DATA PACK

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7b - FLOODLIGHT DATA & EXCEPTION REPORTS

Net Promoter - Ward Breakdown - January 2013

APPENDIX 3

	Ward	30 Dec - 5 Jan	6-12 Jan	13-19 Jan	20-26 Jan	TOTAL
Surgery	Princes 1				87.50	87.50
	Princes 2	50.00			100.00	75.00
	Codicote	100.00	81.25	85.71	75.00	83.87
	5A		100.00	100.00		100.00
	5B			100.00	100.00	100.00
	7BN		30.00	42.31	45.45	40.43
	8A	50.00	0.00	100.00		50.00
	8B		100.00	100.00		100.00
	11 BN	50.00			36.36	37.84
	ITU/HDU	100.00			0.00	33.33
	SURGERY	**69.23**	**64.71**	**69.23**	**58.11**	**63.58**
Medicine	AAU	66.67	100.00	100.00	100.00	90.00
	SSU	62.50	87.50	75.00	100.00	80.00
	MAU		25.00	-100.00	100.00	16.67
	Digswell			-9.09	100.00	14.29
	Stanborough					
	6A					
	6B		100.00	0.00	100.00	85.71
	9A		50.00	100.00	50.00	62.50
	9B S&N	100.00	50.00	-100.00	33.33	40.00
	10B Isolation			100.00		100.00
	10 BS					
	Pirton	100.00	100.00	100.00	100.00	100.00
	Barley	100.00	100.00	100.00		100.00
	MEDICINE	**84.00**	**77.50**	**40.00**	**82.14**	**70.73**
Women's	11A Gynae	100.00	85.71	84.62	83.33	87.50
	Dacre	12.50	75.00	100.00	25.00	36.36
	Gloucester	69.23	77.78	75.00	81.25	76.25
	Consultant Led					
	Midwife Led Unit	100.00	100.00	100.00	100.00	100.00
	WOMEN'S	**75.56**	**86.67**	**88.41**	**76.60**	**82.81**
CSS	Elizabeth House					
	CLINICAL SS					
Cancer	MSH	100.00	100.00	100.00	100.00	100.00
	10	0.00	70.00	42.86	81.82	66.67
	11	100.00	100.00		46.67	77.78
	CANCER	**85.00**	**85.00**	**50.00**	**68.42**	**74.42**
	TOTAL TRUST	**78.64**	**79.22**	**71.07**	**68.45**	**73.63**

NOTE: * For the purpose of reporting, the net promoter question responses made at the end of a patients care, eg on the day of discharge or up to 48 hours post discharge are included. Throughout the Trust an additional 313 Meridian inpatient surveys were completed during the patients stay; the responses to the net promoter question for these surveys cannot be included in the SHA reporting template.

* If the number of 'detractors' exceeds the number of 'promoters' a negative net promoter score is achieved.

	Ext. Likely	Likely	Detractors	Total Responses	Net Promoter	No. of Discharges
30 Dec-5 Jan	84	16	3	103	**78.64**	427
6-12 Jan	129	18	7	154	**79.22**	499
13-19 Jan	124	24	11	159	**71.07**	423
20-26 Jan	139	37	11	187	**68.45**	501
TRUST TOTAL	**476**	**95**	**32**	**603**	**73.63**	**1850**

32.59% response rate (target 10%)

Health & Safety Performance Indicators - January 2013

	2012/13	Yearly RAG Threshold	Monthly Target	April	May	June	July	August	September	October	November	December	January	February	March	YTD
				Financial Year 2012-2013												
Patient Incidents	RIDDOR incidents	Red > 4 Amber 2-4 Green < 2	0.08	0	0	0	0	0	0	0	0	0	0			0
	H&S public liability claims	Red > 2 Amber 2 Green < 2	0.17	0	0	0	0	0	0	0	0	0	0			0
	Slips, Trips & Falls(not including in patient falls)	Red > 2 Amber 2 Green < 2	0.17	1	0	0	0	0	2	0	0	2	2			7
	Physical assault	Red > 69 Amber 64-69 Green < 64	5.33	1	0	0	0	0	0	0	0	0	0			1
Visitor Incidents	RIDDOR incidents	Red > 2 Amber 2 Green < 2	0.17	0	0	1	0	0	0	0	0	0	0			1
	H&S public liability claims	Red > 2 Amber 2 Green < 2	0.17	0	0	0	1	0	0	0	0	0	0			1
	Slips, Trips & Falls	Red > 11 Amber 11 Green < 11	0.92	0	1	1	0	4	3	2	3	0	0			14
The Workforce (Including Contractors) Incidents	RIDDOR incidents	Red > 35 Amber 33-35 Green < 33	2.75	6	1	0	2	1	4	7	2	0	0			23
	Slips, Trips & Falls	Red > 77 Amber 71-74 Green < 74	6.17	1	4	5	3	3	7	2	4	5	8			42
	Employer liability claims	Red > 23 Amber 21-23 Green < 21	1.75	0	0	0	1	2	3	2	2	0	0			10
	Sharps incidents	Red > 129 Amber 118-129 Green < 118	9.83	13	6	4	12	14	15	15	11	5	2			97
	Workplace stress	Red > 219 Amber 199-219 Green < 199	16.58	10	3	4	2	5	1	4	5	2	2			38
	Contact dermatitis/latex	Red > TBA Amber > TBA Green > TBA	TBC	1	6	0	0	0	0	0	0	0	0			7
	Musculoskeletal injuries	Red > 84 Amber 78-84 Green < 78	6.50	6	5	2	4	7	7	7	5	3	7			53
	Physical assault	Red > 188 Amber 171-188 Green < 171	14.25	4	5	2	1	8	6	16	6	5	5			58
	Mandatory training	Red < 90% Amber > N/A Green => 90%	90.0%	TBC	TBC	TBC	TBC	TBC	TBC	8.1%	10.6%	11.5%	12.4%			12.4%
	Significant workplace fires	Red > 2 Amber 2 Green < 2	0.17	0	0	0	0	0	0	0	0	0	0			0

Performance Exception Report – Month 10

Target / Core Standard: SHMI & HSMR (Medicine)

The current red rating is triggered when
SHMI Threshold is ≥105
SHMI with Palliative Care adjustment ≥100
HSMR (Medicine) ≥ 100

The Issue

SHMI

SHMI has been refreshed since last month. The most recently published SHMI (July 2011- June2012) is 110.8 which is 3.3 lower than the previous rolling year (Jan-Dec 2011) and with a downward trajectory for the last 5 data points (15 month period). This now lies within the expected range on the NHS Information centre data. Furthermore the 3 year SHMI is within the expected range on the Trust Development Authority dashboard.

SHMI with Palliative Care adjustment
This has also been refreshed since last month and at 101.1 is 2.6 lower than the last reported value.

HSMR Medicine
The latest rolling 12 months is 100.4 which is lower by 3.3 than my last exception report.

Comments and Actions

For both these indicators there is a substantial lag period between action taken and reflection in the data as the SHMI covers a period from approximately 8-20 month before the reporting month. The The more timely HSMR indicator can be used to herald change and it is gratifying to see the reduction in SHMI predicted by HSMR earlier in the year materialise. The HSMR for Medicine is showing signs of Improvement with ytd performance M1-M7 around 3 points lower than the rolling 12 months figure.
The specific actions being taken to address the mortality rates includes:

a) The nomination of Clinical Coding Leads by Clinical Directors for all relevant specialties
b) The model of a clinician and senior coder meeting regularly to review the clinical quality and coding accuracy of patient deaths has recently been established in the Fractured Neck of Femur service and Care of the Elderly and is being rolled out to other medical specialties.
c) 5 CQUIN pathways have been agreed with NHS Hertfordshire which are Respiratory Infection, UTIs, Acute Renal Failure, Septicaemia and Congestive Cardiac Failure. These are all on track to complete and Q3 targets achieved.
d) A full clinical and coding review are currently being undertaken to address the raised HSMR in Acute renal failure and congestive cardiac failure.
e) A joint mortality review group with West Hertfordshire NHS Trust and NHS Hertfordshire
f) Directorate focus on all above average mortality conditions.
g) Ongoing review of recently reconfigured services (*e.g.* fractured NoF, emergency surgery)
h) Clinical coding review group with increased frequency of meetings(every 2 weeks)
i) Business case for Encoder software that provides coding decision support approved
j) Joint working with Dr Foster
k) Shared learning with other Trusts eg test result assisted coding
l) Use Whittington Hospital expertise.
m) Access to TDA dashboard

LEAD DIRECTOR – Medical Director

Performance Exception Report – February 2013

Cultural Indicators – Recommend Trust, Support from Managers, Opportunities to Influence

NB: In month performance for January 2013 (month 10) = Red

The Issue

Cultural indicators have been updated in December using the data from the Trust's quarterly internal "finger on the pulse" survey. This survey enables us to measure and monitor our progress on some key areas of staff experience that drive overall improvement in staff engagement.

The floodlights have been populated with results from the survey taken in November 2012 and have been benchmarked against the average score for each element from the December 11 & April 12 results.

The following indicators have seen a very small decrease:

- Recommending the Trust as a place to work & receive treatment
- Support from managers – focuses on whether staff receive regular feedback from line managers
- Opportunities to influence – understanding Trust priorities and being involved in decisions and giving ideas

The response rates for the internal survey have decreased as follows:

Dec 2011 – 722 July 2012 – 374 April 2012 – 477 Nov 2012 – 284

Actions Taken

Please see the January report for previously planned actions and the following are updates actions from the start of 2013

- To ensure we have a well staffed hospital we have been working with NHS Employers on Staff Attendance to decrease sickness rates. An implementation report is being considered.
- To engender a healthy working environment for all staff an implementation plan for the Health and Wellbeing Strategy is being developed and will be considered at ARC Steering group on the 12th February
- To help our staff develop their personal communication skills with patients and colleagues the "Delivering Excellent Customer Care" training has been publicised in the Trust and the Senior Management Team has signed up to ensuring all staff attend the training over the next year. The first session starts on the 12th February.
- The Trust are developing a positive working climate so the ARC steering group will consider new proposals for the re launch of the Aiming High awards which gives our staff recognition of their hard work.
- The ARC steering groups will consider the paper recommending changes to increase the response rates for Finger on the Pulse" so that we enable better communication in the Trust.

Next Steps

- The next quarter's (from April 2013) floodlights will be populated with nationally benchmarked results from the annual NHS staff survey.
- ARC sessions in March 2013 will be led by divisions reviewing how ARC has assisted them and what they want for the next year's sessions.
- The Health and Wellbeing strategy will be launched to the whole Trust.

Lead Director – Director of Strategic Development

Performance Exception Report – January 2013

Statutory and Mandatory Training

1.0 Purpose

This paper outlines the January position in the Trust, and includes provision of training, current compliance and predicted trajectories.

2.0 Current Compliance by competency

The table below details percentage of staff compliant by individual competency.

Trust Staff Compliant by Competency %		
	Does not meet requirement	**Meets Requirement**
Conflict Resolution	25.37%	74.63%
Equity and Diversity	49.15%	50.85%
Fire	35.84%	64.16%
General Health & Safety	36.25%	63.75%
Infection Prevention	29.19%	70.81%
Information Governance	34.55%	65.45%
Moving & Handling	29.99%	70.01%
Safeguarding Adults	38.23%	61.77%
Safeguarding Children	26.97%	73.03%

(Data source: ESR 04/02/13)

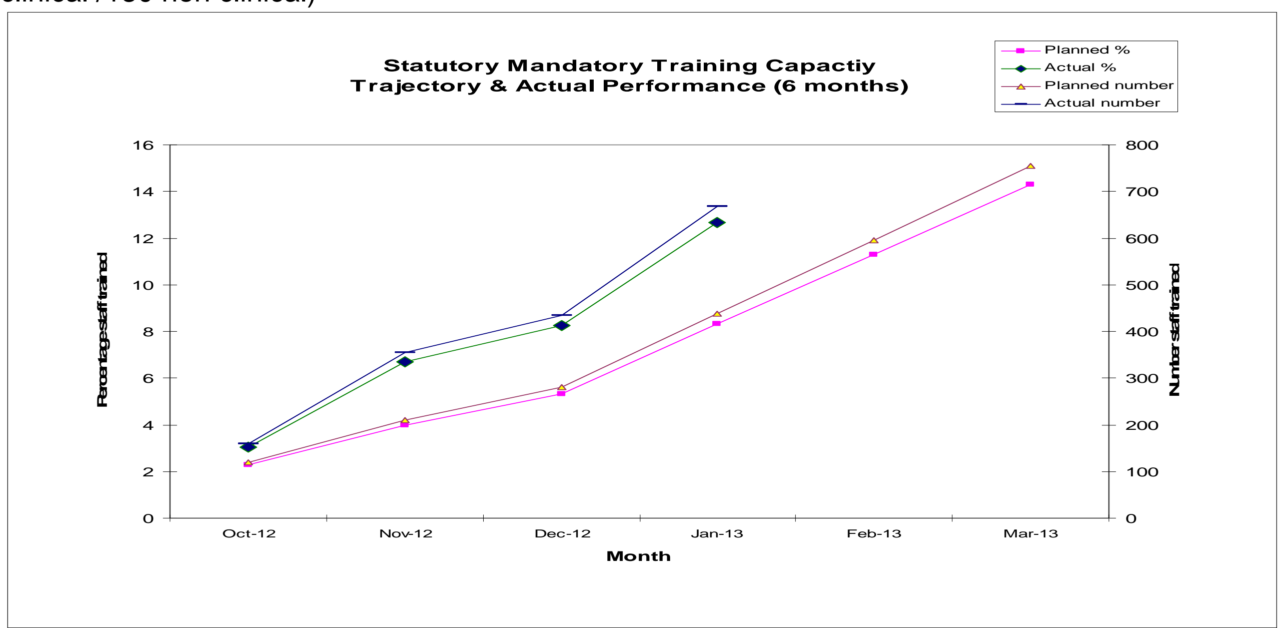
The table below shows current statutory training compliance by staff group (head count) as recorded on ESR as of the 4th February 2013. This shows that 12.43 % (659/5302) of staff are fully compliant with all nine elements of training, an improvement in last month's fully compliant position which stood at 11.49% (608/5293)

Trust Statutory Compliance per job profile							
Staff Group	Partial compliant		Not compliant		compliant		Grand Total
	Number	%	Number	%	Number	%	
Add. Prof. Scientific and Technical	174	91.10%	3	1.57%	14	7.33%	194
Additional Clinical Services	660	82.71%	12	1.50%	126	15.79%	798
Administrative and Clerical	906	85.23%	15	1.41%	142	13.36%	1063
Allied Health Professionals	199	98.03%	2	0.99%	2	0.99%	203
Estates and Ancillary	367	94.59%	11	2.84%	10	2.58%	388
Healthcare Scientists	198	90.41%	1	0.46%	20	9.13%	219
Medical and Dental	619	87.43%	76	10.73%	13	1.84%	708
Nursing and Midwifery Registered	1378	79.70%	19	1.10%	332	19.20%	1729
Students	2	66.67%	1	33.33%			3
Grand Total	*4503*	*84.93%*	*140*	*2.64%*	*659*	*12.43%*	*5302*

(Data source: ESR 04/02/13)

3.0 Statutory Training Trajectory

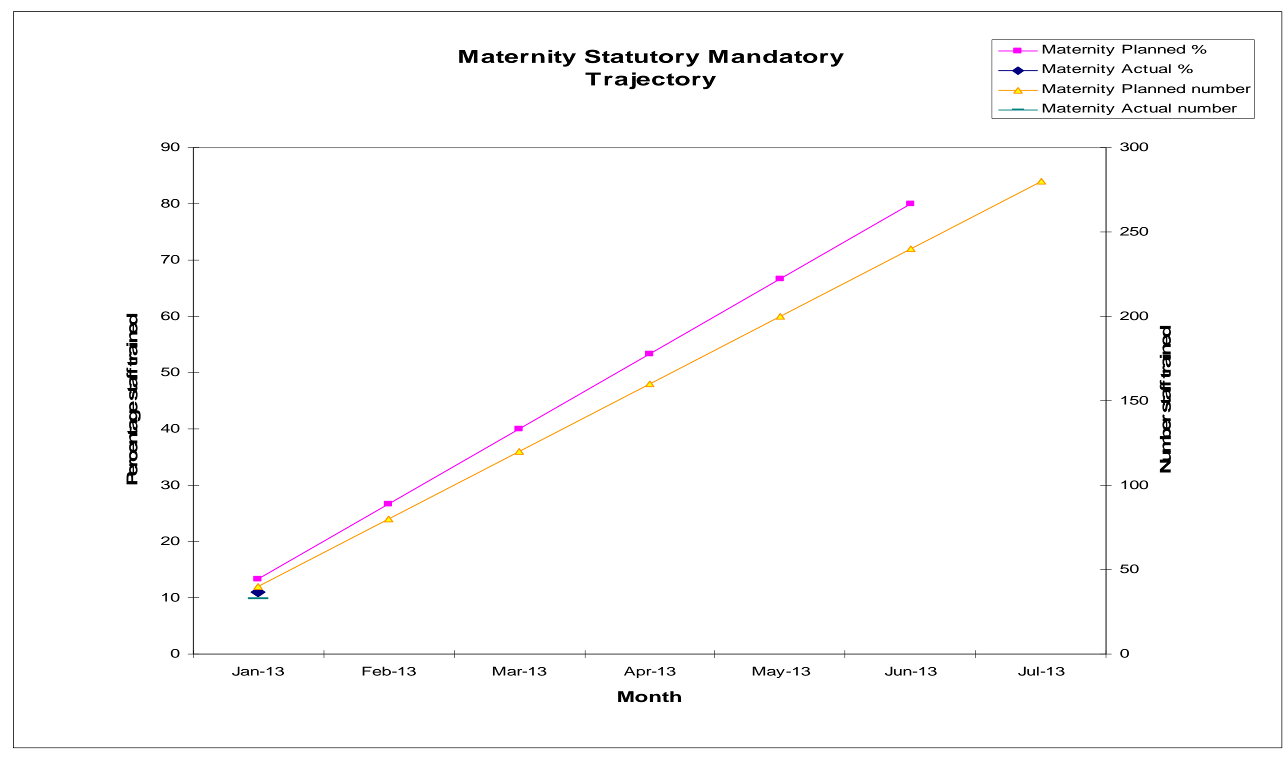
The graph below shows the planned capacity trajectory and the actual number of staff trained in January 2012. The actual number of staff who attended the mandatory programme = 232. (102 clinical /130 non clinical)



Maternity

The CNST assessment is scheduled to take place in September 2013. At time of assessment, 75% of maternity staff are required to be fully compliant with all elements of training. Prioritisation of training places for maternity staff has been agreed. A trajectory has been set to attain this by July 2013. This is based on 40 midwives per month attending a clinical update between January and July 2013.

