# East and North Hertfordshire NHS Trust

# Trust Board Part I

Rooms 2092/2093, The New QEII

10 January 2018 14:00 - 10 January 2018 15:30

# AGENDA

| # | Description | Owner | Time |
|---|---|---|---|
| 1 | Chair's Opening Remarks | Chair | |
| 2 | Declaration of Interests | | |
| 3 | Questions from the Public<br><br>Members of the public are reminded that Trust Board meetings are meetings held in public, not public meetings. However, the Board provides members of the public at the start of each meeting the opportunity to ask questions and/or make statements that relate to the work of the Trust.<br><br>Members of the public are urged to give notice of their questions at least 48 hours before the beginning of the meeting in order that a full answer can be provided; if notice is not given, an answer will be provided whenever possible but the relevant information may not be available at the meeting. If such information is not so available, the Trust will provide a written answer to the question as soon as is practicable after the meeting. The Secretary can be contacted by email (jude.archer@nhs.net), by telephone (01438 285454), by fax (01438 781281) or by post to: Company Secretary, Lister Hospital, Coreys Mill Lane, Stevenage, Herts, SG1 4AB.<br><br>Each person will be allowed to address the meeting for no more than three minutes and will be allowed to ask only one question or make one statement. However, at the discretion of the Chair of the meeting, and if time permits, a second or subsequent question may be allowed.<br><br>Generally, questions and/or statements from members of the public will not be allowed during the course of the meeting. Exceptionally, however, where an issue is of particular interest to the community, the Chairman may allow members of the public to ask questions or make comments immediately before the Board begins its deliberations on that issue, provided the Chairman's consent thereto is obtained before the meeting. | | |
| 4 | Apologies for Absence | | |
| 5 | Minutes of Previous Meeting<br><br>For approval<br><br>5. Draft Minutes from 1 November 2017 Part I.pdf 5 | Chair | |
| 6 | Matters Arising and Actions Log<br><br>For information<br><br>6. Actions Log, Board Part 1 - January 2018.pdf 15 | Chair | |
| 7 | Annual Cycle<br><br>For information<br><br>7. Board Annual Cycle 2017-18.pdf 19 | Company Secretary | |

| # | Description | | Owner | Time |
|---|---|---|---|---|
| 8 | Chief Executive's Report<br>For discussion<br>8. Chief Executive's Board Report - Jan 2018.pdf<br>8. CE Report Appendix - Trust Floodlights 2017-18... | 25<br>27 | Chief Executive | |
| 9 | Finance and Performance Committee Report<br>For discussion<br>9. FPC Report to Board.pdf | 33 | Chair of FPC | 14.15 |
| 9.1 | Finance Report - Month 8<br>For discussion<br>9.1 Finance Report Month 8 - Trust Board Part I.pdf | 37 | Director of Finance | |
| 9.2 | Performance Report<br>For discussion<br>9.2 Performance Report Month 8.pdf | 45 | Chief Operating Officer | |
| 9.3 | Workforce Report<br>For discussion<br>9.3 Workforce Report.pdf | 55 | Chief People Officer | |
| 10 | Risk and Quality Committee Report<br>For discussion<br>10. RAQC Report to Board.pdf | 81 | Chair of RAQC | 14:45 |
| 10.1 | Nursing Establishment Review<br>For approval<br>10.1 Nursing Establishment Review.pdf | 85 | Director of Nursing | |
| 11 | Charity Trustee Committee Report<br>For discussion<br>11. CTC Report to Board.pdf | 115 | Chair of CTC | |

| # | Description | Owner | Time |
|---|---|---|---|
| 11.1 | Charity Strategy<br>For approval<br>[P] 11.1 CTC Report Appendix 1 - Charity Strategy.pdf 119 | Director of Strategy | |
| 12 | Data pack<br>For information<br>[P] 12. Data Pack.pdf 129 | All Directors | |
| 13 | Part II<br>The Trust Board resolves that under Standing Order 3.17(i) representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the matters to be transacted, publicly which would be prejudicial to the public interest. | | 15:45-18:00 |
| 13.1 | Commercial-in-confidence | | |
| 13.2 | Governance Matters | | |
| 13.3 | Personnel Matters | | |
| 14 | Date of next meeting:<br>7 March 2018 - Lister Education Centre | | |

# EAST AND NORTH HERTFORDSHIRE NHS TRUST

## Minutes of the Trust Board meeting held in public on Wednesday 1 November 2017 at 2.00pm at the Herford County Hospital, Hertford

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| **Present:** | Mrs Ellen Schroder | Non-Executive Director (Chair) |
| | Mr Bob Niven | Non-Executive Director |
| | Mr John Gilham | Non-Executive Director |
| | Mrs Alison Bexfield | Non-Executive Director (from 2.27pm) |
| | Ms Val Moore | Non-Executive Director |
| | Mr Jonathan Silver | Non-Executive Director (Designate) |
| | Mr Nick Carver | Chief Executive Officer |
| | Mr Martin Armstrong | Director of Finance |
| | Miss Jane McCue | Medical Director |
| | Ms Liz Lees | Director of Nursing (Acting) |
| | Ms Bernie Bluhm | Interim Chief Operating Officer |
| **In attendance from the Trust:** | Ms Kate Lancaster | Director of Strategy |
| | Mr Tom Simons | Chief People Officer |
| | Mrs Jane Chapman | Board Committee Secretary (minutes) |
| | Mr Joe Maggs | Corporate Governance Officer |
| **In attendance external to the Trust:** | Ms Sue Dearden | JLP |
| | Ms Sally Russell | Member of public |
| | Dr Kate Flavin | Anaesthetist and ICM, North London Hospital |
| | Mr Stuart Taylor | O2 Telephonica |

**ACTION**

**17/188 CHAIR'S OPENING REMARKS**

17/188.1 Mrs Schroder welcomed the visitors and Mr Jonathan Silver, Non-Executive Director (Designate) and incoming Chair of the Audit Committee, to the meeting.

17/188.2 It was noted that this would be the last Board meeting that the Medical Director, Miss Jane McCue, would attend prior to retiring from the Trust. Miss McCue was thanked for her dedicated service to the Trust.

17/188.3 It was also acknowledged that this would be the last Board meeting for Ms Liz Lees in her capacity as the acting Director of Nursing. The Board thanked her for her work in this role.

**17/189 DECLARATIONS OF INTEREST**

17/189.1 There were no declarations of interest.

**17/190 QUESTIONS FROM THE PUBLIC**

17/190.1 There were no questions from the public.

**17/191 APOLOGIES FOR ABSENCE**

17/191.1 Apologises for absence were received from Ms Jude Archer – Company Secretary.

**17/192 MINUTES OF THE PREVIOUS MEETING**

17/192.1 The Board reviewed and approved the draft minutes of the previous meeting.

**17/193 MATTERS ARISING AND ACTIONS LOG**

17/193.1 The Board reviewed and noted the actions log with the following comments:

- 17/125.2: Social Care Funding – a crossover between the previous Chief Operating Officer and the Interim replacement had interrupted reporting; however, an update would be requested for the next A&E Delivery Board and reported back to Board.

- 17/132.3: Nursing and Midwifery Establishment Review –The action was noted as completed and the latest establishment review will be presented to Board in January.

**17/194 ANNUAL CYCLE**

17/194.1 The Board noted the Annual Cycle with the following comment:

Annual Operating Plan and Objectives – Mrs Schroder enquired what the timeframe would be for this item to be presented to Board. The Director of Finance advised that guidance from NHSI is awaited in order to proceed with this item; however, developments have progressed on Business Planning for 2018/19 and will be presented to the Executive Committee tomorrow as well as being on the Finance and Performance Committee agenda at the end of the month.

**17/195 CHIEF EXECUTIVE'S REPORT**

17/195.1 The Chief Executive delivered the Chief Executive's Report, highlighting the following items:

- The newly appointed Director of Nursing, Rachael Corser, will start at the Trust on 2 January 2018. Liz Lees, the Trust's acting Director of Nursing and Patient Experience, will continue in this role until Rachael joins the Trust. The Chief Executive also thanked Liz for her considerable contributions to the Trust in this role over the last year.
- The Chief Executive also gave thanks to Jane McCue, Medical Director, for her contributions to the Trust which were greatly appreciated.
- The weekend of 8 to 11 September 2017 saw the Trust rollout of Lorenzo, a new electronic patient record computer system that provides improved access to patient information in real-time and supports rapid clinical decisions. In addition to Lorenzo, an electronic patient observation system called Nervecentre had also been implemented, allowing clinical staff to enter patient observations that provide automatic escalation of patients who are at risk of deteriorating and need urgent

review.

- The Trust's Butterfly volunteer team, which supports people in the last days of their lives, had been awarded funding worth a total £64,450 over three years from the Dunhill Medical Trust to help continue and expand the service.

17/195.2 The Board noted the latest Floodlight Dashboard. The Director of Finance advised that the Trust is moving towards an integrated Dashboard in 2018/19.

17/195.3 Floodlight data is being finalised to ensure complete and correct information is recorded. The Medical Director advised that data for mortality is provided a month in arrears which could result in discrepancies in rolling data. Previous months' data was not currently updated on the floodlights and therefore indicated an erroneous position. She requested that this be taken into consideration and was in discussion with the Information Team regarding the process.

17/195.4 Mrs Schroder suggested a review of the indicators under sustainability. The Medical Director highlighted that the reference document with the definitions for the indicators had not been included. Mrs Schroder stressed the need for the indicators to be accurate in order to present the correct information whilst the new dashboard is being developed. Mr Niven highlighted that the majority of indicators were showing amber and, therefore, indicated that improvements were required.

**FINANCE AND PERFORMANCE**

**17/196 FPC report to board**

17/196.1 The Board received the report of the Finance and Performance Committee meeting held on 25 October.

17/196.2 Mr Gilham referred to the clinical coding and data capture actions being undertaken and enquired whether there was assurance that the work being carried out is considering why previous actions were not sustainable. The Director of Finance reported that it was being explored whether the same issues were arising. An action plan is now in place and being monitored at the weekly Information Assurance Group meetings to ensure good practice is embedded throughout the organisation and a sustainable position is resumed.

17/196.3 Mrs Schroder was interested to know whether the CIP in month was adverse to plan along with the 30% off plan. The Director of Finance advised that the key challenge involves the Model Hospital scheme and delivery is dependent on the quantum of activity in outpatients to be delivered; however, the throughput is insufficient at the current time to realise the full saving. Mrs Schroder highlighted that September had been a disappointing month financially. The Director of Finance advised that this was due to the reduction of activity in outpatients during the Lorenzo Go Live period being reduced to 80%. Mrs Schroder enquired whether CIPs anticipated being reduced by 30%. The Director of Finance advised that this had not been anticipated; however, some areas of CIP are achieving higher than anticipated. An increased level of activity would have been beneficial and advised the Board that the monitoring of activity levels are now being undertaken and reviewed on a weekly basis in order to consider and mitigate any differences in order to push activities to a higher level

now that tools are available.

17/196.4 The Chief People Officer suggested that the narrative provided in the summary report regarding the Workforce Report was not fully reflective of discussions had at the meeting. The Workforce Report was due to be considered later in the meeting.

**17/197 Finance Report Month 6**

17/197.1 The Director of Finance delivered the Month 6 Finance Report. Key points to be noted included:

- The Trust reported a £1.4m deficit in month, bringing the year to date position to a £16.8m deficit, an adverse variance against plan of £2.1m for the year to date.
- There has been a £0.2m adverse variance against in plan in month, after removing the impact of STF funding.
- As a result of the adverse year to date variance, the Trust has assumed that it will not be eligible for STF funding in Q2.
- The SLA income for September activity shows a £1.1m adverse variance, but this is mainly offset by a positive impact of £1.0m from the refresh of August activity. There is now a £7.9m shortfall on SLA income for the year to date.
- The adverse SLA income receipts are being partially offset by pay and non-pay underspends in the year to date position.
- Savings performance during September fell short of plan, with the theatre and outpatients productivity savings not achieving the anticipated levels of activity.

17/197.2 Actions had been discussed and were being taken in order to improve the current financial position. The focus now included activity and depth of coding. The Trust must be consistent in recording activity.

17/197.3 The Director of Finance highlighted the significant improvements within the Trust over the past 9 months. The challenges with access metrics and improvements to the Emergency Department, Cancer and RTT performance are all underway.

17/197.4 Mr Gilham asked whether there was confidence that work being undertaken would support the delivery of CIPS. The Interim Chief Operating Officer advised that challenges have been identified in Trauma & Orthopaedics and the department is supportive of the recovery plan; however, it is not without risk. She advised that the post Lorenzo challenges do add to the risks. The annual winter risks are being considered together with a plan and ring-fencing beds to medicine is a possibility. Additional work was taking place regarding Orthopaedics, Gastroenterology and ENT outpatients.

17/197.5 Mr Gilham enquired whether the reduction of income levels stated on the year on year comparison were due to the care delivery model and was interested to know if the Trust is confident with the plan going forward. The Director of Finance advised that data for the Mount Vernon Cancer Centre for Cancer performance had changed since the June/July performance was recorded. He advised that the challenge relates to non-elective activity as the capturing of activity was inconsistent.

17/197.6 Mrs Schroder noted that non elective activity was down. The Interim Chief Operating Officer advised it did not feel that way on the ground.

The Director of Finance suggested that not all activity was being recorded and the Information Assurance Group suggested that there continued to be inconsistencies. This would be monitored by FPC.

17/197.7 Mr Niven enquired whether the Trust would be applying to the Department for Health to borrow funds. The Director of Finance advised that this would not be the case at the current time; however, it may be a possibility at the start of 2018. The Trust is limited to the length of acceptable credit especially with smaller companies. Delays in payments could jeopardise supplies. The Trust will be raising the issue with NHSI.

