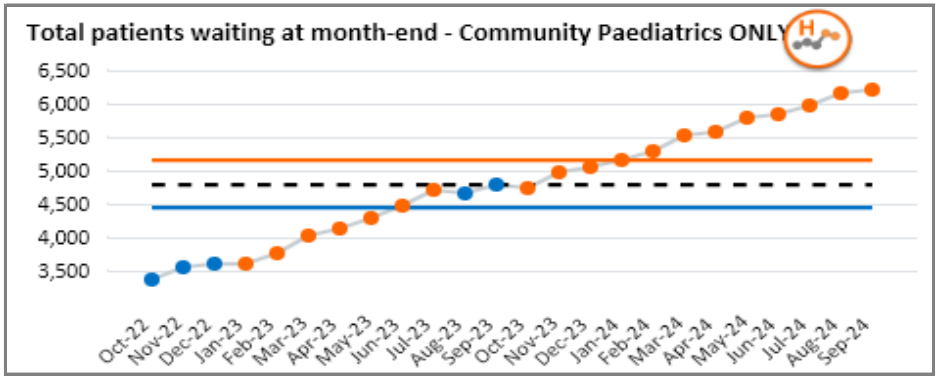












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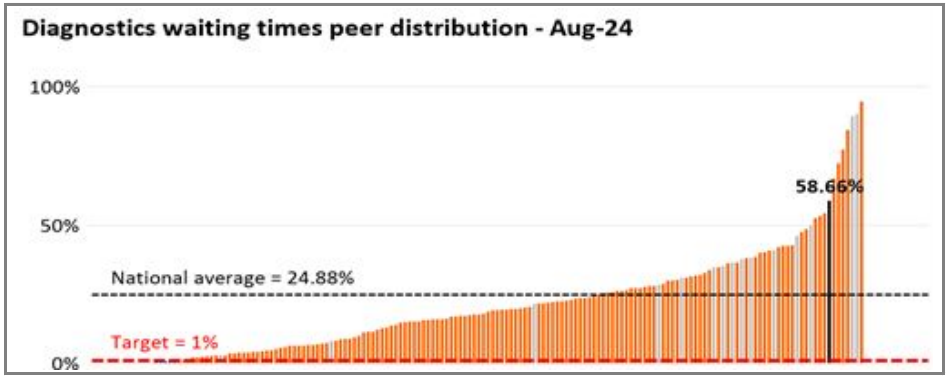
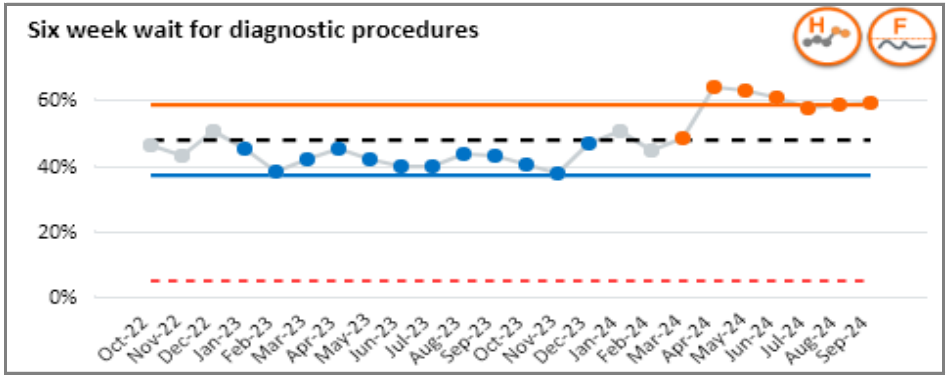
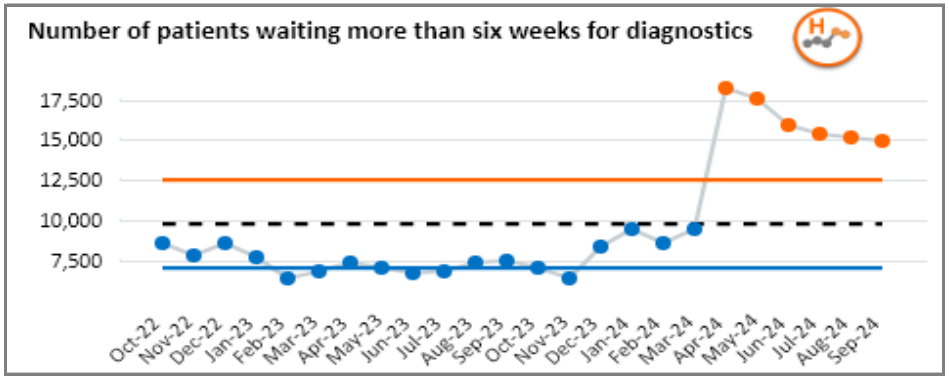
Operations

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- September DM01 performance inclusive of audiology deteriorated slightly from 58.7% to 59.07%
- Excluding audiology, the overall DM01 trajectory is on track to deliver performance by March 2025.
- The overall volume on the DM01 waiting list (excluding Audiology) continued to reduce considerably in September and the overall number of patients waiting >6 weeks and > 13 weeks continued to reduce.

Challenges / Actions

- There is a MRI capacity gap in house to meet service demand and DM01 compliance by March 2025. T&O long waiters being outsourced to Pinehill. Cancer demand has increased and is being addressed through additional MRI van days for August, September and October on the Lister site.
- Refreshed capacity and demand modelling for MRI underway to determine impact of outsourcing and substantive capacity required post backlog clearance.
- Audiology PTL validation is currently underway and is likely to reduce PTL volume; Audiology capacity and demand modelling is underway with development of clear recovery trajectories, using outsourcing where possible. Paeds audiology remains highly challenged, with very little mutual aid possible. Exec involvement with recovery plan and system / regional approaches.
- Increase of referrals for sleep studies has caused capacity gap; plan to arrange additional WLI capacity, D&C model has been completed with compliance in March 25.
- Specialist US MSK, Head & Neck and cardiology CT scans remain a challenge for capacity. Active recruitment underway to address gap in capacity.
- Work with partners to promote GP uptake of community diagnostic capacity.

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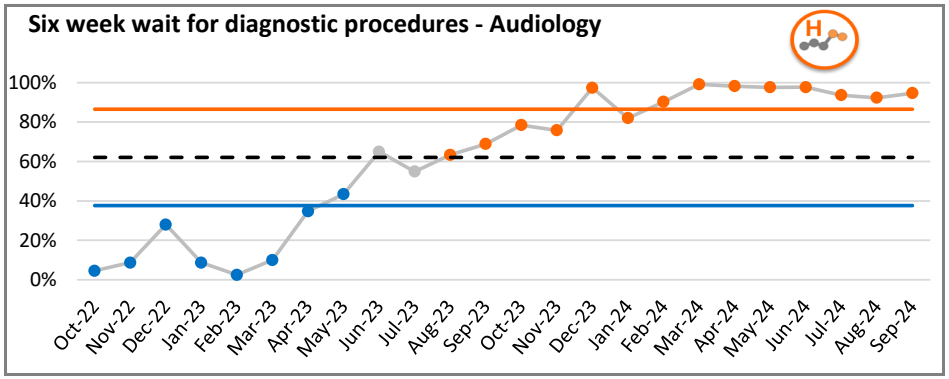
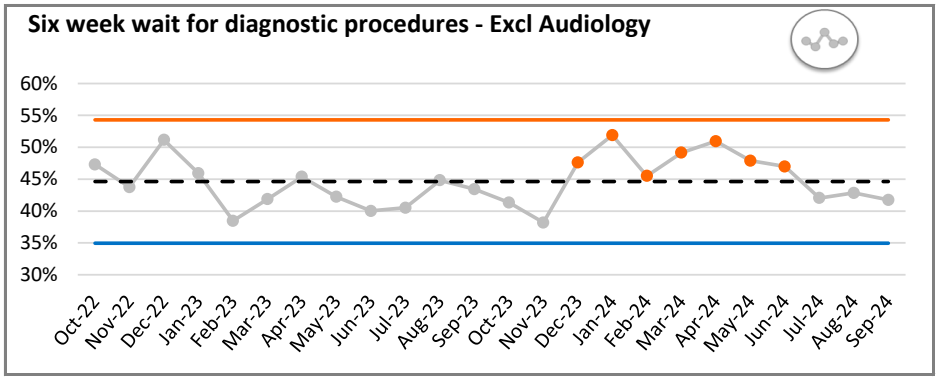
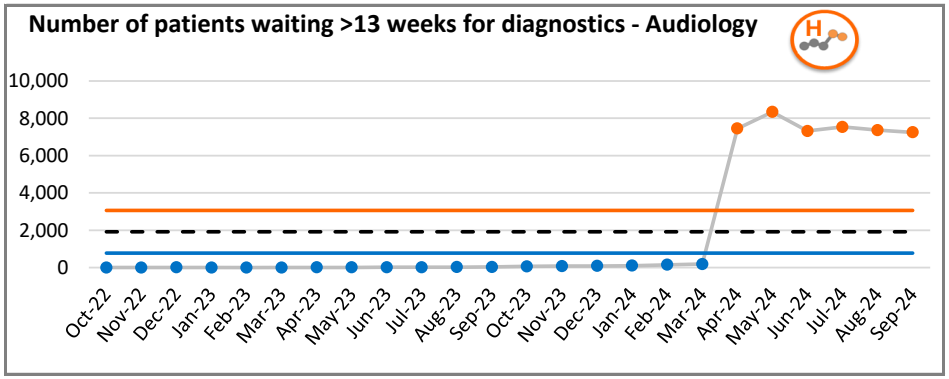
Operations

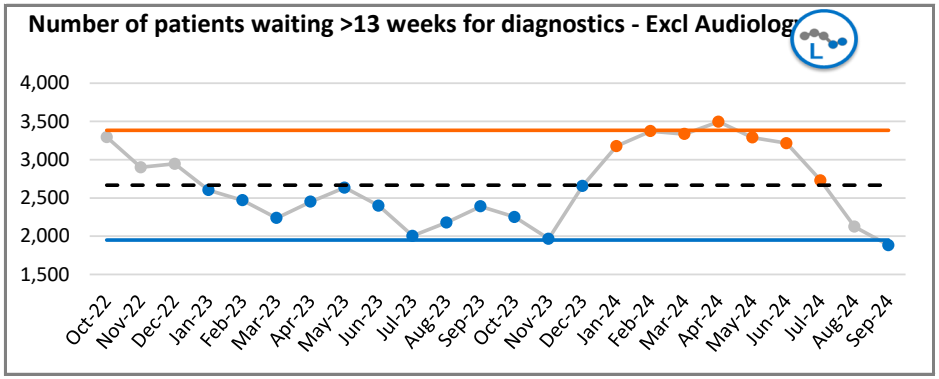
Diagnostics Waiting Times - Audiology

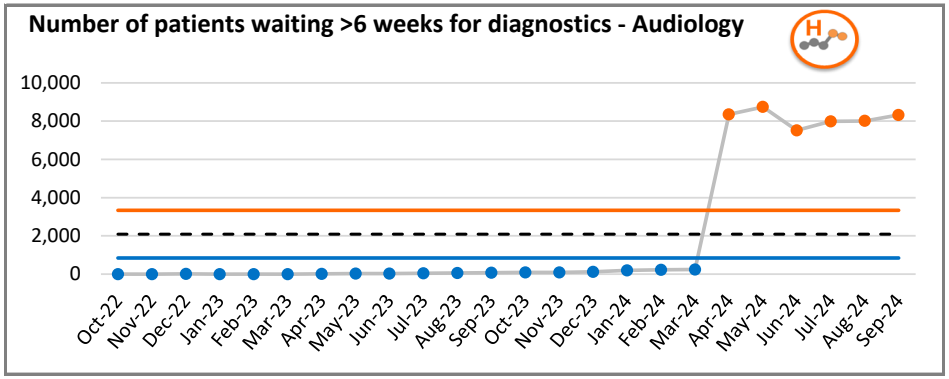
East and North Hertfordshire NHS Trust

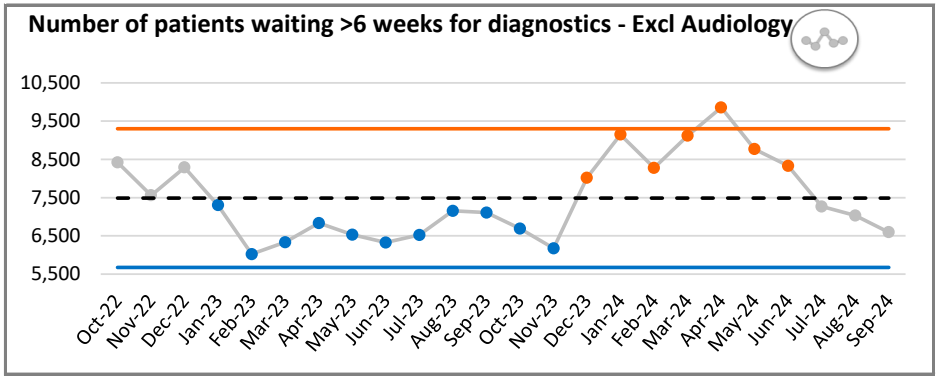












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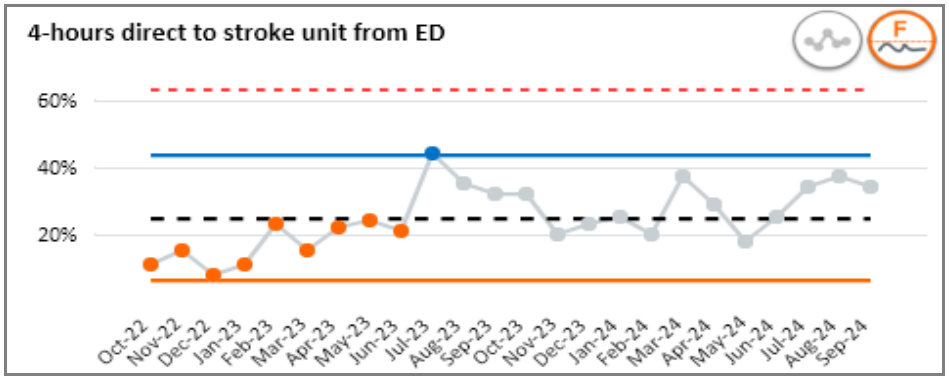
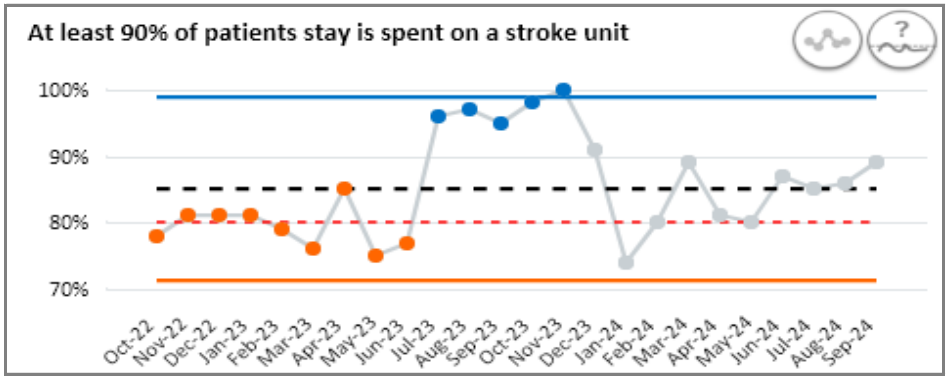
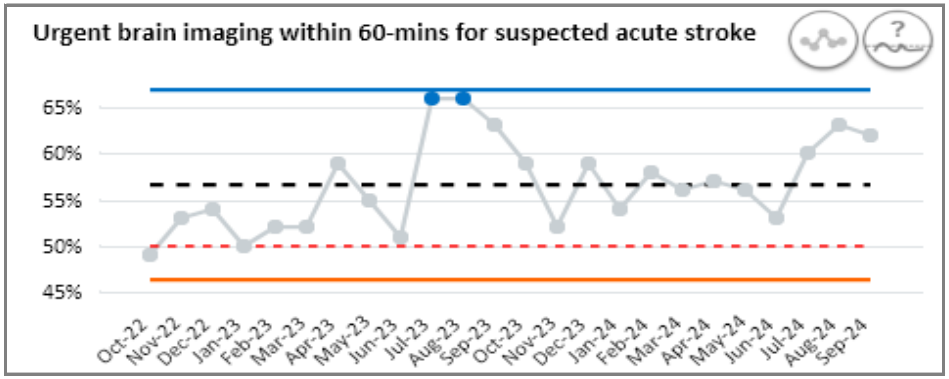
Operations

Stroke Services Supporting Metrics

East and North Hertfordshire NHS Trust

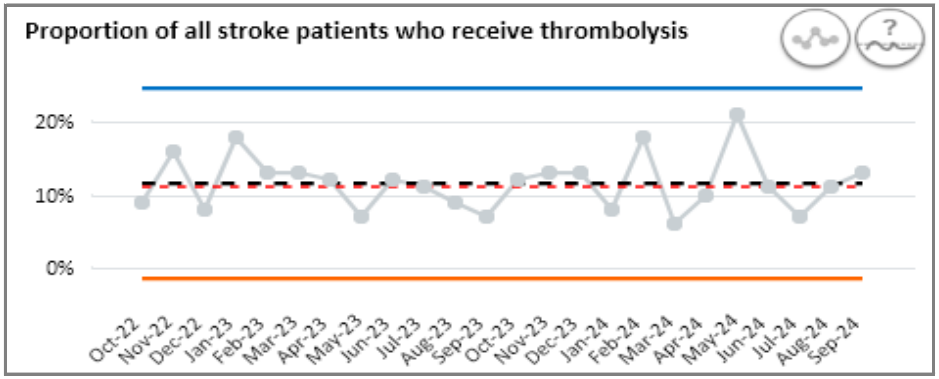






Key Issues and Executive Response

- The SSNAP rating for Q2 (April-June 2024) remained at a B. Thrombolysis rating improved from a D to a C with an improvement in the number of thrombolysed patients. Despite August - Sept increase %, forecast predicts stroke will not maintain C rating in Q3 due to SSNAP dataset change.
- SSNAP dataset anticipated to negatively impact performance with stricter key performance indicators. This will also increase workload particularly within the SALT and data teams. SALT frequency domain (7) declined from C in Q1 to E in Q2. Main issues are % patients given therapy, and frequency of days therapy is required/provided.
- Thrombolysis in Acute Stroke Collaborative (TASC) project underway to improve Thrombolysis performance rate to 14%. Pre-alert & ED Pathways projects underway to streamline ED Stroke pathways. September = 12.5%.
- Radiology consistently meeting KPI scanning patients within 1 hr. However, indicator will change to within 20 minutes from October. Progression to achieve scanning under 15 minutes will enable thrombolysis with a median time of less than 40 mins. New agreed pathway for straight to CT implemented beginning of September. Pathway has proved successful throughout Sept & Oct. CT Perfusion training to be rolled out before December.



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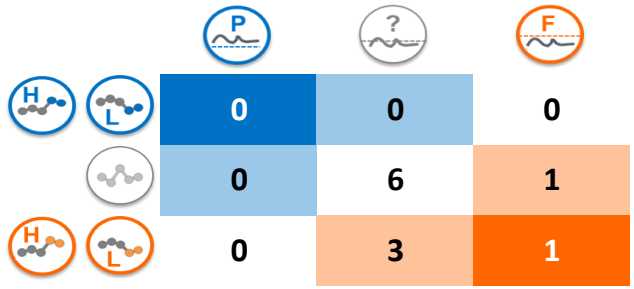
Finance

Month 06 | 2024-25



Finance

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Sep-24	-2.4	0.47		?	Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Sep-24	1,245	3,166			Common cause variation No target
	Cash balance	Sep-24	77.9	37.1	L	F	5 points below the lower process limit Metric will inconsistently pass and fail the target
Key Financial Drivers	Income earned	Sep-24	45.3	56.1		?	Common cause variation Metric will inconsistently pass and fail the target
	Pay costs	Sep-24	29.5	34.2	H	?	10 points above the mean Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	Sep-24	15.5	21.4	H	?	7 points above the mean Metric will inconsistently pass and fail the target

Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Sep-24	24.9	30.4		?	Common cause variation Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	Sep-24	0.9	5.1		F	Common cause variation Metric will consistently fail the target
	Agency costs	Sep-24		0.8			Common cause variation No target
	Unit cost of agency staff	Sep-24		10.1			Common cause variation No target
	Bank costs	Sep-24	3.7	3.1		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Sep-24	0.5	0.9	H	?	16 points above the mean Metric will inconsistently pass and fail the target
Other Financial Metrics	Private patients income earned	Sep-24	0.4	0.6		?	Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	Sep-24	2.8	4.0		?	Common cause variation Metric will inconsistently pass and fail the target

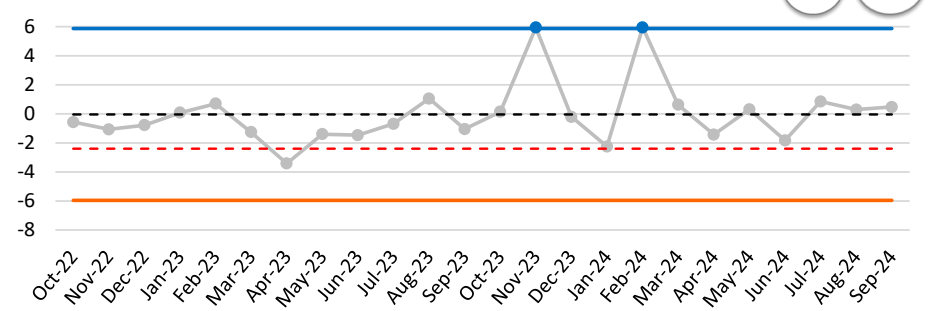
Month 06 | 2024-25

Finance

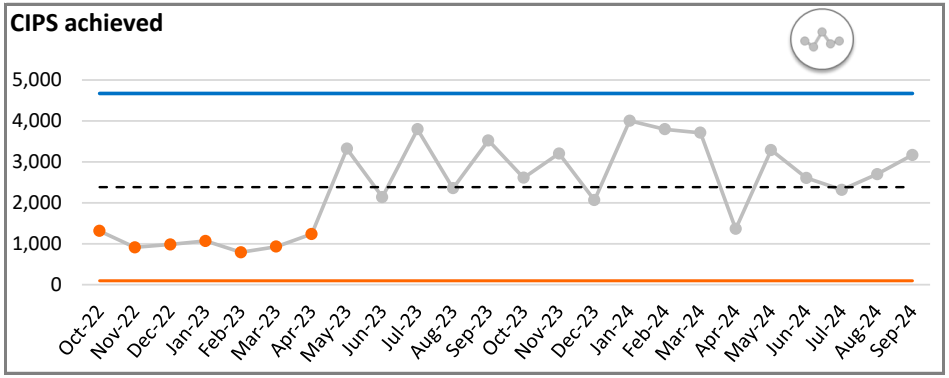
Summary Financial Position

East and North Hertfordshire NHS Trust

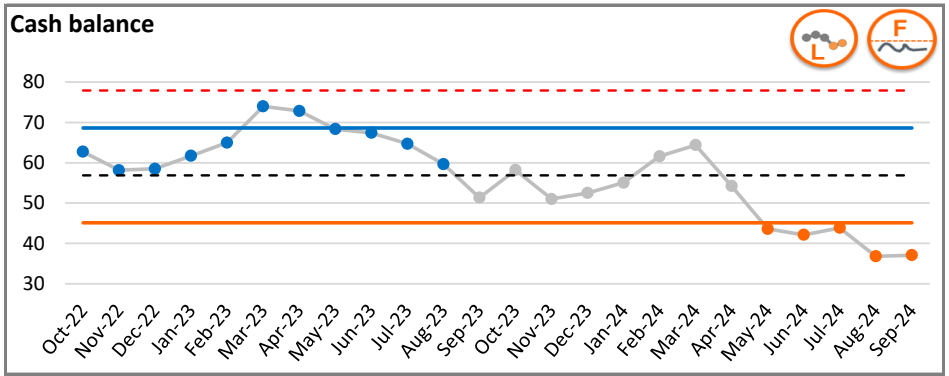
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust approved a surplus plan of £1.0m for 24/25. This plan assumes that both a £33.8m cost improvement programme will be delivered, and ERF performance of 138% will be achieved.
- At Month 6, the Trust has reported an actual deficit of £1.3m. This is adverse to plan by £0.7m. This gaps relates to lost income resulting from Industrial Action earlier in the year.
- The YTD position reports a material shortfall in elective activity delivery compared with plan. Daycase and Inpatient Elective gaps were of particular concern, and reflects a delay in mobilising additional capacity.
- Pay budgets report a YTD overspend of £1.5m. A number of hotspots of concern have also emerged in respect of management of medical, nursing and admin spend staffing spend.
- CIP savings are to date in line with plan expectations, although a series of non recurrent benefits have offset the impact of shortfalls in elective activity delivery.