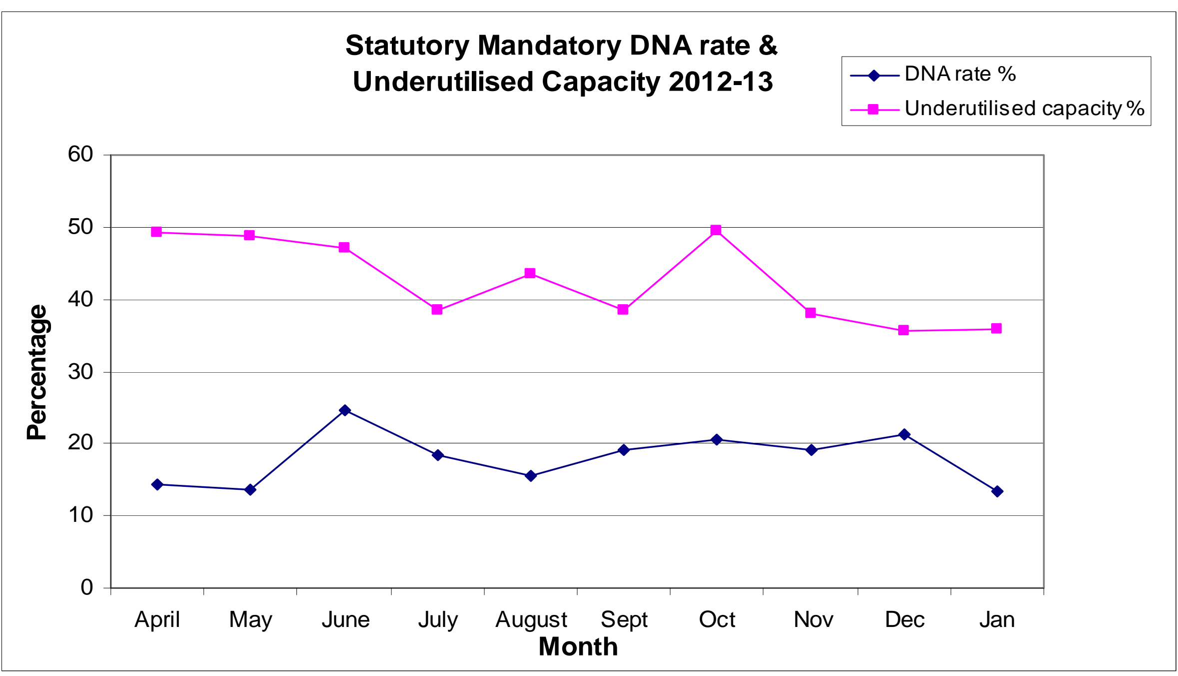
The graph below shows the planned capacity trajectory and the actual number of Midwives trained in January 2013 (n=33)



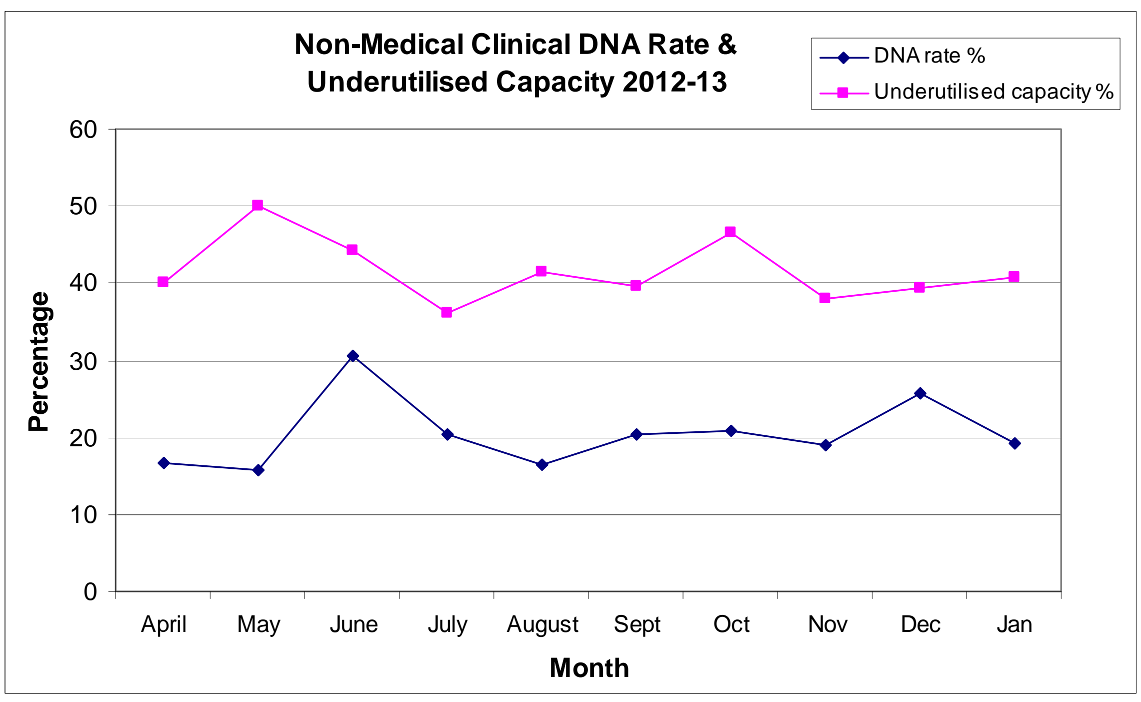
4.0. Current Training Capacity and Utilisation

4.1 Statutory Training Capacity and Utilisation – All staff groups

The DNA rate in January was13.40% (n211) a decrease of 7.89% in the DNA rate recorded in December (21.29% n 258). In January, 2127 training places were provided of which 1364 were utilised resulting in an underutilisation rate of 35.87% (n 763). In January, a reduction in bookings made was noted.



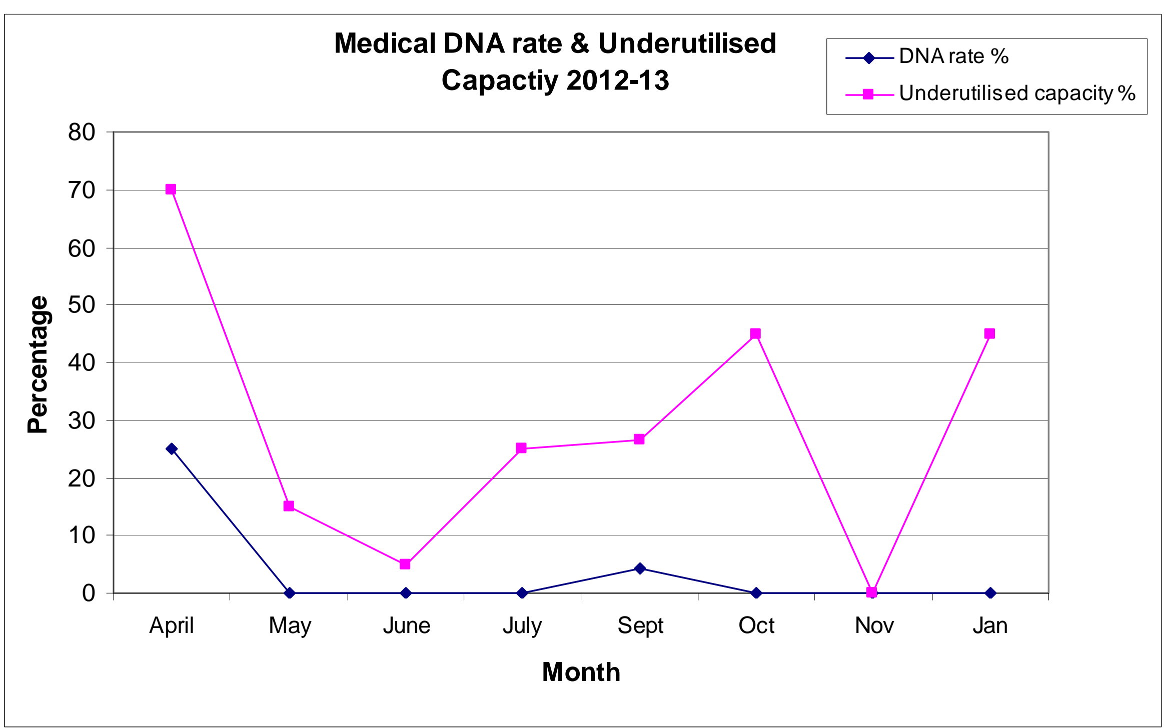
4.1 Non-Medical Clinical Mandatory Training



In January 2013 the DNA rate recorded stood at 19.15% (n 117) compared to the December 2012 figure of 25.71% (n 153).Which shows a decrease of 6.56%. In January 853 training places were provided of which 494 were utilised resulting in an underutilisation rate of 40.84 % (n 341)
It should be noted that the uptake of paediatric resuscitation courses has been poor. No candidates were nominated in January for the basic life support (PBLS) programme and the Paediatric Life Support course was poorly attended.

4.2 Medical and Dental Mandatory Training

This table shows that between April 2012 and January 2013, a total of 140 training places were offered, of which 77 were utilised. The DNA rate recorded was 00.00% and total unused capacity, 45.00% (n 63). A zero DNA rate has consistently been recorded during this period. Two DNAs have been noted throughout the monitored period.



5.0 Ongoing monitoring

Progress against plan is closely monitored by the Non Medical Education and Statutory Mandatory Training Steering Group.

LEAD DIRECTOR – Director of Nursing & Patient Experience

9a - FINANCE APPENDICES

FINANCE REPORT MONTH 10
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FINANCE REPORT MONTH 10
FINANCIAL METRICS

Financial Criteria	Metric to be scored	Weight	Rating categories					Trust YTD figure	Score	Target
			5	4	3	2	1			
Underlying performance	EBITDA margin %	0.25	11%	9%	5%	1%	<1%	3.7%	2	3
Achievement of plan	EBITDA % of plan achieved	0.10	100%	85%	70%	50%	<50%	69.0%	2	5
Financial Efficiency	Net return after financing	0.20	>3%	2%	-0.5%	-5%	<-5%	0.2%	3	3
	I&E surplus margin	0.20	3%	2%	1%	-2%	< -2%	0.3%	2	3
Liquidity	Liquidity ratio (days)	0.25	60	25	15	10	<10	15.0	3	3
Financial Risk rating is the weighted average of financial criteria scores after applying adjustment factors. This gives an indicative risk rating of:									2.5	3.2

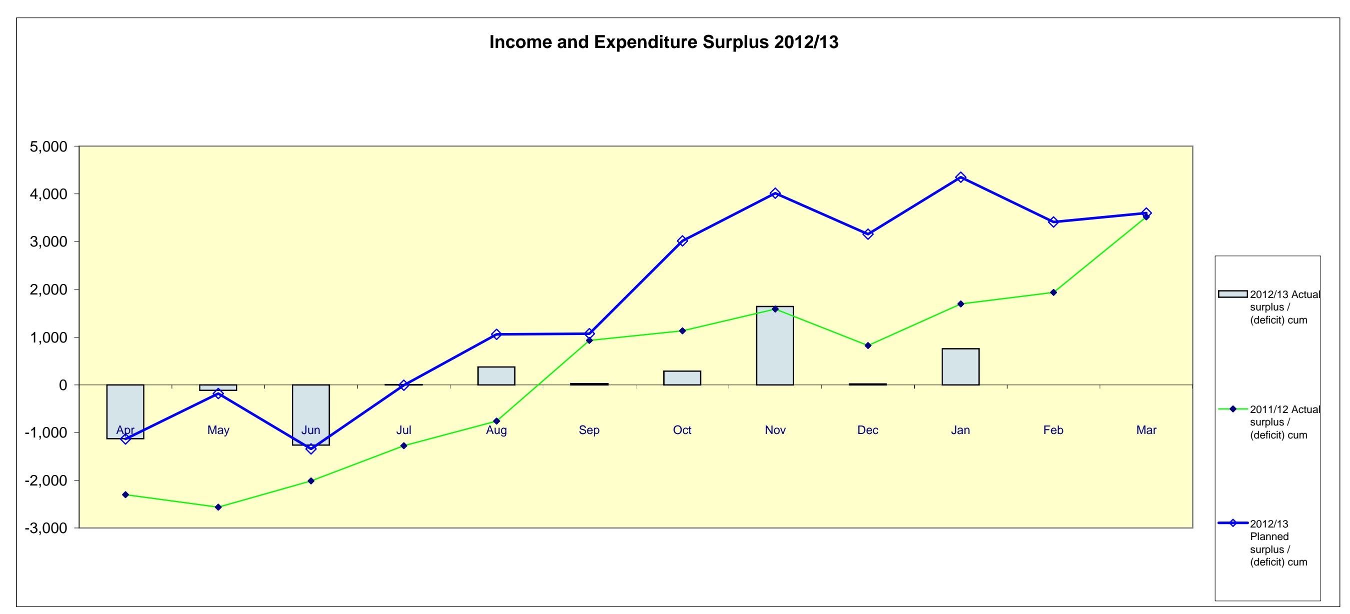
Overriding rules	If yes, maximum overall score	
One financial criterion scored at '1'	No	2
One financial criterion scored at '2'	**Yes**	**3**
Two financial criteria scored at '2'	No	2
Two financial criteria at '1'	No	1
Less than 1 year as an Foundation Trust	Yes	4

Overriding rules rating	2	3

FINANCE REPORT MONTH 10
TRUST INCOME AND EXPENDITURE

	Current Month			Year to Date			Full Year		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Forecast £000	Variance £000
Income									
Income from NHS activities	24,601	24,798	197	235,160	235,534	374	280,066	281,636	1,570
Income from non NHS activities	623	-98	-721	6,211	4,540	-1,671	7,458	5,536	-1,922
Other operating income	4,811	5,409	598	47,251	46,526	-726	56,792	57,652	860
Total Income	**30,035**	**30,108**	**74**	**288,622**	**286,600**	**-2,022**	**344,316**	**344,824**	**508**
Expenditure within Divisions									
Pay	-17,994	-18,495	-501	-181,229	-183,837	-2,608	-217,034	-219,896	-2,862
Non-Pay	-9,633	-10,011	-378	-90,859	-93,671	-2,812	-108,786	-111,984	-3,198
Unallocated Budgets	-114	123	237	-1,159	1,519	2,678	-1,665	-616	1,049
Total expenditure within Divisions	**-27,741**	**-28,383**	**-642**	**-273,247**	**-275,989**	**-2,743**	**-327,486**	**-332,496**	**-5,011**
EBITDA	**2,294**	**1,726**	**-568**	**15,375**	**10,610**	**-4,765**	**16,830**	**12,328**	**-4,502**
PDC Dividends payable	-307	-265	42	-3,069	-2,653	416	-3,683	-3,309	374
Depreciation & minor impairments	-608	-574	34	-6,083	-5,743	340	-7,300	-6,769	531
Investment Revenue	2	1	-1	21	26	5	25	36	10
Finance Costs	-189	-145	44	-1,893	-1,481	412	-2,272	-1,785	487
NET SURPLUS / (DEFICIT)	**1,191**	**742**	**-449**	**4,351**	**758**	**-3,592**	**3,600**	**500**	**-3,100**

EBITDA % delivered = *10,610 /15,375* = *69.0%*
EBITDA margin = *10,610 / 286,600* = *3.7%*
I&E surplus margin = *758 / 286,600* = *0.3%*