**17/198 Performance Report Month 6**

17/198.1 The Interim Chief Operating Officer introduced the Month 6 Performance Report. Key points to note included:

- RTT – Following migration to Lorenzo the Trust is unable to report September's performance against the RTT standard; however, the Trust is committed towards returning to national reporting in November;
- 4 Hour Performance – The Trust is unable to report month 6 performance against the 4 hour standard; furthermore, it does not expect to be able to retrospectively provide month 6 performance due to issues with retrospectively validating pathways. The Trust did return to daily SitRep submissions to NHSI/Unify the week commencing 16 October and is expecting to report a month end performance for October;
- 62-day Performance – The Trust did not achieve the standard or against the recovery trajectory, delivering 72.24%, post breach sharing, against an original trajectory of 85.04%;
- Stroke Performance had not been finalised at this time.
- DMO1 Performance – The Trust is currently unable to report performance against the monthly diagnostic standard: however, it aims to have built the diagnostic PTL by the end of the month so that operational teams can test and check its accuracy. On completion the Trust will be able to return to national reporting with the most likely timeline as reporting November's performance before the submission closure in December.

17/198.2 The Emergency Department was reporting daily and RTT reporting will resume in December by reporting on November's performance. A&E have now been reporting fully since October; however, there have been increased breaches showing due to validation challenges, reporting is therefore potentially appearing worse than it is. Work would take place to review the emergency pathway. A significant pressure was capacity. Mrs Schroder enquired whether beds closed at Easter could be re-opened to alleviate the capacity issue as we approach the winter period. The Interim Chief Operating Officer advised that the winter plan is being reviewed for efficiency and consideration was being given to using ward 7b differently.

17/198.3 Mr Gilham referred to the report and highlighted that cancelled operations appeared to have increased in number. The Interim Chief Operating Officer advised that prior to last week there had been minimal cancellations due to capacity.

17/198.4 Ms Moore enquired how discharges are managed. The Interim Chief Operating Officer advised that daily conference calls with commissioners and partners take place and relationships across the system are positive. The model has been reviewed and improvements are taking place so that staff are aware who to approach.

17/198.5 The Interim Chief Operating Officer also advised the Board that within the Cancer Division, an interim Divisional Director and Cancer Improvement Plan lead had been appointed. Interviews for a permanent Divisional Director took place last week with the successful candidate starting in 3 months.

17/198.6 Mr Gilham enquired whether there are sufficient resources and capacity to deliver the 5 workstreams of the improvement programme. The Interim Chief Operating Officer advised the Board that each workstream has an appointed Executive together with Clinical and Senior Leads. She advised that workstreams are well attended and staff are enthusiastic to achieve the planned improvements. Workstreams now have agreed clear KPIs. The acting Director of Nursing advised the Board that the 'Red to Green Days' scheme was launched this week with the first Board round taking place yesterday. The scheme requires a little more development; however, progress is being made and support is being provided during the implementation period.

**17/199 Workforce Report Month 6**

17/199.1 The Chief People Officer delivered the Month 6 Workforce Report. Key highlights included:

- Temporary Staffing - The monthly agency ceiling target was achieved in month 6 with agency spend under by £455k. Year to date the Trust is under the ceiling target by £1,879k, therefore continuation of this work will ensure that the target is achieved by year end.
- Sickness Rate – between August and September 2017, there was a reduction in the number of days lost by 33 days in month and an overall reduction in the number of long term sickness cases. The annualised sickness absence rate has improved further and reduced to 3.39%.
- Medical Staffing – In September, 15 new full time medical staff were appointed. In the same month, staff in post reduced by 10.5 WTE. This resulted in a net increase of 4.5 WTE for September. Year to date there has been a net increase in medical staff of 19.5 WTE, which is 4.5 WTE away from the year end target. Achievement of this target will reduce the vacancy rate to below 5% based on current establishment.
- Resourcing – the vacancy rate at the end of September 2017 was 8.4%. Compared to the same month last year there has been an additional 198.3 WTE in post (excludes 132.2 WTE for tPP). There are currently 260.8 WTE external candidates undergoing pre-employment checks or waiting to start with the Trust.

17/199.2 Mrs Schroder was interested to know how pay costs had decreased but staffing had increased. The Chief People Officer advised that the majority of resourcing had been focused on clinical roles and agency costs had decreased. He advised that this is the first year that the

budget had been significantly reduced and therefore a review of posts was undertaken to identify posts that were no longer tenable. The Director of Finance advised the Board that there is a legacy of historic staffing budgets that are now being reviewed to reflect the current position.

17/199.3 Mr Gilham referred to the Acute Medicine and Emergency Department working groups and enquired how successful addressing the issues is expected to be and how solutions are being utilised. The Interim Chief Operating Officer advised that the Divisional Chair for Medicine had held discussions with Clinicians and they are aware that Divisions must proceed with the new models. The Medical Director advised that a new proposal had been raised to provide support from Speciality Medicine to the Emergency Department and there would not be a reduction of the Acute Medicine footprint whilst providing additional support. She advised that the loss of Emergency Department trainees is running at 50% which is significantly higher than other areas for training.

**RISK AND QUALITY**

**17/200 Risk and Quality Committee Report**

17/200.1 Mr Niven, acting Chair of the October 2017 Risk and Quality Committee, presented the RAQC Committee report. Key highlights included:

- Safer Nursing staffing levels – the committee agreed that performance and the increase in shifts that remain red should continue to be closely monitored
- Risk register – The number of risks that had been formally approved had decreased compared to the previous report, as had the number that had been reviewed by their area within their pre-defined timeframe. A continued focus was requested.
- Fire safety and BAF discussion – the Trust's largest estates risk item was being addressed in the current year so fire safety would be the top priority for the next year. The Committee were assured by the actions being taken by the Trust and that Hillingdon had engaged regarding MVCC.
- Learning from Deaths – continued improved position, for discussion later in the meeting.
- Complaints and PALS – it was noted that there had been an increase in complaints raised in Q2; this would be kept under review.

17/200.2 Mrs Bexfield enquired if clinical audit findings are clear as to whether actions are critical or not. The Medical Director agreed this could be an area for improvement, including identifying positive changes and sharing findings following the audit process. Mrs Bexfield sought further clarification as to whether any problem areas identified through the audits would be highlighted to the Board. The Medical Director assured the Board that the Clinical Directors deal with the areas and the Director of Nursing confirmed that these are clinical indicators and any issues would also be raised through the Risk and Quality Committee.

17/200.3 The Interim Chief Operating Officer raised a concern of heading into winter pressures and with increased risk on staffing (red shifts). The Director of Nursing confirmed that work was taking place with the temporary staffing team to improve the position. The October position

was considered to be marginally better.

17/200.4 With regards to the increase in complaints, Ms Moore noted that 20% of these were around attitude. The Patient Experience Committee had discussed an initiative for staff involved to write a reflective statement following a complaint and she requested feedback on this. The Director of Nursing confirmed that there is a more intensive support for specific areas incorporated within a current improvement programme.

**17/201 Learning from Deaths Report**

17/201.1 The Medical Director presented the latest quarterly report summarising the results of mortality improvement work including the regular monitoring of mortality rates and outputs from the learning from deaths work that is a continual, on-going process throughout the Trust. The mortality indicators presented an assuring picture within the Trust. SHMI was stable at 102 and it was predicated that this would fall further. The ambition was to achieve a SHMI below 100 before the end of the financial year. Crude mortality continues to benchmark well when Michael Sobel House (hospice) is excluded from the figures.

17/201.2 The report also outlined the further developments in order to continue to improve mortality and presented the new Learning from Deaths Framework and Policy which is also available on the Trust website. There is also a revised mortality case record review policy. The Medical Director confirmed that 89% of deaths had been reviewed and the reviewers had adapted to new requirements well. As part of the process patients need to be discussed in the next rolling half day to identify any additional learning and share the outcome to improve the quality of care of our patients. The new dashboard was presented which was in line with national reporting requirements. It was highlighted that the reporting tool for monitoring daily mortality had not been available since the implementation of Lorenzo but the expectation was that this would be available again soon. It was confirmed that eight care bundles are now in place and there was a commitment to implement a further two by the end of financial year.

17/201.3 Mr Silver enquired why readmissions were flagging as red. The Medical Director explained that these were regularly reviewed and the most recent review of highest alerting pathways identified data capture errors.

17/201.4 In response to a question on the respiratory service, the Medical Director outlined that we have a Specialty Nurse, 7 day consultant service and community service. We have worked on admission avoidance through hot clinics which means that people that come in now are relatively sick. Ms Moore asked regarding the end of life impact and the Medical Director confirmed patients dying with long term conditions that can no longer be controlled should have an advance care plan in place to discuss their preferred place of death and the clinic is now set up for this. At the last inspection the Care Commission stated we have a good service.

17/201.5 Mr Gilham enquired as to why there was a discrepancy in the number of deaths reviewed and deaths in scope reported on the dashboard. The Medical Director assured the Board that no data was missing; however there is a difference as numbers that arise in month are not always reviewed in the same month. It was agreed that a footnote would be added to the dashboard to explain this.

**17/202 Audit Committee Report to Board including the Review of Standing Financial Instructions and Standing Financial Orders**

17/202.1 Mrs Bexfield presented key areas of the Audit Committee Report to Board. The annual review of the standing financial instructions and financial orders had been completed and the Audit Committee endorsed these for final approval. The Board approved these.

17/202.2 The Committee had reviewed the conflicts of interest register for Board Directors for publication and the latest versions of the Gifts and Hospitality registers. It was felt that there had been fewer than expected gifts and hospitality declarations and directorate leaders should be asked to sign off that they believe the register for their area is complete at the end of each quarters. The new Policy will support this.

17/202.3 The governance action plan following the PwC review was noted as under development and Mrs Schroder advised that the Company Secretary would monitor the progress against the action plan and report this to the Board and Audit Committee

17/202.4 It had been noted that a number of actions following internal audits were overdue for completion; these would remain visible at Audit Committee to ensure the risks are being addressed.

**17/203 Charity Trustee Annual Report and Accounts**

17/203.1 The Board reconvened as the Corporate Trustee of the Charity. Mr Niven presented the annual report and accounts noting that these had been subject to a full external audit this year. The external auditor ISA 260 report highlighted three issues and it was confirmed that these adjustments had been made. The accounts and annual report had been considered and endorsed through the Audit Committee and Charity Trustee Committee.

17/203.2 The Chief People Officer asked in relation to the costs versus what had been raised and how this benchmarked against other organisations. The Director of Strategy outlined an historical issue with how this is recorded and that we did not currently benchmark well. Some projects funded over a period of time were incorrectly recorded. She outlined the intention of the new charity strategy will look at the profitability of each event moving forwards. This will improve the benchmark and provide greater visibility to contributors of the return on their donation. It was noted that large purchases will be used for future fundraising communications.

17/203.3 Mr Niven and Mrs Schroder endorsed the good work of the charity. The Board as Corporate Trustee noted the external auditors report, approved the letter of representation and approved the Charity accounts and annual report.

**17/204** **DATA PACK**

17/204.1 The Board noted the data pack.

*There being no further business the Chair closed the meeting at 4.00pm.*

**Ellen Schroder**
**Trust Chair**

November 2017

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

**Agenda item: 6**

# EAST AND NORTH HERTFORDSHIRE NHS TRUST
# TRUST BOARD ACTIONS LOG PART I TO JANUARY 2018

| Meeting Date | Minute ref | Issue | Action | Update | Responsibility | Target Date |
|---|---|---|---|---|---|---|
| 26 July 2017 | 17/125.2 | Social Care Funding | Once each quarter provide a briefing to Board on the progress with workstreams regarding the additional H&SC funding as part of the Performance Report. | **November 2017:** Verbal update to be provided at the meeting.<br><br>**January 2018:** See minutes of 1 November Board meeting (paragraph 17/193.1) for details of discussion regarding this action. Update to be provided at January Trust Board meeting. | Chief Operating Officer | November 2017<br>January 2018 |
| 26 July 2017 | 17/132.3 | Nursing and Midwifery Establishment Review | NHSI Model Hospital bench-marking data to be included in the next Nursing Establishment Review. | **September 2017:** Being presented at October's Board Development session to provide an update on development of an up to date dashboard for workstreams including smart metrics in one location to track progress.<br>**November 2017:** Completed and the latest establishment review will be presented to Board in January. | Director of Nursing | January 2018 |

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

| Meeting Date | Minute ref | Issue | Action | Update | Responsibility | Target Date |
|---|---|---|---|---|---|---|
| 6 Sept 2017 | 17/156.5 | Operational Performance - Cancer | To review PAH cancer pathways to explore if there is learning for the Trust | **January 2018:** Action competed – see update appended to actions log. | Chief Operating Officer | December 2017 (FPC) |
| 6 Sept 2017 | 17/161.2 | Vascular Surgery Hub | Develop a business case in order to ensure a high level of service and to provide assurance. | **January 2018:** In progress – awaiting input from finance team. | Director of Strategy | January 2018 |

**Action 17/156.5 – Update**

The previous interim cancer DD visited PAH on several occasions reviewing their pathways to see what the Trust could learn from them. Additionally via the cancer collaborative and other NHSI network meetings the Trust also liaised with PAH and subsequently we have already introduced three keys changes that PAH implemented:

1. For the 4 main timed tumour sites, e-Ref polling time reduced to 7 days.

2. For patients referred on a 2WW pathway we have adopted a script to be used in the contact centre when booking patients that uses the words ‘referred on an urgent cancer pathway’, this script was approved with the CCG and cancer board and was something that PAH initially implemented to reduce the volume of patients opting to wait beyond the national standards.