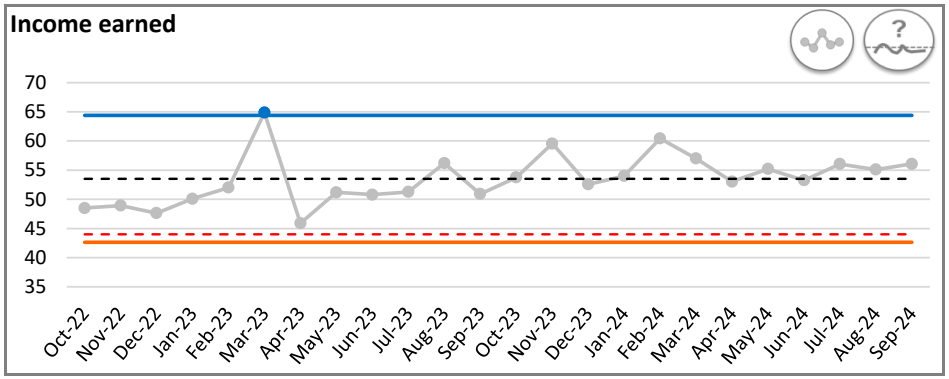
	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	656.3	326.3	328.7	**2.4**
Pay	-407.1	-203.6	-205.1	**-1.5**
Non Pay	-214.5	-106.4	-108.5	**-2.1**
EBITDA	**34.8**	**16.3**	**15.2**	**-1.1**
Financing Costs	-33.8	-16.9	-16.5	**0.4**
Surplus / Deficit (excl Fin Adj's)	**1.0**	**-0.6**	**-1.3**	**-0.7**

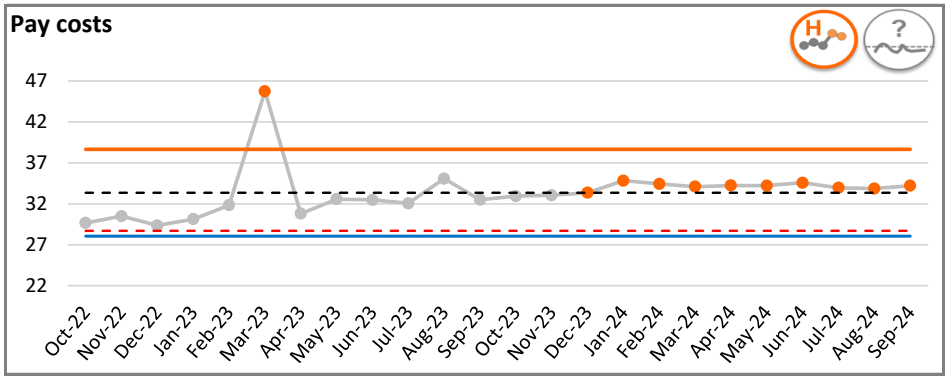
Month 06 | 2024-25

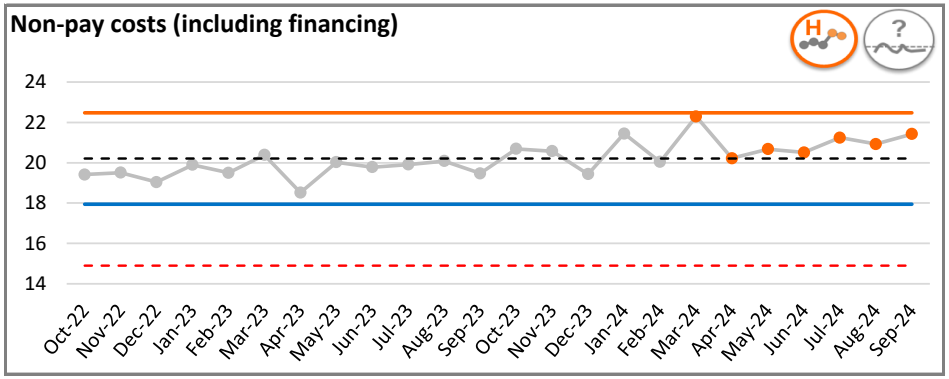
Finance

Key Financial Drivers

East and North Hertfordshire NHS Trust







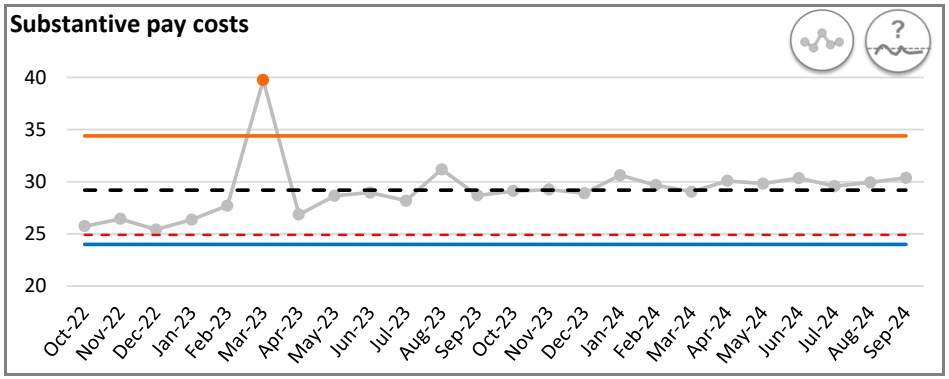
- At Month 6 year to date, there was a planned deficit of £0.6m, and an actual position of £1.3m. The £0.7m adverse variance is entirely due to the ERF activity impact of industrial action in June/July. The reported position for month 6 now assumes that that the costs of covering the industrial action will be funded, in line with National guidance and ICB allocations.
- Excluding the impact of industrial action, the year to date position is in line with plan, however, this includes significant non recurrent reserves. The current run rate and activity delivery is not sustainable and would not allow the Trust to achieve its £1m surplus if this were to continue. Divisions have developed recovery plans to improve the run rate in future months.
- In month, the Trust delivered a £0.5m surplus, which was £0.4m favourable to plan. This includes £0.5m of industrial action funding. The in month position continues to include the release of non recurrent technical benefits/reserves.
- ERF delivery was behind plan in month due to delays in recruitment to new posts and lower activity than run rate for Orthopaedics and Urology. This will be reported in further detail in the ERF and Productivity report.
- Pay was £0.6m adverse to plan in month, excluding non recurrent reserves. High levels of Waiting list initiative payments, high locum usage for medical staff within the ED and Paediatric department and high midwifery usage continue to be the main pay hotspots and actions are being undertaken to mitigate in future months.
- Agency expenditure has decreased in month and was 2.2% of pay expenditure. Year to date is now 3.0%, which is below the 3.2% target set by NHSE.
- There continues to be significant non pay cost pressures within the Pathology department due to pathology tests charged from other Trusts as well as under delivery of CIP schemes. There are also significant non-pay overspends in renal and cardiology, which is only partially explained by an increase in activity. Mitigating actions are being developed as part of the financial recovery plan.
- The Trust has a challenging CIP target of £33.8m this year. To date the Trust has delivered £15.4m savings against a £15.5m plan, however, much of the delivery is through non recurrent schemes.

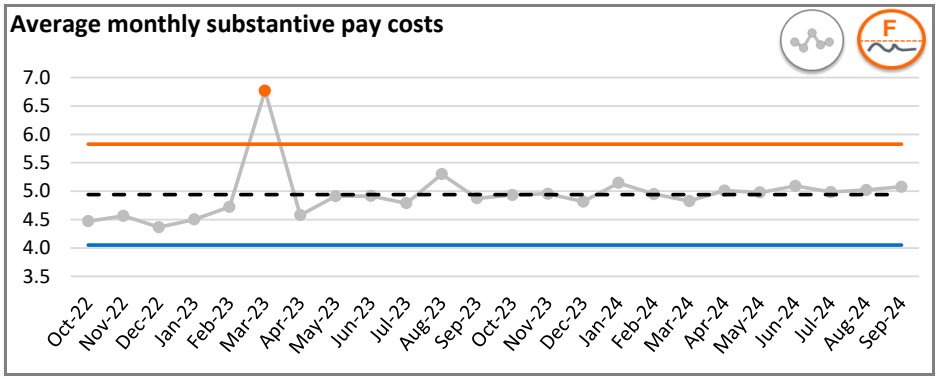
Month 06 | 2024-25

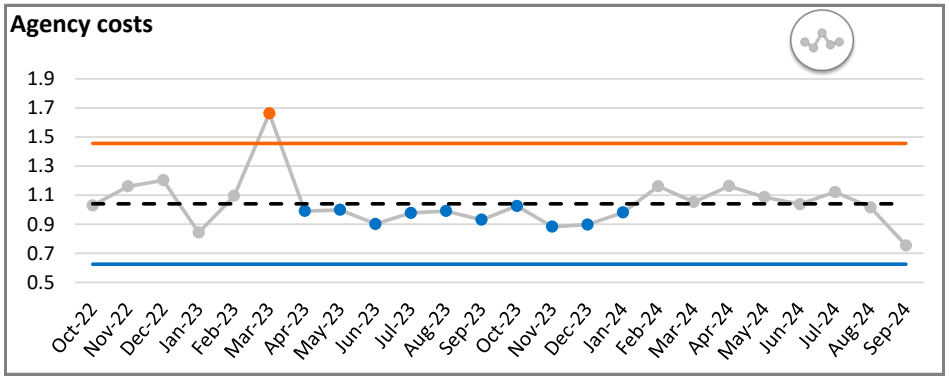
Finance

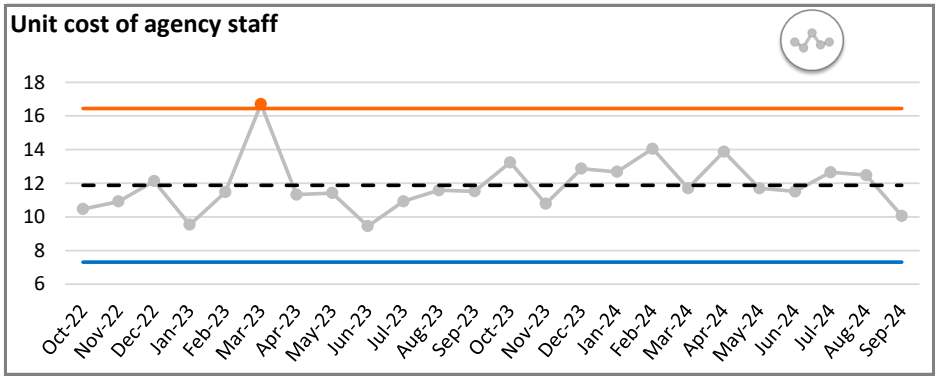
Other Financial Indicators

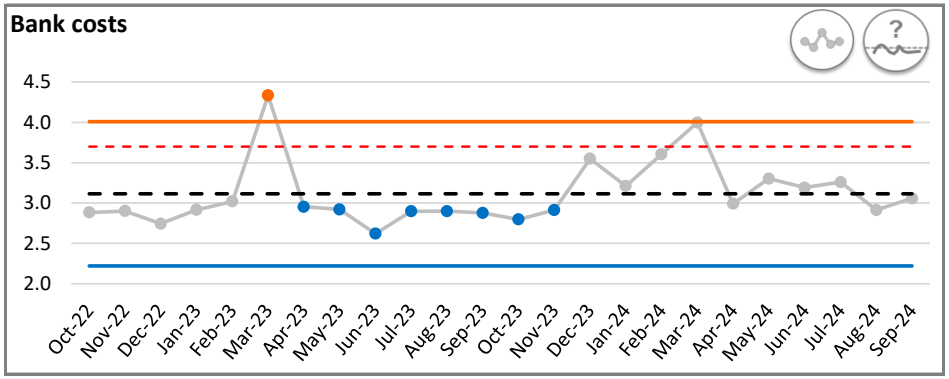
East and North Hertfordshire NHS Trust

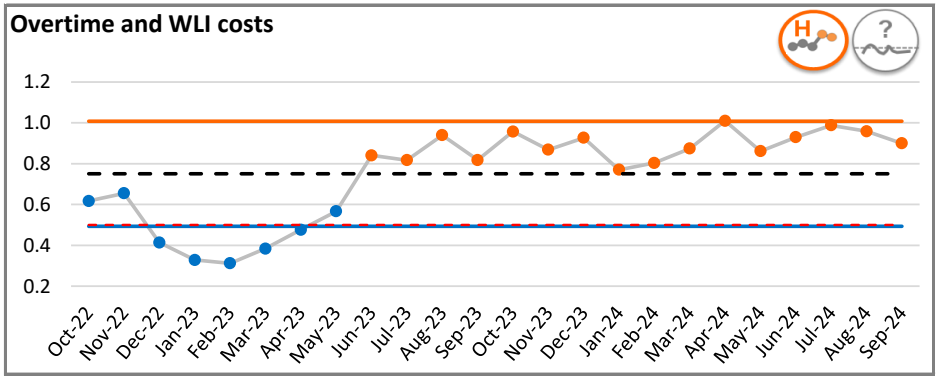










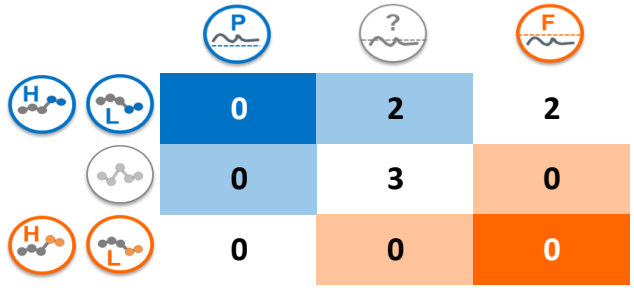


Month 06 | 2024-25

East and North Hertfordshire NHS Trust

People

Month 06 | 2024-25



People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Sep-24	8%	9.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Sep-24	5%	9.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	Sep-24	3%	2.3%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Sep-24	90%	88.9%	H	?	15 points above the mean Metric will inconsistently pass and fail the target
	Appraisal rate	Sep-24	90%	85.1%	H	F	1 point above the upper process limit Metric will consistently fail the target
Thrive	Turnover rate	Sep-24	10.5%	9.2%	L	?	9 points below the lower process limit Metric will inconsistently pass and fail the target
Care	Sickness rate	Sep-24	4.0%	4.5%	L	?	8 points below the mean Metric will inconsistently pass and fail the target

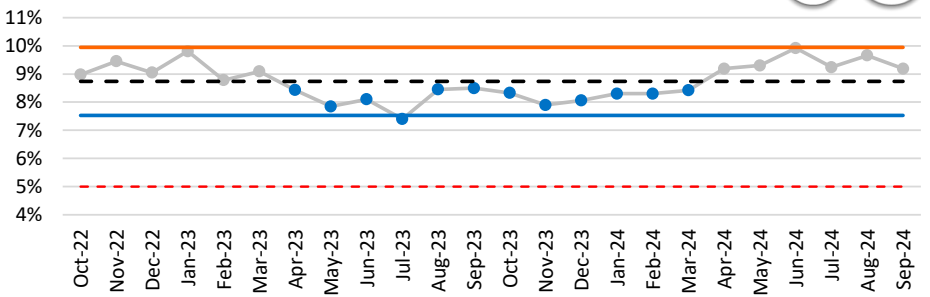
Month 06 | 2024-25

People

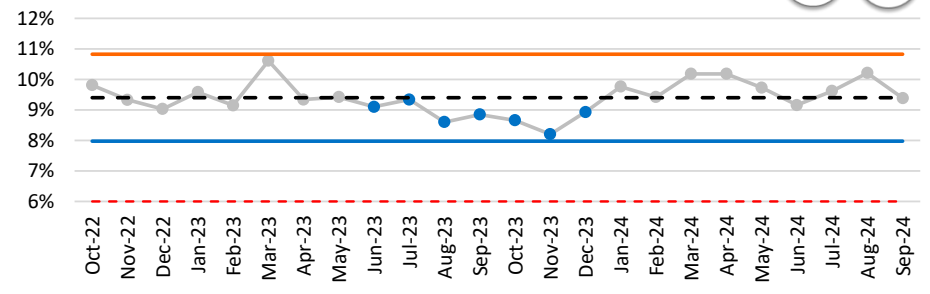
Work Together

East and North Hertfordshire NHS Trust

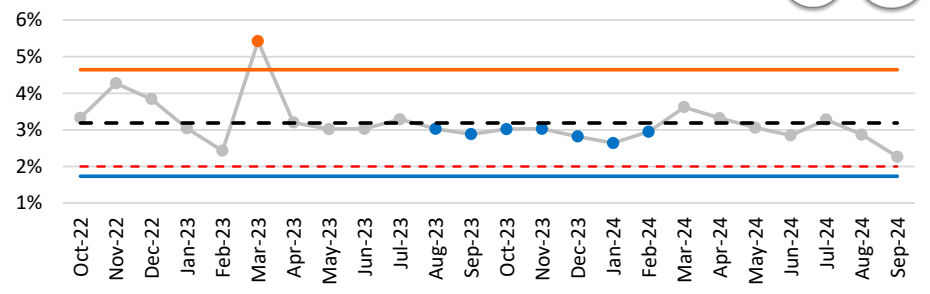
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- The vacancy rate decreased to 9.2% (628 vacancies). Recruitable establishment decreased by 23.5 WTE. There are 142 more staff in post than a year ago.
- Nursing & Midwifery vacancy rate maintained at 11.6%, 59 (Band 5-8a) nurses in the pipeline. 14 RN starters in month.
- 35 Newly Qualified Nurses. 8 newly qualified to still be assigned to a department. 9 midwifes in the pipeline, an additional 18 newly qualified midwifes started in post throughout August and September.
- Hotspot areas include Maternity Theatres, ED, Renal, Critical care, specifically B6 jobs at MVCC in Chemo and John Bush, CDU. Talent acquisition lead is working in partnership with to run targeted recruitment campaigns.
- There are 57 vacancies currently out to advert.
- 12 Care Support Workers (CSWs) commenced in M6, further 7 with start dates booked for October, plus further 30 in pipeline. Review of recruitment strategy underway following Care Support Worker and Clinical Support Worker job role changes.
- There are 411 candidates in the resourcing pipeline.
- Time to hire remains at 14 weeks in M6, the time from conditional offer sent to ready for start date reduced by 9 days (April 2024 compared to September 2024).
- Medical and Dental vacancy rate increased to 3.9%. Successful AACs in M6 resulted in 7 appointments, including Emergency Medicine, Vascular Surgery and Orthodontics.
- 'Great for 8%' temporary staffing pay bill reduced to 11.1%- proactive actions remain underway between Resourcing, Temporary Staffing and Finance triangulation to improve metrics against the 8% target, including reintroducing VCP (exec vacancy control panel).
- 'Triple Lock' control remains in place - ENH falls into the 'light touch' scrutiny i.e. only newly created posts are subject to ICB/NHSE review/approval. M6 workforce tracker submitted to the ICB.

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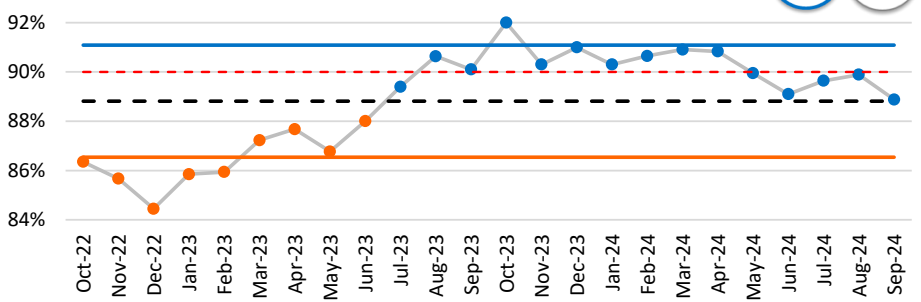
People

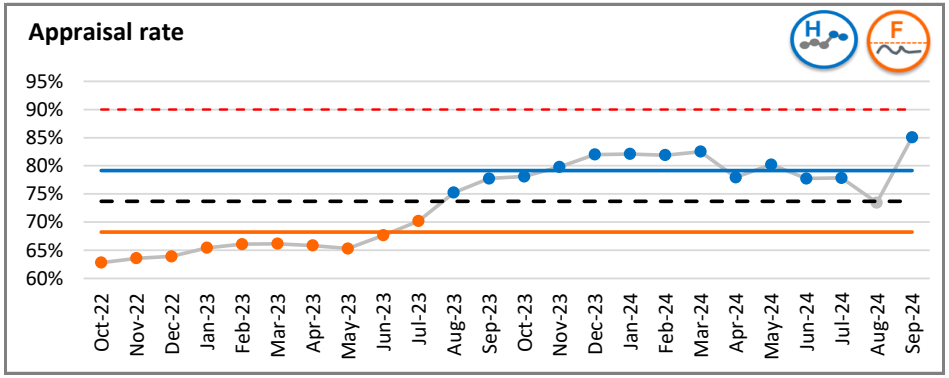
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- Statutory training in M06 shows as 88.9% a slight dip of 1% whereas mandatory training increased by 1.9% and stands at 82.72%.
- Work is underway to explore simplification of the GROW Together appraisal system and appraisal compliance stands at 85.05% showing 770 outstanding appraisals - Corporate divisions are the worst performing with 207 listed as 'not done' of which 87 are Estates & Facility, 64 IT and 24 Nursing & Quality
- National Quarterly Pulse Survey Data (NQPS) unreportable due to staff absence
- Work is commencing on Ward manager competency programme
- Commissioning of refreshed and new online learning modules underway
- 13 SNAs have successfully completed their Nursing Apprenticeship course and will soon be starting their roles as Nursing Associates in the Trust.
- 7 RNAs have successfully completed their Top-Up course and will soon be starting their roles as Registered Nurses in the Trust.
- 7 Individuals have started the programme after successfully passing their OSCE under SIFE pathway.
- 7 RNAs have successfully completed their Top-Up course and will be joining the programme as newly qualified Registered Nurses.
- 13 SNAs have successfully completed the Nursing Apprenticeship Programme and will be joining as newly qualified Nursing Associates.
- 38 newly qualified nurses from the recent recruitment drive will be joining the programme.
- Updated the Preceptorship E-learning available on the ENH Academy to align with the revised Preceptorship Policy.
- CPD - Training Needs Analysis (TNA) template being created for 25/26, to be distributed end of October 2024.

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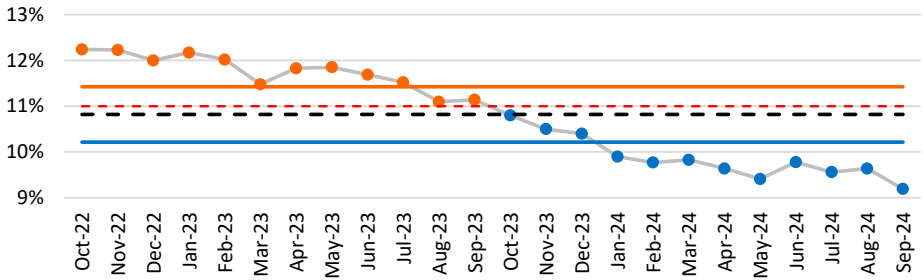
People

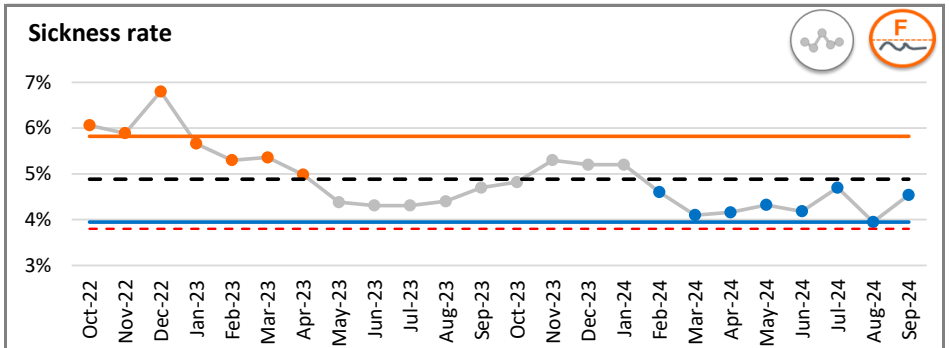
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

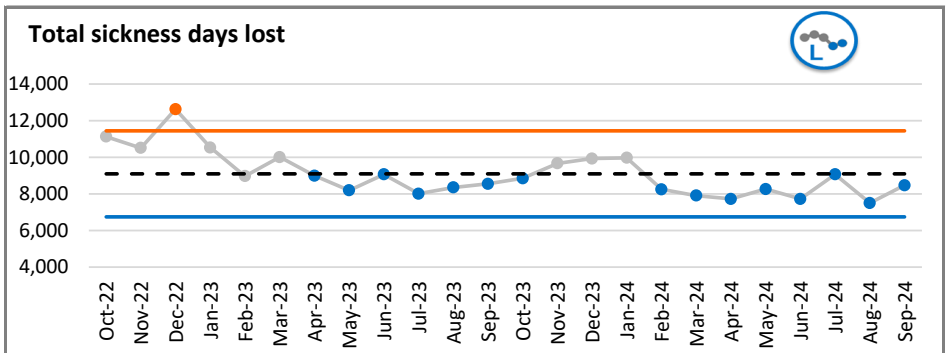
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- We have not had suspensions for several months as a result of working to redeploy staff and keep them in work as a supportive measure
- We continue to work to keep case investigations and processes under 60 days where ever possible and are developing a business case for investment in workplace mediation
- People related policies are now on track with a number of key policies updated and published over the last 6 weeks.

Care Together

- Targeted work to support leaders to prevent and manage sickness absence continues, with coaching for managers, occupational health advice and sickness absence case review meetings.
- Wellbeing promotion events are planned to support colleagues to improve their health and wellbeing. The Hertfordshire Talking Therapies service is being promoted through autumn, 18 October is world menopause day and in November a men's health awareness event is planned.
- Wellbeing conversations are being encouraged, managers who may welcome enhancing their knowledge and confidence with having wellbeing conversations have access to free eLearning.
- Winter flu and COVID vaccines are available for all colleagues in booked clinics, drop in sessions, from roaming teams and peer vaccinators.

Month 06 | 2024-25

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	15.1
Report title	Maternity Safety Support programme – Sustainability Action Plan			**Meeting Date**	6 November 2024
Presenter	Director of Midwifery				
Author	Director of Midwifery				
Responsible Director	Chief Nurse			**Approval Date**	
Purpose (*tick one box only*) [See note 8]	**For information only**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Executive Summary:

The Trust formally entered the Maternity Safety Support Programme in April 2023 and since this time have been working through three identified key workstreams. The Trust are currently in the improvement phase of the programme and a full progress update was presented to the Trust Board in September 2024.

Having demonstrated improvements across all workstreams, and working closely with our maternity improvement advisors, the service has produced a sustainability Action Plan which has been reviewed and approved by our Maternity Improvement Advisor.

An exit meeting and site visit with key stakeholders took place on Thursday 24 October. Representatives from NHSE, ICB, LMNS, Chief Nurse and the Quadrumvirate Leadership Team were in attendance.

The purpose of the meeting was to allow all stakeholders to review progress of the services improvement journey, to review and approve the action plan towards sustained improvement, and to confirm readiness to exit the programme.

The outcome of this meeting is that the Trust has been recommended for exit from the programme.

The sustainability action plan in response to the CQC findings has been focused on three key workstreams:

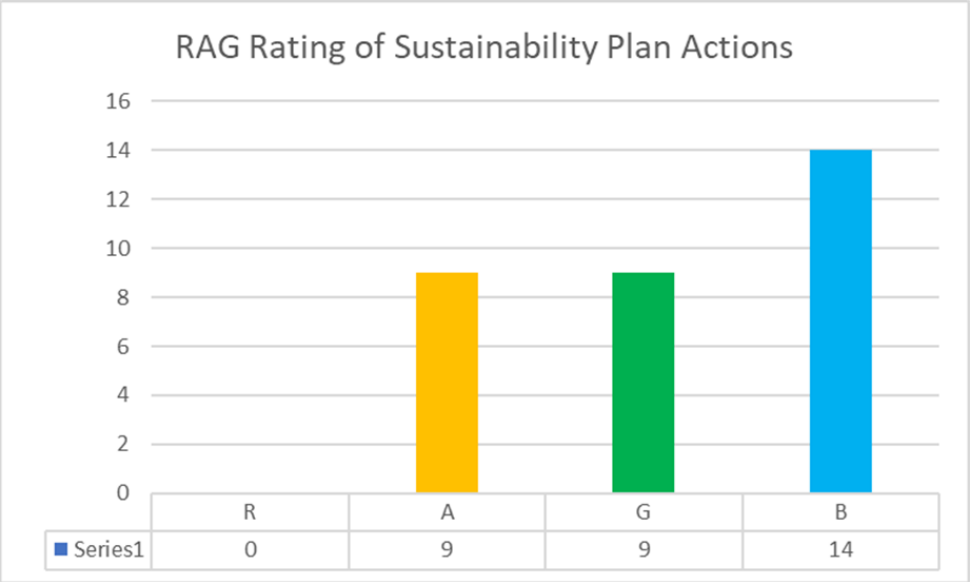
- Leadership and staffing
- Culture and diversity
- Policy and processes

Following the previous stakeholder visit in May 2024 the sustainability action was updated to reflect additional actions and revised target dates providing additional assurance on safe staffing levels compliant with Birthrate plus recommended establishments, Theatre staffing, and equipment replacement and repair. A full progress report was presented and accepted by Trust Board in September.