FINANCE REPORT MONTH 10
ANALYSIS OF CONTRACT INCOME BY SOURCE

	Current Period			Year to Date			Full Year		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Income from activities - NHS									
NHS Hertfordshire	18,876	18,420	-456	179,982	177,671	-2,311	213,716		-213,716
NHS Bedfordshire	1,778	1,913	134	17,118	17,817	700	20,421		-20,421
Specialist Commissioning	1,410	1,464	54	13,733	14,578	844	18,084		-18,084
Hillingdon PCT	564	696	132	5,401	6,257	857	6,780		-6,780
Luton PCT	460	469	9	4,409	4,204	-205	5,257		-5,257
Non Contracted Activity (other PCTs)	565	793	229	5,450	5,674	223	4,575		-4,575
Harrow PCT	277	379	102	2,654	3,152	498	3,343		-3,343
Barnet PCT	168	131	-37	1,605	1,552	-53	1,992		-1,992
Buckinghamshire PCT	159	193	33	1,522	1,676	154	1,813		-1,813
Berkshire East PCT	100	121	21	962	865	-97	1,146		-1,146
Brent PCT	128	105	-23	1,224	945	-279	1,597		-1,597
Ealing PCT	72	78	6	687	677	-10	839		-839
West Essex PCT	22	30	8	215	293	78	257		-257
Enfield PCT	21	6	-15	197	172	-25	249		-249
Total income from activities - NHS	**24,601**	**24,798**	**197**	**235,160**	**235,534**	**374**	**280,066**	**0**	**-280,066**
Income from non-NHS activities									
Private Patients	409	138	-272	4,044	2,897	-1,147	4,863		-4,863
Road Traffic Act	117	-337	-455	1,174	720	-455	1,409		-1,409
Non NHS Other	96	101	5	992	923	-69	1,185		-1,185
Total income from non-NHS activities	**623**	**-98**	**-721**	**6,211**	**4,540**	**-1,671**	**7,458**	**0**	**-7,458**
Other operating income									
Education, Training and Research	1,062	1,069	7	10,212	10,127	-84	12,273		-12,273
Distinction / Merit Awards	88	81	-7	875	807	-68	1,050		-1,050
Hosted Services SLAs	299	297	-1	2,964	2,951	-13	3,556		-3,556
Non Patient Care Services	200	189	-10	2,002	1,834	-168	2,401		-2,401
R&D Income	276	288	12	2,757	2,893	136	3,309		-3,309
Other Income	1,256	1,880	624	12,080	11,501	-579	14,579		-14,579
ISTC: SLAs	872	845	-27	8,761	8,813	52	10,505		-10,505
ISTC: Transitional Relief	760	760	0	7,600	7,600	0	9,120		-9,120
Total other operating income	**4,811**	**5,409**	**598**	**47,251**	**46,526**	**-726**	**56,792**	**0**	**-56,792**
Grand Total	**30,035**	**30,108**	**74**	**288,622**	**286,600**	**-2,022**	**344,316**	**0**	**-344,316**

FINANCE REPORT MONTH 10
ANALYSIS OF CONTRACT INCOME BY TYPE OF ACTIVITY

	Current Period			Year to Date			Full Year		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Income from activities - NHS									
Accident & emergency	**1,140**	**1,123**	**-18**	**11,260**	**11,773**	**513**	**13,432**	**14,294**	**862**
Non-elective short stay	253	332	79	2,501	2,518	17	2,983	2,739	-244
Non-elective standard (incl excess bed days)	5,542	6,221	679	55,317	55,881	564	65,879	66,184	305
Total Non-Elective Inpatients	**5,795**	**6,553**	**758**	**57,818**	**58,399**	**582**	**68,862**	**68,923**	**61**
Day Case	905	871	-34	8,511	8,535	24	10,155	10,277	122
Elective standard (incl excess bed days)	1,606	1,048	-558	15,113	14,253	-860	18,033	17,863	-170
Total Elective Inpatients/Day Case	**2,511**	**1,919**	**-592**	**23,623**	**22,788**	**-836**	**28,188**	**28,140**	**-48**
PbR outpatient consultant led first attendances	1,476	1,400	-76	13,889	13,960	71	16,573	16,639	66
PbR outpatient consultant led follow up attendances	1,469	1,562	92	13,808	13,950	143	16,479	16,357	-122
Outpatient - other	438	473	35	4,105	4,194	88	4,907	5,221	314
Outpatient procedures	327	434	107	2,948	3,564	617	3,568	4,419	851
Total Outpatient	**3,710**	**3,868**	**157**	**34,750**	**35,668**	**918**	**41,527**	**42,636**	**1,109**
Direct access pathology	664	614	-51	6,250	6,419	169	7,458	7,798	340
Direct access radiology	224	256	32	2,105	2,596	491	2,512	3,228	716
Renal dialysis services	1,003	932	-71	9,586	9,387	-200	11,450	11,346	-104
Neonatal & SCBU	377	427	49	3,723	3,666	-57	4,441	4,213	-228
Intensive care	706	778	72	6,972	7,423	451	8,316	8,852	536
Chemotherapy HCD	551	496	-56	4,953	4,957	4	5,770	5,645	-125
PbR drug exclusions	448	453	4	3,759	4,001	241	4,389	4,580	191
Ward attenders	290	296	6	2,733	3,032	299	3,261	3,677	416
Maternity pathway	1,934	1,852	-82	19,090	18,278	-812	22,770	21,782	-988
Other Non-PbR Cost & volume services	340	392	52	3,200	3,485	285	3,818	4,134	316
Non-PbR block services	524	524	0	5,209	5,209	0	6,247	6,247	0
Total Non-PbR cost & volume	**7,062**	**7,018**	**-44**	**67,580**	**68,452**	**872**	**80,433**	**81,503**	**1,070**
CQUIN	**418**	**390**	**-28**	**4,184**	**3,860**	**-323**	**5,020**	**4,608**	**-412**
QIPP Savings Target	0	0	0	0	0	0	0	0	0
Total Acute Services	**20,637**	**20,870**	**233**	**199,213**	**200,940**	**1,726**	**237,462**	**240,104**	**2,642**
Mount Vernon									
PBR	970	992	22	9,333	9,407	74	10,815	10,747	-68
Non PBR	2,909	2,867	-42	25,802	24,567	-1,235	30,824	30,066	-758
CQUIN	85	69	-16	810	619	-191	965	719	-246
Total Mount Vernon	***3,964***	***3,928***	**-36**	**35,946**	**34,594**	**-1,352**	**42,604**	**41,532**	**-1,072**
Total income from activities - NHS	**24,601**	**24,798**	**197**	**235,160**	**235,534**	**374**	**280,066**	**281,636**	**1,570**
Income from non-NHS activities									
Private Patients	409	138	-272	4,044	2,897	-1,147	4,863	3,563	-1,300
Road Traffic Act	117	-337	-455	1,174	720	-455	1,409	856	-553
Non NHS Other	96	101	5	992	923	-69	1,185	1,116	-69
Total income from non-NHS activities	**623**	**-98**	**-721**	**6,211**	**4,540**	**-1,671**	**7,458**	**5,536**	**-1,922**
Other operating income									
Education, Training and Research	1,062	1,069	7	10,212	10,127	-84	12,273	12,018	-254
Distinction / Merit Awards	88	81	-7	875	807	-68	1,050	1,050	0
Hosted Services SLAs	299	297	-1	2,964	2,951	-13	3,556	3,554	-2
Non Patient Care Services	200	189	-10	2,002	1,834	-168	2,401	2,201	-200
R&D Income	276	288	12	2,757	2,893	136	3,309	3,205	-104
Other Income	1,256	1,880	624	12,080	11,501	-579	14,579	15,741	1,162
ISTC: SLAs	872	845	-27	8,761	8,813	52	10,505	10,763	258
ISTC: Transitional Relief	760	760	0	7,600	7,600	0	9,120	9,120	0
Total other operating income	**4,811**	**5,409**	**598**	**47,251**	**46,526**	**-726**	**56,792**	**57,652**	**860**
Grand Total	**30,035**	**30,108**	**74**	**288,623**	**286,599**	**-2,022**	**344,316**	**344,824**	**508**

SERVICE LINE REPORT MONTH 10
ANALYSIS OF INCOME AND EXPENDITURE BY DIVISION

	Cancer			Medicine			Surgery		
	Plan	Actual	Diff	Plan	Actual	Diff	Plan	Actual	Diff
Income									
NHS Activities	46,086	45,261	(825)	80,481	82,427	1,946	62,513	61,952	(562)
Income reported in Divisions	5,966	5,498	(468)	1,035	976	(59)	1,064	818	(246)
Other Operating	4,690	4,267	(422)	14,311	14,017	(294)	14,435	14,150	(285)
Total Income	56,741	55,026	(1,715)	95,827	97,420	1,593	78,012	76,919	(1,092)
Expenditure									
Net Direct	(37,863)	(38,530)	(668)	(52,397)	(53,958)	(1,561)	(52,387)	(53,900)	(1,514)
Income reported in Divisions	(5,966)	(5,498)	468	(1,035)	(976)	59	(1,064)	(818)	246
Direct	(43,829)	(44,028)	(200)	(53,432)	(54,934)	(1,502)	(53,451)	(54,718)	(1,268)
Indirect Clinical Costs	(6,231)	(6,231)	0	(9,883)	(9,883)	0	(5,511)	(5,511)	0
Indirect Overhead Costs	(6,030)	(5,793)	238	(26,385)	(25,783)	602	(24,213)	(23,489)	723
Total Expenditure	(56,090)	(56,052)	38	(89,699)	(90,600)	(900)	(83,174)	(83,719)	(545)
Net Surplus/Deficit	651	(1,026)	(1,677)	6,128	6,820	693	(5,162)	(6,799)	(1,637)
Contribution	*1,992*	*499*	*(1,493)*	*18,201*	*18,586*	*385*	*4,616*	*2,541*	*(2,075)*

	W&C			Clinical Services			Grand Total		
	Plan	Actual	Diff	Plan	Actual	Diff	Plan	Actual	Diff
Income									
NHS Activities	37,550	36,738	(812)	8,530	9,157	627	235,160	235,534	374
Income reported in Divisions	801	880	79	3,091	2,851	(240)	11,957	11,023	(934)
Other Operating	6,790	6,568	(223)	1,280	1,041	(239)	41,506	40,043	(1,463)
Total Income	45,141	44,186	(956)	12,901	13,049	148	288,622	286,600	(2,022)
Expenditure									
Net Direct	(24,956)	(24,770)	187	(37,597)	(38,887)	(1,290)	(205,199)	(210,045)	(4,846)
Income reported in Divisions	(801)	(880)	(79)	(3,091)	(2,851)	240	(11,957)	(11,023)	934
Direct	(25,757)	(25,650)	108	(40,688)	(41,738)	(1,050)	(217,156)	(221,068)	(3,912)
Indirect Clinical Costs	(3,750)	(3,750)	0	25,375	25,375	0	0	0	0
Indirect Overhead Costs	(13,669)	(13,377)	292	3,181	3,668	487	(67,116)	(64,774)	2,342
Total Expenditure	(43,176)	(42,776)	400	(12,132)	(12,695)	(563)	(284,272)	(285,842)	(1,570)
Net Surplus/Deficit	1,966	1,410	(556)	768	354	(414)	4,351	758	(3,592)
Contribution	*8,844*	*8,219*	*(625)*	*(3,692)*	*(4,355)*	*(663)*	*29,961*	*25,489*	*(4,471)*

FINANCE REPORT MONTH 10

EXPENDITURE BY DIVISION AND SPECIALTY/DEPARTMENT

	Current Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Division	£000	£000	£000	£000	£000	£000	£000	£000	£000
Medical Division									
Emergency Care	-2,352	-2,532	-180	-22,515	-23,174	-659	-26,913	-27,604	-691
A&E	-879	-1,028	-149	-8,914	-9,909	-995	-10,663	-11,857	-1,194
Renal	-1,091	-1,117	-25	-10,684	-10,779	-95	-12,833	-12,918	-85
Speciality Medicine	-403	-415	-11	-3,870	-4,073	-203	-4,670	-4,839	-169
Cardiology	-638	-655	-17	-6,413	-6,022	391	-7,683	-7,385	298
Total Medical Division	**-5,364**	**-5,747**	**-383**	**-52,397**	**-53,958**	**-1,561**	**-62,762**	**-64,603**	**-1,841**
Surgical Division									
General Surgery & Urology & Gastroenterology	-1,310	-1,523	-214	-13,138	-14,529	-1,391	-15,761	-17,415	-1,654
Orthopaedics	-840	-1,010	-170	-9,702	-9,422	280	-11,632	-11,426	206
Surgical Specialities	-654	-697	-43	-6,670	-6,663	8	-7,980	-7,973	6
Anaesthetics & Theatres	-1,619	-1,515	104	-15,026	-15,242	-215	-18,038	-18,303	-265
Critical Care	-784	-834	-50	-7,849	-8,038	-189	-9,417	-9,716	-299
Total Surgical Division	**-5,207**	**-5,579**	**-372**	**-52,387**	**-53,893**	**-1,507**	**-62,827**	**-64,833**	**-2,006**
Women's & Children's Division									
Obstetrics & Gynaecology	-1,404	-1,419	-16	-13,916	-13,923	-7	-16,708	-16,731	-23
Paediatrics	-1,102	-1,109	-7	-11,041	-10,847	194	-13,243	-13,080	163
Total Women's & Children's Division	**-2,506**	**-2,528**	**-23**	**-24,956**	**-24,770**	**187**	**-29,951**	**-29,811**	**140**
Cancer Services Division									
Mount Vernon Cancer Services	-3,312	-3,400	-88	-31,032	-31,629	-597	-37,026	-37,873	-847
Oncology & Haematology	-713	-717	-4	-6,830	-6,901	-71	-8,043	-8,043	0
Total Cancer Services Division	**-4,025**	**-4,117**	**-92**	**-37,863**	**-38,530**	**-668**	**-45,068**	**-45,915**	**-847**
Clinical Support Division									
Pathology & EBME & QC	-1,491	-1,606	-115	-14,691	-15,306	-615	-17,640	-18,425	-785
Pharmacy	-865	-827	38	-8,145	-8,079	67	-9,686	-9,509	177
Radiology	-973	-1,030	-57	-9,639	-9,991	-352	-11,605	-11,997	-393
Elizabeth House PP	66	-37	-103	655	439	-217	785	326	-459
Patient Access & Occupational Health	-573	-582	-9	-5,778	-5,950	-173	-6,935	-7,165	-230
Total Clinical Support Division	**-3,837**	**-4,082**	**-245**	**-37,597**	**-38,887**	**-1,290**	**-45,080**	**-46,770**	**-1,690**
ISTC	**318**	**295**	**-23**	**3,185**	**2,923**	**-262**	**3,822**	**3,508**	**-314**
Corporate Directorates									
Finance	-603	-1,103	-500	-6,483	-7,109	-627	-7,690	-8,469	-779
Personnel	-262	-217	45	-3,312	-3,416	-104	-3,836	-3,956	-120
Estates & Strategic Development&Facilities	-1,874	-1,934	-60	-18,386	-18,680	-294	-22,059	-22,389	-330
Trust Management	-637	-635	1	-6,364	-6,364	1	-7,638	-7,606	32
Nursing	-809	-810	-1	-8,098	-8,063	35	-9,717	-9,673	44
Education	-188	-136	52	-1,511	-1,421	91	-1,837	-1,782	55
Total Corporate Departments	**-4,373**	**-4,835**	**-462**	**-44,154**	**-45,052**	**-899**	**-52,777**	**-53,875**	**-1,098**
Reserves									
R&D	-61	-61	0	-628	-628	0	-750	-750	0
Unallocated Budgets - general reserves	-114	123	237	-1,159	467	1,626	-1,665	-616	1,049
Total Unallocated Budgets	**-174**	**62**	**237**	**-1,787**	**-162**	**1,626**	**-2,415**	**-1,366**	**1,049**
Income reported in Divisions	**-2,574**	**-1,852**	**722**	**-25,292**	**-23,654**	**1,638**	**-30,427**	**-28,453**	**1,974**
Total Expenditure within Divisions	**-27,741**	**-28,383**	**-642**	**-273,247**	**-275,983**	**-2,736**	**-327,486**	**-332,120**	**-4,634**

East and North Hertfordshire NHS Trust

FINANCE REPORT MONTH 10
ROLLING 12 MONTHS CASHFLOW

	Jan-13 Actual	Feb-13 Forecast	Mar-13 Forecast	Apr-13 Forecast	May-13 Forecast	Jun-13 Forecast	Jul-13 Forecast	Aug-13 Forecast	Sep-13 Forecast	Oct-13 Forecast	Nov-13 Forecast	Dec-13 Forecast	TOTAL
BALANCE	**807**	**5,702**	**7,569**	**10,366**	**7,029**	**4,753**	**8,368**	**8,242**	**6,826**	**8,924**	**7,443**	**5,960**	**4,477**
RECEIPTS													
NHS ACUTE ACTIVITY INCOME	30,027	22,736	24,736	22,736	22,736	23,236	22,736	22,736	22,736	22,736	22,736	22,736	***282,623***
EDUCATION/MERIT AWARDS/R&D	979	1,224	1,225	1,225	1,225	1,225	1,225	1,225	1,225	1,225	1,225	1,225	***14,453***
OTHER INCOME	1,096	3,778	3,777	3,777	3,777	3,777	3,777	3,777	3,777	3,777	3,777	3,777	***42,644***
INTEREST	1	2	2	2	2	2	2	2	2	2	2	2	***23***
LOAN RECEIVED	4,942	0	5,990	0	0	5,156	2,064		6,412				***24,564***
SUB-TOTAL RECEIPTS	**37,045**	**27,740**	**35,730**	**27,740**	**27,740**	**33,396**	**29,804**	**27,740**	**34,152**	**27,740**	**27,740**	**27,740**	**364,307**
PAYMENTS													
SALARIES & WAGES -TRUST	10,109	9,649	9,649	9,649	9,649	9,649	9,649	9,649	9,649	9,649	9,649	9,649	***116,248***
SALARIES & WAGES - OTHER	132	132	132	132	132	133	134	135	136	137	138	138	***1,611***
PAYE/ SUPERN/ NI - TRUST	7,078	7,129	7,129	7,129	7,129	7,129	7,129	7,129	7,129	7,129	7,129	7,129	***85,497***
PAYE/ SUPN/ NI - OTHER	51	51	51	51	51	51	51	51	51	52	53	53	***617***
CREDITORS	13,058	7,060	5,102	10,846	9,846	9,842	9,842	8,842	8,842	8,842	8,842	8,842	***109,806***
CREDITORS- CAPITAL	1,328	1,852	2,933	3,270	3,209	2,977	3,125	3,350	3,411	3,412	3,412	3,412	***35,691***
DIVIDEND PAID	0	0	1,842	0	0	0	0	0	1,688	0	0	0	***3,530***
INTEREST ON DH LOANS	0	0	544	0	0	0	0	0	415	0	0	0	***959***
DH LOAN REPAYMENTS	394	0	5,552	0	0	0	0	0	733	0	0	0	***6,679***
SUB-TOTAL PAYMENTS	**32,150**	**25,873**	**32,934**	**31,077**	**30,016**	**29,781**	**29,930**	**29,156**	**32,054**	**29,221**	**29,223**	**29,223**	**360,638**
Month end actual and forecast	**5,702**	**7,569**	**10,366**	**7,029**	**4,753**	**8,368**	**8,242**	**6,826**	**8,924**	**7,443**	**5,960**	**4,477**	**8,146**
Trust Cash plan	**9,898**	**8,863**	**10,366**	**10,366**	**10,366**	**10,366**	**10,366**	**10,366**	**10,366**	**10,366**	**10,366**	**10,366**	