3. We have also adopted an earlier escalation process that is used at PAH:

i. Escalated if no key diagnostic by day 21

ii. Escalated if no MDT by day 28

iii. Escalated if no treatment plan by day 31

The majority of the admin processes that support the pathways have been introduced, although require close monitoring and supervision to fully embed. The next main steps are the introduction of the clinical pathways which the Cancer Improvement and Performance Lead is leading on with the clinical teams.

**Board Annual Cycle 2017-18**
- **A Formal Board is held on alternate months.**

***Note: The annual cycle is currently under review following the agreed changes to the Board and Board Committee meeting dates that took effect from September 2017.***

| **Items** | ***Apr 17** | **May 17** | ***Jun 17** | **Jul 17** | **Aug 17** | **6th Sep 2017** | **4th Oct 2017*** | **1st Nov 2017** | **6th Dec 2017*** | **10th Jan 2018** | **7th Feb 2018*** | **7th Mar 2018** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Standing Items** | | | | | | | | | | | | |
| CEO Report inc Floodlight Scorecard | | x | | x | | x | | x | | x | | x |
| Data Pack[i] | | x | | x | | x | | x | | x | | x |
| Patient Testimony (Part 2) | | x | | x | | x | | x | | x | | x |
| Suspensions (Part 2) | | x | | x | | x | | x | | x | | x |
| | | | | | | | | | | | | |
| **Committee Reports** | | | | | | | | | | | | |
| Audit Committee Report | | x | | x | | | | x | | | x | |
| CTC Report<br><br>*May 2017 meeting not held due to Major Incident | | X* | | | | x | | | | x | | |
| FPC Report [ii] | *x | x | *x | x | | | *x | x | *x | x | *x | x |
| RAQC Report | *x | x | *x | x | | | *x | x | *x | x | *x | x |
| | | | | | | | | | | | | |
| **Strategic** | | | | | | | | | | | | |
| Annual Operating Plan and objectives *(subject to change as dependant on national timeline)* | | | | | | | | *x (awaiting national guidance/ timetable) | | | | *x |

**Board Annual Cycle 2017-18**

- **A Formal Board is held on alternate months.**

| **Items** | ***Apr 17** | **May 17** | ***Jun 17** | **Jul 17** | **Aug 17** | **6th Sep 2017** | **4th Oct 2017*** | **1st Nov 2017** | **6th Dec 2017*** | **10th Jan 2018** | **7th Feb 2018*** | **7th Mar 2018** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Review & Financial recovery Plan (TBC) | | | *x (draft recovery plan) | *x (final recovery plan) | | | | *x (final recovery plan) (awaiting confirmation of date / timeline of final submission) | | | | |
| Sustainability and Transformation Plan (STP) (Part 2 new standing item) | | | | x | | x | | x | | x | | x |
| | | | | | | | | | | | | |
| **Other Items** | | | | | | | | | | | | |
| *Audit Committee* | | | | | | | | | | | | |
| Annual Audit Letter | | | | x | | | | | | | | |
| Annual Report and Accounts(Trust), Annual Governance Statement and External Auditor's Report | | x | | | | | | | | | | |
| Audit Committee TOR and Annual Report | | | | x | | | | | | | | |
| Quality Account and External Auditor's Report | | | x | | | | | | | | | |
| Raising Concerns at Work | | | | x | | | | | | | | x |
| Review of SO and SFI | | | | | | | | x | | | | |
| *Charity Trust Committee* | | | | | | | | | | | | |
| Charity Annual Accounts and Report | | | | | | | | x | | | | |
| Charity Trust TOR and Annual Committee Review | | | | | | x | | | | | | |
| *Finance and Performance Committee* | | | | | | | | | | | | |

**Board Annual Cycle 2017-18**

- **A Formal Board is held on alternate months.**

| **Items** | ***Apr 17** | **May 17** | ***Jun 17** | **Jul 17** | **Aug 17** | **6th Sep 2017** | **4th Oct 2017*** | **1st Nov 2017** | **6th Dec 2017*** | **10th Jan 2018** | **7th Feb 2018*** | **7th Mar 2018** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Draft Floodlight Indicators and KPIs | | | | x | | | | | | | | |
| Financial Plan inc CIPs and Capital Plan *(subject to change as dependant on national timeline)* | | | | | | | *x | | *x | | | x |
| FPC TOR and Annual Report | | | x | | | | | | | | | |
| IM&T strategy review | | | | | | | | | | X (revised timescale to be agreed) | | |
| Market Report | | x | | | | | | x | | | | x |
| Market Strategy Review (TBC) | | | | | | | | | | | | x |
| *Risk and Quality Committee* | | | | | | | | | | | | |
| Adult Safeguarding and L.D. Annual Report | | x | | | | | | | | | | |
| Detailed Analysis of Staff Survey Results | x | | | | | | | | | | | |
| Board Assurance Framework and review of delivery of objectives | | | | | | | | | | | | x |
| Equality and Diversity Annual Report and WRES. | | | | X | | | | X (Considered at Trust Board in July) | | | | |
| GMC National Training Survey *(subject to change as dependant on national release)* | | | | | | | | X (reported in RAQC Report at Oct Board Development) | | | | |
| Health and Safety Strategy Review | | | | x | | | | | | | | |
| Improving Patient Outcomes Strategy | | | | x | | | | | | | | |
| Mortality (Learning from Deaths) | x | | | x | | | | x | | | | x |

**Board Annual Cycle 2017-18**

**- A Formal Board is held on alternate months.**

| **Items** | ***Apr 17** | **May 17** | ***Jun 17** | **Jul 17** | **Aug 17** | **6th Sep 2017** | **4th Oct 2017*** | **1st Nov 2017** | **6th Dec 2017*** | **10th Jan 2018** | **7th Feb 2018*** | **7th Mar 2018** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nursing and Midwifery Strategy Review | | | | | | | | X (due to be considered at RAQC in January 2018) | | | | x |
| Nursing Establishment Review | | | | x | | | | | | x | | |
| Patient Experience Strategy Review | | | | X (RAQC/ Data Pack) | | | | | | | | |
| Nursing - PQAF / Education report | | | | | | | | x | | | | |
| RAQC TOR and Annual Review | | | | x | | | | | | | | |
| Research and Development Annual Review | | | X (RAQC) | | | | | | | | | |
| Responsible Officer Annual Review | | | | X (RAQC) | | | | | | | | |
| Safeguarding Children Annual Review | | | | x | | | | | | | | |
| Serious Incidents Report (Part 2) | | | | x | | | | x | | | | x |
| University Status Annual Report | | | | | | | | | | | | X (TBC) |
| **Shareholder / Formal Contracts** | | | | | | | | | | | | |
| ENH Pharma (Part 2) [iii] | | | | x | | | | | | | | x |
| tPP (Part 2) | x | x | x | x | | x | | x | | x | | x |

**Board Annual Cycle 2017-18**
- **A Formal Board is held on alternate months.**

[i] The Data Pack will include the Friends and Family Test, Statutory and Mandatory Training Exception Report, Health and Safety Indicators, Nursing Quality Indicators, Finance Data, Performance Data, CQC Outcomes, Workforce Data, Safer Staffing Data and Infection Prevention and Control Data.
[ii] The FPC Report will include the Committee Report, the Finance Report, Performance Report and Workforce Report for the month.
[iii] To include the Annual Governance Review in July

*Please note Board Development sessions will be held on the 'even' months. This will support flexibility for the Board to be able to be convened for an extraordinary meeting if an urgent decision is required. However forward agenda planning will aim to minimise this. *Items considered at the prior to the Board Development Session.
The Board Annual Cycle will continue to be reviewed in year in line with best practice and any changes to national scheduling.

N.B. May 2017: There have been some delays in finalising May reporting due to the Major Incident – Cyber-attack 12-19 May 2017.
Reviewed September 2017 – April 2018 to reflect changes to Board dates.

**EAST AND NORTH HERTFORDSHIRE NHS TRUST**

**CHIEF EXECUTIVE'S REPORT**

**January 2018**

| | |
|---|---|
| **1.** | **Christmas & New Year**<br><br>Over the Christmas period and particularly New Year there was an incredible commitment from all staff to support our patients during a very challenging time. Staff worked late and came in early, swapped shifts at short notice and cancelled personal engagements to ensure the safe running of our hospital. This has included clinical and non-clinical staff who have worked in unfamiliar areas to support the running of the hospital and relieve clinical staff to care for patients. |
| **2.** | **Winter Pressures**<br><br>Across the country, the NHS is under extreme pressure. The Trust is prioritising the welfare of the very sickest patients who need immediate life-saving care, and have brought in all available additional staff to help, in line with locally agreed winter plans. The Community have been advised anyone coming to the Lister's emergency department with a minor illness or injury is very likely to face a very long wait and advised to use alternative services and keep A&E for those who are gravely ill or injured. Staff have been thanked for their goodwill and resilience. |
| **3.** | **National Staff Survey**<br><br>Outline staff survey results were received in early December. This is not the final, weighted version of the data and no conclusions can be drawn about national comparisons or the national survey results that will be published in February 2018.<br><br>A workshop has been launched and within the first 48 hours nearly 200 staff had joined the online conversation. There will be further formal and informal communications to increase participation levels until the workshop closes on 24 January. The quality of the conversations has in the main been positive and supportive, and focused on how improvements can be made. Outputs from the workshop will be analysed and themed, providing a range of actions that can be prioritised and incorporated into the survey action plans. |
| **4.** | **Medical Director**<br><br>Mike Chilvers, began his new appointment as the Trust's Medical Director in December. Mike has been a consultant at the Trust in anesthesia and critical care since 1999 and divisional chair of surgery for five years. His priorities include engaging with all staff groups with the aim of further improving patient care. |
| **5.** | **Exceptional Ratings for our Services**<br><br>Auditing the Lister's Respiratory Department, the Royal College of Physicians rated the service in the top 5% in the country for reviewing patients after 24 hours and the discharge care bundle they provide. This has meant that patients with chronic obstructive pulmonary disease are getting high quality care and good advice from the respiratory nurses and seven day consultant-led service. |

| | |
|---|---|
| | Following an audit of the Lister's Multiple Pregnancy Team, the service has been rated as exceptional by the Twins and Multiple Births Association. The team has worked to reduce significantly the proportion of second twins being born by caesarean section and are supporting mothers with consistent midwife-led care.<br><br>Finally, auditing the Diabetic Eye Screening team based at Hertford County, Public Health England rated the service as amongst the best in the country. The speed at which patients were seen, uptake of screening and sharing results quickly were all singled out for excellent feedback. |
| **6.** | **Purple Star Award for New QE2**<br><br>The Ambulatory Care Team at the New QEII hospital have received a Purple Star award from Hertfordshire County Council's Health and Community Services People for their work in improving services for people with learning with learning disabilities. This follows the successful completion of a Programme by the Community Learning Disability Service to help the team improve the quality of care and treatment experienced by this very vulnerable group of individuals. |
| **7.** | **Vascular Surgery Team Receives National Recognition**<br><br>Unblocking carotid arteries quickly, which supply blood to the brain, is key in helping reduce the risk of further strokes in patients. Taking a multi-disciplinary approach has seen the Trust's service rated as the second fastest in the country following publication of the 2016 National Vascular Registry report. |
| **8.** | **New Palliative Care Support at Mount Vernon**<br><br>Enhancing supportive care is a new CQUIN initiative run by the Palliative Care Team at Mount Vernon, giving better support to improve quality of life for patients with non-curative cancer. Since April, the enhanced supportive care clinics have seen 162 new patients and 102 follow-up appointments. The team audited the service and the feedback was favourable; the team is hoping it may become an established part of outpatient services. |
| **9.** | **Health Scrutiny Committee Concordat**<br><br>We recently approved the latest Health Scrutiny Committee Concordat – a voluntary, non-binding agreement between the Committee and health partners. The purpose of the Concordat is to create explicit consensus between HSC and the NHS in Hertfordshire about the principles that should underlie good consultation, to enable HSC to prioritise its scrutiny activity and to maintain the role of critical friend and, finally, to assist patients and the public, including HealthWatch Hertfordshire, to understand the principles on which consultation with them is carried out. |
| **10.** | **Outstanding Exam Pass Rate for International Nurses**<br><br>The Trust's international nurses have achieved a 97% pass rate in their exams against the national average of 60%. International nurses need to pass 'OSCEs' (the objective structured clinical exam) to obtain their Nursing and Midwifery Council pin, enabling them to work in the UK. |

**Chief Executive**
**January 2018**

East and North Hertfordshire NHS
NHS Trust

# TRUST FLOODLIGHT

U

# DASHBOARD AND SCORECARD 2017/18

## November 17 - Month 08

The Purpose of this report is to give an overview of Key Performance Indicators (KPI's) which the Trust have agreed to measure and monitor throughout 2017/18.
The indicators compare to monthly and year-to-date performance targets scoped within quarter 1 of this financial year.
The intended audience is the Executive Team, Operations and Governing Bodies to support strategic design making and identify emerging issues across the Trust.