Outstanding CQC actions continue to be progressed and monitored via internal governance processes. It should be noted that these actions are part of the overall maternity improvement plan.

Sustainability Action Plan Progress and Next Steps:
The updated sustainability action plan **(see Appendix 1)** details all actions within the improvement workstreams identified in the diagnostic phase of the MSSP. This continues to be reviewed at regular touchpoints with progress and exception reports presented in divisional governance meetings. Of the 32 actions within the plan, 14 are now fully completed (progressed from 9 in the September report) with no red rag-rated actions.

Table 1.



Next steps:
Following approval of the SAP in the exit meeting on 24 October the Trust Board are now asked to approve the SAP and support the steps outlined that are needed to deliver sustainable improvements across the service.

Maternity Services will be required to continue to provide evidence to the Trust Board, NHS England, and other external partners providing assurance of their continued commitment to quality and safety. Progress towards a sustained improvement in key aspects of care and services with progress will be monitored and tracked through the sustainability action plan.

Impact: tick box if there is any significant impact (positive or negative):											
Equality (patients or staff)	☒	**Patients**	☒	**Finance/ Resourcing**	☒	**System/ Partners**	☒	**Legal/ Regulatory**	☒	**Green/ Sustain-ability**	☐
Sustainability of improvements made have and will continue to benefit staff, service users and families. Sustaining improvements will assure external regulators and internal and external stakeholders.											

Trust strategic objectives: tick which, if any, strategic objective(s) the report relates to:							
Quality Standards	☒	**Thriving People**	☒	**Seamless services**	☒	**Continuous Improvement**	☒

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

Strategic Risk 2 - Health inequalities
Strategic Risk 5 - Culture, leadership and engagement
Strategic Risk 6 - Autonomy and accountability.

Report previously considered by & date(s):	
N/A	
Recommendation	The Board/Committee is asked to: • Note and minute the outcome of the stakeholder exit meeting/visit on 24 October 2024. • Approve the Trust sustainability action plan and support the steps outlined within the plan that are needed to deliver sustainable improvements across the service.

To be trusted to provide consistently outstanding care and exemplary service

Base Document	Action ID	Category	Sub Cat	Sustainability/ Action Plan	Opportunities for Improvement	Specific Actions to be implemented to ensure ongoing sustainability	Progress	Current RAG Rating	Action Owner(s)	Target Date/ Timeline	Evidence & Measurements
Sustainability Action Plan	SAP1	Policy and process	Estates	Assurance that there is a sustainable estates and equipment maintenance programme, with allocation of financial resource to replace and repair equipment in the future	Mapping process of escalation of issues regarding estates. Collection of data for time between reporting and closing the issue, scrutiny on these measures. If there is a financial barrier, then a plan should be made to mitigate risk and the inability to complete the repair put on a register that is reviewed for risk. Ideally, routine estates refurbishment should be budgeted for in the longer term, as this will provide overall cost savings through maintenance.	Conduct a comprehensive mapping of the current escalation process for estate issues. Collect data on the time taken between issue reporting and resolution closure for each case. Scrutinise the collected data to identify bottlenecks and inefficiencies in the issue resolution process. Analyse the root causes contributing to delays in issue resolution. Identify instances where financial constraints hinder the timely completion of repairs. Evaluate the impact of financial barriers on sustainability goals and community well-being. Develop a risk mitigation plan to address financial barriers hindering issue resolution. Explore alternative funding sources or financing options to ensure the completion of necessary repairs. Establish a centralised register to document cases where repairs cannot be completed due to financial constraints. Regularly review the risk register to assess the level of risk associated with unresolved issues and prioritize actions accordingly. Engage with relevant stakeholders, including residents, estate managers, and local authorities, to communicate the importance of timely issue resolution for sustainability. Foster collaboration and partnership to implement solutions and overcome financial barriers. Implement mechanisms for ongoing monitoring and evaluation of the effectiveness of the sustainability action plan. Continuously seek feedback from stakeholders to identify areas for improvement and adjust strategies accordingly. Expected Outcomes: Reduced time between reporting and resolution closure for estate issues. Improved transparency and accountability in the issue resolution process. Mitigation of financial barriers to ensure timely completion of repairs. Enhanced sustainability of estates and improved quality of life for patients and staff	Previous Maternity and Neonatal Estates, Facilities, Equipment Operational Group has now been merged with Maternity IPC meeting allowing for escalation of issues to estates level. In addition to equipemnt servicing needs/shedule there is a plan to work with estates to determine a possible maternity servicing shedule for estates related maintennaice issues. Nicky Ross to provide plan/schedule of servicing from Estates themselves (AS) to chase.	B	Alli Morris - Deputy Director of Estates and Facilities Lesley Overy - Head of Midwifery Alessandro Sironi - Quality & Safety Manager Rebecca Merrifield - Matron Delivery Suite	Jun-24	Engineering and maintenance policy Equipment Replacement & Tracking System example Email Appointment of Equipment Coordinator post commenced May 2023 to ensure maternity equipment servicing schedule and ensure equipment due for servicing was prompt identified and coordinated (JD embedded). Weekly equipment reports sent to Matrons each week to highlight which equipment requires servicing and what equipment is held at EBME. Fortnightly/Weekly(?) Maternity & Neonatal Estates Facility, Equipment & IPC Group. The Terms of Reference (ATTACH) of this group will ensure attendance by the MDT. Escalation pathway to the Divisional Quadrumvirate through Speciality Forum and W&C's Directorate Board and to executive level at QSC and Trust Board.
Sustainability Action Plan	SAP2	Policy and process	Assurance	Maternity Improvement Plan and Action Tracker in place to ensure unit are on track to fulfil Ockenden, Kirkup, SBLCBv3, MIS, 3YDP and Core Competencies Framework.	Admin support to assist training team with recording of mandatory training attendances and updating the Academy Software enrolment for new and rotating staff.	Development of Doctors induction programme by consultant obstetricians Mary Goodin and Sunitha Easwaran, in conjunction with midwifery Education lead.	New and rotating doctors are scheduled in to mandatory training as part of their induction, in a revised programme that is appropriate to their grade – this ensures safe and supported practice as well as MIS Compliance with the Core Competency Framework. AUGUST UPDATE: 1.0 WTE Administrator within Training & Education team for monitoring and recording compliance for mandatory study days. Compliance is monitored by submission of reports to monthly Speciality and W&C's Directorate Board and bi-monthly TWNSQC for oversight and scrutiny.	B	Douglass Salvesen - Divisional Medical Director Women's & Children's Services Sunitha Easwaran - Consultant Obstetrician & Medical Lead for Education Charlotte Brittin - Midwifery Lead for Training & Education	Aug-24	Image of Training compliance and Description
					Work with Trust Appraisal (Grow Together) and Revalidation team to review Appraisal recording and database process.		AUGUST UPDATE: Over the last 12 months managers have been regularly updated and training offered on the importance and how to complete Grow together reviews this information has also been shared Trust wide and user guides updated on ENH Academy. Number of Grow together reviews/Appraisals completed - aligned to Trust target and completion of the Grow together window April 1st 24 - Aug 31st 2024. Grow together meetings, including WMTY (What Matters To You) discussions and objective setting with each team member. are conducted on a cyclical basis and monitored through people metrics on QlikView and staff survey results.	B	Josh Jacobs - Associate People Partner Steve Andrews - Associate Director for Culture, Inclusion, Leadership & Engagement Julia Seez - People's Partner Lesley Overy - Head of Midwifery	Sep-24	**GROW together annual appraisals and 1:1 approach for 24/25 opened 1st April 2024 due for completion in September 2024**
Sustainability Action Plan	SAP3	Policy and process	Midwifery Workforce	To ensure HR processes are in place and used for effective management of sickness absence and non-performance.	Staff satisfaction surveys, initiatives such as team member of the month, and development and retention programme.		AUGUST UPDATE: Sickness absence manager competency training has been completed and is available on ENH Academy and additional sessions are offered to support managers with difficult cases. All staff sickness is regularly reviewed to highlight hot spots. Following the January-March 2024 'Listening events', a relaunch of the Dignity and Respect Pathway (by the Head of Midwifery, Clinical Directors and Operations Manager). EDI Board created and commenced April 2024 and reviewed monthly including initiatives and updates. Regular exit and stay interviews conducted alongside staff survey team talks and other engagement sessions with specific staff groups (IEM's and preceptees) to ensure all staff voices are heard. Recruitment and retention strategy 2024/2025 complete includes all the proposed actions short, medium and long term (see attachment). October 2024 Update: Specific training for staff planned for Sept/Oct 2024/2025 including kindness and civility matters (internal), a kinder life (external), NMC/GMC EDI sessions. Kindness in to Action Masterclass for band 7 & 8's (2 hours duration) advertised for	G	Lesley Overy - Head of Midwifery Ini Orangun - Obstetric Clinical Director	Dec-24	Absence policy Performance policy Listening Event Slides Support Leaflet All maternity staff Communication
Sustainability Action Plan	SAP4	Policy and process	Digital	The Trust is aware that lack of a digital plan poses risk to maternity services	The timescale for maternity is a problem needing an urgent response.	Re-escalate to Trust Board the impact of digital immaturity to include lack of compliance with CNST, impact on audit etc. including financial implications.	AUGUST UPDATE: Maternity EPR launched 30/07/2024. Digital delivery team and provider support for 2/52 on the shop floor to ensure embedding and staff familiarity for smooth transition. Maternity super-user training and operational support ongoing. Business Continuity Plan in place and boxes provided to each clinical area for system down revert to paper plan. System issues, change requests and Priority 1 issues escalated to provider for resolution via Digital Delivery Team. Interviews for Digital Delivery Lead Midwife to take place 27/08/2024. Escalation to NHSR regarding non-compliance for MISY6 SA2 MSDS, in view of non-mandated fields and impact on July scorecard (to be published September 2024). NHSR reports ENHT compliant ahead of publication. If non-compliant on publication, for second opportunity submission October 2024 for December publication. Midwifery and Business Intelligence Teams working on front end (MSDS) and back-end (CDS) reporting needs. Risk of digital immaturity (aged >4yrs) removed from Risk Register 30/07/2024 launch date. Risk of Large Scale Transformational Change remains on Risk Register.	B	Amanda Rowley - Director of Midwifery Adrienne Taylor - Head of Digital Programmes	Jul-24	EPR Programme Board presentation of timescale to implementation and action plan with mitigations Directorate Board Risk Escalation for lack of digital system Risk Management Report April 2024 AUGUST 2024: Risk register aged risk for digital immaturity removed (September 2024 Risk Management & Governance Reports), NHSR email communications re: exemptions.
						Identify clear actions for the Board such a planned date of implementation of digital system.		B		Jul-24	
Sustainability Action Plan	SAP5	Policy and process	QI	Embed QI as standard practice in to maternity services.	Work with QI team to integrate QI methods into teams and staff leading projects. It may be that with specific aims and measures, and a "testing" PDSA approach, improvements on process and outcome measures can support scale and spread of change ideas requiring financial investment and outlay.	Invite QI team to senior team meetings as a regular standing item.	AUGUST UPDATE: QI team has merged with transformation team and now is renamed the Kaizen Promotion Office (KPO). The KPO department are embedding ENH Production System via a number of forums. This includes a 3 hour introduction in to ENH Production System events, available to all staff and includes an ENH Production System course for leaders which trains leaders and QI professionals in Kaizen methodology. In addition the Lead Midwife for Perinatal Quality Improvement commenced in post in June 2024 and has undertaken a scoping exercise to ascertain gaps within the services and priorities for moving forwards.	G	Claire Prew - Lead Midwife for Perinatal Quality Improvement Alessandro Sironi - Quality and Safety Manager for Maternity	May-25	CareQI Suite Example LOG - MS List of QI (and other maternity) activity See Kaizen Suite workstream
						Continued perinatal approach to quality improvement and collaborative working with the MDT and stakeholders	OCTOBER UPDATE: QI team have multiple collaborative projects encorporating the neonatal and maternity teams. This has included transforming the transitional care service inline with safety action 3 of the Maternity Incentive Scheme. In addition to projects to reduce mother and baby seperation are in progress.These includes bedside cannulation in birthing areas, an early respiratory distress pathway and a new pathway for neonatal jaundice reviews. The mat/neo collaborative scoping exercise is ongoing	G			
Sustainability Action Plan	SAP6	Policy and process	Governance	Governance Systems and Process	Try plotting PMRT data onto rare events chart to see if 2022 rise is still a concern.		Meeting arranged April 2024 with Consultant Obstetric Lead for Bereavement to plan representation of PMRT reported data to capital MBRRACE.	B	Rachel Wooldridge - Consultant Obstetrician Josie Reynolds - Lead Midwife for Quality Assurance, Governance & Compliance	Apr-24	**AUGUST UPDATE: MBRRACE portal for PMRT notifications and surveillance provides 'Deaths within your organisation' reports with charts over time by timing of death and type, i.e. Late fetal losses, Stillbirths and Neonatal Deaths. Comparison from January 2022 to current date, shows less frequent deaths and greater number of days between deaths for 2023. Evidence available to download from platform. 'Snipped' graph as evidence for August 2024, also QASC Q1 Apr-Jun 2024 Bereavement report for presentation at September's TWNSQC.**
					Ongoing use of G or T charts for rare events so that effects of learning and improvement work, including SBLCBv3 effects can be clearly visualised.	Use SPC charts to monitor training/education/improvement work Integrate G and T charts into the ongoing monitoring processes for rare events. Ensure that relevant team members are trained in the use of these charts. Collect data on rare events and improvement initiatives, including those related to SBLCBv3. Regularly update the G and T charts with new data to maintain current and accurate visualizations. Use G and T charts to clearly visualize the effects of learning and improvement work on rare events. Highlight trends and changes over time to demonstrate the impact of these initiatives. Regularly review the charts with key stakeholders to interpret the visualized data. Use insights gained from the charts to guide further improvement efforts and decision-making. Incorporate findings from the charts into ongoing learning and improvement strategies. **Expected Outcomes:** Enhanced ability to see the effects of learning and improvement work, including SBLCBv3, on rare events. Improved decision-making based on visualized data trends and patterns. Continuous refinement and enhancement of initiatives based on data-driven insights. 22/08/24 - Taking part in cohort 1 of the Trust new Year long Kaizen training to reflect ENHTs new approach to Quality Improvement	Incident Data Pivot created, from which we can process data to use in G and T charts. ENHance system Dashboard bespoke for Obstetrics & Gynaecology to pull monthly reports of patient safety incidents, themes and trends for review, analysis and escalation at Directorate level.	G	Alessandro Sironi - Quality and Safety Manager for Maternity Josie Reynolds - Lead Midwife for Quality Assurance, Governance & Compliance	Dec-24	Incident data spreadsheet and PIVOT table.
					Work with safeguarding team and stipulation of core competency framework for enhanced safeguarding training to improve SG reporting process for staff (make it easy to do the right thing) and to increase awareness of what needs reporting.		Our current figures for Statutory level 3 safeguarding are 93.77% for Nursing and Midwifery registered staff so attendance is good for level 3 SG training at present. Although we are meeting the previous (and approaching the new) target for compliance, there is a discussion about looking at the efficacy of the training with regard to safeguarding documentation and care, this is a piece of work which will include an ongoing audit of compliance of the safeguarding processes. We have spoken as a team, and with the Maternity leadership and training teams about uploading recordings of 'how to' information for; Completing a an ISF Completing a Children's services referral Navigating the SG information and database All of this information is currently delivered during the training. We feel that by recording this information to be accessed digitally, the training slots will then be freed up for more bespoke and targeted training which would hopefully be beneficial to mitigate any gaps in safeguarding provision. AUGUST UPDATE: Safeguarding training compliance rates presented to SG Operational Group by Lead Midwife for Safeguarding and Head of Midwifery on a monthly basis.	A	Stacey Malone - Safeguarding Lead Lesley Overy - Head of Midwifery Ini Orangun - Obstetric Clinical Director	Jul-24	Monthly Safeguarding Operational Meeting minutes July 2024

LEGEND		
R	**Serious delay to meeting target trajectory**	**0**
A	**Some delay to meeting target trajectory**	**10**
G	**On target for Sustainable Improvement**	**12**
B	**Actions Complete**	**14**

					Involvement of MNVP in Governance processes and Complaints handling. Development of the Patient Safety Partner role in line with national recommendations.		AUGUST UPDATE: MNVP representation requirements discussed at July 2024 TWNSQC and at August 2024 Maternity Improvement Senate. MNVP invitation to September TWNSQC and Divisional Risk Management Group agreed from September 2024. ToR to be adjusted to reflect MNVP presence.	A	Amanda Rowley - Director of Midwifery Josie Reynolds - Lead Midwife for Quality Assurance, Governance & Compliance Frances Kilmurray - Consultant Midwife Rose Bedford - Consultant Midwife	Sep-24	July 2024 TWNSQC minutes and August MIS minutes. TWNSQC and Risk Management meeting ToR.
Sustainability Action Plan	SAP7	Policy and process	Governance	PSIRF process embedded in to Governance structures and evidence available of learning from incidents.	Continue engagement with the new PSIRF framework to shift from current risk management and governance processes into one more focussed on QI and learning from incidents.		AUGIUST UPDATE: Corporate Patient Safety Team PSIRF Transition Group meetings held on a bi-weekly basis. ENHT PSIRF Plan and Policy published November 2023. Awaiting SOP publication Autumn 2024. Awaiting financial support for Divisional training for learning response leads and patient engagement leads. Divisional Leads AAR trained. PSIRF Learning response tools of MDT roundtable reviews and AAR's in progress. Staff debriefs ongoing, supported by Governance team and Professional Midwifery Advocates. Statutory Duty of Candour stages 1 (verbal) and 2 (written) for all moderate harm cases or above, in line with regulation 20 of the Health & Social Care Act (2008). MDT Daily Patient Safety meetings implemented 1st August 2024, for oversight and review of all patient safety incidents reported within the last 24 hours (48/72 hours at the weekends), discuss levels of harm and assign ownership for Duty of Candour, review, actions and closure. Also for escalating incidents not yet reported and ensuring appropriate reporting, avoiding under-reporting. Patient engagement by patient safety midwives and/or women's experience midwife for opportunity for women's/family questions and involvement to be added to the incident reviews and reports. Thematic reviews ongoing for local priorities of MOH and maternal postnatal readmissions. Appointment of second patient safety midwife to the Risk & Governance team. Attendance at daily SitRep meetings on CLU for further oversight and discussion of patient safety issues. Weekly Divisional Incident Review meetings for Obs & Gynae. Incident reports presented to weekly PSERP meetings with corporate oversight and at monthly Speciality, W&C's Directorate Board and LMNS Q&S and PSII meetings.	A	Josie Reynolds / Sarah-Jane Patrick Gayatri Ranjan - Obstetric Risk Lead	Jun-24	**PSIRF Plan as detailed in Maternity Senate Report 22 March 2024**
Sustainability Action Plan	SAP8	Leadership and Staffing	Assurance	Ward to Board reporting process in place, with DoM or other QUAD member reporting at every Board meeting.				B	Amanda Rowley - Director of Midwifery Kate Fruin - Divisional Operational Lead Douglas Salvesen - Divisional Medical Director	Jun-24	**AUGUST UPDATE: Ward to Board meetings continue in the form of Speciality and W&C's Directorate Board monthly. The month of August 2024 was cancelled due to Maternity EPR launch and prioritisation of operational needs.**
Sustainability Action Plan	SAP9	Leadership and Staffing	Obstetric Workforce	Review of Obs & Gynae Consultant workforce.	Review locum/agency consultant spend for past 4 years to justify need for "headroom" due to average absences from sickness, maternity leave, etc.	Compare cost of locum/agency spend versus cost of substantive roles to formulate business cases based on financial evidence.		B	Douglas Salvesen - Divisional Medical Director		
					Look to appoint into roles to reduce agency spend, specifically within the medical rota		2 additional posts out on Trac These jobs are being advertised in April 2024 AUGUST UPDATE: Obs and Gynae consultant appointed, start date by 4/11/24. We have created a what's app group for requesting short term locums and each locum request has an oversight of the Clinical care group lead and Head of Operations.	B	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Amanda Rowley - Director of Midwifery	Jun-24	See Progress Column
								B	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Amanda Rowley - Director of Midwifery Kate Fruin - Divisional Operational Lead	Jun-24	See Progress Column
Sustainability Action Plan	SAP10	Leadership and Staffing	Obstetric Workforce	Look to support substantive roles which will support a reduction the use of locum cover and overspend.	Potential financial savings from reduction in agency/locum consultant spend. Business planning for new consultant posts to include projected savings from reduction in agency/locum spend, as well as potential for savings from QI projects and in helping secure 10% CNST rebate from achieving MIS 10 safety targets.	Identify impact of 10% CNST rebate and include in costings in business cases.	2 additional posts out on Trac These jobs are being advertised in April 2024 AUGUST UPDATE: Obs and Gynae consultant appointed, start date by 4/11/24. We have created a what's app group for requesting short term locums and each locum request has an oversight of the Clinical care group lead and Head of Operations.	B	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Amanda Rowley - Director of Midwifery Kate Fruin - Divisional Operational Lead	Jun-24	See Progress Column
Sustainability Action Plan	SAP11	Leadership and Staffing	Obstetric Workforce	Review PA allocation down to 10-11. This has potential to release 7PA's.	This should reasonably free up 7-15 PAs of funding to create 1-2 new job plans for new Obstetric consultants	Review all consultant job plans and move all Programme Activities(PA)'s to 10-11. August 2024: Continue to do review. This applicable to existing job plans. Aim is to review job plans in order to ensure the PA's are 10-11. Current reviewing Gynae job plans to see if we can get additional consultant	Repurposing our current medical spend from agency use, locum use and the cost associated with programme activates above 10 and using that money to fund x2 Obs&Gynae consultants. AUGUST UPDATE: Continuing to review job plans to see if the PAs can be freed for additional posts in future.	B	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Kate Fruin - Divisional Operational Lead	Jun-24	See Progress Column See SAP 10
					Dilution of the on call cover from 1:12 to 1:14 will significantly improve the work-life balance and sustainability of the obstetric consultant workforce.	Utilise funding to create 1-2 new job plans for new obstetric consultants. After reducing PA, reviewing Gynae PA's to see potential for consultant 2 new Obs and Gynae Consultants appointed following Job Planning exercise	Consultants are OBS and Gynae. Require one more WTE OBS consultant Appointed 2 Obs and Gynae consultants after job planning exercises.	G	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Kate Fruin - Divisional Operational	Oct-24	See Progress Column
Sustainability Action Plan	SAP12	Leadership and Staffing	Obstetric Workforce	On call currently 1:12 potential to review to 1:14 which will significantly improve work-life balance and sustainability of obstetric consultant workforce, or review headroom as none for the medical team currently.	Dilution of the on call cover from 1:12 to 1:14 will significantly improve the work-life balance and sustainability of the obstetric consultant workforce.	Utilise the newly created consultant job plans to adjust on call cover from 1:12 to 1:14.	MAY UPDATE: Interviews for clinical care group leads week commencing 20th May 2024 AUGUST UPDATE: Clinical care group lead for women's services now in post to support QI & Governance. From November 2024 x2 WTE O&G Consultants to commence in post. The medical on-call will be 1:14 which will ensure work life balance with additional on calls. New Consultant posts have SPA time allocated to support leadership responsibilities for SBLCBv3, QI and Risk Management.	B	Douglas Salvesen - Divisional Medical Director Women's & Children's Services	Oct-24	See Progress Column See SAP 10
					This is also an opportunity to allocate leadership and management responsibility towards SBL, QI and Risk management.	Identify within individual roles, leadership responsibility for SBL,QI and Risk Management. Ask MONA	AUGUST UPDATE: New consultant posts will have SPA time allocated to support quality and safety. Through Divisional restructuring there will be a new post of clinical service lead for women's and neonatal services (3 x PA;s) to support QI and governance. The new Perinatal quality Improvement lead midwife is also now in post and leading on SBLCB v3 and lead of QI across perinatal services. Previously only CD led clinical governance this is now strengthened with the	B	Douglas Salvesen - Divisional Medical Director Women's & Children's Services	Apr-24	See Progress Column
Sustainability Action Plan	SAP13	Leadership and Staffing	Midwifery Workforce	Succession planning for both midwifery and medical teams is vital with the opportunity for professional development within the team.		Conduct a thorough assessment to identify key roles within Midwifery and Medical teams. Identify potential successors for these roles based on skills, performance, and career aspirations. Create tailored professional development programs to prepare identified successors for future leadership roles. Include training, mentorship, and skill-building activities in the development programs. Develop a clear framework for succession planning that outlines the process, criteria, and timeline for developing successors. Ensure the framework is transparent and communicated to all team members. Regularly review and update the succession plan to reflect changes in team composition, roles, and individual development. Ensure that the plan remains aligned with the organisation's goals and evolving needs. Provide ongoing support and engagement opportunities to retain talented team members. Foster a positive and supportive work environment that encourages professional growth and development. **Expected Outcomes:** A well-prepared pipeline of qualified successors for key roles in Midwifery and Medical teams. Increased opportunities for team members to develop professionally and advance in their careers.	Annual appraisals and personal development plans for all consultants on an annual basis. Clinical Director for Obstetrics, Labour Ward Lead Consultant and Clinical Director for Gynaecology to provide evidence regarding reverse mentoring examples and other opportunities within the organisation for development. For women's services we have a clinical care group lead in place in the new divisional structure to support succession planning in addtion to having a CD for obstetrics, labour ward lead, fetal monitoring lead, and other postions of responasiblity within the service.	A	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Mona Modi - Consultant Obstetrician and Gynaecologist, CD Obstetrics Josh Jacobs - Associate People Partner Amanda Rowley - Director of Midwifery	Dec-24	**Retention rates** **Sickness Rates** **Turnover Rates** **Compliance with GROW together conversations** **Staff survey reflecting improvements in staff response in opportunities for growth, development and promotion** **GROW together annual appraisals and 1:1 approach for 24/25 opened 1st April 2024 due for completion in September 2024** **Staff survey** **Reduced attrition**
Sustainability Action Plan	SAP14	Leadership and Staffing	Midwifery Workforce	Theatre staff review to incorporate maternity theatre and remove midwives from taking on the role of scrub and circulating nurse in theatre.	Currently midwives are used in maternity theatre to act as scrub and circulating nurse. This is not in line with current national anaesthetic guidance and removes midwives from their role to undertake a role that is for a non-midwife, impacting on workload specifically in the intrapartum areas.	Recruit more appropriate staff such as scrub and recovery nurses with appropriate competency training to undertake these roles and release Midwives. Restructure of Theatre management and transfer of ownership to appropriate division. Business case to support nurse staffing model for theatres and recovery approved by members of TMG on 25th July 2024. Plan for service to move to planned care division by1st April 2024. Shift plans for staffing agreed and budget separated into its own cost code. Recruitment ongoing into vacant nursing post for theatres / recovery.	As of 1st April 2024 we have appointed 2 theatre staff (Theatre RN Band 5) Currently second round of recruitment in progress (Interviews scheduled for 11/04/24) End March 2024: Business case submitted to increase theatre staff by 12 WTE. Midwifery vacancy rate has reduced from 17% to 3 % over the last 12 months. Current midwifery vacancy has been used to advertise for band 5 theatre nurses. Advert closes WC 8th April. Shift plan drafted to identify resource needed for elective and emergency theatre and theatre and recovery budget now separated into its own cost code to provide clarity. Business case completed and submitted which identifies funding needed to provide sustained theatre staffing model. Total cost of £772K. Implementation planned over 3 years with vacancy slippage identified to reduce cost pressure in year 1. Business case included as evidence. AUGUST UPDATE: Plan for staffing transition of obstetric theatres to sit under planned care - shift plans approved by business case to TMG and QSC 26/07/24 and move in progress. Recruited x1 recovery nurse. Maternity Safety Champion reports from staff in July reflect that staffing feels better on the shop floor. Robust incident reporting continues and reviewed at daily patient safety MDT meetings planned from 01/08/24. Business case approved at TMG 26/07/24 for headroom uplift from 17-25%. In house competency package developed by training matron to support newly recruited theatre and recovery staff specific to maternity (bespoke package). All midwifery staff have a competency booklet for theatre, recovery and scrub skills to complete as part of induction. October 2024 Update: Theatre recrutiment open day scheduled for 19th of October. 13 Exression of interest received. Current trajectory is for theatres and recovery to be fully established in nurse-led model ready for planned go-live date for 13 January with full transfer to planned care on track for 1st April 2025	A	Lesley Overy - Head of Midwifery Emma Mulvihill - Deputy Ops Director Janice Boye - Head of Nursng for Planned Care	Nov-24	See Progress Column
										Jun-24	The following training must be completed by the theatre team: PROMPT: undertaken as close to commencing working as possible. Then annual attendance. Breastfeeding: undertaken at induction, with conversations observed and competency signed off by infant feeding team. All theatre staff are receiving a BF update in June Local systems (CMIS/ICE etc.): training provided during induction Baby observations: taught session, with competency assessment Baby saturations: taught session, with competency assessment Theatre practice and scrub skills: supernumerary time