FINANCE REPORT MONTH 10
CASHFLOW PERFORMANCE 2012/13

Cashflow performance against plan

Planned month end balance
Actual cashflow
Forecast cashflow

£000's

14,000
12,000
10,000
8,000
6,000
4,000
2,000
0

Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Cashflow performance against plan excluding capital

Planned month end balance exc cap
Actual cashflow excl capital
Forecast excl capital

£000's

25,000
20,000
15,000
10,000
5,000
0

Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Aged Creditors / Debtors at Mth 10

Aged Creditors
Aged Debtors

£'000s

6000
5000
4000
3000
2000
1000
0

1 - 30 31 - 60 61 - 90 91 +

Days

Prompt payment of invoices against target by volume (BPPC)

Target
Achieved - cumulative

paid within 30 days

100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%
45%
40%

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Appendix 9

FINANCE REPORT MONTH 10
BALANCE SHEET 2012/13

	Opening Balance as at 01/04/12 £000	Balance Sheet as at 31/01/13 £000	Forecast as at 31/03/13 £000
FIXED ASSETS			
Property, Plant Equipment	177,142	182,196	166,589
Trade & Other Receivables N-Current	1,325	1,325	1,359
TOTAL FIXED ASSETS	178,467	183,521	167,948
CURRENT ASSETS			
Inventories	4,738	4,738	4,738
Cash & Cash Equivalents	9,602	5,702	10,366
Trade & Other Receivables - Current	20,504	18,759	19,847
TOTAL CURRENT ASSETS	34,844	29,199	34,951
Creditors: Amounts Falling Due Within One Year	(43,127)	(36,288)	(52,575)
NET CURRENT ASSETS / (LIABILITIES)	(8,283)	(7,089)	(17,624)
FIXED & NET CURRENT ASSETS LESS CURRENT LIABILITIES	170,184	176,432	150,324
Creditors: Amounts Falling Due More Than One Year	(38,065)	(44,346)	(45,160)
Provisions For Liabilities & Charges	(1,079)	(682)	(1,007)
NET ASSETS	131,040	131,404	104,157
FINANCED BY			
TAXPAYERS EQUITY:			
Public Dividend Capital	151,534	151,140	151,140
Revaluation Reserve	67,444	67,444	50,585
Retained Earnings	(87,938)	(87,180)	(97,568)
TOTAL TAXPAYERS EQUITY	131,040	131,404	104,157

East and North Hertfordshire NHS
NHS Trust

FINANCE REPORT MONTH 10
CAPITAL PROGRAMME 2012/2013

Scheme Code	Scheme Description	Approved Budget 2012/13 £000	YTD Plan as at 31/01/13 £000	YTD Expenditure as at 31/01/13 £000	YTD Variance as at 31/01/13 £000	YE Forecast as at 31/03/13 £000
2011/12 projects						
26702	Medical Equipment 10/11	-345	49	47	2	-347
	IM&T	208	173	0	173	135
26706	E-Learning	25	21	7	14	25
26716	CT Scanner	50	42	60	(18)	40
26649	Cardiology - Cath lab	82	68	22	46	82
26657	Electrical Infrastructure	163	122	128	(6)	163
26658	CHP	136	34	129	(95)	136
26695	Other Infrastructure costs	235	364	81	283	235
26612	Maternity	0	0	0	0	0
26696	MV CQC cancer centre	35	29	98	(69)	35
Total b/f 2011/12		**589**	**902**	**572**	**330**	**504**
Additional capital allocation						
26714	MRI scanner - works component	611	459	0	459	400
26713	Endoscopy decontamination - works component	635	477	75	402	829
26715	Linacs software	93	93	76	17	79
2012/13 projects		**1,339**	**1,029**	**151**	**878**	**1,308**
Essential Schemes						
26900	Staff Recharges	1,592	458	754	(296)	1,592
	HCH - PFI Asset	88	0	0	0	88
		1,680	**458**	**754**	**(296)**	**1,680**
New Schemes						
26702	Medical Equipment	951	793	578	215	951
	IM&T	732	610	649	(39)	940
	Maintenance	662	552	819	(267)	662
	Other	0	0	40	(40)	0
	COPD CQUIN	0	0	0	0	18
	Chemotherapy chairs	0	0	0	0	18
	Car Park	75	56	0	56	10
	QEII	100	100	86	14	150
	OCH IT	27	21	3	18	27
	TPP	0	0	97	(97)	74
	Mattress replacements	0	0	26	(26)	26
	Estates Time Management	0	0	0	0	23
	CHP inclusion in Trust Assets	2,044	0	0	0	2,044
	Occupational Health Relocation	0	0	0	0	20
	Main Entrance	0	0	5	(5)	10
	Complaints	0	0	0	0	12
New	Improving Birthing Environments	186	0	0	0	186
New	Linear Accelerator	752	0	0	0	752
Total New Schemes		**5,529**	**2,132**	**2,303**	**(171)**	**5,923**
OCH						
26625	Phase 4 - A&E	5,917	2,568	2,215	353	4,589
	Phase 4 - enabling	1,266	844	7	837	759
26651	Phase 4 - 11a	90	85	4	81	90
26651	Phase 4 - 11a Enabling	0	0	113	(113)	0
26650	Phase 4 - 7a	839	839	648	191	839
26655	Phase 4 - Ward Block	0	0	0	0	1,272
26656	Phase 4 - Theatres	3,502	731	34	697	1,331
26653	Phase 4 - Chemo	517	100	243	(143)	424
26724	Phase 4 - Pathology	290	85	31	54	291
26661	Phase 4 - critical Care	1,825	1,825	1,692	133	1,453
26665	Phase 4 - Medical Records	336	284	97	187	24
26652	Phase 4 - Mortuary	131	131	137	(6)	131
Total OCH		**14,713**	**7,492**	**5,221**	**2,271**	**11,203**
	Undercommitted					
	Programme Total 2012/13	**23,850**	**12,013**	**9,001**	**3,012**	**20,618**

Funding & CRL	
Depreciation	6,477
Loan - Phase 4	13,074
Internally Generated	3,288
PDC repayment	-394
CHP	2,044
Improving Birthing Env	186
Total	**24,675**

Please note that in the light of new information, the planned capital expenditure profile has been revised and is not in line with the FIMs plan.

FINANCE REPORT MONTH 10
SUMMARY OF CIP DELIVERY BY DIVISION

	Current Period			Year to Date			Full Year		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000	Plan £000	Forecast £000	Variance £000
Medical Division	265	255	-10	2,315	2,252	-63	2,843	2,843	0
Surgical Division	281	405	124	2,417	2,356	-61	2,978	2,978	0
Women & Children's Division	125	133	8	1,441	1,437	-4	1,629	1,629	0
Cancer Services Division	191	125	-66	1,439	1,266	-173	1,819	1,820	1
Clinical Support Division	181	189	8	1,665	1,690	25	2,026	2,040	14
Corporate Directorates	334	283	-51	2,494	2,168	-326	3,169	3,251	82
Trust wide	72	72	0	411	411	0	557	557	0
Total	**1,449**	**1,462**	**13**	**12,182**	**11,580**	**-602**	**15,021**	**15,118**	**97**
		100.9%			95.1%			101%	

SUMMARY OF PHASING BY DIVISION

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Medical Division	176	173	174	248	248	248	261	262	261	265	264	263	2843
Surgical Division	128	128	234	253	276	276	278	281	281	281	281	281	2978
Women & Children's Division	140	146	158	158	158	139	139	139	139	125	125	123	1689
Cancer Services Division	73	73	79	128	159	167	189	189	191	191	191	189	1819
Clinical Support Division	141	141	141	159	181	181	181	181	181	181	181	177	2026
Corporate Directorates	111	128	222	222	230	271	309	309	309	334	334	330	3109
Trust wide	0	0	0	41	41	41	72	72	72	72	72	74	557
Total £000	**769**	**789**	**1,008**	**1,209**	**1,293**	**1,323**	**1,429**	**1,433**	**1,434**	**1,449**	**1,448**	**1,437**	**15,021**
Total %	**5.1%**	**5.3%**	**6.7%**	**8.0%**	**8.6%**	**8.8%**	**9.5%**	**9.5%**	**9.5%**	**9.6%**	**9.6%**	**9.6%**	**100%**

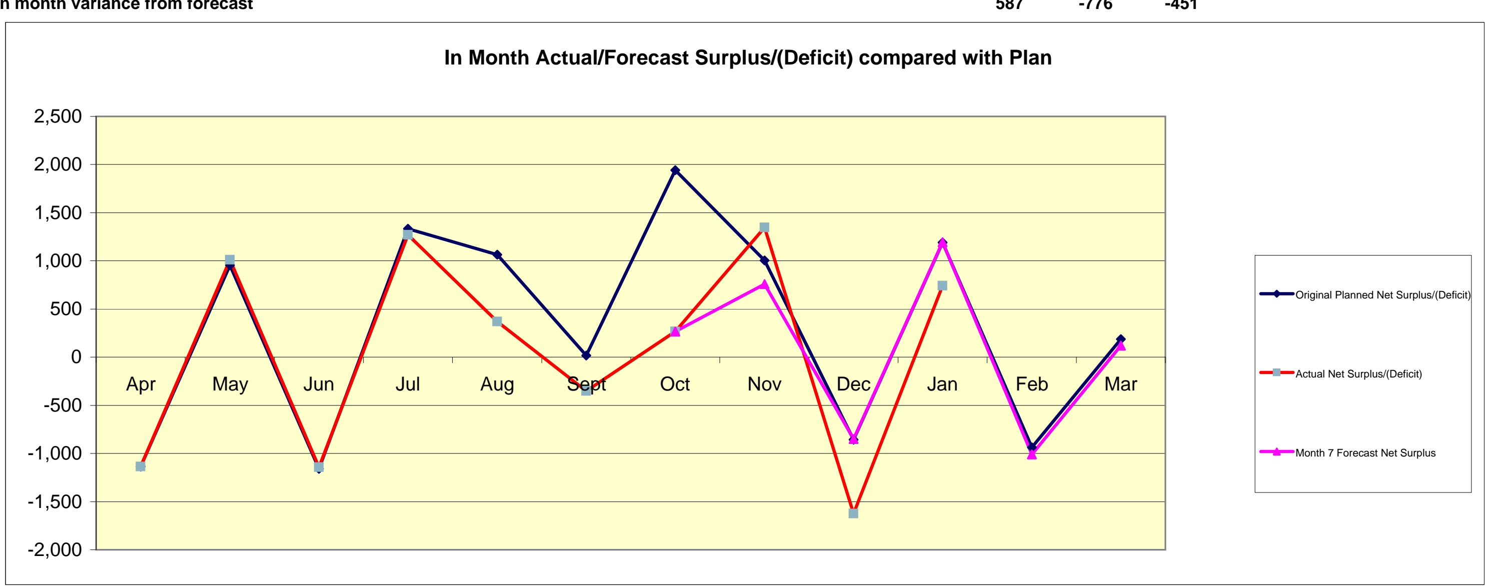
Appendix 12

East and North Hertfordshire NHS Trust

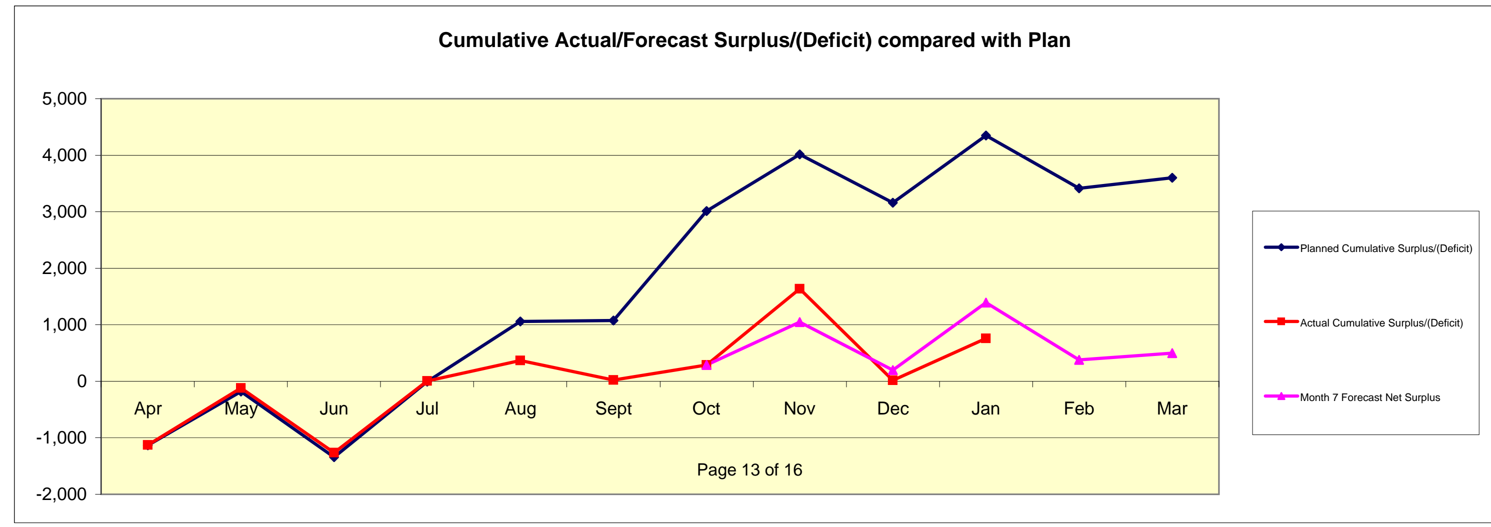
FINANCE REPORT MONTH 10
2012/13 MONTHLY FORECAST TRAJECTORY

In Month Surplus

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Original Planned Net Surplus/(Deficit)	-1,136	954	-1,160	1,334	1,064	17	1,940	1,003	-858	1,191	-936	187	3600
Actual Net Surplus/(Deficit)	-1,136	1,012	-1,141	1,271	371	-350	268	1346	-1625	742			758
Month 7 Forecast Net Surplus							268	759	-849	1193	-1011	119	211
In month variance from forecast								**587**	**-776**	**-451**			



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Planned Cumulative Surplus/(Deficit)	-1,136	-182	-1,342	-8	1,056	1,073	3,013	4,016	3,158	4,349	3,413	3,600
Actual Cumulative Surplus/(Deficit)	-1,130	-119	-1,265	6	370	21	289	1635	16	758		
Month 7 Forecast Net Surplus							289	1048	199	1392	381	500
Cumulative variance from forecast								**587**	**-183**	**-633**		



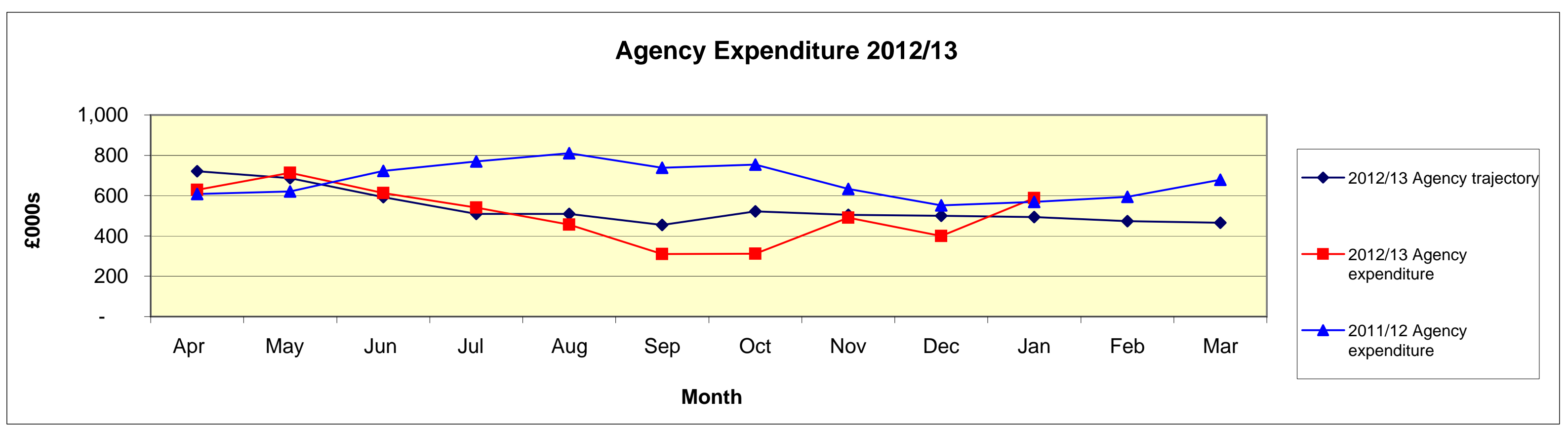
FINANCE REPORT MONTH 10
2012/13 FORECAST FINANCIAL RISK RATING

Financial Criteria	Metric to be scored	Weight	Rating categories					Target	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
			5	4	3	2	1		*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*
Underlying performance	EBITDA margin %	0.25	11%	9%	5%	1%	<1%	3	1	2	2	2	2	2	2	2	2	2	2	2
Achievement of plan	EBITDA % of plan achieved	0.10	100%	85%	70%	50%	<50%	5	5	5	4	4	4	3	3	3	2	2	3	3
Financial Efficiency	Net return after financing	0.20	80%	2%	-0.5%	-5%	<-5%	3	3	3	3	3	3	3	3	3	3	3	3	3
	I&E surplus margin	0.20	3%	2%	1%	-2%	< -2%	3	1	2	2	2	2	2	2	2	2	2	2	2
Liquidity	Liquidity ratio (days)	0.25	60	25	15	10	<10	3	2	3	3	3	3	3	3	3	3	3	3	3
Financial Risk rating is the weighted average of financial criteria scores after applying adjustment factors. This gives an indicative risk rating of:								**3.2**	**2.1**	**2.8**	**2.7**	**2.7**	**2.7**	**2.6**	**2.6**	**2.6**	**2.5**	**2.5**	**2.6**	**2.6**
Overriding rules rating								**3**	**2**	**3**	**3**	**3**	**3**	**3**	**3**	**3**	**2**	**2**	**3**	**3**