# Trust Floodlights Dashboard
# November 2017 (M08)

East and North Hertfordshire NHS
NHS Trust

## Report Structure

| | |
|---|---|
| Executive Summary | • Overview of the Trusts performance when compared to targets and historical performance |
| Dashboard | • High-level visualisation of the Key Performance Indicator Themes grouped to give an indication of overall performance |
| All KPI's by Theme | • Second level of detail of agree Key Performance Indicators showing change in performance when compared to the previous month. |
| Trust Floodlight Scorecard | • Further detail on KPI's showing both monthly and year to date performance RAG to in-month and year-to-date targets with change when compared to the previous month |
| Scorecard 2017/18 | • Full detail of the Key Performance Indicators showing month-on-month performance |
| Targets 2017/18 | • Target and threshold set by the Trust for ease of reference. |
| Data Dictionary | • Link to the Trust Floodlight Data Dictionary which gives detail of how the Key Performance Indicator is calculated, any exceptions, where the information is sourced, system and so on. |

# Trust Floodlights Dashboard November 2017 (M08)

# Monthly Information, Performance and RAG Rating

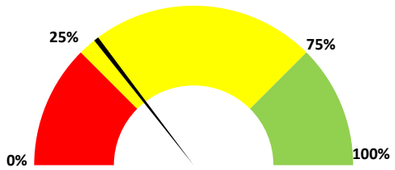
## 1 - Safe

Percentage of KPIs met


| KPI Performance | | | | | |
|---|---|---|---|---|---|
| Improved | | No Change | | Declined | |
| | 11 | | 2 | | 6 |

## 2- Effective

Percentage of KPIs met




| KPI Performance | | | | | |
|---|---|---|---|---|---|
| Improved | | No Change | | Declined | |
| | 5 | | 2 | | 0 |

## 3 - Responsive - Efficiency

Percentage of KPIs met


| KPI Performance | | | | | |
|---|---|---|---|---|---|
| Improved | | No Change | | Declined | |
| | 0 | | 1 | | 5 |

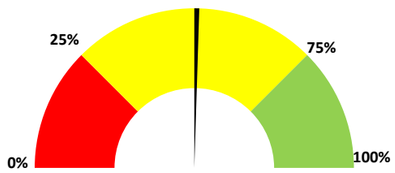
## 4 - Responsive - Key Targets

Percentage of KPIs met


| KPI Performance | | | | | |
|---|---|---|---|---|---|
| Improved | | No Change | | Declined | |
| | 5 | | 0 | | 10 |

## 5 - Caring

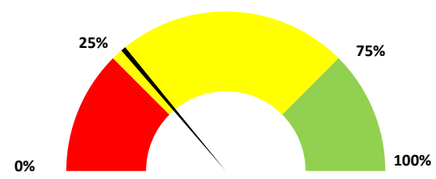
Percentage of KPIs met




| KPI Performance | | | | | |
|---|---|---|---|---|---|
| Improved | | No Change | | Declined | |
| | 2 | | 2 | | 2 |

## 6 - Well-Led

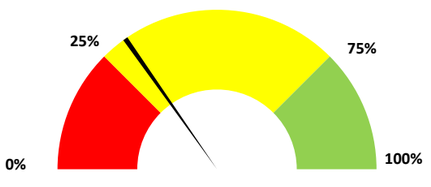
Percentage of KPIs met




| KPI Performance | | | | | |
|---|---|---|---|---|---|
| Improved | | No Change | | Declined | |
| | 5 | | 3 | | 3 |

## 7 - Financial Performance

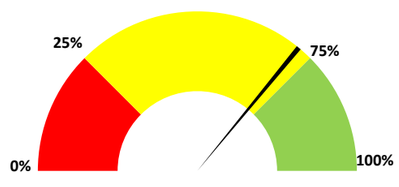
Percentage of KPIs met




| KPI Performance | | | | | |
|---|---|---|---|---|---|
| Improved | | No Change | | Declined | |
| | 1 | | 6 | | 3 |

## 8 - Sustainability

Percentage of KPIs met




| KPI Performance | | | | | |
|---|---|---|---|---|---|
| Improved | | No Change | | Declined | |
| | 4 | | 0 | | 3 |

81.74

# Trust Floodlights Dashboard November 2017 (M08)

# Monthly Information, Performance and RAG Rating

## SAFE

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 1.1 | Never Events 2 | – |
| 1.2 | Safety Thermometer Patients with Harm 182 | ▲ |
| 1.3 | Clostridium Difficile Cases 18 | ▲ |
| 1.4 | MRSA Post 48 hours Cases 1 | – |
| 1.5 | Hospital Acquired Pressure Ulcers Grade 2 or higher 0.11 | ▼ |
| 1.6 | Inpatient Falls 3.01 | ▼ |
| 1.7 | Ambulance Handovers > 30 mins 569 | ▼ |
| 1.8 | Fill Rate RNs (%) 94.6 | ▲ |
| 1.9 | Fill Rate RNs Unreg (%) 93.0 | ▲ |

## EFFECTIVE

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 2.1 | HSMR - 3 month lag 95.4 | ▲ |
| 2.2 | SHMI - 6 month lag 102.69 | – |
| 2.3 | SHMI (Palliative Care Adjustment) - 6 month lag 93.8 | – |

## ADMISSIONS

| | | |
|---|---|---|
| 2.4 | Medical & Surgical Patient Outliers 85 | ▲ |
| 2.5 | Number of Patients with LOS > 14 days 113 | ▲ |
| 2.6 | LOS - Non Elective 3.7 | ▲ |
| 2.7 | Readmissions 7.3 | ▲ |

## RESPONSIVE-EFFICIENCY

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 3.1 | New to Follow-Up Ratio 2.28 | ▼ |
| 3.2 | Overnight Bed Occupancy Rate 87.3 | – |
| 3.3 | Pre OP bed days (elective) | ▼ |
| 3.4 | Delayed Transfer of Care 45 | ▼ |
| 3.5 | Post Acute Transfer Delays | |
| 3.6 | Ward Discharges before Midday 14 | ▼ |
| 3.7 | Cancelled Ops - on Day 558 | ▼ |
| 3.8 | Number of Discharges from Discharge Lounge | |

## CARING

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 5.1 | Inpatient FFT % of patients would recommend 96.4 | ▼ |
| 5.2 | FFT Response Rate % 48.5 | ▲ |
| 5.3 | Friends & Family Recommend Place of Care 74.4 | |
| 5.4 | Complaints - % received telephone call 100.0 | – |
| 5.5 | % of Complaints concluded within agreed timeframe 64.8 | – |
| 5.6 | GP Enquiries Response Rate - Routine 67.0 | ▼ |
| 5.7 | GP Enquiries Response Rate - Urgent 80.0 | ▲ |

## WELL-LED

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 6.1 | Continuity of Services Risk Rating | |
| 6.2 | Risk register | – |
| 6.3 | CQC Outcomes | – |
| 6.4 | NHSI Governance Risk Rating 3 | – |
| 6.5 | Friends & Family Recommend Place of Work 52.4 | ▲ |
| 6.6 | Vacancy Rate % 7.7 | ▲ |
| 6.7 | Vacancy rate (Baseline) 7.5 | ▼ |
| 6.8 | Bank Staff Usage 9.07 | ▲ |
| 6.9 | Agency Staff Usage 5.74 | ▼ |
| 6.10 | Sickness % 3.43 | ▲ |
| 6.11 | Substantive Staff Turnover 13.0 | ▼ |
| 6.12 | Appraisal Rate 82.69 | ▲ |

## HEALTH & SAFETY

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 1.14 | RIDDOR Incidents 0.44 | ▲ |
| 1.15 | Musculosketal Injuries Reported 0.95 | ▲ |
| 1.16 | Physical Assault Incidents 1.42 | ▼ |
| 1.17 | Manager Referrals to OH for Stress 0.66 | ▲ |
| 1.18 | Staff Slips, Trips & Falls 0.86 | ▲ |
| 1.19 | Staff Sharps Injuries 2.26 | ▼ |

## SUSTAINABILITY

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 8.1 | GP referrals Received - 2WW 7499 | ▼ |
| 8.2 | GP referrals Received - non 2WW 67135 | ▲ |
| 8.3 | A&E Attendances 100253 | ▼ |
| 8.4 | Elective Spells (PBR) 31421 | ▲ |
| 8.5 | NonElective Spells 29849 | ▲ |
| 8.6 | OP Attendances/Procs (Total) 310038 | ▲ |
| 8.7 | Outpatient DNA Rate 8% | ▼ |
| 8.8 | Theatre Utilisation | |

## RESPONSIVE - KEY TARGETS

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 4.1 | A&E 4 hour Target 85.1 | ▲ |
| 4.2 | RTT Admitted 73.2 | ▲ |
| 4.3 | RTT Non Admitted 85.5 | ▼ |
| 4.4 | RTT - Open Pathways 85.7 | ▼ |
| 4.5 | RTT Patients Waiting > 18 weeks 4834 | ▼ |
| 4.6 ### | Diagnostic Waits < 6 weeks 98.7 | ▼ |
| 4.7 | Cancer 2week Ref to Appt 97.9 | ▼ |
| 4.8 | Cancer 31day : Diag 91.4 | ▼ |
| 4.9 | Cancer 62day : Urgent RTT inc ITP transfers 74.2 | ▲ |
| 4.10 | TIA: High Risk treatment within 24 hrs 67.8 | ▲ |
| 4.11 | TIA: Low Risk treatment within 7 days from 1st contact 86.2 | ▼ |
| 4.12 | 4 hrs direct to Stroke Unit 78.6 | ▼ |
| 4.13 | 90% of time on the Stroke Unit 87.3 | ▼ |
| 4.14 | 60 minutes to scan 92.7 | ▲ |
| 4.15 | Thrombolysed within 3 hrs 6.1 | ▼ |

## FINANCIAL PERFORMANCE

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 7.1 | Capital Servicing Capacity 4 | – |
| 7.2 | Liquidity Ratio (days) 4 | – |
| 7.3 | I&E Margin 4 | – |
| 7.4 | Distance from financial plan 4 | – |
| 7.5 | Agency spend variance from ceiling 1 | – |
| 7.6 | Overall Finance Metric 3 | – |
| 7.7 | Pay Spend 99.0 | ▼ |
| 7.8 | Capital Plan Trajectory 53 | ▼ |
| 7.9 | CIP Plan delivered 93 | ▼ |
| 7.10 | Cash Plan 142 | ▲ |

## RESPONSIVE

| ID | Indicator (YTD) | Month Change |
|---|---|---|
| 1.10 | Statutory Mandatory Training 88.58 | ▲ |
| 1.11 | Safeguarding Adults Training 89.8 | ▲ |
| 1.12 | Safeguarding Children Training 90.3 | ▲ |
| 1.13 | Competancy Coverage 65.1 | ▼ |

# Trust Floodlights Dashboard
# November 2017 (M08)

## Monthly Information, Performance and RAG Rating

### 1 - SAFE

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Perf. | Month Change | YTD Position |
|---|---|---|---|---|---|---|---|---|
| 1.1 | Never Events | 0 | | 2 | 0 | | | |
| 1.2 | Safety Thermometer Patients with Harm | 336 | 196 | 182 | 14 | | | |
| 1.3 | Clostridium Difficile Cases | 11 | 7 | 18 | 1 | | | |
| 1.4 | MRSA Post 48 hours Cases | 0 | | 1 | 0 | | | |
| 1.5 | Hospital Acquired Pressure Ulcers Grade 2 or higher | 0.16 | | 0.11 | 0.24 | | | |
| 1.6 | Inpatient Falls | 3.17 | | 3.01 | 3.71 | | | |
| 1.7 | Ambulance Handovers > 30 mins | 2604 | 1302 | 569 | 199 | | | |
| 1.8 | Fill Rate RNs (%) | 90 | | 94.6 | 96.3 | | | |
| 1.9 | Fill Rate RNs Unreg (%) | 90 | | 93.0 | 90.0 | | | |
| 1.10 | Statutory Mandatory Training | 90 | | 88.6 | 88.6 | | | |
| 1.11 | Safeguarding Adults Training | 90 | | 89.8 | 89.8 | | | |
| 1.12 | Safeguarding Children Training | 90 | | 90.3 | 90.3 | | | |
| 1.13 | Competancy Coverage | 85 | | 65.1 | 65.1 | | | |
| 1.14 | RIDDOR Incidents | 0.56 | | 0.44 | 0.34 | | | |
| 1.15 | Musculosketal Injuries Reported | 1.09 | | 0.95 | 0.51 | | | |
| 1.16 | Physical Assault Incidents | 1.13 | | 1.42 | 2.53 | | | |
| 1.17 | Manager Referrals to OH for Stress | 0.57 | | 0.66 | 0.67 | | | |
| 1.18 | Staff Slips, Trips & Falls | 1.18 | | 0.86 | 0.34 | | | |
| 1.19 | Staff Sharps Injuries | 2.00 | | 2.26 | 4.04 | | | |

### 2 - EFFECTIVE

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Perf. | Month Change | YTD Position |
|---|---|---|---|---|---|---|---|---|
| 2.1 | HSMR - 3 month lag | 94 | | 95.4 | | | | |
| 2.2 | SHMI - 6 month lag | 100 | | 102.7 | | | | |
| 2.3 | SHMI (Palliative Care Adjustment) - 6 month lag | 95 | | 93.8 | | | | |
| 2.4 | Medical & Surgical Patient Outliers | 50 | | 85 | | | | |
| 2.5 | Number of Patients with LOS > 14 days | 100 | | 113 | | | | |
| 2.6 | LOS - Non Elective | 3.5 | | 3.7 | 3.3 | | | |
| 2.7 | Readmissions | 7.75 | | 7.3 | 5.9 | | | |

### 3 - RESPONSIVE - EFFICIENCY

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Perf. | Month Change | YTD Position |
|---|---|---|---|---|---|---|---|---|
| 3.1 | New to Follow-Up Ratio | 2 | | 2.28 | 2.28 | | | |
| 3.2 | Overnight Bed Occupancy Rate | 85 | | 87.3 | 88.4 | | | |
| 3.3 | Pre OP bed days (elective) | 6 | | 3.3 | 4.5 | | | |
| 3.4 | Delayed Transfer of Care | 8 | | 45 | 6 | | | |
| 3.5 | Post Acute Transfer-Total Avg beds blocked | Method of Data Collection and Definition to be confirmed | | | | | | |
| 3.6 | Ward Discharges before Midday | 13 | | 14.2 | 14.5 | | | |
| 3.7 | Cancelled Ops - on Day | 504 | 252 | 558 | 78 | | | |
| 3.8 | Number of Discharges from Discharge Lounge | Method of Data Collection and Definition to be confirmed | | | | | | |