Sustainability Action Plan	SAP15	Leadership and Staffing	Finance	Budget setting needs to be undertaken collaboratively with the DoM and CD and Operations manager. Projections of clinical activity, staffing needs and adjustments, planned service development and clinical/quality KPI's should be considered.	A balanced scorecard approach may be considered to assist in bringing together financial metrics with quality/safety KPIs and staff/patient experience KPIs, aligned with the trust strategy and the maternity strategy.	Quadrumvirate	Business case considers divisional risks relating to staffing and risk of not supporting the case. The economic case is presented. Quality are all domains on the balanced scorecard which is used in the divisional performance meeting each month.	G	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Amanda Rowley - Director of Midwifery Kate Fruin - Divisional Operational Lead	Jun-24	See SAP 10
					Work with new Div Dir Ops to consider a Balanced Scorecard approach to evaluating drivers and measures for success in the Perinatal service, finding suitable quality measures that will complement the fiscal strategy (e.g. reduction of vacancy rate, reduction of staff turnover, achievement of MIS)	Quadrumvirate	The perinatal clinical surveillance framework is used to collect and report this data. This is included in the Quality and safety committee maternity assurance report and the Maternity IPR that goes to Trust Board each month. Opportunity within monthly exec performance meeting to highlight areas needing escalation or support.	G	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Amanda Rowley - Director of Midwifery Kate Fruin - Divisional Operational Lead	Jun-24	
					The current budgeting process is simplistic in extrapolating previous year's activity and spend. There are flaws in allocating areas for cost improvement (the overspend in middle grade staffing was predictable and the budget was always unrealistic)	Conduct a thorough review of the existing budgeting process to identify strengths, weaknesses, and areas for improvement. Engage relevant stakeholders, including department heads, finance teams, and middle-grade staff, to gather insights and feedback on the current budgeting process. Introduce advanced forecasting techniques that go beyond simplistic extrapolation of previous year's activity. Conduct a detailed analysis to identify areas where cost improvement is needed, based on historical overspending and predictable budget discrepancies. Ensure that budget allocations are aligned with organisational goals and reflect the actual needs of each department. Provide training and capacity-building initiatives to purchasing teams and department heads on advanced budgeting techniques and cost management strategies. Empower staff to actively participate in the budgeting process and contribute to more accurate budget projections. Implement mechanisms for continuous monitoring of budget performance throughout the fiscal year. Regularly review budget variances and make necessary adjustments to ensure alignment with financial goals and objectives. Expected Outcomes: Improved accuracy and reliability of budget projections. Enhanced ability to identify and address areas for cost improvement. More realistic budget allocations that reflect organizational needs and priorities. Increased financial stability and efficiency in resource allocation.	Medical staffing budgets across the trust do not include headroom. The division have worked with finance and medical staffing to clearly identify and explain the areas for overspend. Our overspend position has improved with a better understanding of the drivers and this understanding has supported the business case for additional consultants with a resulting increase in our baseline budget 22/08/24 Monthly divisional finance meetings embedded. These review month and YTD financial position. Financial hot spots identified explored to understand contributing factors. Detailed analysis done of budgets within maternity to understand reasons for cost pressures including temporary medical spend. Agreement for uplift to 25% headroom in maternity to allow for substantive re=recruitment and mitigate need for premium rate bank spend. A Maternity recruitment and retention strategy is supporting with actions need to ensure forward planning and success of initiatives to reduce the impact of sickness on the financial position.	G	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Amanda Rowley - Director of Midwifery Kate Fruin - Divisional Operational Lead David Leigh - Divisional Finance Lead	Oct-24	See Progress Column
Sustainability Action Plan	SAP16	Leadership and Staffing	Finance	Medical and midwifery staffing budgets are reviewed and aligned to reflect sustaining an improved and developing service.	Assurance around head room and shortfalls are proactively managed within and outside the division.	Conduct a thorough review of existing staffing budgets for medical and midwifery services. Analyse historical expenditure and staffing levels to identify trends and patterns. Align staffing budgets with the goals and objectives of service development initiatives. Ensure that staffing levels support the implementation of new programs or services aimed at improving patient care and outcomes. Evaluate the sustainability of current staffing levels and budget allocations. Consider factors such as patient demand, workload, and resource availability to determine the adequacy of staffing budgets. Review headroom to support required training and backfill for sickness and maternity leave. Identify areas where staffing levels may need to be adjusted to better meet service demands and improve efficiency. Consider feedback from healthcare professionals, patient satisfaction surveys, and performance metrics to pinpoint improvement opportunities. Based on the findings from the budget review and assessment, make necessary adjustments to staffing budgets. Allocate resources to areas identified for improvement while ensuring overall budget sustainability. Outcomes: Sustained Service Quality by ensuring that staffing levels are adequate to maintain high-quality care delivery standards. Improved Service Development by aligning staffing budgets with service development goals to support the introduction of new initiatives and enhancements. Optimal Staffing Allocations by adjusting staffing budgets to reflect changing service demands and resource availability, maximizing efficiency and effectiveness.	2 additional WTE consultants approved. Business case to meeting staffing requirements for maternity theatres which will also give assurance of birth-rate plus compliance for maternity services. MAY UPDATE: Review of maternity shift plans completed and aligned with a funded establishment to meet birth-rate+ recommended staffing levels AUGUST UPDATE: Business case approved 25/7 and changes being made to health roster following approval. Revised shift plans will go live on 20th October. Update in SAP 15 regarding budget setting. Business case presented to TMG 26/07/24 approved uplift of headroom from 17-25%. 23 preceptees have been offered and have accepted roles at ENHT. A small number will commence employment in October 2024, the rest to follow in January 2025. Risk still acknowledged on risk register until vacancies filled.	A	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Amanda Rowley - Director of Midwifery		See Progress Column See SAP 10
Sustainability Action Plan	SAP17	Leadership and Staffing	Finance	Assurances around headroom and shortfalls are proactively managed within and outside the Division.	Clear escalation up and down when business cases are submitted, with clear timely outcomes reported back	Conduct regular assessments to determine head room (excess capacity) and identify any shortfalls within the division. Use data analysis to forecast potential shortfalls and areas of excess capacity. Create strategies to manage identified shortfalls, such as reallocating resources or adjusting workloads. Communicate findings and strategies with key stakeholders both within and outside the division. Accurately predict training hours as per TNA to identify shortfalls Set up regular review meetings to discuss current status and adjust strategies as needed. Base training allocation on number o midwives to accurately determine required headroom needed for training that reflects the number of staff working < full time hours Outcomes: Optimised use of available resources to manage head room and shortfalls efficiently. Enhanced collaboration within and outside the division to address shortfalls and share excess capacity. Ongoing monitoring and proactive management lead to sustained operational efficiency and service delivery.	Currently establishments based on 21% headroom for clinic non-medical roles with 17% of that recruitable. We do have 7WTE midwifery posts allocated to support the maternity leave rate of 8-10%. #AUGUST UPDATE: Business case presented to TMG 26/07/24 approved uplift of headroom from 17-25%. 23 preceptees have been offered and have accepted roles at ENHT. A small number will commence employment in October 2024, the rest to follow in January 2025. Risk still acknowledged on risk register until vacancies filled.	G	Amanda Rowley - Director of Midwifery		See Progress Column See SAP 10
Sustainability Action Plan	SAP18	Leadership and Staffing	Finance	Clear escalation up and down when Business cases are submitted, with clear, timely outcomes reported back.	Integration of neonatal and maternity service users' groups into a single MNVP.	Establish clear escalation pathways for business case submissions, outlining the steps for upward and downward escalation. Communicate these pathways to all relevant stakeholders to ensure understanding and compliance. Monitor the progress of business case submissions through the escalation process. Establish reporting mechanisms to provide regular updates on the status and outcomes of submitted business cases. Provide feedback to stakeholders on the outcomes of business cases and any areas for improvement in the process. Maximise opportunities for improvement based on feedback and performance data. **Expected Outcomes:** Clear and well-understood pathways for business case escalation, ensuring all stakeholders know their roles and responsibilities. Establishment of response benchmarks leads to timely and predictable outcomes for business case submissions. Regular updates and feedback loops ensure stakeholders are informed about the status and outcomes of their submissions.	As a divisional leadership team, we can ensure that we provide evidence of clear escalation through good governance processes with regards to reporting. All staffing risks are clearly articulated on our divisional risk register with actions and mitigation where possible identified. AUGUST UPDATE: Business cases for maternity theatres and midwifery staffing to align with birth rate plus and increase headroom now approved. Business planning and prioritisation for 25/26 has commenced within the quadrumvirate ahead of next business planning cycle. Greater understanding within division of systems and processes for business planning and follow up consideration of business cases.	A	Douglas Salvesen - Divisional Medical Director Women's & Children's Services Amanda Rowley - Director of Midwifery Kate Fruin - Divisional Director of Ops	Apr-24	See Progress Column
Sustainability Action Plan	SAP19	Culture and Diversity	Experience	Development of the MNVP.	Integration of the Neonatal and Maternity service users Group in to a single MNVP.		AUGUST UPDATE: MNVP was merged on ?date and now attend regular QI projects as well as the monthly Maternity Improvement Senate meetings. MNVP manage their own Facebook page and forum and hold monthly and quarterly meetings for women and service users to ask questions and receive updates.	G	Frankie Kilmurray - Consultant Midwife Deborah Macpherson - Matron for Community	Jun-24	Same from MIS 7 / local QI projects agreed at MNVP board with LMNS oversight
					The development of patient improvement partners, recruited from the MNVP, who could attend team training in QI via the trust QI team, and could be buddied up with QI projects in the department.			A	Frankie Kilmurray - Consultant Midwife Deborah Macpherson - Matron for Community	Jun-24	
					More widespread engagement of service users, including "lesser heard" groups in the community.			A	Frankie Kilmurray - Consultant Midwife Deborah Macpherson - Matron for Community	Jun-24	
Sustainability Action Plan	SAP20	Leadership and Staffing	Governance	Develop and publish a womens and Neonatal Strategy	Strategy to be aligned to the national Maternity Transformation Programme, local maternity and neonatal systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and the 3 year delivery plan	Strategy to be published by January 2025. Strategy to be published on theTrust website and shared within all areas / teams for awareness and to ensure that all are clear on the stratetic priorities for womens and neonatal services. Quarterly reviews and monitoring through womens and neonatal divisional QSC Strtegy to be incuded in the perinal risk startegy to ensure alignment. Annual engagement event to ensure strategy reflects current priorities and to ensure forward planning.	Divisional and care group strategic objectves for 24/ 25 completed. Quality team collating all ongoing QI workstrems in order to streamline and prioritise. Workshop to scope workstreams in short and long term startegy scheduled for 30th October. Project lead for the devleopment of the startegy assigned - Pam Langford, Better births Midwife.	A	Amanda Rowley - Director of Midwifery Ini Oranugan - CD for Obstetrics Pam Langford - Better Births Midwife	Jan-25	
Sustainability Action Plan	SAP21	Leadership and Staffing	Governance	Continue to stregthen and support perinatal pathways and ways of working through collaborative role modelling and positive leadershp	Pathways between CLU and neontates Transtional care capacity and support. Collaborative working and stregthened sense of team MDT approach to cultural improvements	Attendance across maternity, Obstretric and Neonates to professional conversations workshops. Review of daily sit rep to ensure always MDT with opportunity for neonetal team to share challenges / escaltions. Leadership forus on processes related to inutero transfers.	Monthly perinatal Quad meetings continue to progress the action plan in response to the SCORE survey across all areas. Use triangualtion of data from incidents, complaints and staff feedback to inform and progress strengthened perinatal working at all levels of the service.	G	Amanda Rowley - Director of Midwifery Mona Modi - CD neonates Laura Kelly - Matron for neonatal unit Emma Mulvihill - Deputy Director of operations for W&C	Jan-25	
Sustainability Action Plan	SAP22	Leadership and Staffing	Governance	Ensure the continued high profile of maternity services at Trust Board and Management Executive, ensuring any barriers to progressing improvements are raised through exective and perfomance meetings	Strengthen governance at care group level following the appointment of clinical care group lead and creation of the triumvirate for the womens and neontal care group	Following appointment of clinical services lead (MM) new Obstetric CD appointed (IO). Completion of Strategic Objectectives for womens service care group Team development led by triumvirate for womens care group.	First care goup away day held with the care group triumviraes. Plans to build o this with future away days and coaching and development programme.	G			
					Introduction and opportunities for the Lead Divisional Director to build influence	Director of Midwifery to present at each Trust Board and contribute to board seninar meetings. Diresor of Midwifery as lead Divisonal Director to chair the divisional performance Board and give assurance and take overall accountability for financial sustainability of materntiy services at divisonal level, escalating challenges or barriers through performance meetings. Review role and contribution of the NED board level safety champion in strengthening the voice of maternity services at Trust Board.	Director of Midwifery appointed as lead Divisional Director for Womens and childrens and is now a member fo the Trust Management Group ensuring that all serfives in the diviison are represented. New NED safety Champion appointed. Monthly walkarounds and a new safety champion monthly meeting now established with clear terms of refererence. Continued attendance of the safety champions minimum of quarterly at Quadumvirate meetings. Clear routes of escalation and requests for support through the divisional performance meetings (monthly). Director of Midwifery attending bi monhtly trust Board seminars in new role as Lead Divisional Director	G			

Hertfordshire and West Essex Integrated Care System

HWE ICS Performance Report

September 2024

Working together
for a healthier future

Executive Summary – KPI Risk Summary

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

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

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

Low Risk	Programme
2 Hour UCR	UEC
Patients discharged before Noon	UEC
Community Waits (Adults)	Community

Variable Risk	Programme
% of on the day GP Appointments	Primary Care
% of <14 day GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
NHS 111 Calls Abandoned	UEC
Ambulance Handovers	UEC
ED 4 Hour Standard	UEC
No Criteria to Reside (NCTR)	UEC
Out of Area Placements	Mental Health
Talking Therapies	Mental Health
Severe Mental Illness (SMI) Health Checks	Mental Health
31 Day Standard	Cancer
62 Day Backlog	Cancer
62 Day Standard	Cancer
RTT 78 Week Waits	Elective
RTT 52 Week Waits	Elective

High Risk	Programme
Ambulance Response Times	UEC
CAMHS 28 Day Standard	Mental Health
Community MH - CYP Waits for 1st Appt	Mental Health
Community MH - Adult Waits for 2nd Appt	Mental Health
RTT 65 Week Waits	Elective
Theatre Utilisation	Elective
Autism Spectrum Disorder (ASD)	Community
Attention Deficit Hyperactivity Disorder (ADHD)	Community

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

Executive summary

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

- Hours lost to handover >15mins continues a trend of improvement. 1,960 hours were lost in July, which is ahead of trajectory to reach the system's fair shares target by Mar-25
- 4-hour ED performance improved to 75.2%, narrowly missing the July recovery trajectory of 76.2%. Largely driven by WHTH gains. Significant variation at Place level (ENH 72.9%; SWH 83.5%; WE 65.8%)
- NHS 111 abandoned call performance continues to improve. Whist not achieving the 3% national standard, July's abandonment rate of 4.9% was the lowest since September 23
- Category 2 ambulance response times reduced slightly to 48 minutes in July. However, HWE continues to have the longest response times in the region, with the EOE average being 34 minutes

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

- Following a 7-month trend of reduction, the overall elective PTL has grown slightly in each of the last 4 months
- 78-week waits continue to improve, with WHTH and PAH both reporting zero at end of July. ENHT are forecasting zero for September
- 65-week waits are behind planned trajectory overall for the system, with PAH being the most pressured trust. The latest end of September forecast is 359 against the national zero ambition

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

- 6-week wait performance across the ICS fell to 55.5%, primarily driven by a decline at ENHT following the inclusion of Audiology data. HWE now has the lowest system performance in England

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

- 28-day Faster Diagnosis Standard (FDS) performance improved in May and June months and is meeting this year's 77% ambition at 80.2%
- 62-day performance is meeting the 70% target, but with notable variation at Trust level (ENHT 82.8%; WHTH 74.1%; PAH 52.3%). 31-day performance continues to fluctuate just short of the national 96% standard

MENTAL HEALTH / LD	**Community MH (1st appt)**	**National: HWE better than average (Adult)**	**LDAHC**	**Regional: HWE better than average**

- Learning Disability Annual Health Checks (LDAHC) – performance remains strong with all three Places exceeding their equivalent 23/24 positions at this point in the year
- The rise in Out of Area Placements (OAPs) seen in early 2024 has been stemmed, with current levels fluctuating around the historic average. Aston Ward at The Lister remains closed with ongoing estates work
- Community Adult MH waits for a 2nd contact improved further to 53 days for the quarter to June. This is now back to the historic mean, and significantly better than the national average of 129 days

CHILDREN	**Various**	**Community 18 Week %: HWE worse than national**	**Community MH 2nd Appts: HWE better than national**

- The total number of children on community waiting lists remains very high but has plateaued over the last 14 months. Longest waits have increased further to 127 weeks, compared to 51 weeks for adults
- 18 week % for children's community waits is 43.2%, compared to the national average of 55.8%. The main pressure areas continue to be Community Paediatrics, therapies and Audiology services
- Autism Spectrum Disorder (ASD) waiting lists and times continue to grow as 24/25 funding / investment remains unresolved. ADHD services are also high risk due to rising demand and waiting lists
- The 28-day CAMHS access standard in Hertfordshire has not been achieved since 2021. At c.70%, performance is notably better than Q4 23/24, but continuing vacancies are impacting full recovery
- Children's waits for a Community MH 1st appointment continue to better the national average. However median waits are 133 days, compared to 53 days for a 2nd contact in adult services

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

- The % of adults waiting <18 weeks remains strong at 92.6% compared to the national average of 84.9%

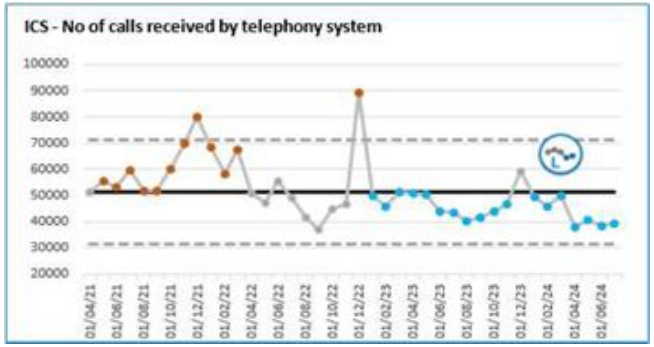
PRIMARY CARE & CHC	**Appointments <14 Days**	**National: HWE in line with national average**

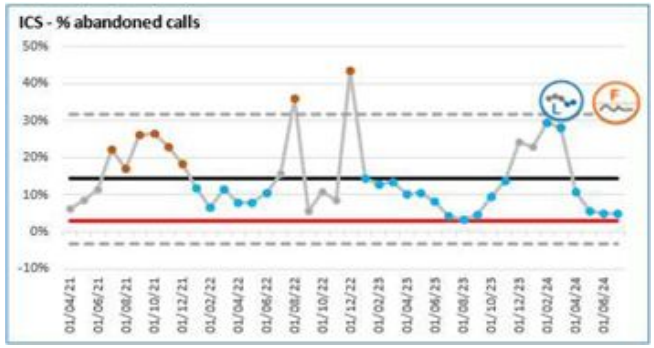
- GPPS 2024 Dental Access results shows HWE as the best performing in East of England
- The % of appointments seen on the same day remains within common cause variation limits. The % seen within 14 days of booking is marginally below this year's plan of 89%
- CHC assessments within 28 days have improved slightly over the last two months but remain significantly challenged, most notably in South & West Hertfordshire with performance at 28% in June

Performance by work programme

Hertfordshire and West Essex Integrated Care System

NHS 111

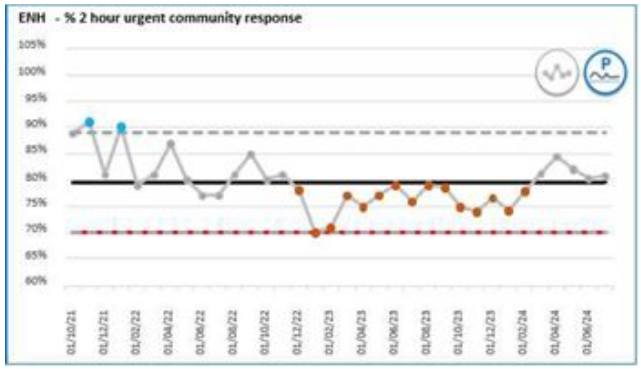


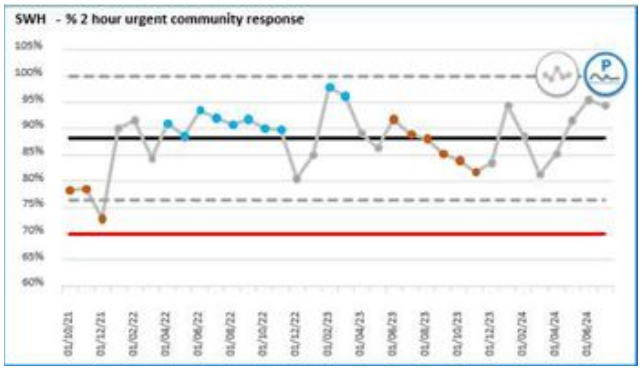


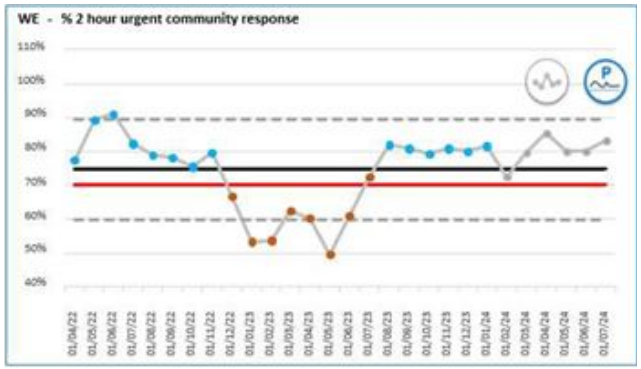
ICB Area	What the charts tell us	Issues	Actions
HUC	• Call volumes have been consistently trending below the historic mean for the last 17 months, other than a spike in December when more than 10,000 additional calls were received • Significant improvement in abandoned call rates from the yearly highs seen in February and March	• Recruitment continues to be challenging, particularly for evening / weekend shift patterns as these are not desirable • Volume of high calibre candidates for future training courses has been hindered. Candidates delay start of training due to summer holidays and childcare • National shortage of smartcards has increased the average handling time for new starters, of which c.30% are in their probation period	• Escalation of smartcard shortage issue to NHSE • Cross-site networking remains in place as HUC moves to a pan-HUC model to increase efficiencies and resilience. As a result, rota fill has continued to improve through July • Deep dive into average handling time to review mitigations and improve KPI performance • Deep dive into pan-HUC rotas to ensure resilience against demand spikes and seasonal variation • Actively promoting health and wellbeing to ensure staff are well supported • Continued assessment centres to support high attrition levels. Regular meetings are taking place with recruitment teams, and strategic plan in place for the next 3 months

Hertfordshire and West Essex Integrated Care System

Urgent 2 Hour Community Response (UCR)







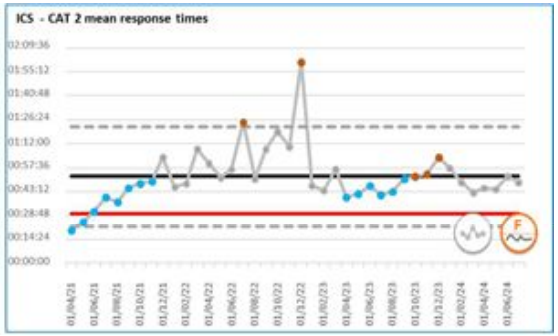
Activity	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
West Essex	330	394	399	453	344	301	313	317	412	397	416	391	461
East & North Herts	641	649	693	643	631	650	709	568	707	736	691	621	659
South & West Herts	232	159	175	180	158	157	213	212	209	237	217	246	204

ICB Issues, escalation and next steps

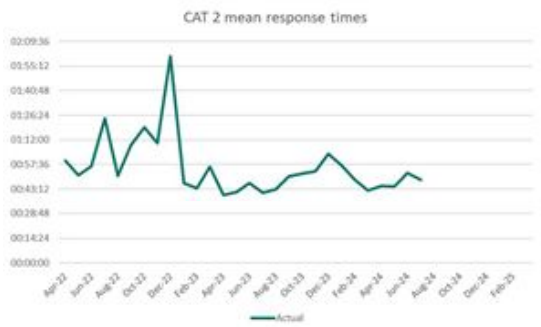
- The ICS and all 3 Places continue to achieve the 70% standard
- CLCH Trust wide task and finish group set up to ensure data is pulled correctly. Weekly validation between divisional business team and service remain in place