Overriding rules - if answer is yes, then a maximum overall score is applied	
One financial criterion scored at '1'	Yes, max = 2
One financial criterion scored at '2'	Yes, max = 3
Two financial criteria scored at '2'	Yes, max = 2
Two financial criteria at '1'	Yes, max = 1
Less than 1 year as an Foundation Trust	Yes. max = 4

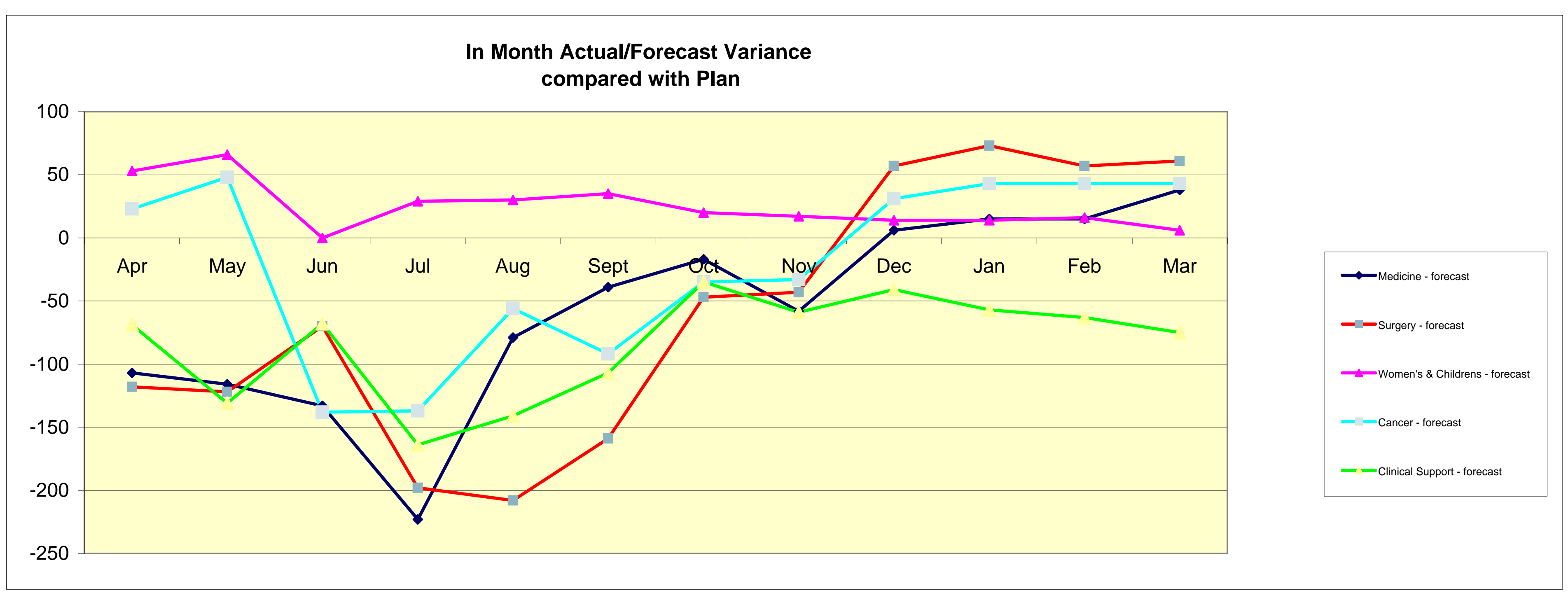
FINANCE REPORT MONTH 10
2012/13 AGENCY EXPENDITURE AGAINST TRAJECTORY

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13 Agency trajectory	721	686	593	509	509	454	522	504	500	493	473	465
2012/13 Agency expenditure	628	714	613	541	455	310	311	490	400	587		
2011/12 Agency expenditure	609	621	722	770	810	738	753	634	552	569	593	679
2012/13 Agency worked WTE	75	86	68	63	59	32	32	58	57	79		



FINANCE REPORT MONTH 10
2012/13 MONTHLY FORECAST TRAJECTORY - BY DIVISION

Actual/Forecast Variance	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Year-End**
Medicine - forecast	-107	-116	-133	-223	-79	-39	-17	-58	6	15	15	38	-698
Surgery - forecast	-118	-122	-70	-198	-208	-159	-47	-43	57	73	57	61	-717
Women's & Childrens - forecast	53	66	0	29	30	35	20	17	14	14	16	6	300
Cancer - forecast	23	48	-138	-137	-56	-92	-35	-33	31	43	43	43	-260
Clinical Support - forecast	-69	-131	-68	-164	-141	-107	-35	-59	-41	-57	-63	-75	-1010
Total	**-218**	**-255**	**-409**	**-693**	**-454**	**-362**	**-114**	**-176**	**67**	**88**	**68**	**73**	**-2385**



9b - PERFORMANCE DATA

Monitor Compliance Framework and SHA Provider Management Regime

Monitor Compliance Framework - Performance Thresholds for 2012-13

Achieve	Under-achieve	Fail	Weighting	Area	Indicator	Lead Director	2011-12 Q4	2012-13 Q1	2012-13 Q2	Month	Year to date	Qtr-end	PF RR
≤ 14		>14	1.0	Safety	Clostridium Difficile	AT	2	5	4	2	12		1
0	≤ 3	>3	1.0	Safety	MRSA	AT	0	1	1	0	2		0
>96%	-	<96%	0.5	Quality	*All Cancers: 31-day wait from diagnosis to treatment 96% (1month in arrears)	JW	98.3%	97.5%	98.0%	100.0%	99.9%		0
All 3 targets met	-	1 or more target failed	1.0	Quality	*All Cancers: 31-day wait for second or subsequent treatment - Surgery ≥94% (1month in arrears)	JW	97.7%	96.8%	98.1%	100.0%	97.7%		0
				Quality	*All Cancers: 31-day wait for second or subsequent treatment - Drug ≥98% (1month in arrears)	JW	99.7%	100.0%	99.7%	100.0%	99.9%		0
				Quality	*All Cancers: 31-day wait for second or subsequent treatment - Radiotherapy ≥94% (1month in arrears)	JW	99.3%	99.2%	99.6%	100.0%	99.6%		0
Both targets met	-	1 or more target failed	1.0	Quality	*All Cancers: 62-day wait for first treatment - Urgent GP referral ≥85% (1month in arrears)	JW	87.6%	87.9%	86.7%	86.7%	87.1%		0
				Quality	*All Cancers: 62-day wait for first treatment - Consultant Screening Service ≥90% (1month in arrears)	JW	100.0%	94.7%	92.4%	100.0%	93.4%		0
Both targets met	-	1 or more target failed	0.5	Quality	*Cancer 2-week wait from referral to date first seen - All cancers ≥93% (1month in arrears)	JW	99.2%	99.3%	98.3%	99.0%	98.5%		0
				Quality	*Cancer 2-week wait from referral to date first seen - Symptomatic breast patients ≥93% (1month in arrears)	JW	99.6%	96.5%	96.3%	93.7%	96.3%		0
≥ 90%	-	< 90%	1.0	Patient Experience	Maximum Waiting Time of 18-weeks from Referral to Treatment - Admitted	JW	91.3%	91.8%	90.6%	95.0%	91.8%		0
≥ 95%	-	< 95%	1.0	Patient Experience	Maximum Waiting Time of 18-weeks from Referral to Treatment - Non-Admitted	JW	97.9%	97.8%	97.1%	97.1%	97.2%		0
≥ 92%	-	< 92%	1.0	Patient Experience	Maximum Waiting Time of 18-weeks from Referral to Treatment - Incomplete	JW	95.3%	96.5%	95.6%	95.3%	95.3%		0
95%	-	<95%	1.0	Quality	A&E: Maximum Waiting Time of four hours from Arrival to Discharge or Admission	JW	95.3%	97.4%	97.0%	93.5%	96.0%		1
Compliant	-	Non-compliant	0.5	Patient Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	AT							0

cancer performance figures are not finalised until 6-weeks after month-end and may therefore be subject to change.

Monitor Compliance Framework GRR - Quality Overrides

				Area	Indicator	Lead Director	2011-12 Q4	2012-13 Q1	2012-13 Q2	Month	Year to date	Qtr-end
Level 2				MCF Override	NHS Litigation Authority Level 1-3	JMc						
Level 1				MCF Override	CNST Level 1-3 (Against Plan Level 1 > April 2012)	AT						
				MCF Override	Other Certification - Financial Compliance, Cooperation with Other NHS Bodies & Local Authorities, Information Governance, Cooperation & Competition Panel)	PT						

Monitor Compliance Framework Quarterly Risk Rating (Q3) — Amber / Green — 1.0
SHA Provider Management Regime Monthly Governance Risk Rating (GRR) — Amber/Red — 2.0

Department of Health Operating Framework measures

(Excludes Indicators already covered above)

Service Performance Indicators for 2012-13

Achieve	Under-achieve	Fail	Weighting	Area	Indicator	Lead Director	2011-12 Q4	2012-13 Q1	2012-13 Q2	Month	Year to date	Qtr-end
0	≤ 20	>20		Patient Experience	RTT Delivery in all Specialties (Treatment Functions not delivered (Admitted, Non-Admitted & Incomplete Pathways)	JW		4.3	3.8	1	5.4	
≤ 1%	≤ 5%	>5%		Patient Experience	Diagnostic Test Waiting Times (patients waiting >6-weeks for 15 key diagnostic tests)	JW	0.35%	1.9%	0.96%	0.64%	1.14%	
≤ 3.5%	≤ 5%	>5%		Quality	Delayed Transfers of Care - DTCs	JW	2.4%	2.7%	2.4%	3.6%	2.6%	
≤ 0%	≤ 0.5%	>0.5%		Patient Experience	MSA breaches - Numbers of unjustified breaches	AT	0	0	0	0	0	
≥ 98%	≤ 93%	<93%		Safety	VTE Risk Assessment	JM	98.2%	99.6%	99.3%	98.7%	99.3%	

Trust Clinical Efficiency KPIs

(Excludes Indicators already covered above)

Performance Thresholds for 2012-13

Achieve	Under-achieve	Fail	Weighting	Area	Indicator	Lead Director	2011-12 Q4	2012-13 Q1	2012-13 Q2	Month	Year to date	Qtr-end
≤Plan	≤ Plan +1%	> Plan +1%		Productivity	DNA rate	JW	8.2%	7.7%	6.9%	8.3%	7.0%	
<=1.75	<=2.27	>2.27		Productivity	New to Follow-up outpatient appointment ratio	JW	1.76	2.12	2.22	2.38	2.25	
<=6.0%	<=12.0%	>12%		Productivity	*Pre-op bed-days	JW	4.0%	9.0%	6.3%	3.2%	7.8%	
Within Plan	>2% Variance	>5% Variance		Resources	*Occupied Bed Days (OBDs)	JW	-30.8%	18.3%	-26.1%	-58.7%	-20.2%	
-	-	-		Resources	*Spells*	JW	-10.7%	-2.7%	-5.1%	-9.8%	-19.8%	
<=4.5	<=6	>6		Resources	*Length of Stay (Overall)*	JW	5.17	4.54	4.28	5.10	4.89	
>=87.5%	>=75%	<75%		Productivity	Theatre Utilisation (1month in arrears)	JW	93.1%	93.8%	95.6%	96.1%	94.9%	
<=9%	<=13%	>13%		Productivity	Readmissions *(2mths in arrears)*	JW		11.2%	10.1%	9.8%	10.5%	

**Figures are provisional and are subject to change.*

East & North Hertfordshire NHS Trust :Board Performance Report (2012-13) - Month 10

Publication Date: 14/02/2013

East and North Hertfordshire NHS NHS Trust

Key Contract Requirements

(Excludes Indicators already covered above)

Performance Thresholds for 2012-13

Achieve	Under-achieve	Fail	Weighting	Area	Indicator	Lead Director	2011-12 Q4	2012-13 Q1	2012-13 Q2	Month	Year to date	Qtr-end
≤ 4-hours	From Q2 ≥ 1 Timeliness indicator to be achieved	From Q2 ≥ 1 Timeliness indicator to be achieved	1.0 (failing 3 or more) OR 0.5 (failing 2 or less)	Quality	A&E Quality Indicator - Total Time in A&E (95th percentile)	JW	≥ 1 'Timeliness' indicator achieved	≥ 1 'Timeliness' indicator achieved	≥ 1 'Timeliness' indicator achieved	≥ 1 'Timeliness' indicator achieved	≥ 1 'Timeliness' indicator achieved	
≤ 15 minutes				Quality	A&E Quality Indicator - Time to initial assessment (95th percentile)	JW						
≤ 60 minutes				Quality	A&E Quality Indicator - Time to treatment decision (median)	JW						
≤ 5%	From Q2 ≥ 1 'Impact' indicator achieved	From Q2 ≥ 1 'Impact' indicator achieved		Quality	A&E Quality Indicator - Unplanned reattendance rate	JW	≥ 1 'Impact' indicator achieved	≥ 1 'Impact' indicator achieved	≥ 1 'Impact' indicator achieved	≥ 1 'Impact' indicator achieved	≥ 1 'Impact' indicator achieved	
≤ 5%				Quality	A&E Quality Indicator - Left without being seen	JW						
TBC				Quality	Ambulance Turnaround (To Apply from Q2)	JW			60.8%	68.7%	63.1%	
<5%	>5 % <EoE	>EoE Avg		Quality	Choose & Book Slot issues under 5%	JW	8.5%	12.20%	11.90%	3.40%	10.50%	
<0.8%	>0.8% <1.5%	>1.5%		Quality	Cancelled Operations - on the day	JW	0.78%	0.64%	0.34%	0.65%	0.50%	
100%	>98%	<98%		Quality	Cancelled Operations - readmitted <28-days	JW	100.0%	97.7%	100.0%	100.00%	99.0%	
0		>1 per month		Quality	Admissions to a Critical Care Bed <4-hours from Decision to Admit	JW		0	0	0	0	
≥ Quarterly target*		<90%		Quality	Admissions to a Stroke Bed <4-hours from Arrival at A&E (1 month in arrears)* (*Q1 – 50% pts, Q2 – 70% pts, Q3 – 90% pts, Q4 - 90% pts)	JW		40.0%	53.7%	42.1%	47.5%	

As at 02/12/2012

Local Priorities

(Excludes Indicators already covered above)

Performance Thresholds for 2012-13

Achieve	Under-achieve	Fail	Weighting	Area	Indicator	Lead Director	2011-12 Q4	2012-13 Q1	2012-13 Q2	Month	Year to date	Qtr-end
>=80%		<70%		Local Priority	Stroke Care - % of patients spending 90% of hospital stay on a specialist stroke unit (1mth in arrears)	JW	80.2%	83.2%	81.7%	78.9%	81.4%	
>=60%		<54%		Local Priority	Stroke Care - % patients with high risk TIA seen and scanned/treated within 24 hours (1mth in arrears)	JW	33.3%	62.5%	54.5%	15.8%	50.2%	
>=80%		<75%		Local Priority	PPCI – 150 minute call to balloon time	JW	100.0%	85.7%	87.5%	100.0%	86.8%	
>=98%		<98%		Local Priority	Two-week wait access for Rapid Access Chest Pain Clinics.	JW	100.0%	100.0%	100.0%	100.0%	100.0%	
100%	>=99%	<99%		Local Priority	MRSA Elective screening	AT	99.7%	99.96%	99.9%	100.0%	99.9%	
100%	>=95%	<95%		Local Priority	MRSA Emergency screening (*provisional figures)	AT		90.2%	88.8%	90.1%	90.8%	

PERFORMANCE REPORT - EXCEPTION REPORT – February 2013

Target /Core Standard: 95% A&E maximum waiting time of four hours from Arrival to Discharge or Admission

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1. Background

- ENHT failed Q3 (94.57%) due to the December performance being 91.31%.
- ENHT failed January 2013 performance 93.5%
- The position at the time of writing the report;

Year to date	96.0%
Quarter 4 (as of 13/02/2013)	94.09%
February (as of 13/02/2013)	95.31%

1.1 Demand

- Attendances to the Trusts two Emergency Departments demonstrate no significant shift in numbers presenting compared to the same period last year.

1.2 Capacity

Analysis suggests a reduction in discharge rates is a key factor in the drop in performance. A proportion of this drop relates to the following:

- 108 reportable delays transfers of care during the month of January 2013.
- There has been a daily average of 20 patients accepted as requiring Intermediate Care. On average 6 Intermediate Care (IC) beds per day are available across East & North Hertfordshire. The monthly cumulative beddays lost will be captured and reported from March.
- Some of the delays may relate to Therapy staffing pressures in Hertfordshire Community Trust. It is believed Hertfordshire Community Services and Social Services have experienced increasing difficulties in sourcing packages of care throughout January. The beddays lost needs to be fully captured.
- Staff feedback suggests some increase in acuity but definitive evidence is lacking more analysis is required to substantiate.
- The analysis requires more systematic information of discharge performance which will be developed for the March report. Nonetheless the view is discharge performance may be the key factor in the deterioration in ED performance via compromised bed flow.