### 4 - RESPONSIVE - KEY TARGETS

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Perf. | Month Change | YTD Position |
|---|---|---|---|---|---|---|---|---|
| 4.1 | A&E 4 hour Target | 95 | | 85.1 | 81.7 | | | |
| 4.2 | RTT Admitted | 0 | | 73.2 | 70.9 | | | |
| 4.3 | RTT Non Admitted | 0 | | 85.5 | 82.5 | | | |
| 4.4 | RTT - Open Pathways | 92 | | 85.7 | 85.7 | | | |
| 4.5 | RTT Patients Waiting > 18 weeks | 1231 | | 4834 | 4834 | | | |
| 4.6 | Diagnostic Waits < 6 weeks | 99 | | 98.7 | 96.7 | | | |
| 4.7 | Cancer 2week Ref to Appt | 93 | | 97.9 | 97.1 | | | |
| 4.8 | Cancer 31day : Diag | 96 | | 91.4 | 91.6 | | | |
| 4.9 | Cancer 62day : Urgent RTT inc ITP transfers | 85 | | 74.2 | 79.1 | | | |
| 4.10 | TIA: High Risk treatment within 24 hrs | 62.5 | | 67.8 | 55.6 | | | |
| 4.11 | TIA: Low Risk treatment within 7 days from 1st contact | 85 | | 86.2 | 91.3 | | | |
| 4.12 | 4 hrs direct to Stroke Unit | 90 | | 78.6 | 71.2 | | | |
| 4.13 | 90% of time on the Stroke Unit | 80 | | 87.3 | 79.7 | | | |
| 4.14 | 60 minutes to scan | 90 | | 92.7 | 90.9 | | | |
| 4.15 | Thrombolysed within 3 hrs | 12 | | 6.1 | 1.6 | | | |

### 5 - CARING

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Perf. | Month Change | YTD Position |
|---|---|---|---|---|---|---|---|---|
| 5.1 | Inpatient FFT % of patients would recommend | 95 | | 96.4 | 96.4 | | | |
| 5.2 | FFT Response Rate % | 40 | | 48.5 | 48.5 | | | |
| 5.3 | Friends & Family Recommend Place of Care | 76 | | 74.4 | 74.4 | | | |
| 5.4 | Complaints - % received telephone call | 85 | | 100.0 | 100.0 | | | |
| 5.5 | % of Complaints concluded within agreed timeframe | 75 | | 64.8 | 64.0 | | | |
| 5.6 | GP Enquiries Response Rate - Routine | 80 | | 67.0 | 67.0 | | | |
| 5.7 | GP Enquiries Response Rate - Urgent | 95 | | 80.0 | 80.0 | | | |

### 6 - WELL-LED

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Perf. | Month Change | YTD Position |
|---|---|---|---|---|---|---|---|---|
| 6.1 | Continuity of Services Risk Rating | 0 | | 0 | 0 | | | |
| 6.2 | Risk register | 1 | | 3 | 0 | | | |
| 6.3 | CQC Outcomes | 1 | | 2 | 0 | | | |
| 6.4 | NHSI Governance Risk Rating | 4 | | 3 | 0 | | | |
| 6.5 | Friends & Family Recommend Place of Work | 61 | | 52.42 | 52.42 | | | |
| 6.6 | Vacancy Rate % | 10 | | 7.66 | 7.66 | | | |
| 6.7 | Vacancy rate (Baseline) | 5 | | 7.45 | 7.45 | | | |
| 6.8 | Bank Staff Usage | 9 | | 9.07 | 9.07 | | | |
| 6.9 | Agency Staff Usage | 7 | | 5.74 | 5.74 | | | |
| 6.10 | Sickness % | 3.5 | | 3.43 | 3.43 | | | |
| 6.11 | Substantive Staff Turnover | 11 | | 13.02 | 13.02 | | | |
| 6.12 | Appraisal Rate | 85 | | 82.69 | 82.69 | | | |

### 7 - FINANCIAL PERFORMANCE

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Perf. | Month Change | YTD Position |
|---|---|---|---|---|---|---|---|---|
| 7.1 | Capital Servicing Capacity | 1 | | 4.0 | 4.0 | | | |
| 7.2 | Liquidity Ratio (days) | 1 | | 4.0 | 4.0 | | | |
| 7.3 | I&E Margin | 1 | | 4.0 | 4.0 | | | |
| 7.4 | Distance from financial plan | 1 | | 4.0 | 4.0 | | | |
| 7.5 | Agency spend variance from ceiling | 1 | | 1.0 | 1.0 | | | |
| 7.6 | Overall Finance Metric | 1 | | 3.0 | 3.0 | | | |
| 7.7 | Pay Spend | 100 | | 99.0 | 105.0 | | | |
| 7.8 | Capital Plan Trajectory | 90 | | 53.0 | 22.0 | | | |
| 7.9 | CIP Plan delivered | 100 | | 93.0 | 26.0 | | | |
| 7.10 | Cash Plan | 90 | | 142.0 | 142.0 | | | |

### 8 - SUSTAINABILITY

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Perf. | Month Change | YTD Position |
|---|---|---|---|---|---|---|---|---|
| 8.1 | GP referrals Received - 2WW | | | 7,499 | 1,269 | | | |
| 8.2 | GP referrals Received - non 2WW | | | 67,135 | 9,969 | | | |
| 8.3 | A&E Attendances | 147,144 | 98,355 | 100,253 | 12,381 | | | |
| 8.4 | Elective Spells (PBR) | 37,060 | 24,849 | 31,421 | 4,229 | | | |
| 8.5 | NonElective Spells | 46,703 | 30,885 | 29,849 | 3,811 | | | |
| 8.6 | OP Attendances/Procs (Total) | 471,770 | 316,385 | 310,038 | 43,676 | | | |
| 8.7 | Outpatient DNA Rate | 8 | | 8.5% | 9.9% | | | |
| 8.8 | Theatre Utilisation | Method of Data Collection and Definition to be confirmed | | | | | | |

**Key: Monthly Change**

| | |
|---|---|
| ▲ | Improvement in monthly performance |
| ▬ | Monthly performance remains constant |
| ▼ | Deterioration in monthly performance |

**Trust Floodlight Scorecard -** The Scorecard shows a summary of performance against each KPI. The KPIs are displayed in the KPI Groups and contain the details of the Target set for 2017/18 and the Target YTD if this is different. The Actual YTD and Actual month performance are detailed separately even if the YTD is the same as the monthly figure. The RAG rating for the month is derived from comparing the monthly reported data against the monthly target. the Month change indicator reflects whether performance has improved, stayed the same or declined when compared to last month. the RAG for YTD is a comparison of the YTD performance for the KPI against the target levels.

# Trust Floodlights Dashboard November 2017 (M08)

# Monthly Information, Performance and RAG Rating

## 1 - SAFE

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Performance | Monthly Change | YTD Position | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1 | Never Events | 0 | | 2 | 0 | | | | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | | | | |
| 1.2 | Safety Thermometer Patients with Harm | 336 | 196 | 182 | 14 | | | | 20 | 24 | 34 | 20 | 18 | 21 | 31 | 14 | | | | |
| 1.3 | Clostridium Difficile Cases | 11 | 7 | 18 | 1 | | | | 2 | 2 | 3 | 4 | 2 | 2 | 2 | 1 | | | | |
| 1.4 | MRSA Post 48 hours Cases | 0 | | 1 | 0 | | | | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | |
| 1.5 | Hospital Acquired Pressure Ulcers Grade 2 or higher | 0.16 | | 0.11 | 0.24 | | | | 0.000 | 0.188 | 0.100 | 0.000 | 0.241 | data not available | | | | | | |
| 1.6 | Inpatient Falls | 3.17 | | 3.01 | 3.71 | | | | 2.66 | 2.40 | 3.10 | 3.22 | 3.71 | data not available | | | | | | |
| 1.7 | Ambulance Handovers > 30 mins | 2604 | 1302 | 569 | 199 | | | | 42 | 94 | 44 | 43 | 147 | 199 | DQ issue due to change to ARP | One month in arrears | | | | |
| 1.8 | Fill Rate RNs (%) | 90 | | 95 | 96 | | | | 96.1 | 96.3 | 95.7 | 94.1 | 93.6 | 92.1 | 92.6 | 96.3 | | | | |
| 1.9 | Fill Rate RNs Unreg (%) | 90 | | 93 | 90 | | | | 104.3 | 94.8 | 91.5 | 93.3 | 91.4 | 92.3 | 86.5 | 90.0 | | | | |
| 1.10 | Statutory Mandatory Training | 90 | | 88.6 | 88.6 | | | | 89.3 | 87.8 | 88.3 | 87.3 | 87.5 | 86.4 | 87.8 | 88.6 | | | | |
| 1.11 | Safeguarding Adults Training | 90 | | 89.8 | 89.8 | | | | 90.5 | 89.2 | 89.5 | 88.2 | 87.5 | 87.0 | 88.7 | 89.8 | | | | |
| 1.12 | Safeguarding Children Training | 90 | | 90.3 | 90.3 | | | | 91.1 | 89.6 | 90.0 | 88.8 | 88.0 | 87.2 | 89.1 | 90.3 | | | | |
| 1.13 | Competancy Coverage | 85 | | 65.1 | 65.1 | | | | 66.4 | 64.0 | 64.8 | 64.1 | 64.8 | 63.8 | 65.3 | 65.1 | | | | |
| 1.14 | RIDDOR Incidents | 0.56 | | 0.44 | 0.34 | | | | 0.36 | 0.54 | 0.90 | 0.36 | 0.36 | 0.17 | 0.51 | 0.34 | | | | |
| 1.15 | Musculosketal Injuries Reported | 1.09 | | 0.95 | 0.51 | | | | 0.91 | 0.54 | 1.45 | 0.54 | 1.44 | 0.85 | 1.36 | 0.51 | | | | |
| 1.16 | Physical Assault Incidents | 1.13 | | 1.42 | 2.53 | | | | 0.73 | 0.00 | 1.81 | 1.61 | 2.16 | 1.53 | 1.02 | 2.53 | | | | |
| 1.17 | Manager Referrals to OH for Stress | 0.57 | | 0.66 | 0.67 | | | | 1.09 | 0.36 | 0.18 | 0.54 | 1.26 | 0.51 | 0.68 | 0.67 | | | | |
| 1.18 | Staff Slips, Trips & Falls | 1.18 | | 0.86 | 0.34 | | | | 0.18 | 0.90 | 1.27 | 1.08 | 0.90 | 0.85 | 1.36 | 0.34 | | | | |
| 1.19 | Staff Sharps Injuries | 2.00 | | 2.26 | 4.04 | | | | 1.99 | 1.27 | 2.17 | 2.15 | 2.70 | 2.21 | 1.53 | 4.04 | | | | |

## 2 - EFFECTIVE

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Performance | Monthly Change | YTD Position | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.1 | HSMR - 3 month lag | 94.0 | | 95.4 | | | | | 95.0 | 95.0 | 94.4 | 93.7 | 92.5 | 95.0 | 95.6 | 95.4 | | | | |
| 2.2 | SHMI - 6 month lag | 100 | | 102.7 | | | | | n/a | n/a | 102.3 | n/a | n/a | 102.69 | 102.69 | 102.69 | | | | |
| 2.3 | SHMI (Palliative Care Adjustment) - 6 month lag | 95.0 | | 93.8 | | | | | n/a | n/a | 92.9 | n/a | n/a | 93.82 | 93.82 | 93.82 | | | | |
| 2.4 | Medical & Surgical Patient Outliers | 50 | | 85 | | | | | 91 | 91 | 88 | 108 | 85 | data not available | | | | | | |
| 2.5 | Number of Patients with LOS > 14 days | 100 | | 113 | | | | | 172 | 148 | 129 | 116 | 126 | 112 | 126 | 113 | | | | |
| 2.6 | LOS - Non Elective | 3.5 | | 3.7 | 3.3 | | | | 3.8 | 4.0 | 3.8 | 3.6 | 4.1 | 3.3 | 3.8 | 3.3 | | | | |
| 2.7 | Readmissions | 7.75 | | 7.26 | 5.9 | | | | 8.7 | 8.1 | 7.7 | 7.7 | 7.1 | 6.1 | 6.8 | 5.9 | | | | |

## 3 - RESPONSIVE - EFFICIENCY

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Performance | Monthly Change | YTD Position | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1 | New to Follow-Up Ratio | 2.0 | | 2.28 | 2.28 | | | | 2.19 | 2.18 | 2.16 | 2.15 | 2.14 | 2.21 | 2.25 | 2.28 | | | | |
| 3.2 | Overnight Bed Occupancy Rate | 85 | | 87.30 | 88.44 | | | | 84.8 | 87.5 | 88.4 | 88.4 | data not available | | | | | | | |
| 3.3 | Pre OP bed days (elective) | 6 | | 3.30 | 4.5 | | | | 4.1 | 2.1 | 2.5 | 4.5 | data not available | | | One month in arrears | | | | |
| 3.4 | Delayed Transfer of Care | 8 | | 45 | 6 | | | | 5 | 0 | 3 | 10 | 3 | 14 | 4 | 6 | | | | |
| 3.5 | Post Acute Transfer-Total Avg beds blocked | Method of Data Collection and Definition to be confirmed | | | | | | | | | | | | | | | | | | |
| 3.6 | Ward Discharges before Midday | 13.0 | | 14.2 | 14.5 | | | | 14.5 | 14.0 | 13.2 | 13.0 | 14.3 | 15.3 | 14.5 | 14.5 | | | | |
| 3.7 | Cancelled Ops - on Day | 504 | 252 | 558 | 78 | | | | 46 | 71 | 157 | 97 | 74 | 35 | 78 | data not available | | | | |
| 3.8 | Number of Discharges from Discharge Lounge | Method of Data Collection to be confirmed | | | | | | | | | | | | | | | | | | |