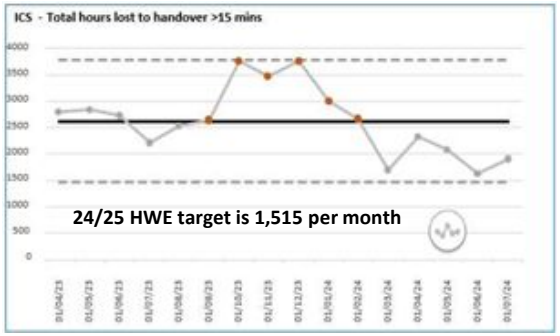
Hertfordshire and West Essex Integrated Care System

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



Recovery Trajectories





What the charts tell us

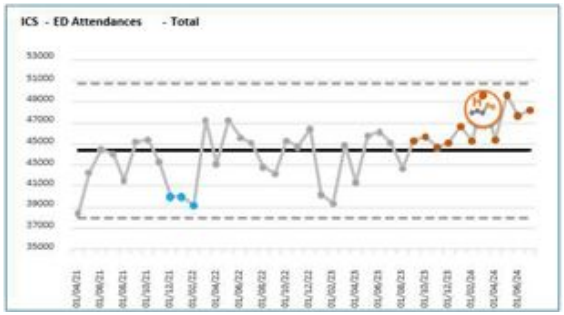
- The mean Category 2 ambulance response time was 48 minutes in July. This is higher than Jul-23 (41 minutes) and is significantly adrift of the national 30-minute standard
- Mean C2 response times in HWE are consistently longer than the regional average, which in Jul-24 was 34 minutes
- Hours lost to handover >15 mins have decreased significantly from a peak of 3757 in Dec-23 to 1960 in Jul-24. This is ahead of the trajectory to reach the system's fair shares target by Mar-25

ICB Issues and actions

- Ambulance incidents across the system were 8% higher in Jul-24 compared to Jul-23
- c.90 WTE vacancies at EEAST in the HWE region
- This means that the patient facing staffing hours per ambulance incident was 5.2 in HWE in Jul-24 compared to 5.9 across the region as a whole
- From September, EEAST is going to be a Tier 1 organisation and subject to Tier 1 meetings with NHSE. This is primarily in response to EEAST's CAT 2 mean response time performance

Hertfordshire and West Essex Integrated Care System

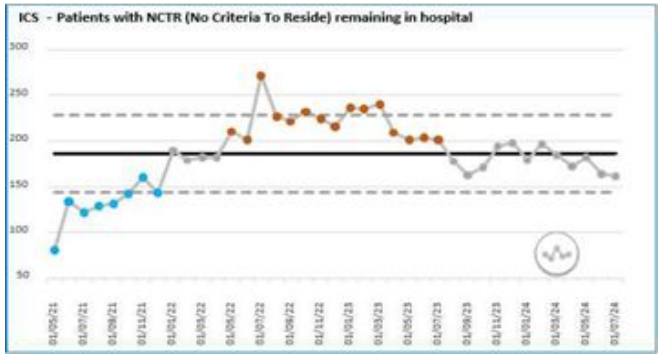
UEC – Emergency Department

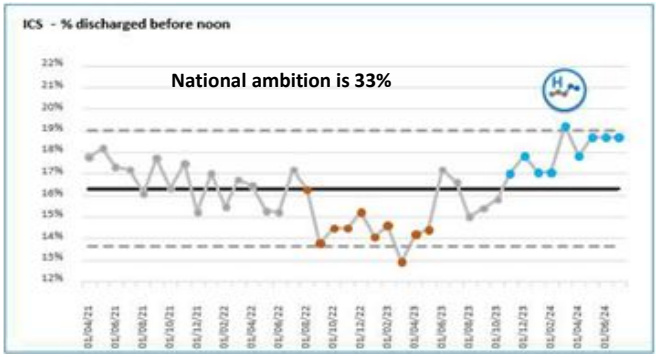


Recovery Trajectory

What the charts tell us	Issues	Actions
• 4-hour ED performance at a system level improved from 74.4% in June to 75.2% in July • This is the fifth month in a row when the ED performance has been above / close to the upper process limit • However, performance remains slightly below the recovery trajectory target of 76.2% for Jul-24 • The number of attendances remain high and have been above average for 11 months in a row • There is significant variation at place level and the gaps between places have increased. In July: o SWH = 83.5% Improving trend o ENH = 72.9% Improving trend o WE = 65.8 Common cause variation	• Continued high demand and high acuity of patients. ED attendances across the system were 7% higher in Jul-24 than they were in Jul-23 • Mental Health (MH) presentations at ED remain high, coupled with a shortage of beds / assessment space. Analysis suggests that MH patients are more likely to wait >12 hours • Hospital flow remains challenging with high occupancy rates, especially at PAH where average bed occupancy in July was 96.5%	**System** • System-wide demand management workshop taking place in August **East and North Herts** • Lister UTC opening hours extending to 12pm (Aug-24) • New ED registrar rosters start (Aug-24) • CDU chairs expand to 10 (Aug-24) • Paediatric UTC (Aug-24) • New Combined Streaming & Triage (Striage) process • ED admitting rights for some defined pathways **West Essex** • Review of Medical and Surgical SDEC demand vs staffing capacity across 7 days (Aug-24) • Refocus on Clinically Ready to Proceed within Furthers (Aug-24) • Child Health and Women's Services Division (CHAWS) focus on 4 key work streams: Model of Care, Governance, Pathways, Data & BI (Aug-24) • DVT pathway established - SDEC to IUATC (Aug-24) **South and West Herts** • West Herts had the fifth best ED performance nationally in July (excluding specialist children's hospitals) • Forthcoming actions focused more on discharge / flow and are therefore covered in the following section

UEC – Discharge & Flow

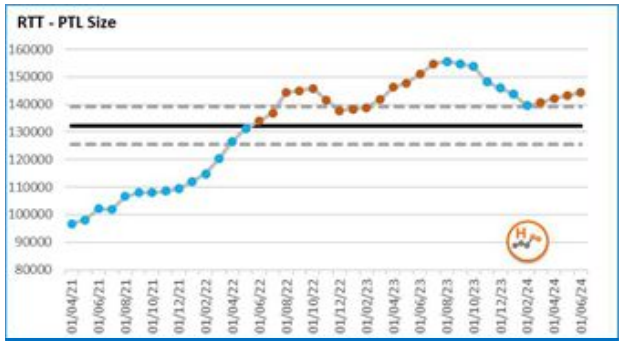


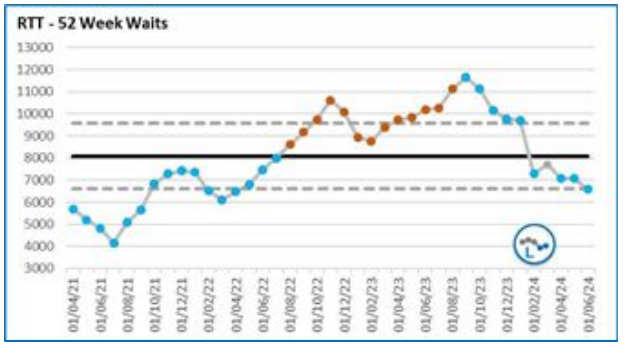


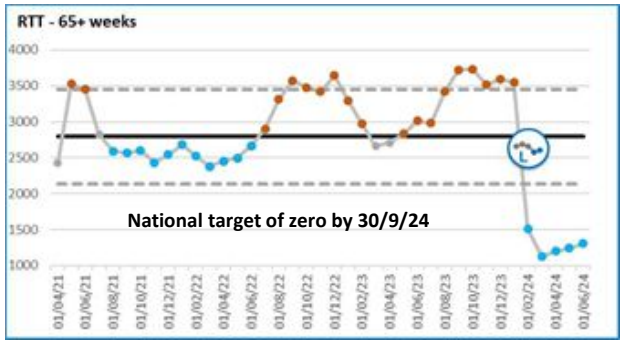
What the charts tell us	Issues	Actions
• The system-level daily average number of patients with no criteria to reside remaining in hospital has been reducing over the last two years, but remains within common cause variation limits • The Jul-24 figure of 162 patients per day is the lowest since Dec-21 • The % of patients discharged before noon is improving, but this is primarily driven by improvements at WHHT	• There remains significant variation across the three HWE acute trusts for the % of patients discharged before Noon. In Jul-24: o ENHT – 17.9% o WHTH – 23.3% o PAH – 11.8% • The issues are typical discharge challenges, including: o Availability of out-of-hospital capacity o Complex discharges o Internal process delays	**East and North Herts** • Set parameters for discharge improvement work. MADE week 9th -13th September 2024 • New complex care pathway implemented • Review TOCH function **West Essex** • 2-week audits conducted - community bed utilisation review and VH referrals and utilisation of capacity • Design Voluntary Sector Role in D2A (Pathway 0 & 1) (Aug-24) • Refreshed focus on Pathway 0 discharges and discharges before 12pm (Aug-24) • CCC patient tracker to be shared with Place UEC leads (Aug-24) **South and West Herts** • Develop proposal for transfer of care hub and share with senior leaders (Sep-24) • Discharge-to-assess staff in place (Aug-24) • Develop detailed resource map for discharge pathway

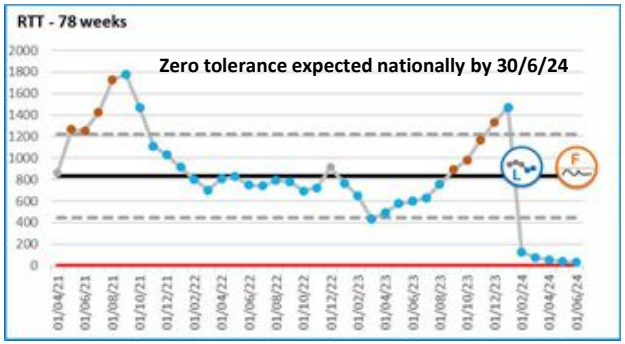
Hertfordshire and West Essex Integrated Care System

Planned Care – PTL Size and Long Waits









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

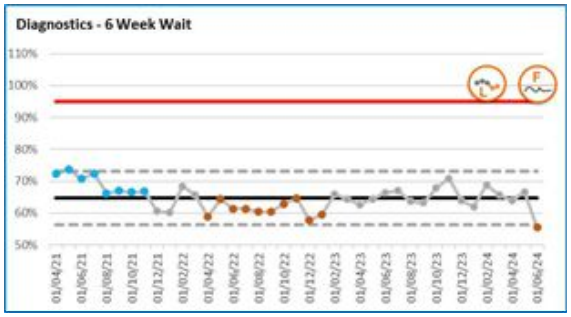
Planned Care – PTL Size and Long Waits

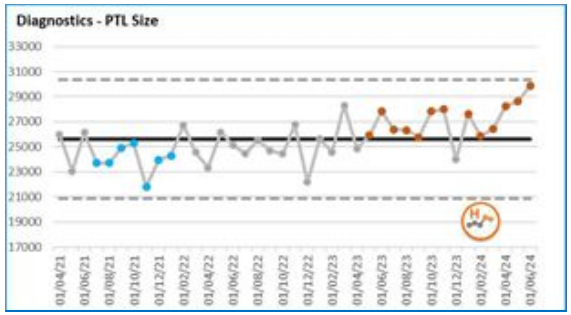
ICB Area	What the charts tell us	Issues	Actions

HWE	• June saw a decrease in 78ww long wait breaches, with PAH reaching zero breaches in July (WHTH zero since April) and ENHT forecasting reaching zero by September
	• The number of patients waiting >65 weeks has been steadily increasing over the last four months
	• Excluding Community Paediatrics, the number of patients waiting >52 weeks has shown a decreasing trend over the last seven months
	• The overall PTL size remains high. Uptick in the last four months, following a 7-month period of reduction
	• Due to the change in national guidance, Community Paediatrics patients have been excluded from RTT reporting from February 2024. Waiting lists therefore show significant reductions from February 2024. These waits are included within the Community section of this report
		• The latest 78ww August forecast (as of 28/8) for the system is 14
		  ○ 8 at ENHT
		  ○ 6 in the independent sector (transferred from PAH)
		• 65ww actuals are behind planned trajectory overall for the system, primarily driven by slippage at PAH. The target is to reach zero by end of September, although the current HWE system forecast is 359
		• The 65ww at risk cohort is on trajectory in Hertfordshire, but not meeting plan at PAH
		• Two theatres closed at PAH in mid-August due to failure of air-cooling systems. Capacity impacted / risk to 65-week recovery
		• Trauma and Orthopaedics (T&O) remains the main specialty under pressure, with ENT also a notable risk
		• Staffing remains a challenge, particularly in Anaesthetics
			• Princess Alexandra Hospital is in Tier 2 of the national oversight and support infrastructure for Elective (including Diagnostics) recovery. Fortnightly tiering meetings with the NHSE EOE regional team commenced on 9th May
			• Incident Management Team (IMT) established to manage reopening of two closed PAH theatres. Mutual Aid and ISP support across the system enacted
			Management of waiting lists
			• System focus on reducing number of patients waiting >78 weeks and >65 weeks, with regional and national oversight
			• Demand, capacity & recovery plans are in place to monitor 78 & 65 weeks
			• Weekly KLOEs in place with NHSE to track 104/78/65-week positions
			• Fortnightly performance meetings with each of the three acute Trusts are in place with NHSE support
			• Validation and robust PTL management in place
			Increasing capacity and improving productivity
			• Repair works have commenced on the two currently closed PAH theatres. Operating scheduled to recommence 9th September
			• Pro-active identification of pressured specialties with mutual aid sought via local, regional & national processes
			• Outpatients has a full programme of work to increase productivity including PIFU (patient initiated follow up), reducing follow ups including discharging where appropriate, and increasing take up of advice & guidance
			• Maximising use of ISP capacity and WLIs where possible
			• Theatre Utilisation Programmes in place including an ICB wide programme
			• Anaesthetist recruitment
			• PAH Vanguard Theatre live 19th August

Hertfordshire and West Essex Integrated Care System

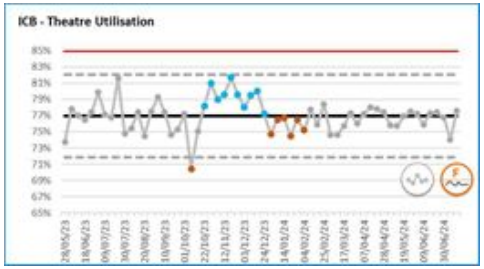
Planned Care – Diagnostics

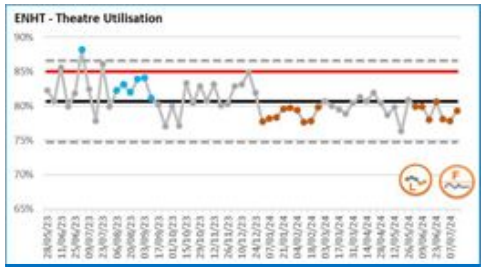


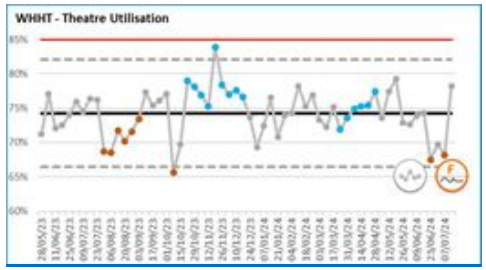


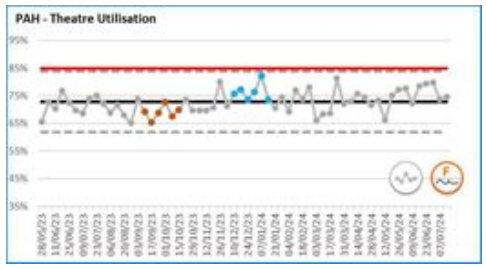
What the charts tell us	Issues	Actions
• 6-week wait performance across the ICS fell to 55.5%, primarily driven by a decline at ENHT following the inclusion of Audiology data • Performance improved at WHTH to 91.6% and dipped slightly at PAH to 69.9% • The overall PTL has shown a continuous increase over the last five months and is at the upper common cause variation limit	• Significant variation in Trust performance: ENHT – 39.2% / WHTH – 91.6% / PAH – 69.6% **ENHT** • The significant drop in % of patients waiting <6 weeks has been caused by Audiology returning to reporting. There are notable capacity issues within the service • Audiology DM01 performance in June was 2.3% • Ex. Audiology, the longest waits remain in DEXA and MRI **PAH** • Non-Obstetric Ultrasound (NOUS), Echocardiography, Cystoscopy and Audiology remain the key challenges at PAH • There has been notable improvement in Endoscopy performance compared to last year **WHTH** • Audiology remains the most significant risk to performance	**ENHT** • Adult Audiology: exploring outsourcing options; waiting list cleansing exercise under-way; 1WTE new starter in August • Paediatric Audiology: mutual aid is being provided by CUH, MSE and CHEAR; band 7 Audiologist starting in October; insourcing companies being explored but there are issues with the suitability of the rooms at ENHT • ENHT is progressing with several initiatives to increase imaging capacity, including: o Continued outsourcing MRI to Pinehill and utilising a mobile scanner on the Lister site o CT increasing capacity for evening / weekend sessions o DEXA increasing capacity through return to work of 0.4WTE and DEXA lead post out to advert. o New Ultrasound sonographer moved to 8 sessions per week at the end of July **PAH** • PAH CDC is live for MRI, X-Ray and US Extended Access through insourcing and existing facilities • Significant slippage with St Margarets CDC build. PAH, ICB, and NHSE regional / national teams working together to resolve • NOUS weekend insourcing in place and has cleared c.650 patients from the backlog • Echo funding secured for additional Cardiographer, but recruitment is challenging. Currently a 55-capacity gap per week • There has been improvement in the 6-week backlog in Cystoscopy with an improved June performance of 63.8% • Audiology insourcing was deployed in July with capacity for 74 assessments per week **WHTH** • Audiology is improving month on month and work is ongoing

Planned Care – Theatre Utilisation / Productivity





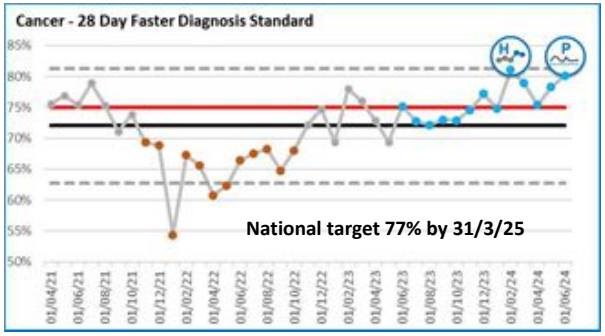


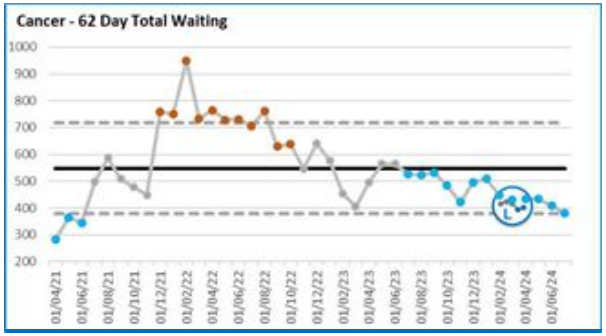


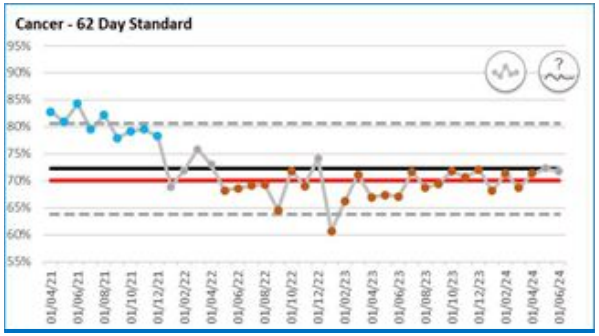
ICB Area	What the charts tell us	Issues	Actions
HWEICB	• ICB theatre utilisation is 77.2% against an 85% target • Comparable performance v. peers for all aspects, excluding average unplanned extensions **Other data** • Average cases per session for the ICB (2.3) is on a par with peers, although PAH is below average at 1.8 • For sessions finishing early, the average minutes lost was 82 for the ICB, which is worse than peers who have an average of 79 minutes, and much higher than the expected 15-30 minutes	• Overall productivity has improved in July, with a significant improvement at WHTH. ENHT and PAH have remained relatively static • ENHT – although generally good performance, capped utilisation has yet to achieve the national target of 85% and is currently 79% • PAH – consistently high conversion from day case to inpatient rate, alongside a low day case rate, with capped utilisation dropping in June with a small improvement in July reaching 75% • WHTH - capped utilisation rates dropped in June but made significant improvements in July	• Improvement programmes are discussed at the Theatre Utilisation Network Group • A series of reviews have taken place with Trusts through the GIRFT theatre programme team and improvements are underway as can be seen through the improved numbers • Active theatre improvement programmes at each of the acute providers • There is a GIRFT review planned for H3

Hertfordshire and West Essex Integrated Care System

Cancer







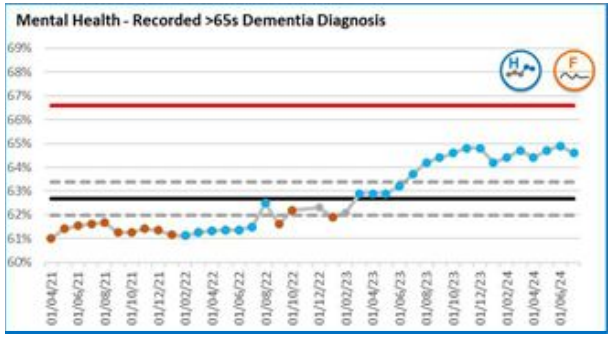
Hertfordshire and West Essex Integrated Care System

Cancer

What the charts tell us	Issues	Actions

• 28-day Faster Diagnosis Standard (FDS) performance has improved over the last two months and is above target at 80.2%
• All three acute Trusts surpassed the 75% FDS standard in June
• The 31-day target was reached collectively in June, although both PAH and WHTH narrowly missed the target
• Performance against the 62-day standard remains below the national target but is achieving the 70% standard expected in the 24/25 National Planning Guidance
• There is significant 62-day variation between Trusts:
  ○ ENHT 82.8%
  ○ WHTH 74.1%
  ○ PAH 52.3%
• The 62-day backlog has been improving over the last three months
	• There are no 62-day backlog targets for 24/25
	• Oversight is focussed on achievement of the national FDS, 31 & 62-day standards
	
	ENHT
	• In June, the 62-day standard was not met - 82.8% vs 85% standard. However, the Trust's performance is above the planning guidance target of 70% and above the national average of 67.4% in June
	• The Urology pathway had the highest number of 62-day standard breaches in June
	• For the week ending 4 August, there were 187 patients on the cancer 62-day backlog following an urgent suspected cancer referral. There have been some increases in recent weeks, but the Trust is close to its recovery trajectory for 24/25
	
	WHTH
	• 28-day FDS Improvement seen overall, however some smaller volume pathways are not meeting the standard (Haematology, H&N, Lung)
	• 31-day performance is variable, however continual under performance in Breast. Short term closure of a theatre due to CDC development has impacted, however cancer lists are being prioritised
	• 62-day Improvement in Gynae and LGI in June in comparison to the proceeding months
	
	PAH
	• Urology staffing / capacity. Urology is particularly challenged in both FDS and 62-day % performance
	• Increase in Skin referrals
	• Skin / Oral and Maxillofacial Surgery (OMFS) capacity
	• Reliance on tertiary centres for multiple tumour sites
		ENHT
		• The Urology two-stop service was not introduced at the end of July as planned. However once the MRI capacity is in place, this pathway change will be made. Urology nurse has been trained to start TP biopsies by end of September 24
		• Associate Medical Director for Cancer to meet with Breast Lead to implement negative result letter
		• Head & Neck – Increased one stop service to 8 slots per week at the end of July
		• Gynaecology – complete pathway analysis by end of September
		
		WHTH
		• Cancer Improvement Programme Board continues to oversee service level plans and service developments
		• Pathway analyser work to be carried out on the Haematology, H&N and Lung Pathways
		• Benign diagnosis project completed, and all tumour sites now live
		• Revised Gynae and Urology urgent suspected cancer referral forms are in use
		• Development continues of one stop diagnostic pathway for Urology. Looking at operational planning and reviewing job plans due to recruitment challenges. Go live delayed as dependent on recruitment of workforce
		• Redistribution of Cancer Transformation Funding agreed to support pathway challenges attributed to Radiology
		• Planning continues for transformation of Acute Oncology Service (AOS) and the establishment of a Cancer / Haematology ward (Granger) at WGH
		
		PAH
		• Princess Alexandra Hospital remains in Tier 2 of the national oversight and support infrastructure for Cancer recovery. Fortnightly tiering meetings with the NHSE EOE regional team
		• Work is progressing with all services to align their improvement plans to support the 62-day recovery, with regular reviews at PTL level
		• Vanguard Theatre goes live 19/8/24 and will free up main theatres for additional cancer capacity
		• Skin are working on a joint clinic with their OMFS colleagues that will improve the front end of the pathway, resulting in a quicker pathway into treatments for patients with a confirmed cancer
		• Implementation of robotic surgery in Gynaecology and actively recruiting additional doctors
		• Focussed work to drive more timely transfers to tertiary providers

Mental Health – Dementia Diagnosis in Primary Care



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
ENHCCH	59.4%	59.7%	60.2%	60.2%	60.2%	59.5%	59.3%	59.5%	59.2%	59.0%	58.8%	59.2%	59.2%	59.2%	59.0%	59.1%	60.9%	59.0%	59.8%	59.7%	59.6%	59.7%	60.5%	60.7%	60.7%	61.3%	61.8%	62.5%	63.0%	63.6%	63.8%	63.7%	62.7%	62.8%	63.7%	62.9%	62.9%	63.1%	62.9%
HVCCG	59.2%	59.6%	59.6%	59.8%	60.0%	59.8%	60.1%	60.3%	60.6%	60.5%	60.6%	60.4%	60.6%	60.8%	60.7%	60.6%	61.2%	60.9%	61.3%	61.7%	61.3%	61.1%	61.1%	61.4%	61.3%	61.3%	61.5%	61.9%	62.2%	62.2%	62.1%	62.1%	61.9%	62.1%	62.0%	62.0%	62.6%	62.5%	62.3%
WECCG	67.6%	68.0%	67.7%	67.7%	67.6%	67.3%	67.1%	67.0%	66.7%	66.4%	66.5%	66.6%	66.6%	66.5%	66.9%	67.6%	67.7%	67.6%	68.5%	68.3%	67.6%	68.3%	69.9%	69.9%	69.7%	70.0%	69.8%	70.4%	70.9%	70.9%	71.5%	71.5%	71.5%	71.2%	71.2%	71.5%	71.3%	71.7%	72.2%	72.1%
ICS	61.0%	61.4%	61.5%	61.6%	61.7%	61.3%	61.3%	61.4%	61.4%	61.2%	61.1%	61.2%	61.3%	61.3%	61.4%	61.5%	62.5%	61.6%	62.2%	62.3%	61.9%	62.1%	62.1%	62.9%	62.9%	62.9%	63.2%	63.7%	64.2%	64.4%	64.6%	64.8%	64.8%	64.2%	64.4%	64.7%	64.4%	64.7%	64.9%	64.6%