1.3 Requirements

- To achieve compliance with the 95% for Q4 (at the time of writing this report), we need to ensure there are fewer than 12 breaches per day across the Trust.

2. Actions Taken

Action	Lead	Impact date	Further Actions
Enhanced Consultant led support to junior doctors working in the ED – Consultant input at weekends cover for 6 hours per day	JB	01/11/12	Consultant cover continues over weekend for 6 hours per day.
Recruitment of Consultants to provide senior decision making- complete- will impact from February 13, 2 WTE additional Consultant posts	FW	01/02/13	Job descriptions up to date and recruitment taking place.
Model of working agreed with key partners to ensure equity of access to community based beds for the assessment of patients awaiting long term placement	Nicky Poulain (CCG)	4/12/12	Work on going with the Discharge team to ensure all those patients waiting long term placement are identified.
Nursing, Doctor and reception rotas between the QEII and Lister to balance staffing levels according to the activity and demand shifts between the 2 ED departments	FW/EC	Ongoing	
Senior clinical management support available on site up until 21:00	EC	01/12/12	
Opening of additional beds as surge capacity – 8 beds on at QEII & 14 beds on 11A	SE	31/12/12	
Review of paediatric medical & nursing support to ensure adequate cover in place for the ED	EC/DB	07/12/12	GM for ED and Nursing service manager for Paeds working together to ensure adequate cover in place.
Escalation of those patients in the ED with no plan at 2.5 hours to the Director of Operations and the Divisional Director of Medicine in hours and the Senior Manager and Exec on call out of hours	SE	Ongoing	
Increase in Medical and Surgical SpR support in the ED over the Xmas and New Year break	BZ/PM	21/12/12	
Review of Consultant job plans to support 7 day working including consultant cover until 22:00	JB	completed	
Review of the impact of the Clinical Navigator role to ensure the ability to access appropriate services such as, packages of care and intermediate care beds has identified access to intermediate care and enabling care packages as blocks.	SE	completed	
Daily teleconferencing calls with stakeholders to support complex discharges	SE	ongoing	
Opening further contingency/surge capacity beds as demand dictates	SE	completed	
Prioritising Winter pressures funding	SE	completed	
Fortnightly Peer review of all inpatients at Consultant level	MC/JB	ongoing	

3. Further initiatives

i. Work up of a Senior Manager rota to oversee and provide additional “grip” on bed flow and Emergency Department flow to be in place if required from mid February till the end of March 2013.

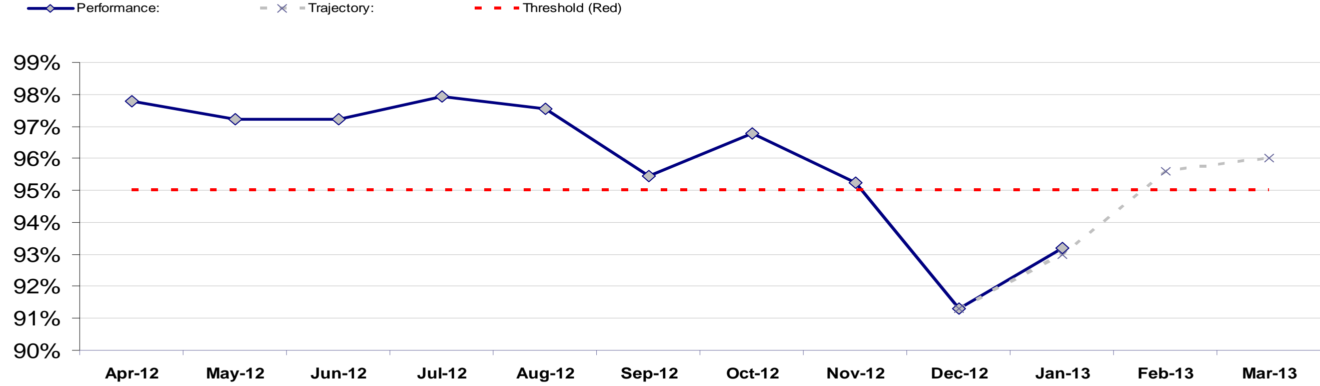
ii. To work with colleagues to ensure the safety of patients within the Emergency department at times of increasing pressure i.e establishment of an escalation and trigger policy - "Code Crimson"

iii. To ensure Winter Contingency monies have been successfully deployed.

iv. To evidence why we believe there has been an increase in acuity of patients. To obtain data on trends on Ambulance conveyances, to identify if this is a factor.

v. To understand what the bedday numbers are of having Delayed Transfers of Care (DToCs) to the Trust and ensuring we are recording all DToCs.

4. Performance and Trajectory to improve



LEAD DIRECTOR – Director of Operations

PERFORMANCE REPORT - EXCEPTION REPORT – February 2013

Target /Core Standard: New to Follow up Ratio (1.75 : 1)

The Issue

- In 2010 concerns were highlighted within the Trust with follow-up appointment booking processes relating to a risk of patients being lost in the system when a follow-up appointment was not booked during the patient's attendance or where a patient cancelled or did not attend their appointment. There was no way of tracking the ongoing requirement for a follow up appointment for this group of patients.

- The decision was therefore taken to introduce a Follow-up PTL to manage the process by which patients requiring a follow-up appointment after an attendance at an outpatient clinic is managed.

- In addition, a booking timescale rule was introduced where follow-up appointments clinically required to be seen again in clinic, less than 6 weeks in advance, would be provided their appointment on leaving the clinic. All other appointment requests were to be added to a follow-up tracking list and patients provided appointments 6 weeks prior to their clinical need date. The purpose was to align appointment booking to the consultant leave timetable, thus significantly reducing the level of hospital cancellations. The introduction of this rule reduced hospital cancellations by approximately 35%, with a correlated reduction in patient complaints regarding cancelled appointments.

- The follow-up waiting list proved successful in capturing patients requiring follow up appointments. However the number of patients requiring a follow up appointment continued to increase beyond normal capacity and therefore a review of the processes implemented in 2010 was undertaken. In September 2012, there were a total of 78120 patients on the follow up PTL.

- The Director of Operations established a formal meeting structure to undertake the review of the Follow-up PTL and the management of the associated actions as a result of the review.
  The aims & output of the programme board were;
    - Develop an accurate PTL to book appointments from
    - Clearance of any backlogs
    - Identify & manage any risk to patient in backlog
    - Ensure staff are trained and competent in capacity assessment.

- The programme board agreed that an urgent validation exercise of all patients on the follow-up tracking list with 'to be seen' dates up to the end of September 2012. A two stage process was agreed with Divisional Chairs to engage clinical involvement when required to identify clinical risk and not waste clinical time. This exercise took place between 15 October 2012 and 19 November 2012. No clinic risk was identified from this review. Of the total of 6047 patients, 1892 required appointments all of which were made by end of November 2012.

- Following this exercise the decision was taken to review all patients on the Follow-up PTL with an appointment due by date of on or before 31 December 2012. The process would include a clerical and clinical validation of each patient and a dedicated outpatient team to book follow up appointments when required. No clinic risk was identified from this review at the present time.

- Following validation of each appointment request on the follow-up tracking list, a significant proportion required follow up appointments and Divisional teams were required to provide additional capacity in order to book appointments for patients with historical clinical need dates.

- The provision and booking into the additional follow up capacity in order to clear any backlog has had a detrimental effect on the Trust's new to follow-up ratio. Although efforts are continuing to reduce the follow-up tracking list further, the increased new to follow-up ratio is not expected to continue at a recent levels due to the reducing levels of patients on the follow-up tracking list without an appointment.

Actions Taken

- A 'Booking on the Day' model of managing follow-up appointments was reintroduced on the 29th October 2012 with a positive response from both clinicians and patients.

- The number of appointment requests held within the follow up tracking list has reduced significantly as the table below indicates.

Month	Total on Tracking List
2011 - 12	72283
2012 - 01	73604
2012 - 02	74569
2012 - 03	75775
2012 - 04	76849
2012 - 05	78120
2012 - 06	79859
2012 - 07	81651
2012 - 08	71281
2012 - 09	72010
2012 - 10	70524
2012 - 11	70140
as at 31/1/13	20575
NB the totals included relate to all patients on the PTL, some of whom have appointment by dates up to and including 2017	

- In addition weekly ‘error reports’ have been developed for review at APMG to support the closure of any errors in real time.

  These error reports are;

    - No due date
    - Duplicates
    - DNA discharge
    - Multiple DNAs (Discharge as per Access policy)
    - Multiple patient cancellations (Discharge as per Access Policy).

- The purpose of the error report is to ensure any issues are closed down in real time as all patients on the follow up PTL should have an appointment and should only appear if there is not sufficient capacity in the ‘ to be booked ‘ group

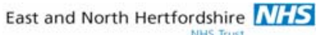
Next Steps

- Continue to manage a monthly follow-up PTL at APMG to minimise any risks associated with outstanding appointment requests.

- Additional review weekly error reports to reduce the risk of increasing the numbers of appointment requests on the follow-up PTL by managing issues as they arise.

- Further develop robust PAS booking training programme for all staff booking appointments on PAS.

LEAD DIRECTOR – Acting Divisional Director, Clinical Support Services



December 2012 - Performance Exception Report

Local Standard: Proportion of patients admitted to the stroke unit within 4 hours of arrival

Reported one month in arrears

Numerator = Stroke patients who have been admitted to the ward within 4 hours of arrival to hospital

Denominator =All Stroke patients

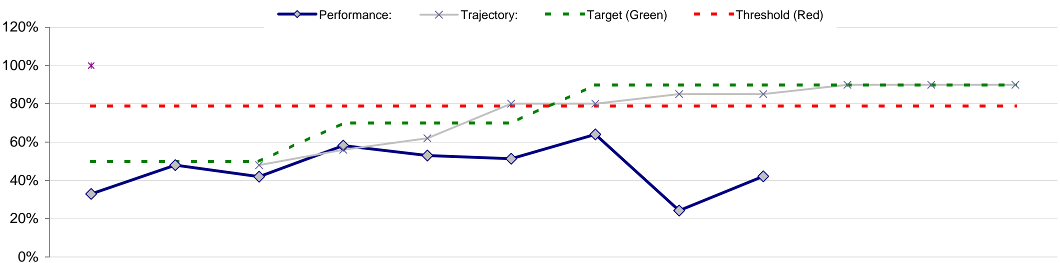
The Issue

- ENHT failed January 2013 performance 42.1%
- October and November saw high admission rates to the wards of 85 and 81 patients but with discharges of only 50 and 47 for November and December, indicating a longer Length of Stay or delays in transfer of care. The beddays lost due to those patients delayed in discharge will be captured and reported from March.
- October and November had 5 patients with Delayed Transfer of Care reflecting an extra 37 days stay on the ward impacting on December's figures.
- Data input and quality may be the key factor in Stroke performance; analysis requires a more systematic approach.
- The inability to recruit to the Data Entry position requires urgent action.
- Lack of a "Stroke Champion" in the Emergency department to ensure the "pull through" of Stroke patients.

Recovery Plan

Actions (ref)	Action Description	Lead	Date
a	Review the process of stroke need daily - Nurse in charge of 6AS to contact ED at the beginning of each shift - capacity required and need to alert ward as soon as stroke pt expected.	*CNS*	*13/02/2013*
b	*Stroke bleep held in and out of hours, ED to pre alert using bleep of any expected stroke.*	*CNS*	*13/02/2013*
c	*Daily meeting with Director of Operations and Stroke team to review previous days admisssions*	*Direcotr Of Ops*	*13/02/2013*
d	*Recruit to data cordinator post substantively*	*JL*	*13/02/02013*
e	*To ensure data input is entered daily with validation and spot checking of validation with stroke consultant to ensure only patients on database with a primary diagnosis of stroke*	JL/CON	Ongoing
f	Identification of a "Stroke Champion" Consultant & Nurse in the ED to work with the Stroke team to "pull" patients through the patient pathway	*DOK/SE/JB*	*14/02/2013*
g	*To work with the Community and Heart & Stroke network to maintain a database of those patients waiting due to delays in transfers of care. To be able to quantify the beddays lost.*	*JL*	*14/02/2013*

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Performance:	**33%**	**48%**	**42%**	**58.1%**	**52.9%**	**51.3%**	**64.0%**	**24.2%**	**42.1%**			
Trajectory:			48.0%	56.0%	62.0%	80.0%	80.0%	85.0%	85.0%	90.0%	90.0%	90.0%
Target (Green)	50%	50%	50%	70%	70%	70%	90%	90%	90%	90%	90%	90%
Threshold (Red)	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%



Executive Director:	**Director of Operations**

Green:	>	60
Amber:	<	60
Red:	<	45

Local Standard: High risk TIAs scanned / treated within 24-hours (not admitted)

Reported one month in arrears

Numerator = Number of people who have a TIA who are scanned and treated within 24 hours (& not admitted)

Denominator = Number of people who have a TIA who are high risk

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The Issue

- % percentage of patients seen and treated with high risk TIA within 24 hours – 15.8%
- Incomplete data set due to the lack input of data for the month of December 2012
- Timely referral of patients suspected of having had a TIA
- Lack of "Grip" on internal administration process in TIA pathways.

Demand

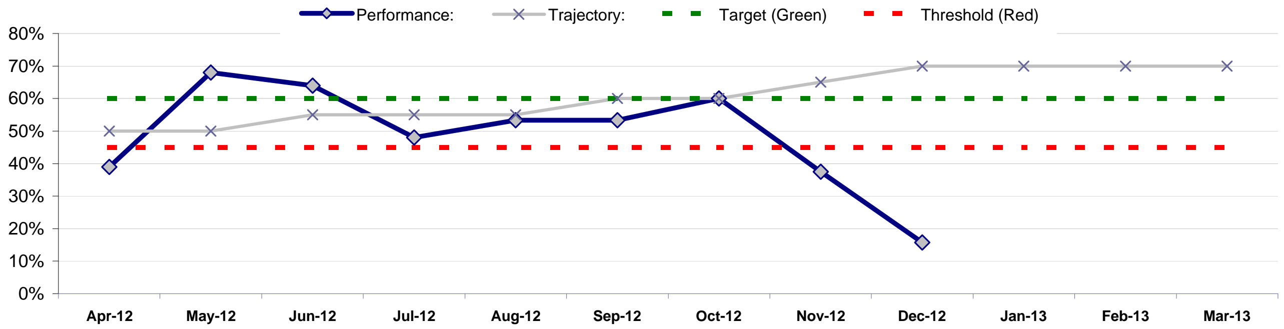
- 45 TIA referrals for December, 26 low risk and 19 high risk TIA's
- Of the 19 patients High Risk TIA referrals, 3 were seen and treated within the 24 hour standard.

The reasons for the failure of the 16 are set out below.