## 4 - RESPONSIVE - KEY TARGETS

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Performance | Monthly Change | YTD Position | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1 | A&E 4 hour Target | 95 | | 85.1 | 81.7 | | | | 89.23 | 84.07 | 87.53 | 87.77 | 85.06 | No Submission | 80.54 | 81.74 | | | | |
| 4.2 | RTT Admitted | 0 | | 73.2 | 70.9 | | | | 74.8 | 78.8 | 73.6 | 67.8 | 70.9 | No Submission | No Submission | No Submission | | | | |
| 4.3 | RTT Non Admitted | 0 | | 85.5 | 82.5 | | | | 87.2 | 86.0 | 88.6 | 83.1 | 82.5 | No Submission | No Submission | No Submission | | | | |
| 4.4 | RTT - Open Pathways | 92 | | 85.7 | 85.7 | | | | 92.2 | 90.5 | 88.9 | 87.4 | 85.7 | No Submission | No Submission | No Submission | | | | |
| 4.5 | RTT Patients Waiting > 18 weeks | 1231 | | 4834 | 4834 | | | | 2022 | 2436 | 3191 | 4140 | 4834 | No Submission | No Submission | No Submission | | | | |
| 4.6 | Diagnostic Waits < 6 weeks | 99 | | 98.7 | 96.7 | | | | 99.72 | 99.00 | 99.55 | 96.65 | No Submission | No Submission | No Submission | One month in arrears | | | | |
| 4.7 | Cancer 2week Ref to Appt | 93 | | 97.9 | 97.1 | | | | 98.6 | 98.3 | 98.2 | 98.7 | 97.6 | 97.6 | 97.3 | 97.1 | | | | |
| 4.8 | Cancer 31day : Diag | 96 | | 91.4 | 91.6 | | | | 93.0 | 86.3 | 90.3 | 90.7 | 93.8 | 92.1 | 93.9 | 91.6 | | | | |
| 4.9 | Cancer 62day : Urgent RTT inc ITP transfers | 85 | | 74.2 | 79.1 | | | | 73.5 | 77.9 | 71.0 | 66.4 | 74.9 | 72.2 | 78.8 | 79.1 | | | | |
| 4.10 | TIA: High Risk treatment within 24 hrs | 62.5 | | 67.8 | 55.6 | | | | 91.7 | 57.9 | 60.0 | 73.7 | 82.4 | 51.6 | 55.6 | data not available | | | | |
| 4.11 | TIA: Low Risk treatment within 7 days from 1st contact | 85 | | 86.2 | 91.3 | | | | 88.0 | 81.3 | 79.3 | 86.7 | 81.0 | 96.6 | 91.3 | data not available | | | | |
| 4.12 | 4 hrs direct to Stroke Unit | 90 | | 78.6 | 71.2 | | | | 82.5 | 76.6 | 77.6 | 78.6 | 71.7 | 71.6 | 71.2 | data not available | | | | |
| 4.13 | 90% of time on the Stroke Unit | 80 | | 87.3 | 79.7 | | | | 88.9 | 91.4 | 88.5 | 88.0 | 83.9 | 88.9 | 79.7 | data not available | | | | |
| 4.14 | 60 minutes to scan | 90 | | 92.7 | 90.9 | | | | 95.2 | 91.7 | 87.8 | 96.2 | 92.9 | 87.8 | 90.9 | data not available | | | | |
| 4.15 | Thrombolysed within 3 hrs | 12 | | 6.1 | 1.6 | | | | 10.8 | 6.6 | 9.0 | 14.3 | 6.3 | 4.8 | 1.6 | data not available | | | | |

## 5 - CARING

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Performance | Monthly Change | YTD Position | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.1 | Inpatient FFT % of patients would recommend | 95 | | 96.4 | 96.4 | | | | 96.6 | 97.0 | 97.2 | 97.5 | 97.5 | 97.4 | 97.0 | 96.4 | | | | |
| 5.2 | FFT Response Rate % | 40 | | 48.5 | 48.5 | | | | 52.84 | 51.45 | 44.06 | 49.11 | 44.16 | 39.61 | 46.01 | 48.5 | | | | |
| 5.3 | Friends & Family Recommend Place of Care | 76.0 | | 74.4 | 74.4 | | | | 75.0 | | | 74.4 | | | | | | | | |
| 5.4 | Complaints - % received telephone call | 85 | | 100.0 | 100 | | | | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | | | | |
| 5.5 | % of Complaints concluded within agreed timeframe | 75 | | 64.8 | 64 | | | | 68 | 74 | 67 | 53 | 51 | 77 | 64 | 64 | | | | |
| 5.6 | GP Enquiries Response Rate - Routine | 80 | | 67.0 | 67.0 | | | | 58 | 74 | 86 | 89 | 60 | 74 | 67 | One month in arrears | | | | |
| 5.7 | GP Enquiries Response Rate - Urgent | 95 | | 80.0 | 80.0 | | | | 100 | 80 | 100 | 100 | 18 | 75 | 80 | One month in arrears | | | | |

## 6 - WELL-LED

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Performance | Monthly Change | YTD Position | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.1 | Continuity of Services Risk Rating | | | | | | | | Metric removed in September 2016. | | | | | | | | | | | |
| 6.2 | Risk register | 1 | | 3 | | | | | 3 | 3 | 2 | 3 | 3 | 3 | 3 | 3 | | | | |
| 6.3 | CQC Outcomes | 1 | | 2 | | | | | 2 | 2 | 2 | 2 | 2 | 2 | 2 | data not available | | | | |
| 6.4 | NHSI Governance Risk Rating | 4 | | 3 | | | | | 3 | 3 | 3 | 3 | 3 | 3 | 3 | data not available | | | | |
| 6.5 | Friends & Family Recommend Place of Work | 61 | | 52.4 | 52.4 | | | | 46.60 | | | 52.42 | | | | | | | | |
| 6.6 | Vacancy Rate % | 10 | | 7.7 | 7.7 | | | | 12.13 | 9.66 | 10.71 | 8.56 | 8.92 | 8.90 | 8.53 | 7.66 | | | | |
| 6.7 | Vacancy rate (Baseline) | 5.0 | | 7.5 | 7.5 | | | | 5.48 | 9.02 | 9.07 | 8.09 | 8.43 | 8.38 | 8.40 | 7.45 | | | | |
| 6.8 | Bank Staff Usage | 9 | | 9.1 | 9.1 | | | | 5.9 | 8.23 | 5.9 | 10.22 | 8.61 | 9.39 | 8.57 | 9.07 | | | | |
| 6.9 | Agency Staff Usage | 7 | | 5.7 | 5.7 | | | | 5.4 | 5.7 | 5.34 | 5.68 | 4.93 | 4.3 | 3.79 | 5.74 | | | | |
| 6.10 | Sickness % | 3.5 | | 3.4 | 3.4 | | | | 3.64 | 3.62 | 3.58 | 3.46 | 3.41 | 3.39 | 3.44 | 3.43 | | | | |
| 6.11 | Substantive Staff Turnover | 11.0 | | 13.0 | 13.0 | | | | 13.2 | 13.2 | 13.2 | 12.8 | 12.6 | 12.7 | 12.7 | 13.0 | | | | |
| 6.12 | Appraisal Rate | 85 | | 82.7 | 82.7 | | | | 81.9 | 82.7 | 83.7 | 84.2 | 85.4 | 80.7 | 80.4 | 82.7 | | | | |

## 7 - FINANCIAL PERFORMANCE

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Performance | Monthly Change | YTD Position | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7.1 | Capital Servicing Capacity | 1 | | 4 | 4 | | | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | | | | |
| 7.2 | Liquidity Ratio (days) | 1 | | 4 | 4 | | | | 3 | 3 | 3 | 3 | 3 | 3 | 4 | 4 | | | | |
| 7.3 | I&E Margin | 1 | | 4 | 4 | | | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | | | | |
| 7.4 | Distance from financial plan | 1 | | 4 | 4 | | | | 2 | 4 | 1 | 2 | 4 | 3 | 4 | 4 | | | | |
| 7.5 | Agency spend variance from ceiling | 1 | | 1 | 1 | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | |
| 7.6 | Overall Finance Metric | 1 | | 3 | 3 | | | | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | | | | |
| 7.7 | Pay Spend | 100 | | 99 | 105.0 | | | | 97.0 | 98.0 | 96.0 | 100.0 | 100.0 | 101.0 | 101.0 | 105.0 | | | | |
| 7.8 | Capital Plan Trajectory | 90 | | 53 | 22.0 | | | | 13 | 108.2 | 149 | 84 | 89 | 44 | 59 | 22 | | | | |
| 7.9 | CIP Plan delivered | 100 | | 93 | 26.0 | | | | 122 | 107 | 120 | 102 | 61 | 66 | 81 | 26 | | | | |
| 7.10 | Cash Plan | 90 | | 142 | 142.0 | | | | 146.5 | 131.0 | 135.6 | 124.2 | 117.7 | 253.0 | 138.0 | 142.0 | | | | |

## 8 - SUSTAINABILITY

| ID | Indicator | Target 17-18 | Target YTD | Actual YTD | Actual Month | Month Performance | Monthly Change | YTD Position | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8.1 | GP referrals Received - 2WW | | | 7499 | 1269 | | | | 532 | 649 | 795 | 870 | 887 | 1175 | 1322 | 1269 | | | | |
| 8.2 | GP referrals Received - non 2WW | | | 67135 | 9969 | | | | 7671 | 8537 | 8432 | 8036 | 7776 | 7584 | 9130 | 9969 | | | | |
| 8.3 | A&E Attendances | 147,144 | 98,355 | 100253 | 12381 | | | | 12354 | 12706 | 12835 | 12849 | 11920 | 12384 | 12824 | 12381 | | | | |
| 8.4 | Elective Spells (PBR) | 37,060 | 24,849 | 31421 | 4229 | | | | 2947 | 3285 | 3347 | 3553 | 4946 | 5185 | 3929 | 4229 | | | | |
| 8.5 | NonElective Spells | 46,703 | 30,885 | 29849 | 3811 | | | | 3691 | 3747 | 3876 | 3780 | 3675 | 3543 | 3726 | 3811 | | | | |
| 8.6 | OP Attendances/Procs (Total) | 471,770 | 316,385 | 310038 | 43676 | | | | 33886 | 41380 | 42996 | 39670 | 31341 | 29003 | 48086 | 43676 | | | | |
| 8.7 | Outpatient DNA Rate | 8 | | 8% | 10% | | | | 7.2% | 8.1% | 7.5% | 7.2% | 8.2% | 10.2% | 9.5% | 9.9% | | | | |
| 8.8 | Theatre Utilisation | Method of Data Collection and Definition to be confirmed | | | | | | | | | | | | | | | | | | |

**Agenda Item: 9**

**TRUST BOARD PART 1 – 10 JANUARY 2018**

**FINANCE AND PERFORMANCE COMMITTEE – 20 DECEMBER 2017**
**EXECUTIVE SUMMARY REPORT**

| | |
|---|---|
| **PURPOSE** | To present to the Board Development meeting the report from the Finance and Performance Committee (FPC) meeting of 20 December 2017 |
| **PREVIOUSLY CONSIDERED BY** | N/A |
| **Objective(s) to which issue relates *** | ☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme.<br>☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations<br>☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.** |
| **Risk Issues**<br>(Quality, safety, financial, HR, legal issues, equality issues) | Key assurance committee reporting to the Board<br>Financial risks as outlined in paper |
| **Healthcare/National Policy**<br>(includes CQC/Monitor) | Potential risk to CQC outcomes<br>Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards |
| **CRR/Board Assurance Framework *** | ☐ **Corporate Risk Register** ☑ **BAF** |

**ACTION REQUIRED ***

| | | | |
|---|---|---|---|
| For approval | ☐ | For decision | ☐ |
| For discussion | ☑ | For information | ☐ |

| | |
|---|---|
| **DIRECTOR:** | CHAIRMAN OF FPC |
| **PRESENTED BY:** | CHAIRMAN OF FPC |
| **AUTHOR:** | CORPORATE GOVERNANCE OFFICER/COMPANY SECRETARY |
| **DATE:** | DECEMBER 2017 |

**We put our patients first We work as a team We value everybody We are open and honest We strive for excellence and continuous improvement**

**FINANCE AND PERFORMANCE COMMITTEE – 20 DECEMBER 2017**

**EXECUTIVE SUMMARY REPORT TO TRUST BOARD – 10 JANUARY 2018**

The following Non-Executive Directors were present:
Nick Swift (FPC Chair), Ellen Schroder (Trust Chair), Alison Bexfield, Jonathan Silver.

The following core attendees were present:
Jude Archer (Company Secretary), Martin Armstrong (Director of Finance), Kate Lancaster (Director of Strategy). The Deputy Director of Operations, Deputy Chief People Officer and Deputy Director of Nursing were also in attendance.

**DECISIONS MADE UNDER DELEGATED AUTHORITY:**

The Finance and Performance Committee (FPC) made no decisions on behalf of the Trust under the authority delegated to it within its terms of reference at this meeting.