ICB Area	What the charts tell us	Issues	Actions
Dementia Diagnosis in Primary Care	• ICB – 64.6% - this is below the national target of 66.7%, but broadly in line with our June planned performance • West Essex continue to achieve the standard at 72.1%, but down 0.6% from June • East and North Herts achieved 62.9%, down 0.2% from June • South and West Herts achieved 62.3%, down 0.2% from June	• High demand for memory assessment services with significant waiting lists (especially in Herts) • Estimated prevalence rate of people with dementia rises month on month • Coding exercise and case finding needed in primary care but issues with GP capacity and prioritisation, i.e. not mandated in ECF • A trajectory is now in place to reduce the waiting list and therefore recover performance against the 12 week wait to diagnosis KPI by the end of Q4	• Twice monthly meetings continue to monitor HPFT progress in Herts. Weekly performance report is produced • Herts memory service aiming to recover their KPI in Q4 • Diagnosis remains a key focus of the Herts Dementia Strategy, with a subgroup progressing actions to improve diagnosis • Need to explore improvement actions with Primary Care

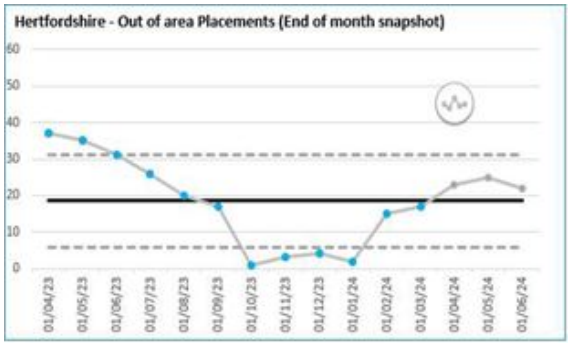
Hertfordshire and West Essex Integrated Care System

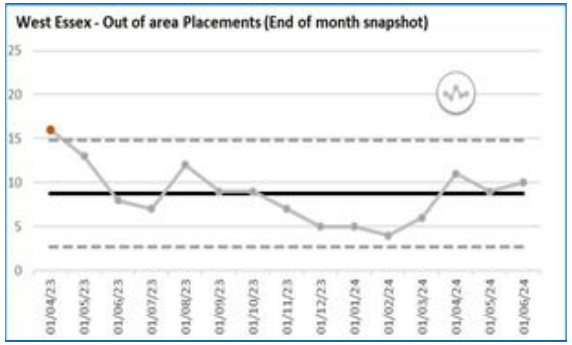
Mental Health – Out of Area Placements (OAPs)

Number of active inappropriate adult acute OAPs at month end

- The basis for measurement of OAPs has changed for 24/25
- Previous reporting was based on the number of out of area bed days in the month
- From April 24, reporting is based on the number of active OAPs at month end

HWE June total out of area placements:
32 vs. 11 plan

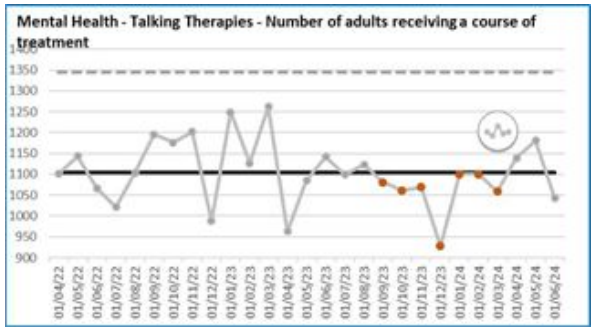




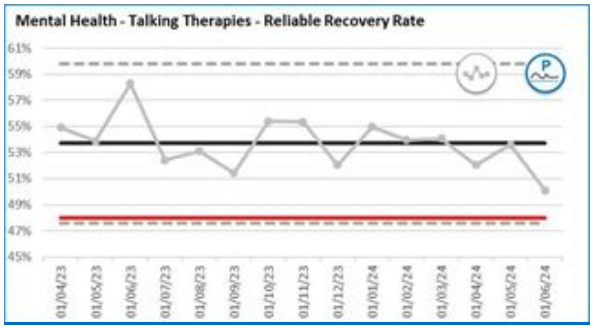
ICB Area	What the charts tell us	Issues	Actions
West Essex	• The number of OAPs continues to fluctuate within expected common cause variation limits	• A national shortage of MH beds and increased pressures on service use of inappropriate OOA beds is likely to continue • Essex risk share of inpatient beds, with increased usage of beds at place by Essex wide footprint	• Review of Essex bed stock and Essex wide risk share contract continues • Review of West Essex Community Rehab has seen an increase in discharges at place to support repatriation • Weekly system DTOC calls and ongoing focus on 'time to care and purposeful admissions' • OOAP Elimination & Sustainability Impact System Group (Essex wide) • Continued engagement with national Getting It Right First Time (GIRFT) programme to identify areas of improvement • Full review of bed occupancy and risk share agreement across Essex, including OOA, rehab and repatriation
Herts	• Following a sustained period of improvement, Out of Area Bed Days rose in early 2024 due to a combination of increased demand and delayed transfers, as well as the closure of Aston ward (20 beds) at Lister site due to Water Safety Incident	• Reduced capacity due to Aston Ward closure. No firm date as yet for re-opening. Additional beds have been purchased from trusted providers • Herts low number of beds per population – now supported by provision of additional block beds • National shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Placement challenges for service users with complex needs who are ready for discharge • Inpatient and Community recruitment	• Further alternatives to admission – Crisis House – in place • Wider Executive led work at system level to support placement of longer term DTOCs • Bed management system went live in Hertfordshire w/c 17 June 2024, supported by new arrangements in place to monitor demand and capacity • No firm date for access to Aston ward which had been expected in July. Ongoing joint working with ENHT to resolve the estates issue. OAP trajectory being monitored regularly and adjusted accordingly. Challenging to produce a trajectory for reduction with present uncertainties • The National Director for MH issued a Letter in May 24 regarding reducing mental health OAPs. The communication included initial proposals for national and regional action, setting actions for providers to reduce these placements. Much of the ask is already in place in HWE • A group from across the system established will continue to meet to review and oversee some of more complex discharge issues • Invitation letter from DHSC and NHSE for an information gathering visit to Hertfordshire ICS to help develop future policy and plans on discharge from mental health settings – initial meeting on 4 Sep 2024

Talking Therapies

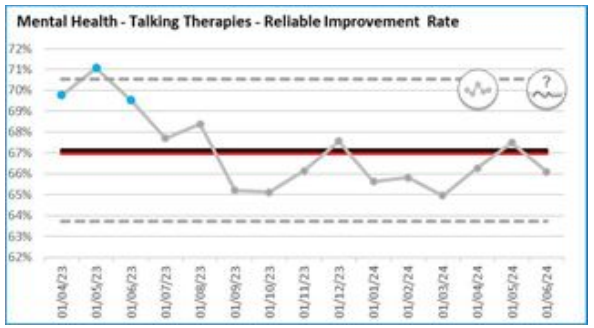
Number of people who are discharged having completed a course of treatment
Number of patients that achieved reliable recovery
Number of patients that achieved reliable improvement



Adults receiving treatment	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Hertfordshire	969	933	976	921	901	923	778	925	930	875	925	956	845
WECCG	173	166	147	160	160	146	150	175	170	184	214	225	199
ICS	1142	1099	1123	1081	1061	1069	928	1100	1100	1059	1,139	1181	1044



Reliable recovery rate	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Hertfordshire - Actual	50.4%	52.4%	53.1%	51.3%	55.8%	55.6%	52.6%	55.2%	53.9%	54.0%	50.8%	52.6%	49.7%
West Essex - Actual	55.9%	53.1%	52.4%	57.1%	44.0%	42.9%	33.3%	48.0%	56.0%	57.1%	57.0%	57.5%	51.79%
ICS Actual	54.3%	52.4%	53.1%	51.4%	55.4%	55.3%	52.0%	53.0%	54.0%	54.1%	52.1%	53.6%	50.11%



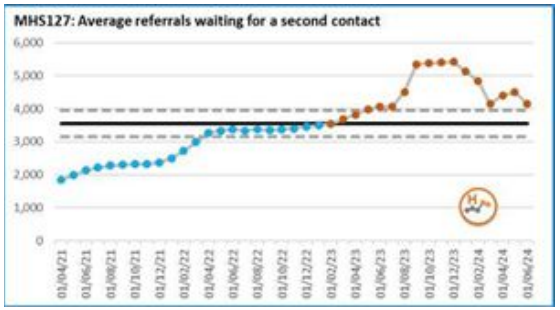
Reliable improvement rate	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Hertfordshire - Actual	68.9%	67.1%	67.7%	65.1%	64.3%	66.3%	68.3%	65.7%	65.3%	63.7%	64.8%	66.8%	64.5%
West Essex - Actual	72.83%	71.10%	75.38%	65.63%	70.00%	65.67%	64.00%	65.14%	68.82%	71.20%	72.90%	70.5%	72.9%
ICS - Actual	69.53%	67.72%	68.40%	65.22%	65.11%	66.14%	67.56%	65.64%	65.82%	64.97%	66.29%	67.5%	66.1%

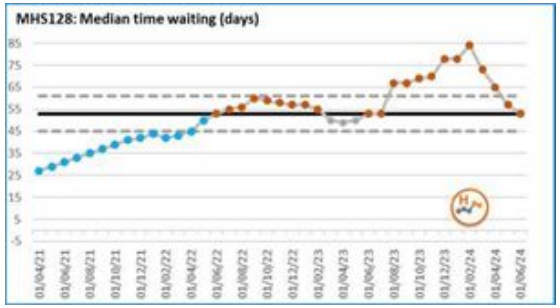
ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• Decline across the system compared to May, but the number of people completing a course of treatment is within expected common cause variation limits • The System and Places are consistently achieving the reliable recovery 48% standard • West Essex is achieving the reliable improvement 67% standard. Hertfordshire performance is slightly lower at 64.5%	• Understanding and interpreting the new national targets to ensure consistency of data collection and quality across the system • Continuing focus on addressing attrition and drop-out rates are a key challenge following the change in counting for 24/25 • Measurement now relates to completion of a course, with at least two appointments. Previously was access / first appointments • Reliable improvement rate for those completing a course of treatment in Hertfordshire requires slight improvement. Target was reached in May at 66.8% but dipped to 64.5% in June	• Ongoing partnership working across the system with NHSE to provide support clarity and data validation • Introduction of a ICB wide NHS Talking Therapy group specifically looking at new metrics that will support HWE performance as well as an Essex wide contract forum • Ongoing conversation with NHSE regarding additional trainee posts for services in line with workforce planning ICB wide • Procurement of counselling providers in Hertfordshire by January 25, leading to an improvement of pathways and ensuring right modality in place for service user

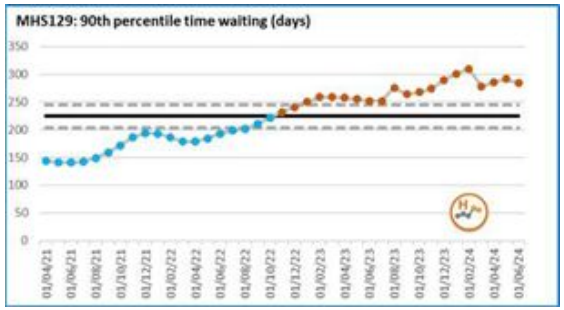
Hertfordshire and West Essex Integrated Care System

Mental Health – Community Waits

Adults and Older Adults – time still waiting for second contact







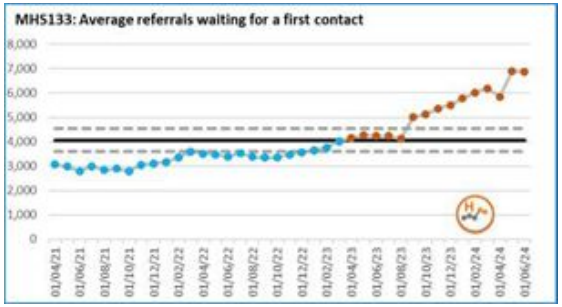
ICB Area	What the charts tell us	Issues	Actions

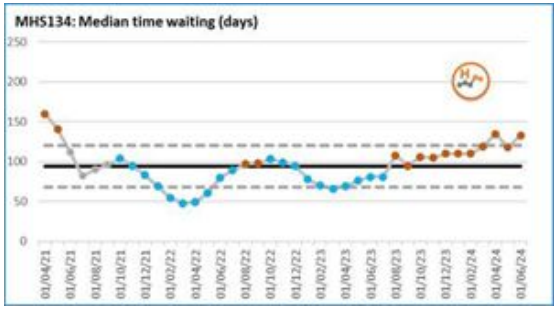
Hertfordshire & West Essex	• Median waiting times for a 2nd appt. for the quarter to June were 53 days
	• 53 days benchmarks well against the national average of 129 days, and represents the 4th consecutive month of improvement
	• Within the system there is variation of between 41 and 68 days:
	  • East & North Herts 41 days
	  • South & West Herts 68 days
	  • West Essex 45 days
	• 90th percentile waits for the quarter to June were 284 days
	• 284 days benchmarks well against the national average of 802 days, however there is a long-term trend of variation above the historic norm
	• Within the system there is variation of between 269 & 348 days:
	  • East & North Herts 269 days
	  • South & West Herts 286 days
	  • West Essex 348 days
		• Datasets are not currently complete, and work is ongoing with ICBs and NHSE to finalise collections and reporting. Issue is related to data validation as here is variation from local data sets to nationally published data
		• In Hertfordshire the data flow from Primary care and VCSFE providers to MHSDS or the GP equivalent has not been worked through. This relates to the transformed PCN areas that have ARRS workers and Enhanced Primary Care. The data collection from these new services is recorded locally on System one or EMIS but this is not a shared system with the MH Trust
		• West Essex VSCE data flow is via a shared system with MH Trust
			• NHSE working with all ICBs to finalise the data and understand variations
			• In Hertfordshire, a CQI approach is being taken to introducing the new waiting times. Current workstreams are developing internal reporting in the absence of NHSE SQL scripts being made available and ensuring all SNOMED codes are mapped correctly. Data is being analysed to understand the reasons for the longest waits
			• Hertfordshire is also working with NHSE and Voluntary Community, Faith and Social Enterprise (VCFSE) providers to look at the data flow from them to MHSDS, to include as part of the second contact information
			• Additional CQI process for Older Peoples services to ensure that refs and treatment are recorded as for adults
			• Work underway in Herts to eliminate all waiters over 104 weeks

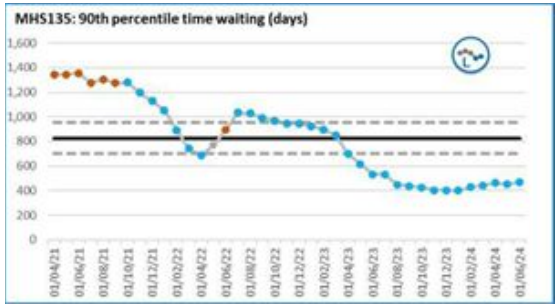
Hertfordshire and West Essex Integrated Care System

Mental Health – Community Waits

Children – time still waiting for a first contact





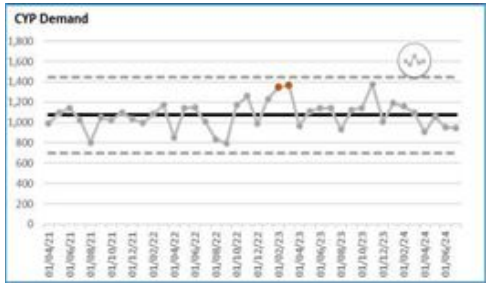


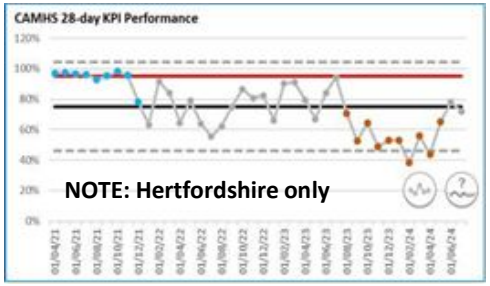
ICB Area	What the charts tell us	Issues	Actions

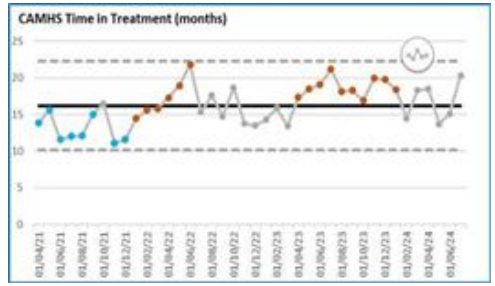
Hertfordshire & West Essex	• Median waiting times increased to 133 days and have been trending above the historic mean since August 23
	• 133 days benchmarks well against the national average of 208 days
	• Within the system there is variation of between 46 and 161 days:
	  • East & North Herts 46 days
	  • South & West Herts 161 days
	  • West Essex 96 days
	• 90th percentile waiting times for the quarter to June were 469 days, and on a long-term trend of improvement
	• 469 days benchmarks well against the national average of 752 days
	• Within the system there is variation of between 255 & 493 days:
	  • East & North Herts 255 days
	  • South & West Herts 493 days
	  • West Essex 362 days
		• The biggest impact on the Hertfordshire waiting list and long waiters is Autism & ADHD backlogs / waiting lists for diagnostic pathways
		• South & West Hertfordshire data is reflective of the historically longer waiting times in the patch
		• The 18+ week waiters within West Essex (NELFT) are predominately within the Getting Help element of the Thrive model. As @ end of April there were 3 x 18+ week waiters in the service
			• In Hertfordshire a CQI project has been initiated to take forward the new waiting times and ensure that they are reflected in the design and processes of services. Ongoing work to produce internal reporting, finalise SNOMED codes and better understand the reasons for some of the longer waits
			• GIRFT project looking at CYPMHS waiting times (up to Dec 2023) excluding ASD/ADHD
			• Local provider dashboards in place assessment & treatment activity, caseloads and waiting times. Recovery action plans in place where applicable and closely monitored by commissioning leads
			• Commissioners, HPFT and now a HCT representative are linked into EOE waiting times standards group. HPFT submitted their readiness slide to NHSE. HCT is working on theirs
			• In NELFT all waiters over 18 weeks have a clinical harm review in place and teams are working towards seeing all longest waiters

Hertfordshire and West Essex Integrated Care System

Mental Health – CAMHS Services







What the charts tell us	Issues	Actions
West Essex • West Essex does not have a formal KPI for 28 days, but this is monitored at monthly provider meetings • Demand at SPA decreased during Q1 2024/25, and caseload at end Q1 slightly higher when compared to Q4 2023/24 **Herts** • Demand into the service remains stable and within expected seasonal variation patterns • Caseloads are steady, within expected common cause variation limits and tracking around the historic median • 28 days performance has improved back to historic mean levels, but remains short of target • Time in treatment is variable, close to the historic mean	**West Essex** • Challenges continue with recruitment to specialist community eating disorder team manager and clinical lead roles **Herts** • Increased acuity / complexity of casload • Active issue regarding recruitment to vacancies impacting on capacity and performance • Acquiring highly skilled CAMHS clinicians remains difficult. Non-health support roles being used to bolster teams	**West Essex** • Recruitment drives ongoing in NELFT with rolling advertisement for ED team manager and clinical lead roles. Support to the CYP ED team provided from within the wider organisation to minimise any impact on CYP engaged with the service; progress monitored at contract meetings **Herts** • West & East CAMHS quadrants indicating improvements against recovery actions • Visible & accessible operational leadership support to sustain progress • Community Quadrant Teams action plans is in place with weekly recovery meetings focusing on safety and waiting well, in addition to recruitment & review of resources across all teams • West, South and East Teams are being supported by the wider leadership team • Ongoing focus on recruitment and retention in HPFT • Workforce Skill analysis & local plans informing recruitment activity with valued based & targeted short -term agency backfill • SPA Triage Tool improved to meet “5 day pass on to teams” target in Hertfordshire • Due to ongoing vacancies, recovery of the 28-day KPI has been revised to Autumn 24 – trajectory TBC

Hertfordshire and West Essex Integrated Care System

Mental Health – Learning Disability (LD) Health Checks

LD Health Checks June 2024	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks *	Comparison to June 2023
NHS Hertfordshire and West Essex ICB	**7,727**	**779**	**12**	**6,936**	**10.1%**	**9.9%**
East & North Hertfordshire	3,191	378	0	2,813	**11.8%**	**11.1%**
South & West Hertfordshire	3,383	288	8	3,087	**8.5%**	**8.3%**
West Essex	1,153	113	4	1,036	**9.8%**	**9.5%**

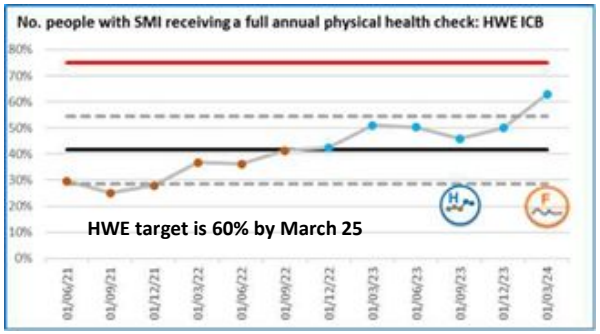
*** 75% Year End Target**

ICB Area	What the charts tell us	Issues	Actions
Hertfordshire & West Essex	• All three places achieved the 75% standard in 23/24 • June 24 data shows the ICB and each place ahead of the equivalent 2023 position at this point in the year	• It is challenging to forecast end of year performance against the 75% LD Health Checks standard, as a large proportion of health checks are carried out towards the end of the year, and particularly in Quarter 4	• Ongoing work between HWE Team and NHSE to cross check local data against national systems

Hertfordshire and West Essex Integrated Care System

Severe Mental Illness (SMI) Health Checks

Number of people with severe mental illness (SMI) receiving a full annual physical health check – percentage achievement in the 12 months to the end of the period



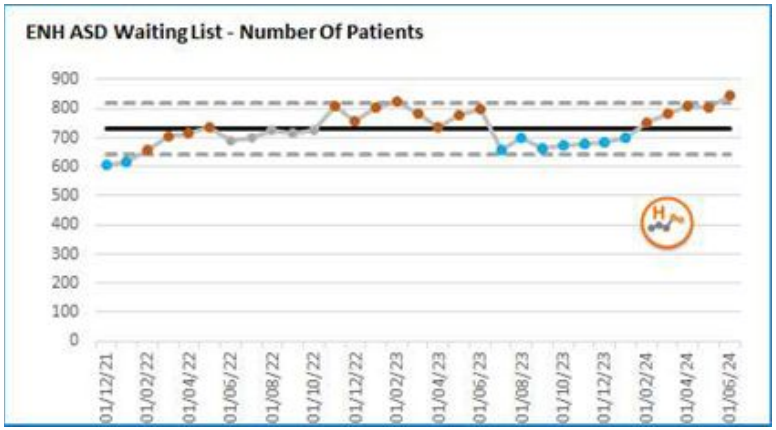
	2021/22				2022/23				2023/24			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
East and North Herts Place	19.6%	11.9%	15.1%	25.8%	24.0%	36.3%	40.4%	45.9%	49.7%	47.7%	49.4%	60.5%
South West Herts Place	39.4%	38.2%	39.5%	47.5%	44.6%	46.4%	43.6%	55.9%	51.0%	44.8%	52.2%	66.9%
West Essex Place	28.9%	24.5%	30.6%	36.5%	38.5%	38.9%	44.0%	50.4%	49.4%	44.8%	46.4%	59.2%
NHS Herts & West Essex ICB	**29.6%**	**25.1%**	**27.9%**	**36.7%**	**36.1%**	**41.3%**	**42.4%**	**51.0%**	**50.2%**	**45.9%**	**50.0%**	**63.0%**

- The systems for submitting and reporting of SMI Health Checks data has changed for 24/25
- At the point of writing Q1 data is yet to be published, but we hope to include in the next report

ICB Area	What the charts tell us	Issues	Actions
West Essex	• Notable improvement in Quarter 4. 60% end of year HWE achieved, but not achieving the 75% national standard	• Requirement to develop and sustain services that meet the physical health care needs for people with a severe mental illness diagnosis, including physical health checks and onward service provision	• Terms of reference circulated to the Local Implementation Group; extended members added to membership • Action plan in place across providers and commissioning to include support to GPs to provide improved uptake, data analysis following the check, and pathway tools to support ongoing physical health pathways • Review of current pilot to support the assertive outreach to those who do not come forward for a check • MH leads to understand population health needs across the ICB for those under MH service • Review local treatment pathways and accompanying protocols and guidance in collaboration with primary care commissioners • Identify any gaps in provision • Primary care commissioning to support the monitor performance against the physical health check performance targets • Agree service developments and joint working with primary care • Monitor quality and improvement • Support the improvement of interoperability and provider electronic care records and information systems to enable monitoring of performance against equity of access to care • Working with Regional MH Team support and feedback to the NHS England regional and national teams • Agree actions in line with national audits
Herts	• Notable improvement in Quarter 4. 60% end of year HWE achieved, but not achieving the 75% national standard		

Hertfordshire and West Essex Integrated Care System

Autism Spectrum Disorder (ASD) – East & North Hertfordshire



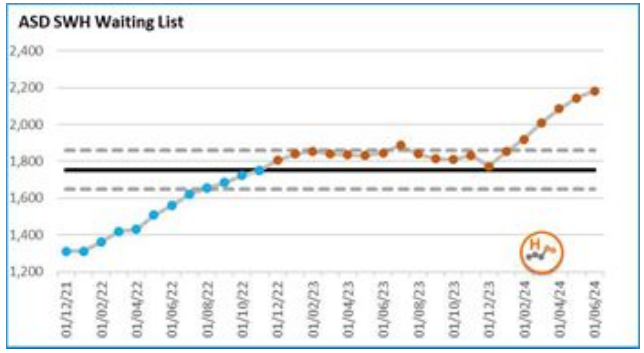
- In ENH, patients have a first appointment with Community Paediatrics. If the clinician then considers that the patient requires an ASD assessment then they are added to the ASD waiting list
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments once a patient has been added to the ASD assessment waiting list. However, data is not available for both pathways combined
- The chart opposite shows the trend in the number of patients waiting for an ASD assessment once they have been referred by a community paediatrician
- The table below summarises how long patients on the ASD waiting list have been waiting (as of Jun-24):