Late Referrals	Admin errors	Lack of capacity	Consultant cover	Transport	weekends	Other
1	4	1	2	1	3	4

Action	Action Description	Lead	Date
a	*Letters will be sent to all referrers where there has been a delay in the referrel being faxed to the Stroke service*	CNS	Ongoing
b	TIA/Stroke CNS to check weekend and out of hours TIA/Stroke activity in conjunction with the designated Lead in ED each Monday.	*CNS*	*14/02/2013*
c	Feedback to GP with regards to the late/quality of the initial patient referral. Dtabase to be kept of performance.	CNS	*14/02/2013*
d	Daily performance management with the Stroke team for new TIA patient referrals	Director of Ops	*13/02/2013*
e	*To improve the provision of data input and to ensure compliance with data governance*	*JL*	*13/02/2013*
f	To recruit to the substantive Data Entry position	JL	01/05/2013
g	B/Case to be completed for the Third Stroke Consultant	DOK/BZ/JL/ SE/JB	due February 2013
h	*Identification of a Stroke Champion for Consultant & Nurse in the ED to take responsbility for the compliance of performance in realtion to stroke provision.*	*DOK/JB/SE*	*14/02/2013*

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Performance:	39%	68%	64%	48.0%	53.3%	53.3%	60.0%	37.5%	15.7%			
Trajectory:	50.0%	50.0%	55.0%	55.0%	55.0%	60.0%	60.0%	65.0%	70.0%	70.0%	70.0%	70.0%
Target (Green)	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%
Threshold (Red)	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%	45%



Executive Director: Director of Operations

CQC Outcomes Summary

Registration Position 11/12 - All locations / Regulatory Activites	Outcome	Regulation	CQC ESSENTIAL STANDARDS OF QUALITY & SA	DIRECTOR LEAD	Current Registration Position - Feb 13 Lister	QEII	MVCC	Hertford County	Anticipated Full Year Position 2012/ 13- All locations /Regulatory Activities
	Section 1: Involvement and Communication								
C	1	17	Respecting and involving people who use services	Director of Nursing	C	C	C	C	Compliant - No compliance conditions
C	2	18	Consent to care and treatment	Medical Director	C	C	C	C	Compliant - No compliance conditions
C	3	21	Fees etc. (applies to people how pay for their care)	Director of Finance	C	C	C	C	Compliant - (No declaration required)
	Section 2: Personalised Care Treatment and Support								
C	4	9	Care and welfare of people who use services	Director of Nursing	C	C	C	C	Compliant - No compliance conditions
C	5	14	Meeting nutritional needs	Director of Nursing	C	C	C	C	Compliant - No compliance conditions
C	6	24	Cooperating with other providers	Director of Operations	C	C	C	C	Compliant - No compliance conditions
	Section 3: Safeguarding and Safety								
C x 3 sites Lister site - Minor concern Q4 only	7	11	Safeguarding vulnerable service users	Director of Nursing	C	C	C	C	Compliant - No compliance conditions
C	8	12	Cleanliness and infection control	Director of Nursing	C	C	C	C	Compliant - No compliance conditions
C	9	13	Management of medicines	Medical Director	C	C	C	C	Compliant - No compliance conditions
C	10	15	Safety and suitability of premises	Director of Strategic	C	C	C	C	Compliant - No compliance conditions
C	11	16	Safety, availability and suitability of equipment	Director of Nursing	C	C	C	C	Compliant - No compliance conditions
	Section 4: Suitability of Staffing								
C	12	21	Requirements relating to workers	Director of HR	C	C	C	C	Compliant - No compliance conditions
C	13	22	Staffing	Director of HR	C	C	C	C	Compliant - No compliance conditions
C x 3 sites Lister site - Minor concern Q4 only	14	23	Supportng workers	Director of HR	C	C	C	C	Compliant - No compliance conditions
	Section 5: Quality and management								
C	15	8	Statement of Purpose	Director of Finance	Compliant				Compliant
C	16	9	Assessing and monitoring the quality of service provision	Medical Director	C	C	C	C	Compliant - No compliance conditions
C	17		Complaints	Director of Nursing	C	C	C	C	Compliant - No compliance conditions
C	18	17	Notification of Death of a Service User	Director of Nursing	C	C	C	C	Compliant
C	19	18	Notification of death or unauthorised absence of a service user who is detailed or liable to be detailed under the Mental Health Act 1983	Director of Nursing	C	C	C	C	Compliant
C	20	29	Notification of other incidents	Diector of Nursing	C	C	C	C	Compliant
C	21	20	Records	Director of Operations	C	C	C	C	Compliant - No compliance conditions
	Section 6: Suitability of management								
N/A	22	4	Requirements where the service provider is an individual of partnership	Not applicable to NHS					N/A
C	23	5	Requirement where the service provider is a body other than a partnership (nominated individual)	Director of HR	Trust Nominated Individual is the Chief Executive				Compliant
N/A	24	6	Requirements relating to registered managers	Not applicable to NHS					N/A
C	25	7	Registered Person: training	Director of HR	C				Compliant
N/A	26	12	Financial position	Not applicable to NHS					N/A
C	27	14	Notice of absence	Director of Finance	C	C	C	C	Compliant
C	28	15	Notice of changes	Director of Finance	C	C	C	C	Compliant

From 1st April 2010 the Trust has been formally registered with the CQC under the Health and Social Care Act 2008 to provide the following regulated activities at the specified locations.

REGULATORY ACTIVITY	Locations: LISTER HOSPITAL	QEII	MVCC	HERTFORD (INCLUDING UCC)
Treatment of disease, disorder or injury	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions
Surgical procedures	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions	
Diagnostic and screening procedures	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions
Maternity and midwifery services	Registered - no compliance conditions	Registered - no compliance conditions		Registered - no compliance conditions
Termination of pregnancies	Registered - no compliance conditions	Registered - no compliance conditions		
Family Planning Services	Registered - no compliance conditions	Registered - no compliance conditions		Registered - no compliance conditions

Assessment or medical treatment of people detained under the Mental Health Act 1983	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions	

Risk rating	Outcome
LOW GREEN	Outcome 12: Requirements relating to workers Outcome 21: Records
HIGH GREEN	Outcome 8: Cleanliness and infection control Outcome 11: Safety, availability and suitability of equipment
LOW YELLOW	Outcome 1:Respecting and involving people who use services Outcome 2: Consent to care and treatment Outcome 4: Care and welfare of people who use services Outcome 5: Meeting nutritional needs Outcome 6: Cooperating with other providers Outcome 7: Safeguarding people who use services from abuse Outcome 9: Management of medicines Outcome 10:Safety and suitability of premises Outcome 14: Supporting workers Outcome 16: Assessing and monitoring the quality of service provision Outcome 17: Complaints
HIGH YELLOW	Outcome 13: Staffing
LOW AMBER	Nil
HIGH AMBER	Nil
LOW RED	Nil
HIGH RED	Nil since March 2011

QUALITY

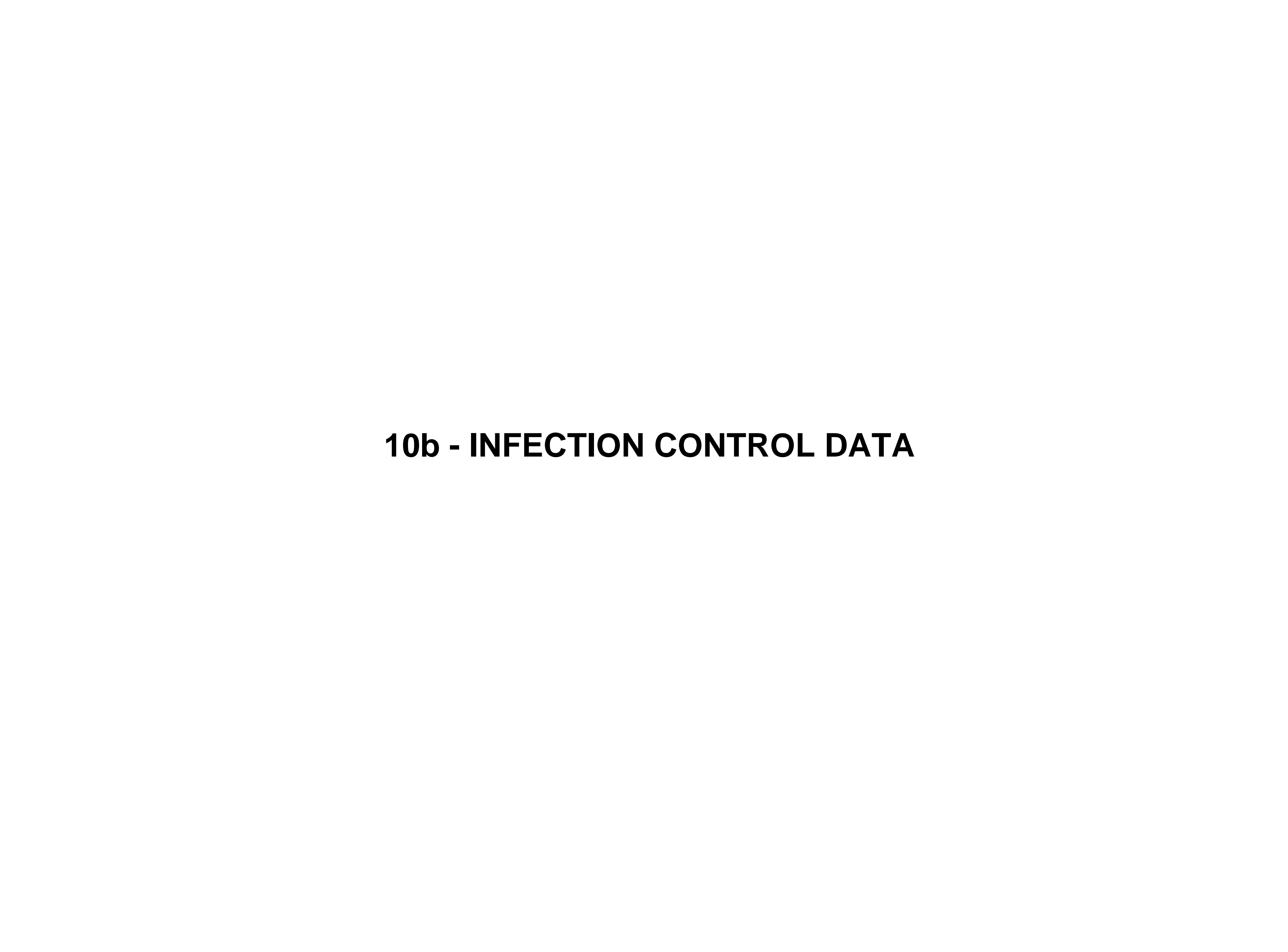
Information to inform the discussion meeting

East and North Hertfordshire NHS Trust

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Board Action
1	SHMI - latest data	Score	120.0	120.0	117.7	117.7	117.7	113.6	113.6	113.6	114.1	114.1	114.1	110.8	Period: July 11 - June 2012
2	Venous Thromboembolism (VTE) Screening	%	97.50%	97.70%	99.40%	99.70%	99.59%	99.45%	99.2%	99.3%	99.3%	99.5%	99.5%	98.7%	99.34% YTD
3a	Elective MRSA Screening	%	99.90%	99.70%	100%	100%	99.86%	99.89%	99.8%	100.0%	100.0%	99.9%	100.0%	100.0%	99.9% YTD
3b	Non Elective MRSA Screening	%	70%	88.90%	87.80%	92.40%	90.50%	87.69%	88.7%	91.8%	93.5%	95.3%	91.6%	90.1%	90.83% YTD
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	9	12	3	3	4	2	24	25	17	17	14	16	Includes all Open SIs
6	"Never Events" occurring in month	Number	0	0	0	0	0	0	0	0	0	1	0	0	Maternity 'never event' occurred in November and was reported on 3rd December 2012; full investigation completed & action plan in place
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	Lister Hospital CQC report received from December 2012 inspection - compliant with standards inspected
8	Open Central Alert System (CAS) Alerts	Number	7	8	8	8	11	2	8	8	6	6	2	5	Dealt with appropriately
9	RED rated areas on your maternity dashboard?	Number	0	0	2	2	1	2	0	4	2	2	2	4	Reg flags: C section, IOL, early neonatal deaths, breast feeding initiative: RAC's in progress
10	Falls resulting in severe injury or death	Number	3	1	3	1	0	1	0	3	1	2	1	2	
11	Grade 3 or 4 pressure ulcers	Number	2	8	3	10	2	3	1	7	4	4	5	0	G3 x 0, G4 x 0
12	100% compliance with WHO surgical checklist	Y/N	N	N	Y	N	N	N	N	N	N	N	Y	Y	100% for January 2013. New methodology checking 100% WHO checklist to commenced 1 Jan 2013.
13	Formal complaints received	Number	99	94	92	97	71	74	78	75	84	91	64	99	
14	Agency as a % of Employee Benefit Expenditure	%	3.20%	3.60%	3.90%	3.30%	3.00%	2.50%	1.70%	1.70%	2.80%	2.80%	2.30%	2.70%	
15	Sickness absence rate	%	4%	3.53%	3.10%	3.27%	3.30%	3.40%	3.50%	3.60%	3.50%	3.50%	3.90%	4.00%	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	New indicator - in process of establishing method of data collection. New database to support revalidation in place - will be fully operational by April 2013; will enable capture of fully completed PDP's as revalidation is rolled out



10b - INFECTION CONTROL DATA

Infection Prevention and Control Board Report

January 2013

Purpose

The purpose of this report is to provide the Trust Board with an update of Infection Prevention & Control performance for period of 1st of January to 31st January 2013, and for the previous 11 months.

Performance

There have been 0 cases of hospital acquired MRSA Bacteraemia in January 2013.

Target 2012/13 = 3 YTD = 2

There have been 0 cases of hospital acquired MSSA bacteraemia post 48 hours in January 2013.

Target 2012-2013 = (No Target) YTD 14

There has been 1 case of hospital acquired E.Coli Bacteraemia in January 2013.
Target 2012/13 = (No Target) YTD = 35

There have been 0 cases of hospital acquired Vancomycin Resistant Enterococci for January 2013.

Target 2012/13 = (No Target) YTD = 3

There have been 2 cases of hospital acquired C.d*ifficile* in January 2013.

Target 2012/13 =14 YTD = 12

Elective MRSA Screening Compliance in January 2013 100%

Target 2012/13 = 100% YTD = 99.9%

Emergency MRSA Screening Compliance in January 2013 90.05%
Target 2012/13 =100% YTD = 90.83%

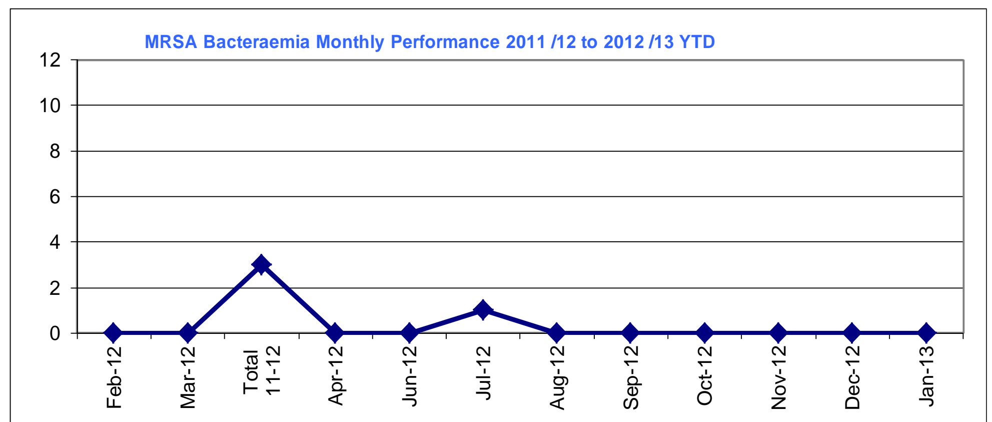
Infection Outbreaks
There were no outbreaks in January 2013

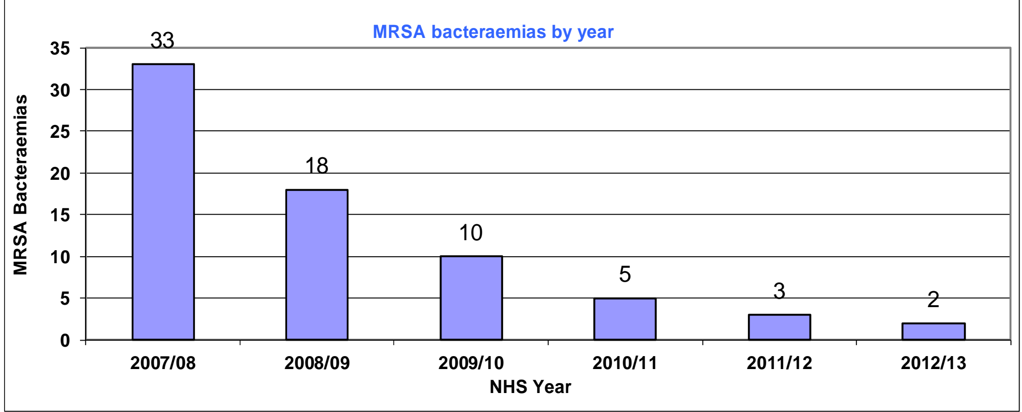
High Impact Interventions
All Clinical Audits of H.I.I s above 95%.

DH-Deep Clean Program 2012 – 2013
No further Deep Cleans this year.

Summary
1. On trajectory for MRSA bacteraemia target
2. On trajectory for Clostridium *difficile* target
3. Elective MRSA screening maintained at 100%
4. Emergency MRSA screening compliance below 95% - see exception report
5. Surgical Site Surveillance report –see attached

MRSA BACTERAEMIA





MRSA bacteraemia Apr12 - Mar13	
No. of MRSA Bacteraemia	2
No. of Occupied Bed Days	86,900
MRSA Bacteraemia per 1,000 bed days	0.02

MRSA bacteraemia by Division

Division	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Cancer	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicine	0	0	2	0	0	0	1	0	0	0	0	0	0
Surgical	0	0	1	0	0	0	0	0	0	0	0	0	0
Women & Children	0	0	0	0	1	0	0	0	0	0	0	0	0
Grand Total	0	0	3	0	1	0	1	0	0	0	0	0	0

East and North Hertfordshire NHS Trust

MRSA bacteraemia by Ward

Ward	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Lister CCU	0	0	0	0	0	0	1	0	0	0	0	0	0
Lister 10BN	0	0	1	0	0	0	0	0	0	0	0	0	0
Bayford	0	0	0	0	0	0	0	0	0	0	0	0	0
Barley	0	0	1	0	0	0	0	0	0	0	0	0	0
Knebworth	0	0	1	0	0	0	0	0	0	0	0	0	0
Princes	0	0	0	0	0	0	0	0	0	0	0	0	0
Neonatal ITU	0	0	0	0	1	0	0	0	0	0	0	0	0
Grand Total	0	0	3	0	1	0	1	0	0	0	0	0	0

MRSA Infection Prevention & Control Key Performance Indicators

MRSA bacteraemia	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
Post 48 hour cases	0	0	3	0	1	0	1	0	0	0	0	0	0	2
Pre 48 hour cases	0	0	1	0	0	0	0	0	0	0	0	0	0	0

Death Certificates	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
MRSA as Part 1a or 1b	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MRSA as Part 2	0	0	0	0	0	0	0	0	0	0	0	0	0	0

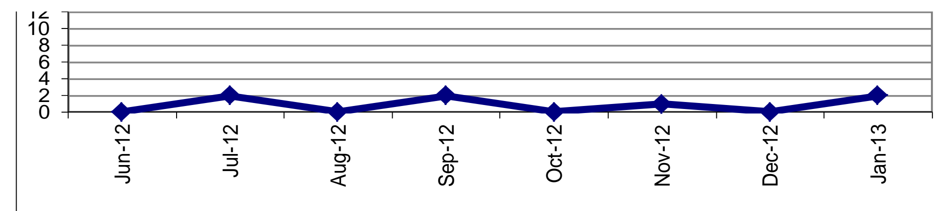
Screening Compliance (rounded to nearest % point)