**OTHER MATTERS CONSIDERED BY THE COMMITTEE:**

**Financial Recovery**
**Reports received:**

- Finance Report Month 8
- Financial Improvement Plan Update
- Report from Savings Programmes
- Model Hospital Framework
- Performance Management Framework (deferred to January 2018 meeting)

The FPC considered the Finance Report for month 8. The Trust reported a £1.3m deficit in month, bringing the year to date position to a £19.3m deficit. This represented a £1.1m variance against the original plan in month. Income had improved in month 8 and Outpatient activity in month had increased to the highest level of 17/18. Furthermore, day case activity throughput had been higher in November. In terms of SLA activity performance, it was noted that emergency activity was reduced whilst Length of Stay was increased on last year's position. There had been a significant increase in pay expenditure in month, partially due to some pay arrears as well as increasing costs to support operational management and Lorenzo. A significant element was therefore expected to be non-recurrent. Non-pay was higher than forecast levels, principally as a consequence of shortfalls in achieving the desired reductions in discretionary spend. There was some discussion around run rates and it was agreed that there would be a more detailed look at this data at a future meeting.

The Committee also received an update regarding the financial recovery plan. The slides of a presentation the Trust delivered to NHSI regarding the financial recovery plan were included with the meeting pack. The slides included a look at some of the forecast mitigating actions, details of possible unplanned pressures and opportunities and provided three outturn forecast ranges (a base, downside and upside forecast). The Trust remains determined to deliver as close to the control totals as possible and had agreed an approach (to be confirmed in writing) to reforecasting with NHSI for the January review.

The Committee also received details of some of the Trust's major improvement programmes and specifically discussed the work taking place regarding Outpatients. It was reported that some of the work had been hampered by challenges that had arisen post Lorenzo, but work was progressing in other areas, such as with regard to efforts to reduce the number of 'did not attend' appointments. It was agreed to look at the job planning and theatres productivity schemes at the next meeting. The Committee also looked at the NHSI Model Hospital portal and benchmarking. The Committee discussed the potential savings that the portal suggested the Trust could achieve and requested further detail as part of the planning process. The committee also requested the agenda item on performance management be deferred to the January meeting.

**Performance**

**Reports received:**

- Performance Report Month 8
- ED Performance and Patient Flow – Project Plan Update

The Deputy Director of Operations provided an update regarding performance. Following the migration to Lorenzo, the Trust remained unable to report November's performance against the RTT standard. Cancer performance for October was 79.1% but it was considered that the 62day backlog position meant that the Trust could not achieve the original target. The trajectory had been reforecast based on an underlying action plan to achieve the target by March 2018. The Board would be required to approve the new trajectory. The Committee requested a more detailed look at the underlying plan at the next meeting.

The ED 4 hour performance was 81.79%, but reporting remained a challenge post Lorenzo and it was considered that breach volumes were potentially being overstated whilst the operational teams continue to embed new practices and behaviours. Work was taking place to review breach numbers manually over a 24 hour period to establish the accuracy of the reporting.

The Committee also received an update regarding the ED performance and patient flow project plan. The plan was mapped to a Gantt chart. It was reported that the 7 initial work streams were being refined into 3 key work streams. Part of the work for the project going forward would be to review patient pathways as a whole and explore options for providing an ambulatory emergency care service in ED. The committee thanked Claire Badenhorst for her work in setting up this programme and requested monthly updates.

**Lorenzo Stabilisation / Optimisation**

**Reports received:**

- Lorenzo Stabilisation
- Data Quality Update
- Clinical Coding Update
- Floodlight Scorecard Month 8

Scott Sommerville, the Trust's new stabilisation director, attended this section of the meeting to provide his initial thoughts on the issues and way forward. The Trust had asked NHS Digital to review the Trust's draft stabilisation plan. NHS Digital were positive regarding the Trust's actions to date and considered that the stabilisation plan could be successfully executed if focus was given to the three core priorities articulated in the report. For the next meeting, the FPC requested the plan be developed further for the January meeting to include a process overview; a properly sequenced, resourced and costed plan for stabilisation then optimisation; and recommended governance, to include change control.

The Committee also discussed the Performance Report which could be usefully updated through the planning process with the aim of introducing an integrated dashboard from April 2018.

**Strategy / Workforce**

**Reports received:**

- Workforce Report Month 8
- Apprenticeship Levy – Update on Utilisation
- Sustainability Update

The FPC received the month 8 Workforce Report. The vacancy rate at the end of November 2017 was 8.2%, a positive improvement from the start of the year (11.9%). The monthly agency ceiling target was achieved in month 8 with agency spend under by £104k. It was expected that the Trust would remain under the target each month until the end of the financial year. In November the turn-over rate increased slightly compared with prior months to 13.02% and put the Trust 1.02% away from the end of year target. Plans were being developed as part of the NHSI led retention initiative to improve turnover. It was also noted that the new Leadership, Management and Coaching Development Pathway (LMDCP) launched later in the month.

It was reported that the staff survey had closed earlier in December and detail of the results would be provided in the next report in January. Workshops would be held in January to consider some of the issues that had been identified. The importance of properly addressing issues raised in the survey was noted as part of broader cultural change required to support plans and strategy over the short and medium term.

The Committee noted the Apprenticeship Levy Update and Sustainability Update papers.

**Nick Swift**
**Committee Chair**

20 December 2017

**Agenda Item: 9.1**

# TRUST BOARD PART 1 – 10 JANUARY 2018

## FINANCE REPORT MONTH 8

| | |
|---|---|
| **PURPOSE** | To set out the Trust's financial position for Month 8. |
| **PREVIOUSLY CONSIDERED BY** | FPC |
| **Objective(s) to which issue relates *** | ☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme.<br>☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations<br>☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.** |
| **Risk Issues**<br><br>(Quality, safety, financial, HR, legal issues, equality issues) | Financial risks are described in the main report |
| **Healthcare/ National Policy**<br><br>(includes CQC/Monitor) | |
| **CRR/Board Assurance Framework *** | ☐ **Corporate Risk Register** ☑ **BAF** |

**ACTION REQUIRED ***

| | | | |
|---|---|---|---|
| For approval | ☐ | For decision | ☐ |
| For discussion | ☑ | For information | ☐ |

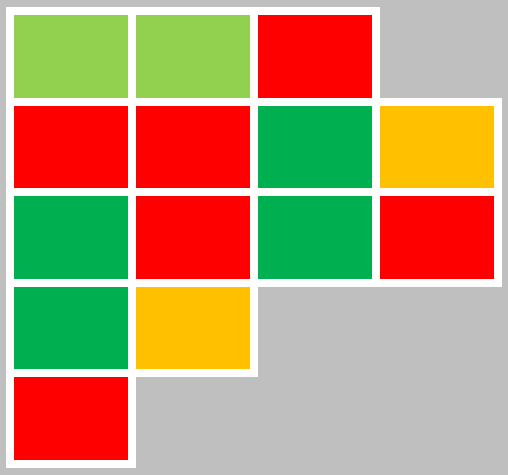
| | |
|---|---|
| **DIRECTOR:** | Director of Finance |
| **PRESENTED BY:** | Director of Finance |
| **AUTHOR:** | Director of Finance |
| **DATE:** | January 2018 |

**We put our patients first We work as a team We value everybody We are open and honest**
**We strive for excellence and continuous improvement**

***** tick applicable box

East and North Hertfordshire NHS
NHS Trust

# Finance Report



## Month 8 - 2017/18

# Mth 8 Finance Report - Commentary

## KEY BOARD MESSAGES

- Income achievement continues to fall short of plan, but is in line with forecast for November
- CIP delivery is falling short of target
- Pay spend was materially adverse to forecast although a significant element of this is expected to be non-recurrent.
- Non-pay was higher than forecast levels principally as a consequence of shortfalls in achieving desired reductions in discretionary spend.

## SUMMARY

- The Trust reported a £1.3m deficit in month, bringing the year to date position to a £19.3m deficit. This represents a £1.1m adverse variance against the original plan in month, after removing the impact of STF funding.
- As a result of the adverse year to date variance, the Trust has assumed that it will not be eligible for STF funding in Q2 and Q3.
- A year end forecast, and monthly phasing, was presented within the last finance digest. An update to this forecast, including the month 8 results, will be presented separately.
- There was a significant increase in pay expenditure in month, partially due to some pay arrears as well as increasing costs to support Operational management and Lorenzo.
- CIP performance during November was poor compared with plan, but was broadly in line with forecast.

## EXCEPTIONAL ITEMS

- The normalised I & E run rate analysis within the report presents exceptional items.
- The M8 reported position assumes that the Trust will not receive any STF funding for Q2 or Q3. The Trust is only expecting to receive £1.3m, relating to Q1.
- The SLA income in month has had a positive benefit from the refresh of M7 income of £132k.
- There has been £228k of pay arrears, particularly related to temporary staffing, incurred in the month.
- There has been an adverse impact on the pay expenditure owing to £73k of backdated arrears to reflect the 2nd tranche of Consultant job plans. The ongoing impact also reflects a cost pressure to the current forecast. This exercise had been expected to realise savings for the Trust.
- There is a tranche of costs related to the consultancy expenses related to the Financial Recovery Plan and the Lorenzo implementatio that have been incurred during the YTD.

## SLA ACTIVITY & INCOME PERFORMANCE

- The Trust continues to report significant under performance against its SLA plan. This adverse variance now totals £9.0m for YTD M8. The material drivers of the shortfall are detailed below:

| Issue | Impact |
|---|---|
| Reduced Elective Activity - DC & EL | £1.9m |
| Non-elective - reduced volume & casemix | £3.4m |
| Outpatient activity below plan | £2.2m |
| Reduced Maternity Antenatal bookings | £1.0m |
| Cyber Attack - reduced activity | £0.7m |

- Non Elective inpatient activity saw an increase in Mth 8 but is still far below previous monthly figures. Non Elective is now just under 863 spells below plan, equating to £3.4m in financial underperformance. The overwhelming majority of the underperformance is volume as opposed to price driven.

## Mth 8 Finance Report - Commentary

- In November the Trust has seen some impact from the extensive activity recovery plans that are presently being delivered. In Mth 8 Outpatient activity increased to the highest level of 17/18.
- Furthermore, day case activity throughput was higher in November. Elective activity saw a modest increase on the preceding month, although is still well below target.
- Work is continuing to reverse the observed decline in depth of coding and also the timely and accurate capture of all activity undertaken within the Trust.
- The volume and income associated with WLI activity has reduced materially compared with prior years. However, separate analysis within the report demonstrates that the impact on the Trust financial bottom line is minimal given the small contribution generated by this activity i.e. reduced income is offset by reduced cost.

### DIVISIONAL FINANCIAL PERFORMANCE

- Medicine, Surgery and W&C divisions all report significant YTD adverse variances against budgets. In all cases this is Largely driven by under performance on SLA income/activity.
- The Clinical Support Division has a £0.9m adverse variance to budget in M7 (£1.8m ytd). Of this £0.65m relates to lower SLA income than planned for diagnostic imaging and PBR drugs.

### YEAR ON YEAR COMPARISON

- Income levels are now showing a £2.3m increase compared to the same period in 2016/17. Of this increase, £1.6m relates to an increase in training and education income, which is offset by costs. SLA income is broadly in line with the same period in 2016/17.
- Elective activity is 10% down on previous year, although this is partially offset by an increase in day-case activity. Whilst Non elective activity is down 3%, year on year. This is atypical compared with other local providers and the national picture.
- Both Outpatient first and follow up attendances, as well as outpatient procedures, are significantly below volumes delivered last year.
- Pay expenditure in 17/18 is lower than at the same period last year. This is despite the impact of the current year pay award and the transfer of Pathology staff (£2.7m ytd).

### PAY-BILL METRICS

- The Trust reported an over spend of £1.1m against its pay budget in November. Pay budgets are underspent by £1.0m in the year to date.
- The pay expenditure was £0.7m higher than in October, of which £0.5m was agency.
- The agency expenditure increase included £228k of expenditure relating to prior months, particularly for October. There will be an increased focus at the weekly Grip & Control meetings to ensure that operational teams both book and authorise any shifts via NHSP or direct, on a timely basis.
- As expected, there was a second tranche (£73k) of backdated pay arrears in month relating to Consultant job plan changes. This is in addition to the £150k paid in October, as well as an ongoing monthly cost.
- During November the Trust also incurred significant additional costs associated with Lorenzo related admin staff pressures and also the impact of steps to support operational management capacity. These total c. £250k.
- Agency expenditure is £8.6m year to date, which is below the NHSI agency ceiling target.
- The Trust continues to make modest but consistent progress in expanding its substantive work force numbers, particularly for nursing and has seen a number of overseas nurses commence in the month. These nurses are working as supernumerary for an initial period.

### CIP PERFORMANCE METRICS

- The Trust has delivered £12.1m savings year to date against a plan of £12.8m. There is an adverse variance year to date of £0.7m.
- This assessment includes the impact of below pay budget expenditure that has resulted from better than planned impacts from Grip and Control arrangements
- In month CIP delivery was £1.8m, however, the CIP delivery was £579k adverse to plan, due to the step up in planned delivery.
- The theatre and outpatient efficiency schemes, in particular, are not delivering to the scale anticipated, although there have been some improvements seen in October and November, for both outpatients and theatres. There continues to be weekly information assurance meeting and CIP meetings, in an effort to secure savings anticipated in future months.