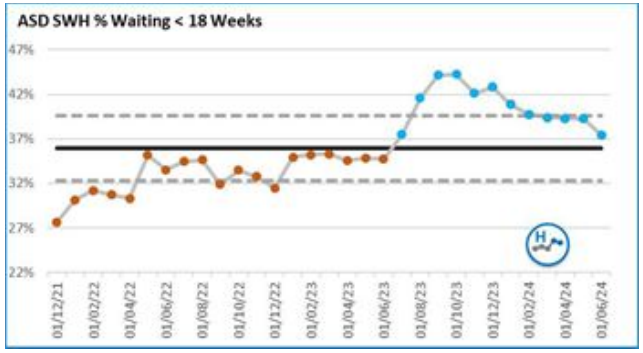
Waiting list bucket	Number of patients (Apr-24)	Number of patients (Jun-24)
<18 weeks	136	49
18 – 65 weeks	450	524
66 – 78 weeks	86	82
>78 weeks	135	188

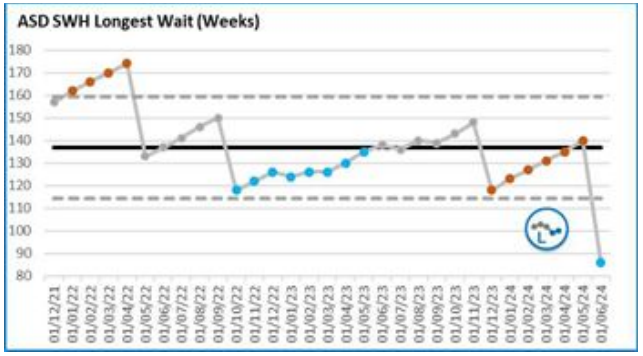
ICB Area	What the charts tell us	Issues	Actions
East & North Herts	• The ASD waiting backlog waiting list has been increasing in recent months and reached 843 patients in Jun-24 which is the highest since at least Dec-21 • The number of patients waiting >78 weeks for an ASD assessment has been increasing in recent months and has gone from 86 in Dec-23 to 188 in Jun-24 • The waiting list shown above does not include patients waiting for their first community paediatrics appointment, even if they have been referred by their GP as query ASD. It only shows patients who have been assessed by a community paediatrician and referred for a detailed ASD assessment	• Data not currently reportable on the same basis as the other two ICB Places • Backlog funding ended December 2023 and waiting lists are increasing. In addition to this, further increases in demand predicted • Awaiting confirmation of investment into the service for 2024/25	• Procurement process to outsource assessments for autism paused as funding has not been confirmed • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through clinical governance and agreed by operational teams to inform the business case. The business case is complete and agreement on governance route is being confirmed • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in 2024 / early 2025 • Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB was successful. The 25 schools identified in Hertfordshire are currently completing self-assessments to inform planning with the pilot due to run from Sept 2024 to March 2025

Autism Spectrum Disorder (ASD) – South & West Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	Children	2142	2181	↑	39.26%	37.46%	↓	140	86	↓	June



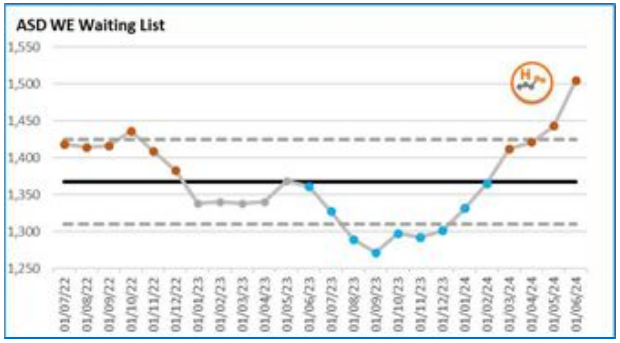


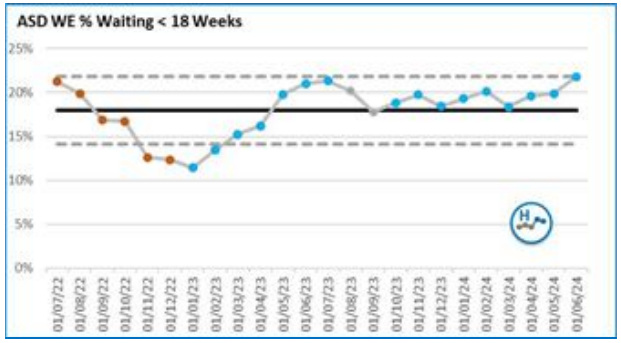


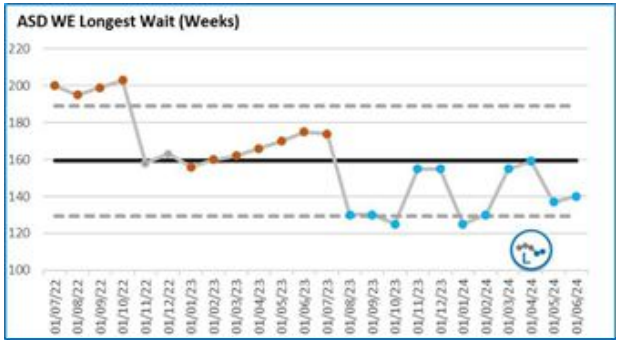
ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• The overall waiting list remains consistently above the historic mean and increased further to its highest level in June • The % of ASD waiters < 18 weeks remains just above the historic mean, but has fallen by c.8% since October • The longest wait improved significantly in June to 86 weeks	• Capacity in existing services does not meet demand • Further increases in demand predicted • Awaiting confirmation of investment into the service for 2024/25	• Procurement process is progressing to outsource assessments for autism due to provider agreed funding • Additional internal capacity and processes have been improved significantly • Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through clinical governance and agreed by operational teams to inform the business case. The business case is complete and agreement on governance route is being confirmed • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in 2024 / early 2025 • Partnership for Inclusion of Neurodiversity in schools (PINs programme) on behalf of Herts and West Essex ICB was successful. The 25 schools identified in Hertfordshire are currently completing self-assessments to inform planning with the pilot due to run from Sept 2024 to March 2025

Autism Spectrum Disorder (ASD) – West Essex

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	1443	1505	↑	19.89%	21.79%	↑	137	140	↑	June







ICB Area	What the charts tell us	Issues	Actions
West Essex	• The ASD waiting list continues to increase and is now at its highest reported level • The number of ASD waiters <18 weeks remains low, but is above the historic average • The longest wait increased slightly to 140 but remains just below the historic mean • 200 of the 1,505 total waiting list are >104 weeks	• Average monthly referral rate further increased from 73 in Q4, to 87 in Q1 of this year. This is against a current commissioned capacity of 40 assessments per month • Demand and capacity analysis forecasts continued waiting list growth • Imminent CQC / Ofsted SEND Inspection for Essex. ASD waiting times and progress with improvement since last inspections in 2019 and 2022 expected to be highlighted	• Business case submitted to increase core capacity for sustainable delivery - remains open. The gap in capacity vs. demand therefore remains. Potential ICS wide funding progressing through triple lock • 'Waiting well' workstream continues with local partners at Place, led by HCRG, also linking in with Essex wide joint commissioning initiatives • Redesign of the ADHD pathway will include ASD / JADES, with an aim of developing a single Neuro Diagnostic pathway, due to complete during Q3

Hertfordshire and West Essex Integrated Care System

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

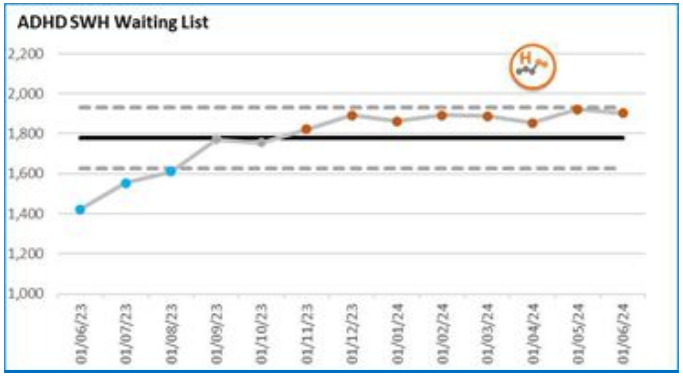
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	ENHT Paediatrics Service	Children	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	June
WE	HCRG	Children	259	262	↑	91.12%	84.73%	↓	84	88	↑	June

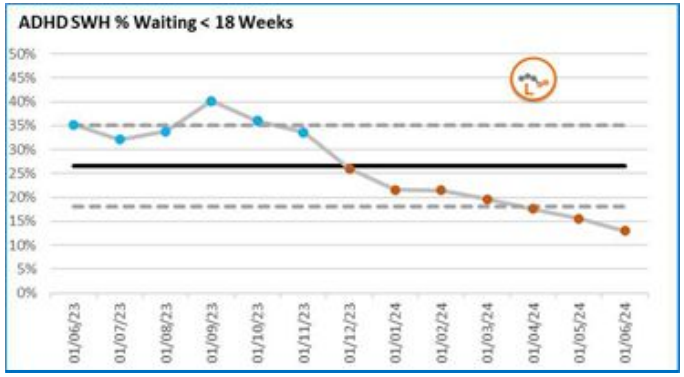
ICB Area	What the charts tell us	Issues	Actions
West Essex	• West Essex waiting lists in June were broadly similar to May • The % of children waiting <18 weeks fell by c.6% in month • The longest wait in West Essex increased to 88 weeks • ENHT is not currently able to report on waiting times / waiting list sizes for patients waiting for an ADHD assessment	• HCRG have commenced reporting of the Essex ADHD Minimum Dataset. Several data recording issues have been identified in the initial reporting, therefore the above manually collected figures may be subject to change once full reporting is rolled out in Q3 • Referral rates continues to rise, resulting in risk to maintaining waiting list performance	• Working with HCRG to resolve data quality issues • Pathway redesign planned to incorporate ASD and ADHD into a single Neuro Diagnostic Service. Full accurate reporting will not be possible until this work is complete – ambition to complete by Q3. In the interim, manual ADHD has been included in this report • As noted in the ASD slide, business case submitted to increase core capacity for sustainable service has not been supported due to available funding but remains open, evidencing the gap in capacity vs. demand. In the meantime, waiting times will continue to rise

Hertfordshire and West Essex Integrated Care System

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

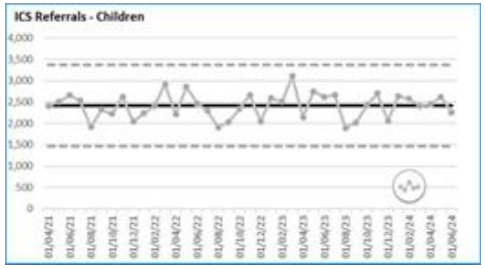
			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HPFT	Children	1921	1902		15.56%	13.04%		159	163		June

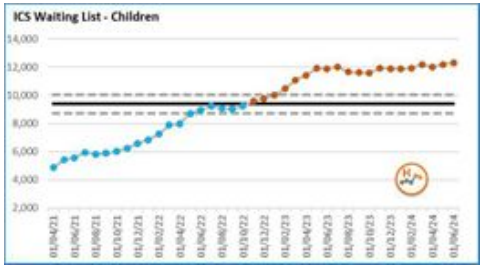


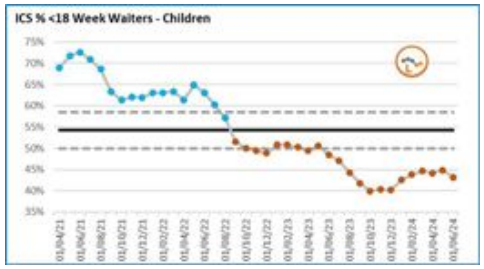


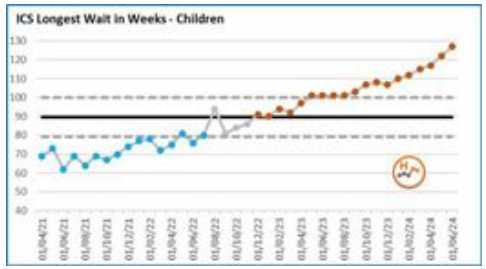
ICB Area	What the charts tell us	Issues	Actions
West Essex	• Overall waiting list is steady at c.1,900 patients but has been consistently above the historic mean for the last eight months • The % of ADHD waiting <18 weeks has been consistently deteriorating for the last nine months • Although the longest wait at end of June was 163 days, the average wait was 57 weeks	• Awaiting confirmation of investment into the service for 2024/25	• Learning Disabilities, Mental Health and Autism HCP continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with Autism and / or ADHD. Funding has been agreed until March 2025 for the Neurodiversity Support Centre, and further funding has been agreed for 2024/25 for a framework of support for children and young people to understand their diagnosis and improve their mental wellbeing • Clinicians have agreed future best practice Neurodiversity Model for Hertfordshire. This has been signed off through clinical governance and agreed by operational teams to inform the business case. The business case is complete and agreement on governance route is being confirmed • Hertfordshire wide single point of referral for all ASD and ADHD is progressing well with providers working together to plan full implementation in 2024 / early 2025

Community Waiting Times (Children)









		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	2624	2257	↓	12199	12322	↑	44.84%	43.18%	↓	122	127	↑	June
Place	Provider													
ENH	HCT	326	288	↓	877	861	↓	74.12%	73.05%	↓	46	50	↑	June
ENH	AJM/Millbrook	19	39	↑	131	149	↑	72.52%	73.83%	↑	41	45	↑	June
ENH	ENHT Community Paeds.	289	245	↓	5779	5842	↑	17.77%	16.31%	↓	122	127	↑	June
ENH	**All**	**634**	**572**	↓	**6787**	**6852**	↑	**26.11%**	**24.60%**	↓	**122**	**127**	↑	**June**
Place	Provider													
SWH	HCT	1482	1256	↓	4478	4353	↓	64.05%	61.13%	↓	76	73	↓	June
SWH	AJM/Millbrook	33	28	↓	126	143	↑	77.78%	65.73%	↓	36	40	↑	June
SWH	**All**	**1515**	**1284**	↓	**4604**	**4496**	↓	**64.42%**	**61.28%**	↓	**76**	**73**	↓	**June**
Place	Provider													
WE	EPUT - Wheelchairs	26	22	↓	34	30	↓	97.06%	96.67%	↓	20	24	↑	June
WE	HCRG / Virgin	449	379	↓	774	944	↑	90.31%	89.51%	↓	36	36	→	June
WE	**All**	**475**	**401**	↓	**808**	**974**	↑	**90.59%**	**89.73%**	↓	**36**	**36**	→	**June**

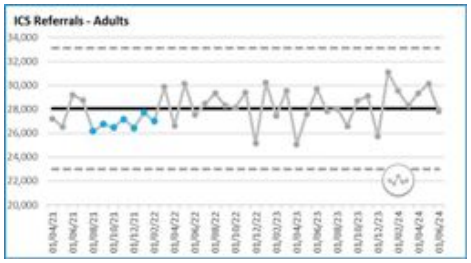
Hertfordshire and West Essex Integrated Care System

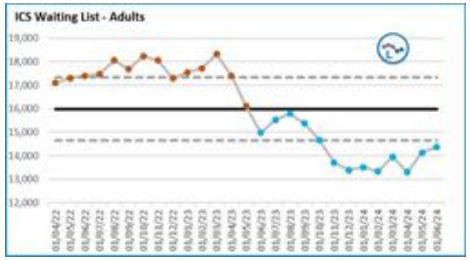
Community Waiting Times (Children)

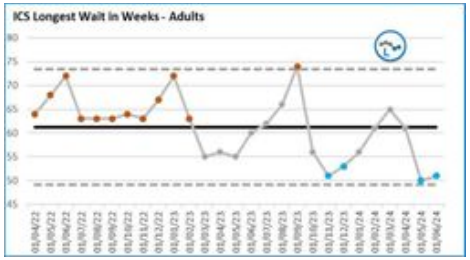
The NHS 18-week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services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

ICB Area	What the charts tell us	Issues	Actions
ICB	• Overall referrals to all services continue to fluctuate within expected common cause variation limits • The total number of children on waiting lists remains very high, but has plateaued at c.12,000 • The % of children waiting less than 18 weeks remains of concern at 43.2%, and lower than the national average of 55.8% • The longest waits are within the ENHT Community Paediatrics Service at 127 weeks. There are also long waits of up to 73 weeks within HCT services in South & West Hertfordshire • Consultant led 18-week RTT performance: SWH Community Paediatrics – 46.9% SWH Children's Audiology – 59.1% ENH Community Paediatrics – 16.3% WE Community Paediatrics – 91.6%	**Hertfordshire** • Most HCT children's specialist services are seeing a marked increase in demand • Waiting times in the SWH HCT Community Paediatrics service are improving, with a decreasing number of long waiters • There are continued waiting time pressures in Paediatric Audiology in SWH, but there has been improvement with a 26% decrease in total waiters since a high point in June 2023. The service is also currently supporting ENHT newborn hearing pathways • Waiting times across Hertfordshire for children's therapies (OT, Speech & Language and Physiotherapy) remain under pressure, but EHCP performance and workforce position is improving **West Essex (WE)** • 18 week % continues to decline, but remains comparatively strong at 89.7% • The volumes on the Community Paediatrics waiting list continue to increase • Waits for first appointments have increased – ongoing demand and capacity challenge • Community Nursing caseload increasing in number and time remaining on the caseload, reflecting the increasing complexity of children	**Hertfordshire** • For HCT services the number of over 52-week waits has reduced from 605 in July 2023, to 253 in July this year, and continues to improve in the most recent data • Focus on reducing DNA / NBI rates for children living in relatively more deprived neighbourhoods • Outsourcing in place in several services • Waiting list initiatives in place for some services to achieve no 65+ week waiters by the end of September • Community Paediatrics in SWH is receiving non-recurrent additional investment to increase workforce capacity and introduce new specialist nursing posts. Recruitment remains a risk • Community Paediatrics also working with NHSE Elect to optimise waiting list management • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow ups, and signposting to interim advice whilst awaiting assessment. Demand and capacity analysis now completed to identify required staffing model to reduce the waiting list • Children's Therapies – increasing capacity through successful recruitment, waiting list initiatives and outsourcing. Pilot for self-booking in one locality has reduced NBI by over 50% • EHCP dashboard developed to improve waiting list management **Community paediatrics ENHT** • New clinical model agreed by all providers: HPFT, HCT and ENHT • Business case has been developed and is currently being reviewed by exec sponsors to agree next steps through governance. Implementation plan for new model TBC following this process • Single system referral form agreed by clinicians and digital design underway. Target implementation date for the new referral process is Apr-25 • Outsourcing for ASD assessments has not been agreed for 24/25 due to funding constraints • ICB / HCC have agreed to expand the Neurodiversity Support Centre across Hertfordshire until Mar-25 (staffed by experts by experience). Diagnosis not required to access the support • HCC local offer has been updated with consolidated support, patient signposting and waiting times **West Essex (WE)** • Community Paediatrics Business Case is ongoing • Ongoing Community Paediatric caseload cleanse. Impact expected over the coming months • Service reviews requested by Community Nursing and Physiotherapy leads • Procurement planning initiated. Gap in current funding envelope. Investment will be required to procure a sustainable service going forward • Dietetic position remains vacant, patients being supported by Allergy dietitian

Community Waiting Times (Adults)







		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	30105	27847	↓	14126	14380	↑	92.59%	91.66%	↓	50	51	↑	June
Place	Provider													
ENH	HCT	8921	7833	↓	7827	7921	↑	91.89%	91.73%	↓	47	51	↑	June
ENH	AJM/Millbrook	107	115	↑	555	602	↑	73.51%	69.10%	↓	47	51	↑	June
ENH	**All**	**9028**	**7948**	↓	**8382**	**8523**	↑	**90.67%**	**90.13%**	↓	**47**	**51**	↑	**June**
Place	Provider													
SWH	CLCH	7329	6876	↓	1496	1545	↑	99.60%	99.48%	↓	23	24	↑	June
SWH	Circle	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	NO DATA	NO DATA	-	June
SWH	HCT	954	884	↓	1197	1194	↓	89.72%	88.11%	↓	50	50	⇨	June
SWH	AJM/Millbrook	134	132	↓	630	690	↑	79.37%	70.87%	↓	46	50	↑	June
SWH	**All**	**8417**	**7892**	↓	**3323**	**3429**	↑	**92.21%**	**89.76%**	↓	**50**	**50**	⇨	**June**
Place	Provider													
WE	EPUT	12558	11904	↓	2314	2315	↑	99.78%	99.70%	↓	24	28	↑	June
WE	EPUT - Wheelchairs	102	103	↑	107	113	↑	99.07%	100.00%	↑	20	17	↓	June
WE	**All**	**12660**	**12007**	↓	**2421**	**2428**	↑	**99.75%**	**99.71%**	↓	**24**	**28**	↑	**June**

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

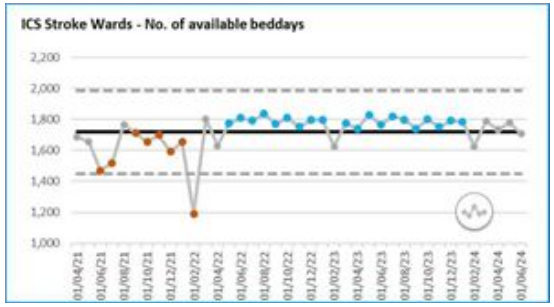
Hertfordshire and West Essex Integrated Care System

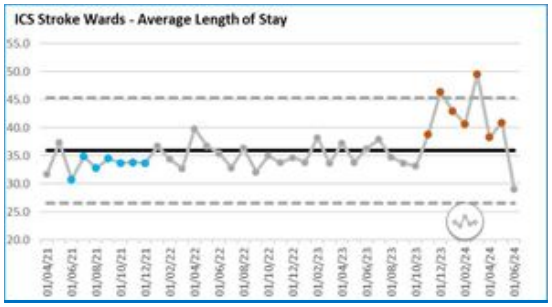
Community Waiting Times (Adults)

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

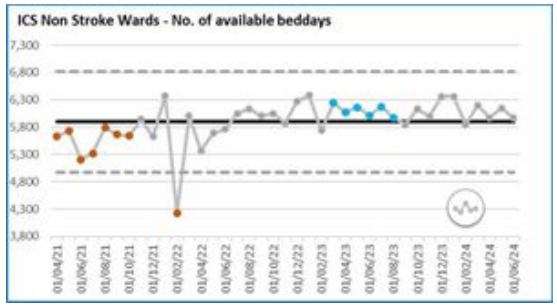
ICB Area	What the charts tell us	Issues	Actions
ICB	• **SWH MSK data excluded from reporting following DQ issues in April data after award of new contract to Circle** • Overall referrals to all services continue to fluctuate within expected common cause variation limits • The % of patients waiting less than 18 weeks continues to fluctuate at c.92%, compared to the national average of 84.9% • There is a 12-month trend of improvement for the total number of adults waiting on waiting lists, although there have been increases in the last 2 months • Longest waits are within HCT services in East & North Hertfordshire • Consultant led 18-week RTT performance: ENH Skin Health – 92.7% SWH Respiratory – 98.9% WE Podiatric Surgery – 85.4%	**East & North Hertfordshire (ENH)** • Referrals have increased compared to 2022/23 • Overall 'waiting within target' performance continues to be more favourable when compared to the pre-pandemic baseline **South & West Hertfordshire (SWH)** • MSK services previously delivered by Connect have been reprocured with Circle. Work continues to resolve a number of data quality issues before incorporation into this report • Slight decrease in referrals at CLCH • CLCH longest waiter remains within the Neuro Rehab service. However long waiters for ABI Psychology input have reduced significantly • Lymphoedema service has been impacted by staff sickness **West Essex (WE)** • Capacity issues in SLT following reduction in staffing hours and lack of bank take up • MSK & Podiatry breaches following transfer of iMSK patients from Stellar Healthcare on contract termination	**East & North Hertfordshire (ENH)** • All waits are closely monitored and subject to robust internal governance • Service productivity initiatives continue • Forecasting suggests a stable trend over the next 12 months, and that overall current waiting time performance will be maintained or slightly improved • Comprehensive health inequalities metrics in place and analysis has allowed the Trust to compare waiting times and DNA rates for those living in relative deprivation versus those that do not, and targets have been set to address discrepancies **South & West Hertfordshire (SWH)** • Working with Circle and ICB contract leads to resolve reporting issues following re-tender of SWH MSK contract from 1st April. Data expected to be reinstated in the next report • External provider continuing to support with PD / MS Nursing and ABI caseloads • External provider now also supporting with planned care therapy and NETT waits • Divisional weekly waiting times group remains in place which also feeds into Trust group • Division specific recruitment plan underway, including developing videos to compliment adverts and targeting social media channels. A number of recruitment fairs held, with more being planned • Trajectories now in place for all services of concern. These are reviewed and monitored weekly **West Essex (WE)** • Pulmonary Rehab continues to recover following recruitment to vacancies. Compliance with 8-week contract standard was narrowly missed in June with just one breach • Recruitment to plug SLT reduction in hours • iMSK recovery plan agreed with full recovery expected to take 6 months. Trajectory TBC

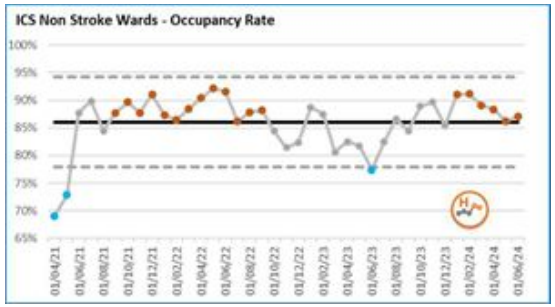
Community Beds (Stroke & Non-Stroke)

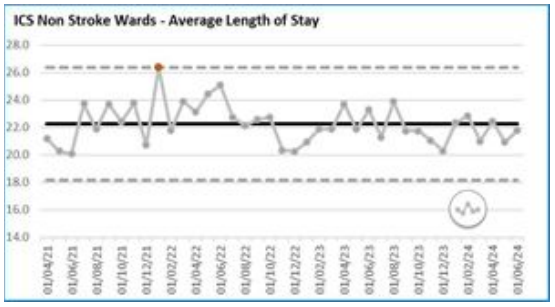




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	720	720	⇨	96.11%	97.92%	↑	36.7	32.3	↓	June
SWH	CLCH	624	569	↓	99.52%	97.89%	↓	39.0	25.0	↓	June
WE	EPUT	434	420	↓	85.94%	83.10%	↓	52.0	NO DATA	-	June
ICS	**All**	**1778**	**1709**	↓	**94.83%**	**94.27%**	↓	**40.9**	**29.1**	↓	**June**