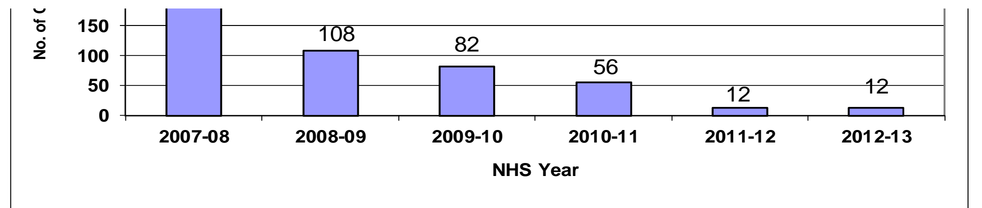
Elective Admissions MRSA Screens	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
% Compliance	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Emergency Admissions MRSA Screens	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
% Compliance	89%	89%	89%	88%	92%	90%	88%	89%	92%	94%	95%	92%	*90%*	91%

East and North Hertfordshire NHS
NHS Trust

CLOSTRIDIUM DIFFICILE





Clostridium difficile Apr 12 - Mar 13	
No. of C.diff. Cases	12
No. of General admissions	53,579
C.diff. Cases per 1,000 general admissions	0.22

C-DIFF via Division

Division	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
Cancer	0	1	1	0	2	0	0	0	0	0	0	0	0	2
Medicine	0	1	7	1	1	0	0	0	1	0	0	0	2	5
Surgical	0	0	4	1	0	0	2	0	1	0	1	0	0	5
Women & Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total	0	2	12	2	3	0	2	0	2	0	1	0	2	12

CLOSTRIDIUM DIFFICILE

C.*diff* via Ward

Ward	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
10BN			0		1									1
5AN			1											
10BS			0						1				1	2
6AN			0											
6AS			1											
6B			0	1			1							2
7B			0				1							1
7BN			1											
8A			0											
8B			0											
8BN			1											
8BS			0											
9A			0											
9AS			0										1	1
9B			0											
AAU			1											
Barley			3											
Bayford QEII			0											
CCU			0											
Codicote			0											
Digswell			0											
Elizabeth House			0											
ICU			0						1					1
HDU			0								1			1
Knebworth			0											
Lemsford			0											
MAU			0											
Marie Curie (MVCC)			0											
Pirton		1	2											
Princes			0	1										1
Sandridge			0											
SSU			1											
Stanborough			0											
Ward 10 (MVCC)		1	1		1									1
Ward 11 (MVCC)			0		1									1
Grand Total	**0**	**2**	12	**2**	**3**	**0**	**2**	**0**	**2**	**0**	**1**	0	2	**12**

CLOSTRIDIUM DIFFICILE

<u>*C.diff* Specimen Testing (All Specimens Received Including Community)</u>

Criteria for testing DH (2008) Bristol Stool Chart types 5-7

Samples	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
No. of Specimens for CDT to lab	485	548	3003	210	237	140	191	178	155	158	175	162	173	1779
No. Tested	237	262	1514	121	114	96	131	125	133	151	126	103	117	1217
No. Not tested for lab reasons				61	82	22	40	40	14	24	23	22	29	357
No. Not tested as advised by the ICT				28	32	17	20	13	8	23	26	37	27	231
% of Specimen's tested	48.90%	52.19%	49.6%	57.6%	48.1%	68.6%	68.6%	70.2%	85.8%	95.6%	72.0%	63.6%	67.6%	69.04%

Stools samples from GPs from <65 yrs are no longer tested for *C diff*, unless explicitly requested by the GP.

Clostridium *difficile* Infection Prevention & Control Key Performance Indicators

Total number hospital acquired C.*diff*	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
	0	2	12	2	3	0	2	0	2	0	1	0	2	12

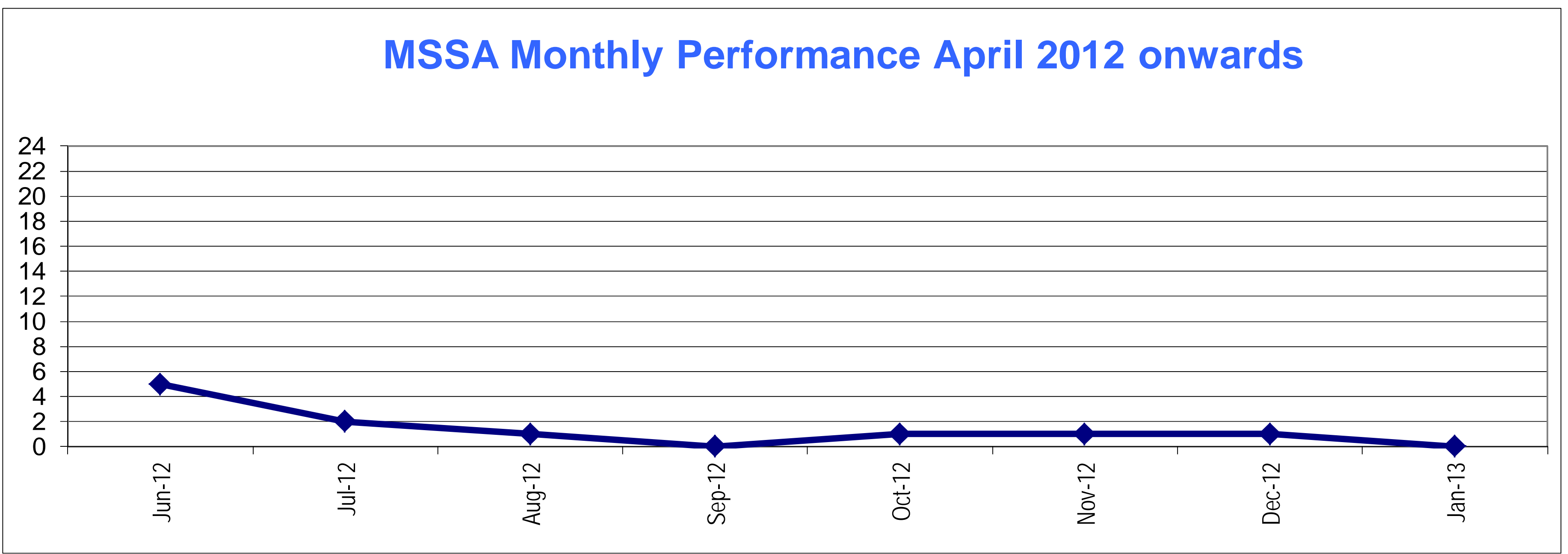
Hospital acquired C.*diff* by age group	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
Age 2 - 64 years	0	0	0	0	3	0	0	0	2	0	1	0	0	6
Age over 65	0	2	12	2	0	0	2	0	0	0	0	0	2	6

Other key performance indicators	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
Colectomies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Moves to ITU/HDU for *C.diff.*	0	0	0	0	0	0	0	0	0	0	0	0	0	0

High Impact Intervention Key Performance Indicators

High Impact Interventions	Feb-12	Mar-12	Total 11-12	RAG rate	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD	RAG rate
Hand Hygeine	99.62	98.87	99.34	▲	98.50	99.12	99.32	98.98	99.13	99.80	99.46	98.52	99.16	99.61	99.11	▲
Surgical Site Observation Tool	95.42	98.48	95.65	▲	99.04	97.41	100.00	99.21	100.00	99.30	99.69	94.52	98.43	99.46	98.68	▲
PVC(Insertion)	94.07	99.45	97.74	▲	95.48	97.07	98.40	97.69	96.12	94.68*	95.89	94.15	95.98	97.51	96.55	▲
PVC(Continuing Care)	100.00	100.00	93.88	▼	98.10	99.96	98.39	98.43	98.57	96.83	97.43	97.48	97.79	98.03	98.15	▲
Urinary Catheter(Insertion)	97.20	97.53	98.51	▲	99.27	98.98	98.97	99.62	97.27	98.10	99.89	100.00	99.70	99.07	98.80	▼
Urinary Catheter (Continuing Care)	95.81	99.30	97.66	▲	97.44	99.18	97.32	99.90	99.03	98.45	98.21	99.00	98.94	98.09	98.56	▼
Renal Dialysis Catheter Insertion	100.00	100.00	98.90	▲	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	◀
Renal Dialysis(Continuing Care)	100.00	100.00	98.90	▲	95.75	98.89	100.00	96.00	100.00	97.50	100.00	100.00	93.75	100.00	98.26	▲
Environment and Safety	97.53	97.37	97.09	▲	97.23	97.76	97.53	97.79	97.59	97.66	98.19	97.15	97.69	98.01	97.58	▲
Ventilator Catheter Insertion	100.00	100.00	100.00	▲	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	◀
Ventilator(Continuing Care)	100.00	100.00	100.00	▲	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	95.14	99.13	▼
Central Venous Catheter Insertion	100.00	100.00	99.55	▲	99.59	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	99.96	◀
Central Venous Catheter Care	100.00	100.00	99.52	▲	100.00	97.37	100.00	96.43	100.00	95.60	97.22	100.00	100.00	100.00	98.70	◀

MSSA BACTERAEMIA



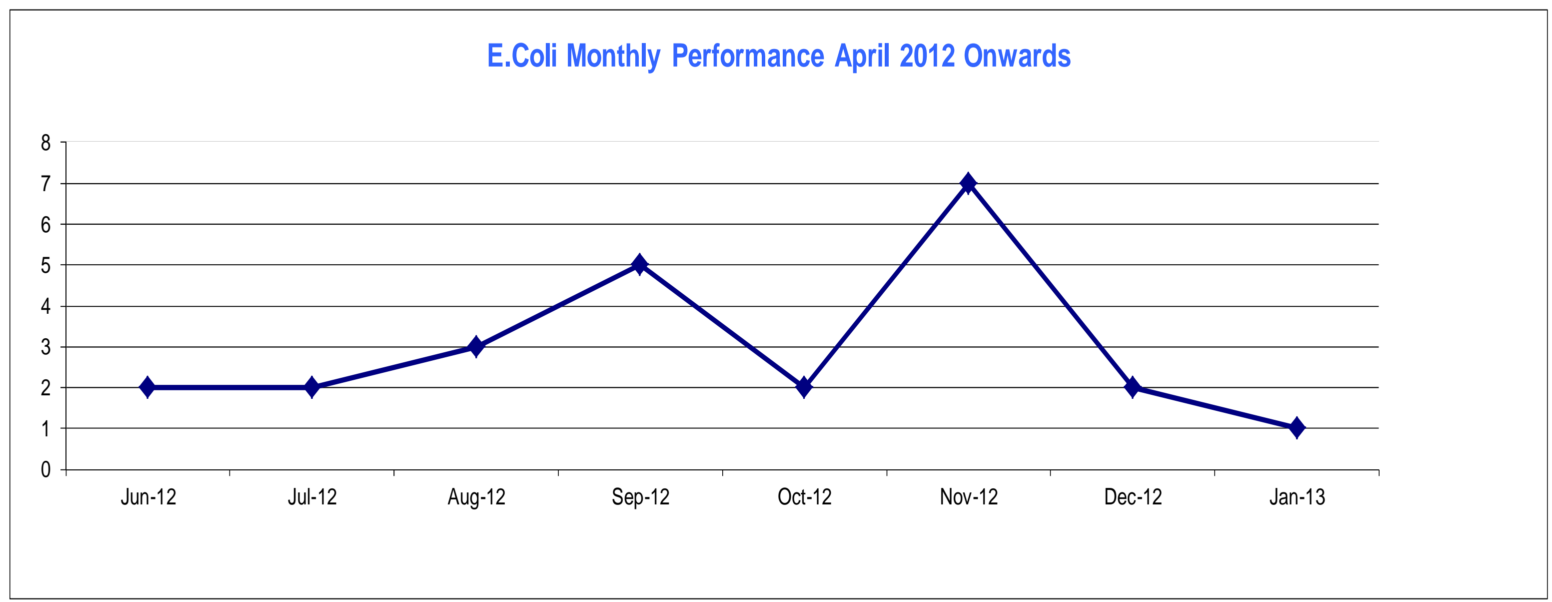
Hospital acquired MSSA by Division	Feb-12	Mar-12	Total 11-12 YTD	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Total 12-13 YTD
Cancer	0	1	2	0	0	0	0	0	0	0	0	0	0	0
Medicine	1	1	10	2	0	2	2	1	0	1	1	1	0	10
Surgical	1	0	3	0	1	1	0	0	0	0	0	0	0	2
Women & (	0	0	1	0	0	2	0	0	0	0	0	0	0	2
Grand Tota	2	2	16	2	1	5	2	1	0	1	1	1	0	14

Samples	Feb-12	Mar-12	Total 11-12 YTD	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
Specimen Received in Lab				731	828	792	803	723	763					4640
No. Contaminated				39	36	40	29	30	32					206
% Contaminated				5.3%	4.3%	5.1%	3.6%	4.1%	4.2%					4.4%

MSSA via Ward

Ward	Feb-12	Mar-12	Total 11-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
5AS						1								1
5BS							1							1
5BN					1									1
6AN							1							1
6BN														
8BN														
9AN						1								1
10BN				1										1
Codicote				1										1
Digswell												1		1
HDU										1				1
Knebworth														
ICU QE2						1								1
N-ICU						2								2
Pirton											1			1
Stanborough								1						1
GRAND TOTAL	**2**	**2**	**16**	**2**	**1**	**5**	**2**	**1**	**0**	**1**	**1**	**1**	**0**	**14**

E.COLI BACTERAEMIA



E.Coli Bacteraemia April 2012 Onwards	
E.Coli Bacteraemia	35
No. of Occupied Bed Days	86,900
MSSA Bacteraemia per 1,000 bed days	0.40

Hospital Acquired E.Coli by Division

Division	Feb-12	Mar-12	Total 11-12 YTD	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	YTD
Cancer	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Medicine	1	1	16	4	3	2	1	1	3	0	4	1	1	20
Surgical	2	0	13	2	1	0	1	2	1	1	2	1	0	11
Women & Children	0	0	3	1	0	0	0	0	0	1	1	0	0	3
Grand Total	**3**	**1**	**32**	**7**	**4**	**2**	**2**	**3**	**5**	**2**	**7**	**2**	**1**	**35**

EXCEPTION REPORT: COMPLIANCE & CLINICAL EFFICIENCY OCTOBER 2012
Target /Core Standard:

MRSA (Meticillin resistant Staphylococcus *aureus*) – Emergency. DH Gateway ref. document 13482, Operational guidance No. 3

Target Definition:
Screening of all 'relevant' patients admitted through the emergency pathway for Meticillin resistant Staphylococcus *aureus* from 31 December 2010

The Issue:

- Not achieving 95% or above
- Patients being missed particularly in Emergency Department
- Missed patients not always being followed up by ward
- Swabs taken discarded by laboratory as not adequately labelled
- Increased use of bank and agency staff in the Emergency Dept. may be a contributing factor of lapses in failure to follow policy with regard to swabbing all relevant emergency admissions

Monthly compliance scores	Percentage
Nov	60%
Dec	67%
Jan	70%
Feb	89%
Mar	89%
Apr	88%
May	92%
Jun	90%
Jul	89.50%
Aug	88%
Sept	92%
Oct	93.50%
Nov	95%
Dec	91%
Jan	90%

Actions Taken:

- Designated person follows up missed cases with daily phone calls to wards
- ED Matron checking swabs have been taken by checking sheets following day
- Daily compliance reports from infomatics and weekly reporting on APMG.
- Nurse in charge of ED informed at time of swabs received in lab not adequately labelled and asked to resend.
- Reviewed at divisional IP&C meetings monthly
- Infection Prevention Nursing Team chasing up missed cases with wards.

Next Steps:

- ED staff recruitment process in place
- All ED staff inducting bank and agency staff to department to focus on need to swab
- ADIPC to produce induction aide memoire to be given to all bank and agency staff at induction to the ED highlighting 'need to swab' procedure
- Review compliance score weekly and review
- Implement changes as required to achieve and sustain improvement.

Lead Director Angela Thompson 8.1.2013

MANDATORY ORTHOPAEDIC SURGICAL SITE SURVEILLANCE

Operation	**Period 4 1 Oct-31 Dec 2012**	**Period 1 1Jan-31Mar 2013**	**Period 2 1Apr-31June 2013**	**Period 3 1Jul-30 Sept 2013**	**Period 4 1 Oct-31 Dec 2013**	**Total No .of infections Ytd**	**National average ytd**
Total Knee Rep.	1 (4.7%)	0 (0.0%)				0	0.5-0.6%
Total Hip Rep.	3 (7.5%)	1 (4.5%)				1	0.7-0.8%
#NOF	3 (2.3%)	0 (0.0%)				0	1.5-1.8%

Actions taken:

- Last years action plan reviewed, incomplete actions carried forward to Second Stage Action Plan (attached)
- Planning RCAs continue and findings addressed as per action plan
- Observational audit of Maternity Theatre undertaken in December 2012, issues identified in Second Stage Action Plan
- Findings of orthopaedic skin prep. observational audit fed back to orthopaedic surgeons. Further training planned for February 2013
- Review of RCAs undertaken in Surgicentre almost complete (2 RCAs to be completed). Findings to date shared with Surgicentre and action plan presented to Surgicentre Infection Prevention Committee in January 2013

Next Steps:

- Work through second stage action plan
- Undertake outstanding RCAs in January 2013 and review action plan
- Undertaken general observational audit of General Theatres and feed back
- Undertake observational audit of skin prep. in General and Maternity Theatres
- Provide retraining of skin preparation at Princes Theatres
- ADIPC with Consultant IC Lead for General Surgery to attend General Surgery rolling half day to present hypothermia audit outcome, gown strike through audit outcome
- Consultant Anaesthetist IC Lead to present same at Anaesthetist rolling half day and include NICE inadvertent hypothermia and hypoglycaemia guidelines

Lead Director Angela Thompson 8.1.2013