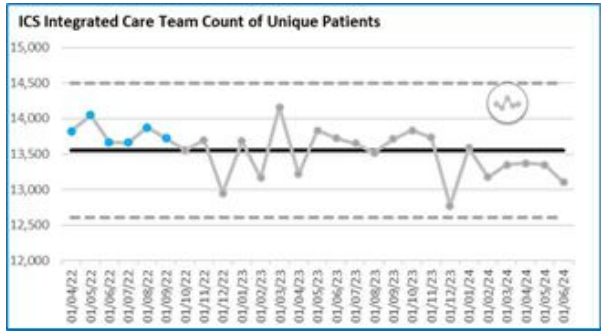
Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1590	1590	⇨	86.86%	80.06%	↓	26.1	24.8	↓	June
SWH	CLCH	2297	2186	↓	83.28%	92.31%	↑	24.0	23.9	↓	June
WE	EPUT	2263	2190	↓	88.60%	87.03%	↓	14.5	17.5	↑	June
ICS	**All**	**6150**	**5966**	↓	**86.16%**	**87.11%**	↑	**21.0**	**21.8**	↑	**June**

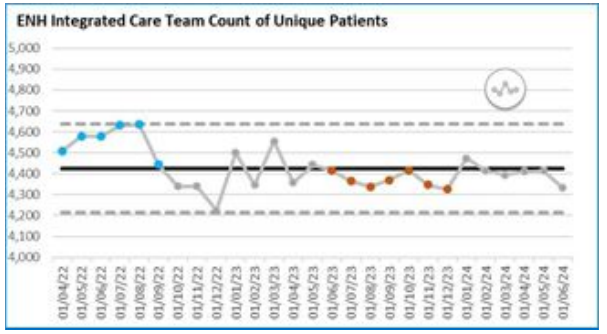
Community Beds (Stroke & Non-Stroke)

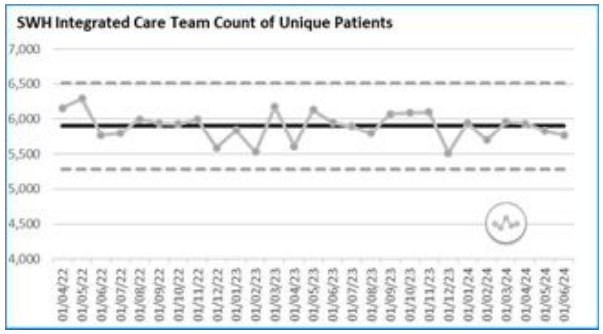
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds Days** • Available stroke bed days remain consistent at c.1,750 per month • Overall stroke bed occupancy rates continue to trend above the historic mean • Overall length of stay reduced considerably in June, but the data is skewed as EPUT had no stroke discharges in month • Length of stay did however improve in both HCT & CLCH **Non-Stroke Beds Days** • Available non-stroke bed days remain consistent at c.6,000 per month • Overall occupancy rates across the system have trended above the historic mean for the last 6 months • Overall length of stay remains within common cause variation limits	**East & North Hertfordshire (ENH)** • Bed occupancy remains the highest at Danesbury with an average of 93% over the past 12 months. Herts & Essex and QVM have an average occupancy of 80% and 84% respectively • Average length of stay over the past 12 months for Herts & Essex averaged 25 days, and 27 days at QVM. At Danesbury, there is now normal variation with an average of 39 days. Admissions into community hospitals show no significant change in trend at Herts and Essex and QVM • Danesbury has the least admissions with an average of 17 a month, with QVM averaging 18, and Herts & Essex averaging 31 **South & West Hertfordshire (SWH)** • Continued high occupancy rates across all beds due to supporting system flow and admitting higher acuity patients • Average length of stay continues to reduce **West Essex (WE)** • Length of stay on stroke ward continues to be impacted by a complex patient. Extension to stay has been agreed with ICB commissioners	**East & North Hertfordshire (ENH)** • New process regarding criteria to reside in place to support discharge **South & West Hertfordshire (SWH)** • Daily assurance calls remain in place with HCC with clear escalation process • In collaboration with system partners, action plan agreed to support flow and winter plan also drafted • In collaboration with system partners, SPOC review completed, and action plan agreed which is currently being worked through (most actions completed) • In partnership with social care colleagues, currently reviewing escalation plan **West Essex (WE)** • Daily escalation calls in place to support all delayed discharges • ICB to undertake an audit of the community hospital beds at St Margaret's Epping. Findings will be shared at the August Intermediate Care Board for system discussion on utilisation

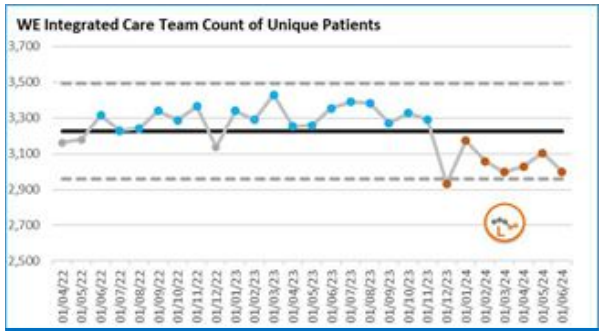
Hertfordshire and West Essex Integrated Care System

Integrated Care Teams (ICT)









			Contacts (unique patients)			Contacts (unique patients) per 1000 population			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	All	4414	4332		7.0	6.8		June
SWH	CLCH	All	5832	5770		8.5	8.4		June
WE	EPUT	All	3103	2999		9.3	9.0		June
ICS	**All**	**All**	**13349**	**13101**		**8.1**	**7.9**		**June**

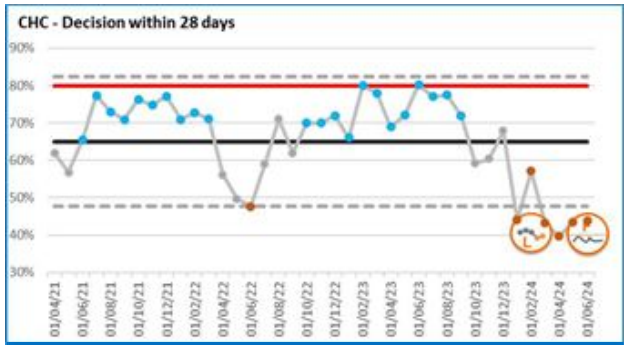
Hertfordshire and West Essex Integrated Care System

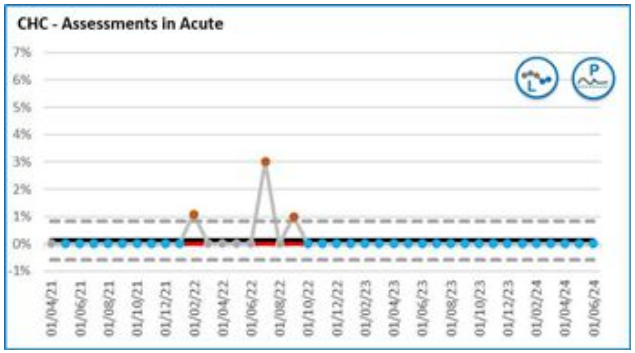
Integrated Care Teams (ICT)

ICB Area	What the charts tell us	Issues	Actions
ICB	• Unique contacts across the ICS and within the two Hertfordshire Places are within expected common cause variation limits • Unique contacts in West Essex have trended below the historic mean for the last 7 months	**East & North Hertfordshire (ENH)** • The number of individuals rereferred to the ICT is similar to pre-pandemic • Contacts per month are lower than pre-pandemic (linked to increasing complexity) and there is an increase in the first-to-follow-up appointment ratio • The net effect of these factors is that the overall caseload is much higher than in 2019/20 • Patient complexity is increasing, with more intensive treatments required. e.g., numbers of intravenous antibiotics (IV) and End of Life (EOL) patients • Performance focus on deferral rates **South & West Hertfordshire (SWH)** • Slight reduction in overall number of unique contacts in month **West Essex (WE)** • Since April 2021 ICTs have seen a reduction in referrals. Contacts per patient however have increased from 7.5% to 9.7% (c.30% increase), suggesting an increase in acuity of patients receiving care in the community	• Community services review underway across HWE to reduce variation and shift to reporting outcomes and impact, to compliment the activity driven data that exists **East & North Hertfordshire (ENH)** • Steering group in place chaired by HCT Chief Operating Officer • A comprehensive transformation programme in place focused on workforce, wound care and diabetes management with the ICT • SystmOne optimisation project underway aiming to streamline use of clinical systems with a prospective productivity gain. Some promising initial progress in relation to revised design • The Hospital at Home service appears to be effectively supressing Acute demand **West Essex (WE)** • Investment since 2021 into the Urgent Community Response (UCR) Team has reduced the number of urgent referrals to the ICTs. This has in turn provided additional capacity to support the shift to pro-active care delivery in the Integrated Neighbourhood Teams • Increased joint working between the ICTs and the community urgent care pathways via the Care Co-ordination centre • Continued focussed work with Care Homes by the ICTs to maximise use of all community urgent care pathways and reduce calls to 999

Hertfordshire and West Essex Integrated Care System

Continuing Health Care (CHC)



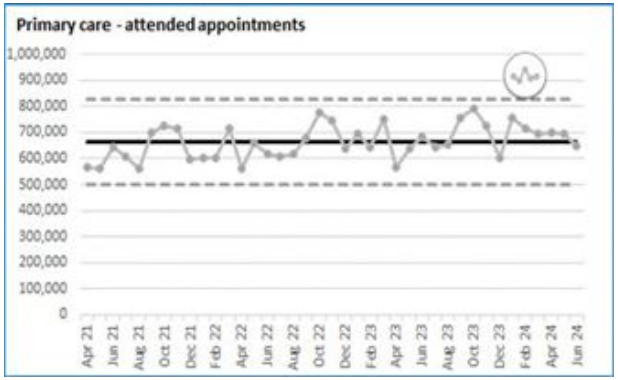


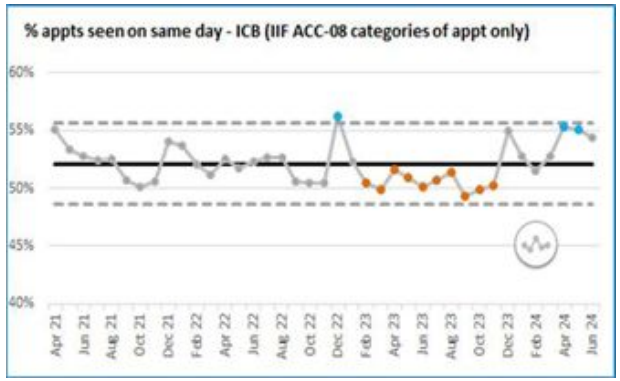
	What the charts tell us	Issues	Actions

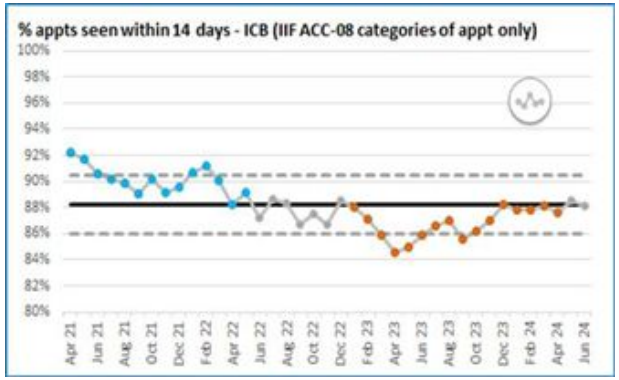
HWEICB	• The 28-day standard continues to present a significant challenge, most notably in South & West Hertfordshire
	• Performance has deteriorated for the last 3 months, however ICB projections for the quarter have been met (>=40% to 49.9%)
	• June overall performance is similar to May as below, but there has been further slippage in ENH:
	  ○ Overall ICB – 44%
	  ○ West Essex – 72%
	  ○ ENH – 49%
	  ○ SWH – 28%
	• The assessments in an acute setting <15% standard continues to be routinely achieved
		• Workforce - new starters do not have CHC experience and require robust training and development
		• Recovery of the 28-day standard is forecast to take at least 6 months and targets will be met by Q4 24/25. This has been agreed with NHSE
		• ENH 28-day performance is 23% worse in June vs. May. Key issue is delays in allocation of social workers from HCC due to resource challenges, as well as workforce issues around sickness across the service.
			• Weekly meetings are in place across all areas to monitor performance. Additional assurance meetings are being held with NHSE
			• A further comprehensive layer of management control and support has been implemented across the SWH service to significantly improve work allocation, daily analysis of completed work, case status and risk identification
			• The same process for all areas will be implemented moving forwards

Hertfordshire and West Essex Integrated Care System

Primary Care







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

What the charts tell us

- GP appointments attended each month remain within expected common cause variation limits. However, there are indications of an overall growing trend in attendances, with only two of the last ten months being below the mean line
- The % of appointments seen on the same day of booking has been above the long-term mean for six of the last seven months, and there are indications that there has been an increase at system level in the % of appointments seen on the same day. The chart above now shows the % of same day appointments for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups (IIF ACC-08 categories of appointment)
- The % of appointments which were seen within 14 days of booking has been consistently below the mean since Jan-23. However, there are signs of a return towards the mean over the last two months, and performance is only marginally below this year's plan of 89%. The chart above now shows the % of same day attendances for a subset of appointment types where the patient would typically want the first available appointment, rather than reviews / check-ups (IIF ACC-08 categories of appointment)

Hertfordshire and West Essex Integrated Care System

Primary Care

ICB Area	Issues	Actions
ICB	• Potential for practice participation in national collective action • General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal • National contract for 24/25 imposed without agreement from profession, with Industrial Action in Primary Care a possibility and added to the risk register • 24/25 focus on cutting bureaucracy, helping practices with cash flow and increase financial flexibilities and continue to improve patient experience of access	**Engagement with the National Access Recovery Plan** • Logging local intelligence on practices taking part in collective action (one or more of 9 possible actions), ongoing work with HETCG and liaison with LMC to identify and mitigate any issues arising • Annual GP Patient Survey (GPPS) now published (data collected Jan –Mar 24). Overall practices appear to demonstrate a slight improvement but noting changes to questions this year. BI and primary care teams looking at data which will be presented at Primary Care Transformation Committee and STQIC. Triangulation with other data held does not show any strong correlation e.g. number of appointments, digital telephony etc. • GPPS 2024 Dental Access results shows HWE as best performing in East of England • 23/24 PCN Access Improvement Plans (AIP): A year-end qualitative & quantitative review now undertaken; reported to ICB Board • Majority of PCNs/Practices have been able to demonstrate access improvements through the year to merit award of the full funding at the discretion of the ICB • ICB support will continue through 24/25, albeit reflecting the 'lighter-touch' national direction based on Clinical Directors' declaration of PCN/Practice status • Many practices transitioning to Modern General Practice (MGP) through demand / capacity analysis, use of cloud-based telephony, roll out NHS app, online GP registration, development of GP and PCN websites and testing triage models • Support PCNs to increase functionality of new cloud-based telephony systems / online consultation availability/use. This remains an area of considerable variation • National GP Improvement Programme - 30 practices & 4 PCNs participated in this nationally supported facilitated programme • 28 sites have received cloud base telephony. A further 6 practices are now being upgraded from sub-optimal CBT systems to advanced CBT. 16 practices have been offered free of charge upgrades on their current systems which are CBT but lacking some functions. 16 practices currently have no funded upgrade path but are using a sub-optimal CBT system. Currently working with Region to understand options for these • Good progress on prospective records access. Many practices are now actively moving towards full enablement or have plans in place to enable; almost 700k patients across HWE have access to their records; over 90% of practices have as the default for new NHS app users; 60% of practices have 90%+ of patients with online access + records access enabled; almost 80% of practices with 80%+ • Partnership working to increase self-referrals in high volume services: Physio, IAPT, Podiatry etc. • Support Level Framework (SLF): Self-assessment tool to support practice teams in understanding what they do well, what they might wish to do better, and where they might benefit from development support. Roll-out of SLF facilitated sessions for practices at increased pace in 24/25 • Communications to support ICB and practice websites, media statements and patient comms re the Delivery Plan • Development of PC Dashboard to include further metrics to allow triangulation / narrative in the absence of plan / reporting requirement in national contract **Other** • Enhanced Commissioning Framework (ECF) refined for 24/25 and include shared care monitoring arrangements • Trend analysis to identify practices with poor access via complaints and patient contacts • PCCC and Primary Care Board oversight of GPPS results. Action plan developed through the Access MDT Group • Initiatives for Primary Care Workforce to support recruitment and retention, supported by the HSE ICB Training Hub • Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices • Pharmacy First now live, work with Community Pharmacy leads and practices to promote service

Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	17
Report title	Finance Performance and Planning Committee – Highlight report September	**Meeting Date**	6 November 2024
Chair	Richard Oosterom - Committee Chair and Non-Executive Director		
Author	Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Finance Position Month 5
- CIP
- Capital Programme update
- Outturn Forecast/including system position
- 2025/26 Business planning
- Procurement update
- Productivity and ERF report
- Performance report
- Diagnostics update
- IT/Digital update

Alert:

- The Trust reported a deficit of £1.8m which was £1.1m over plan. It was advised that the Trust was reporting around £1m deficit each month.
- A number of schemes part of the CIP works had reported a 0 value due to the original plan not being delivered.
- The East of England was £77m overspent, with the system currently £8.5m overspent. It was advised that the target for the system for the remainder of the year was £20m.
- Risks areas within EPR were raised – Configuration requests and the financial position of the ICB.

Advise:

- It was raised that a number of divisions and services did not have the confidence to complete the CIP schemes. - It was advised that the works in Digswell had a financial impact for this year which would also transfer into the following year. - It was highlighted that the Trust had committed to high spend for 2025/26 and had sent queries over to the ICS and were currently awaiting further clarification. - Training was being arranged in relation to the new procurement act. - It was reported that in relation to audiology the team had returned to reporting a PTL. - A number of Diagnostic pathways remained paused; however, it was agreed for a third pathway to open within Paediatric Audiology. - DM01 was currently sitting at 40% for the month.	
Assurance:	
- Capital spend in Month 5 reported to perform better than plan.	
Important Items to come back to committee:	
Items referred to the Board or a Committee for decision or action:	- 2025/26 Business Planning – referred to Board Seminar for further discussion.

Recommendation	N/A

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	18
Report title	Quality and Safety Committee 25 September 2024 - highlight report	**Meeting Date**	6 November 2024
Chair	Dr David Buckle - Committee Chair and Non-Executive Director		
Author	Deputy Company Secretary		
Quorate	**Yes** ☒	**No** ☐	

Agenda:

- Allergies update
- Safe, Care, Effective update
- Maternity Assurance report
- Clinical audit and effectiveness report
- Update on trauma group
- Complaints, PALS and Patient Experience annual report
- Duty of Candour policy
- Integrated compliance report- incident, compliance and risk report
- National cancer patient experience survey
- Learning from death report
- Roald Dahl Children with Medical Complexity (CMC)
- Clinical Effectiveness Committee escalation report
- Patient Safety Forum
- Audiology update.

Alert:

- Regarding Patient Advice and Liaison Service (PALS), a high volume of emails and phone calls were still being received. The Trust not having a reception remained an issue for the PALs team due to where they are situated.
- The Maternity service made a recommendation of readiness to exit the Maternity Safety Support Programme (MSSP) and was supported by the Board. Encouraging e-mails were received from stakeholders supporting the service's exit of the programme by end of December 2024.
- On open incidents, it was recorded that an overall 34% reduction of 'open incidents was being investigated' had been seen from June 2024 to August 2024. This remained an improvement priority to achieve an overall 50% reduction.

Advise:

N/A

Assurance:

- The Committee was assured that cultural improvement work continued to be a priority in the Maternity Unit. Staff were speaking up and Managers were also listening up more.
- As assurance to the Committee, it was reported that divisions in the Trust had been advised to ensure all risks raised were evaluated and approved or rejected, within one month. Also, new risks appropriately rated/scored with current and target ratings.
- On Audiology, the committee was re-assured that there is no backlog for children with complex needs.

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

- Seven-day hospital services
- Audiology.

Items referred to the Board or a committee for a decision/action:	
• N/A	
Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report.

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18a
Report title	Quality and Safety Committee 23 October 2024 - highlight report			**Meeting Date**	6 November 2024
Chair	Dr David Buckle - Committee Chair and Non-Executive Director				
Author	Deputy Company Secretary				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Duty of Candour
- Safe, Care, Effective update
- Maternity and Newborn Safety Investigation (MNSI)/Patient Safety Incident Investigation (PSII)
- NHSE National Invasive Procedures Standards (NATSSIP)
- Maternity Assurance report
- Dementia update
- Fuller Enquiry (Mortuary)
- Inpatient survey results action plan
- Integrated compliance report- incident, compliance and risk report
- Board Assurance Framework
- Estates and Facilities PAM
- Nutrition and Hydration Strategy
- Health and Safety Assurance Report
- Review of CIP programme (quality risk assessments)
- Responsible Officer / revalidation appraisal resource (AR) + organisational audit report
- Clinical Effectiveness Committee escalation report.

Alert:

- On security related matters, the Committee was advised that there is due to be another violence and aggression assessment completed to establish how many measures are in place and what else we need to improve, in line with the NHS guidelines.
- There was reasonable assurance that the Trust was compliant against the National Invasive Procedures Standards (NATSIPPS) in clinical areas undertaking invasive procedures, and specific compliance against key safety check points. However, this is a challenging task and the Committee will continue to monitor this. The data sets will be complemented by quality assurance observations.
- On the Maternity Safety Support Programme (MSSP) update, the service made a recommendation of readiness to exit the programme which was supported by the Committee.
- The number of PALs referrals remains high and a concern. This is under regular review.

Advise:

- There are 17 recommendations from the Fuller enquiry. The Trust met or partially met 15. The Committee is satisfied with progress and will monitor until all 17 are fully met (expected early spring next year).

Assurance:

- The Committee was assured that the number of accumulated open incidents remains an improvement priority across divisions. Significant positive improvement was noted across Planned Care.

• As assurance to the Committee, it was reported that a quality improvement project (QIP) is underway to improve patient access to information relating to planning their care, treatment escalation planning and ReSPECT conversations. • On re-admissions, the Trust's performance has remained well positioned in comparison to national and our Model Hospital peer group. • The National Emergency Laparotomy audit (NELA) reported a low mortality rate. This was a pleasing result having been high some years ago.
Important items to come back to committee (items committee keeping an eye on):
• Duty of candour policy.
Items referred to the Board or a Committee for a decision/action:
• N/A

Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report.

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	19
Report title	People and Culture Committee – Highlight report 17 September 2024	**Meeting Date**	6 November 2024
Chair	Janet Scotcher - Committee Chair and Non-Executive Director		
Author	Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- People Report
- Board Assurance Framework
- Maternity Culture update
- Unplanned Care Culture update – Verbal
- Divisional Update- Staff Experience and Staff Engagement Improvement Plans – Planned Care
- Voice of our People LGBTQ+ Network
- Health and Wellbeing
- Apprenticeship Report
- Resourcing
- Temporary Staffing
- Improving Working Lives of Doctors In Training
- Grow Together Review
- Exit Interviews

Alert:

- Culture and diversity were one of the concerns outlined in the CQC report following their interviews with staff members. This led to the cultural improvement action plan which was to aid staff feeling valued and able to raise their concerns directly with their managers.
- The current vacancy rate was 9.2% there had been an increase in establishment and turn over however the Trust were keen to drive the figures down.

Advise:	
- It was reported that Women's and Children's had made the commitment to recruit all of their level 3 midwives this year. - It was stated that there was now an aim to incorporate the action plans from the staff survey into the care groups where it was asked for service leaders to add the action plan into their meetings. - It was highlighted that across the ICB the Trust had the most apprentices however on average the Trust was only spending 70% of its levy per month.	
Assurance:	
-	
Important Items to come back to committee:	
Items referred to the Board or a Committee for decision or action:	- Request made to provide a fast-track service for treatment to staff in order for them to be able to return to work and continue their patient care which was seeking approval from the Committee which was received. Board to sign off.

Recommendation	N/A

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Board

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	20
Report title	Charity Trustee Committee – Highlight report 9 September 2024	**Meeting Date**	6 November 2024
Chair	Dr David Buckle – Committee Chair and Non-Executive Director		
Author	Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Major Projects update
- Charity Finance Report
- Investment Portfolio report from Rathbones
- Approvals in Excess of £5000
- Charity impact report
- Charity highlight report including update on charity risks and 3-year policy reviews

Alert:

- Total income at the end of July 2024 was £9k below budget (excluding gift in kind).

Advise:

- Year to date legacy income of £24k represented 7% of the target legacy value of the year, however legacy income was reported to often be erratic.
- It was reported that at month 4 the fundraiser income was on plan. The charity had raised £341m which was £77k more than the previous year.
- A management exercise had taken place which had resulted in some costs being moved from the ‘cost of fundraising’ allocation into ‘governance and running cost of fundraising’, excluding legacy, to 30%.
- The charity continued to work well achieving its strategic objectives and their current key activities were a door drop mailing campaign for MVCC, new appeals in development and opening events for two capital projects recently completed.
- 6 projects over £5,000 were approved, some of which would require fund raising:

Planned – Renal	X4 Philips Lumify Ultrasound scanners x L 12-4 Transducers on an android operating platform (x4 tablets) and 5-year warranty for the 4 satellite renal sites	£19,800		Fully funded by LAKPA as a donation to our hospital charity.
W&C	Twin cot	£5442	Laura Kelly	To fundraise for
W&C	Establish and sustain bereavement antenatal classes aimed at supporting families who have experience late miscarriage and stillbirths (8 beneficiaries)	£5500 annually	Jessica Maund	
Renal-Unplanned	14 Patient reclining chairs for the treatment area	£1960 per chair (£27,440)	Patricia Milward	To fundraise for-one at a time
ENT – Planned	To establish of an ENT procedures room in Area 10 – *nb concept approval required, will then come back after working up*	£120,000	Maneesha Purandare Speciality doctors, ENT	To fundraise for

	plan with estates.			
Cancer MVCC	14 Richmond electric hospital patient reclining chair with lateral backrest support	£32,928 £2352 per chair. *NB includes VAT which we wouldn't pay*	Dean Weston	John Bush Legacy funds already banked.

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

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

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Board Annual Cycle 2024-25

Notes regarding the annual cycle:

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

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

Board Annual Cycle 2024-25

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

Board Annual Cycle 2024-25

Items	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
Review of Trust Standing Orders and Standing Financial Instructions (if required)													
Charity Trustee Committee													
Charity Annual Accounts and Report									X				
Charity Trust TOR and Annual Committee Review	X												
Finance, Performance and Planning Committee													
FPPC TOR and Annual Report					X								
Quality and Safety Committee													
Complaints, PALS and Patient Experience Annual Report							*X*						
Safeguarding and L.D. Annual Report (Adult and Children)													
Staff Survey Results	**X**		**X**										**X**
Learning from Deaths			X		X				X		X		
Nursing Establishment Review											X		
Patient Safety and Incident Report (Part 2)			X						X				
Teaching Status Report			***X***										
QSC TOR and Annual Review (if required)			X										
People Committee & Culture													
Workforce Plan													

Board Annual Cycle 2024-25

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