## Mth 8 Finance Report - Commentary

### CASH

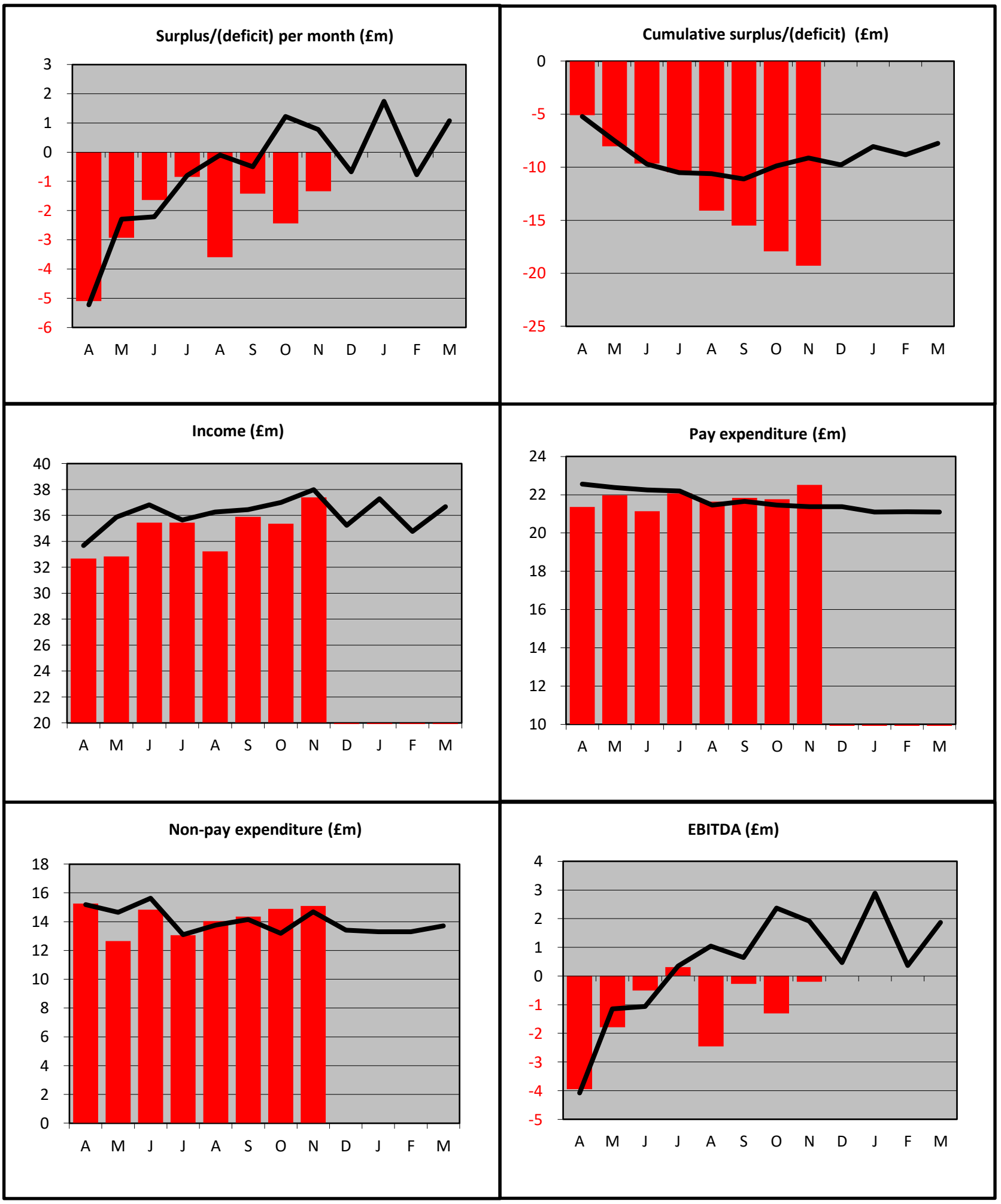
- Non-achievement of planned levels of income and expenditure, including non-receipt of Strategic Transformation Fund monies will lead to a cash shortfall, which will need to be actively managed. The Trust has been in discussion with NHSI regarding access to cash support, and this was summarised in a paper to the Board in December. There is a high focus on both debtor and creditor management.
- Every effort will be made to reduce the risk of the deferral of goods and services.
- A separate paper has been provided to the FPC outlining cash pressures and actions required.

### CAPITAL AND BALANCE SHEET

- Although the Trust is facing significant cash pressures, it is still forecasting to be able to deliver its capital programme and commitments have been entered into on this basis. However, this will require active management of its working capital position.

# Summary Financial Performance

| | Annual Plan £m | Budget Mth £m | Actual Mth £m | Variance mth £m | Budget YTD £m | Actual YTD £m | Variance YTD £m |
|---|---|---|---|---|---|---|---|
| Income | **423.5** | 37.0 | 37.4 | **0.4** | 284.1 | 277.0 | **-7.1** |
| Pay | **-260.0** | -21.4 | -22.5 | **-1.1** | -175.3 | -174.3 | **1.0** |
| Non Pay | **-168.1** | -14.7 | -15.1 | **-0.4** | -114.4 | -114.2 | **0.2** |
| **EBITDA** | **-4.6** | **0.9** | **-0.2** | **-1.1** | **-5.6** | **-11.5** | **-5.9** |
| Financing Costs | **-13.4** | -1.1 | -1.1 | **0.0** | -9.1 | -9.1 | **0.0** |
| STF Monies | **10.2** | 1.0 | 0.0 | **-1.0** | 5.6 | 1.3 | **-4.3** |
| **Retained Deficit** | **-7.7** | **0.8** | **-1.3** | **-2.1** | **-9.1** | **-19.3** | **-10.2** |



# Income & Expenditure Account Overview

| | Annual Plan £000's | Actual £000's | | | | | | | | Monthly Plan £000's | Monthly Actual £000's | Monthly Var £000's | Plan to Date £000's | Actual to Date £000's | Var to Date £000's |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | | | | | | |
| Catering Income | 1,153 | 90 | 93 | 81 | 80 | 32 | 122 | 103 | 116 | 96 | 116 | 20 | 767 | 719 | -49 |
| NHS Non Patient Care Income | 1,931 | 323 | 144 | 141 | 207 | 130 | 201 | 145 | 258 | 146 | 258 | 112 | 1,345 | 1,550 | 205 |
| NHS Patient Care Income | 383,935 | 28,969 | 29,160 | 31,494 | 31,586 | 30,781 | 31,896 | 32,051 | 33,125 | 33,428 | 33,125 | -303 | 257,644 | 249,061 | -8,582 |
| Other Income Category C | 20,793 | 1,414 | 1,412 | 1,477 | 1,474 | 312 | 1,150 | 899 | 1,621 | 2,084 | 1,621 | -464 | 12,788 | 9,758 | -3,030 |
| Other Patient Care Income | 72 | 4 | 4 | 4 | 4 | 5 | 4 | 5 | 3 | 6 | 3 | -2 | 43 | 33 | -10 |
| Private Patients | 5,172 | 308 | 356 | 466 | 348 | 328 | 326 | 359 | 481 | 488 | 481 | -7 | 3,430 | 2,972 | -458 |
| R&D Income | 5,081 | 468 | 399 | 448 | 416 | 395 | 447 | 441 | 481 | 424 | 481 | 57 | 3,387 | 3,494 | 107 |
| RTA Income | 1,173 | -39 | 144 | 205 | 58 | 91 | 111 | 109 | 89 | 98 | 89 | -9 | 782 | 769 | -13 |
| Training & Education Income | 14,408 | 1,135 | 1,136 | 1,135 | 1,269 | 1,150 | 1,642 | 1,258 | 1,228 | 1,214 | 1,228 | 14 | 9,550 | 9,954 | 404 |
| **Income Total** | **433,718** | **32,672** | **32,849** | **35,452** | **35,444** | **33,224** | **35,899** | **35,369** | **37,402** | **37,984** | **37,402** | **-582** | **289,735** | **278,310** | **-11,425** |
| Admin Staff | -36,065 | -2,919 | -3,021 | -2,701 | -2,990 | -2,986 | -2,994 | -3,052 | -3,213 | -2,991 | -3,213 | -222 | -24,111 | -23,878 | 233 |
| Ambulance Service Staff | 10 | 16 | -2 | -2 | -2 | -2 | -2 | -2 | -2 | 1 | -2 | -3 | 6 | 3 | -4 |
| Ancillary Staff | -7,611 | -669 | -697 | -668 | -701 | -693 | -655 | -651 | -666 | -625 | -666 | -41 | -5,110 | -5,400 | -291 |
| Clinical Support Staff | -15,585 | -1,387 | -1,349 | -1,306 | -1,392 | -1,424 | -1,349 | -1,343 | -1,368 | -1,236 | -1,368 | -132 | -10,408 | -10,918 | -510 |
| Maintenance & Works Staff | -979 | -70 | -68 | -68 | -66 | -69 | -69 | -69 | -73 | -81 | -73 | 8 | -655 | -552 | 102 |
| Medical Staff | -82,446 | -6,889 | -7,013 | -6,799 | -7,008 | -6,941 | -7,126 | -7,109 | -7,261 | -6,832 | -7,261 | -429 | -55,239 | -56,145 | -907 |
| Nursing Staff | -81,158 | -6,550 | -6,672 | -6,498 | -6,692 | -6,568 | -6,563 | -6,508 | -6,728 | -6,809 | -6,728 | 81 | -54,244 | -52,779 | 1,466 |
| Other Staff | 43 | -17 | -6 | -1 | -20 | -13 | -6 | -14 | 12 | 4 | 12 | 8 | 29 | -65 | -93 |
| Pay Reserves | 2,111 | -197 | -106 | -24 | -98 | 109 | -82 | -51 | -83 | 413 | -83 | -497 | -112 | -532 | -421 |
| Scientific Theraputic & Technical | -32,983 | -2,283 | -2,659 | -2,665 | -2,717 | -2,650 | -2,576 | -2,539 | -2,683 | -2,773 | -2,683 | 90 | -21,917 | -20,772 | 1,145 |
| Senior Managers | -5,269 | -387 | -370 | -394 | -379 | -388 | -400 | -427 | -437 | -439 | -437 | 2 | -3,512 | -3,183 | 329 |
| Social Care Staff | -84 | -10 | -9 | -10 | -11 | -10 | -10 | -6 | -7 | -6 | -7 | -0 | -58 | -72 | -14 |
| **Pay Total** | **-260,014** | **-21,363** | **-21,973** | **-21,135** | **-22,077** | **-21,634** | **-21,830** | **-21,770** | **-22,511** | **-21,376** | **-22,511** | **-1,135** | **-175,330** | **-174,293** | **1,037** |
| Admin Expenses | -26,594 | -2,720 | -3,048 | -2,278 | -2,131 | -2,105 | -2,027 | -2,636 | -2,059 | -2,032 | -2,059 | -26 | -18,701 | -19,004 | -303 |
| Catering | -1,805 | -169 | -154 | -166 | -155 | -189 | -174 | -148 | -175 | -149 | -175 | -26 | -1,210 | -1,329 | -119 |
| Commissioning Expenditure | -182 | -5 | -7 | 1 | -10 | -5 | -44 | -10 | -19 | -71 | -19 | 52 | -115 | -100 | 15 |
| Drugs, Blood & Lab Consumables | -45,649 | -3,773 | -3,558 | -4,197 | -3,215 | -3,984 | -4,008 | -3,695 | -4,992 | -4,912 | -4,992 | -80 | -30,706 | -31,421 | -714 |
| Energy & Utilities | -2,287 | -224 | -196 | -127 | -189 | -186 | -93 | -175 | -215 | -187 | -215 | -28 | -1,539 | -1,405 | 135 |
| IM&T Costs | -2,911 | -248 | -219 | -303 | -240 | -228 | -282 | -236 | -187 | -257 | -187 | 70 | -2,078 | -1,943 | 135 |
| Internal Recharges | -30 | -0 | 0 | 0 | 0 | -0 | 0 | 0 | 0 | -2 | 0 | 2 | -20 | 0 | 20 |
| Medical Consumables | -17,846 | -1,341 | -1,502 | -1,448 | -1,488 | -1,494 | -1,482 | -1,540 | -1,541 | -1,525 | -1,541 | -17 | -11,905 | -11,836 | 69 |
| Non Pay Reserves | -3,545 | -65 | 888 | -293 | 17 | -193 | -376 | -836 | 1,371 | 1,344 | 1,371 | 27 | -1,843 | 515 | 2,358 |
| P or L - Sale of Fixed Assets | 700 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Property Costs | -5,165 | -429 | -421 | -418 | -472 | -415 | -499 | -430 | -473 | -433 | -473 | -41 | -3,463 | -3,557 | -95 |
| Purch & Maint of Equip - Medical | -16,663 | -1,307 | -1,339 | -1,380 | -1,364 | -1,381 | -1,353 | -1,337 | -1,597 | -1,731 | -1,597 | 133 | -11,250 | -11,058 | 192 |
| Purch & Maint of Equip - Non Medical | -1,677 | -147 | -125 | -298 | 26 | -69 | -88 | -136 | -160 | -139 | -160 | -21 | -1,123 | -997 | 126 |
| Purchase of Healthcare - Non NHS | -6,981 | -553 | -622 | -561 | -559 | -607 | -588 | -601 | -651 | -585 | -651 | -66 | -4,711 | -4,741 | -30 |
| Recharges In / Out | -1,373 | -117 | -154 | -138 | -174 | -135 | -144 | -193 | -146 | -150 | -146 | 4 | -1,007 | -1,199 | -192 |
| Services from Other NHS bodies | -20,401 | -2,769 | -840 | -1,574 | -1,468 | -1,422 | -1,498 | -1,305 | -2,997 | -2,652 | -2,997 | -345 | -13,754 | -13,874 | -120 |
| Site Support Services | -14,621 | -1,342 | -1,268 | -1,582 | -1,566 | -1,584 | -1,650 | -1,575 | -1,174 | -1,124 | -1,174 | -50 | -10,249 | -11,742 | -1,493 |
| Suspense Accounts | 0 | -1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Training Costs | -1,065 | -53 | -97 | -65 | -67 | -49 | -41 | -46 | -82 | -89 | -82 | 7 | -714 | -502 | 212 |
| **Non Pay Total** | **-168,095** | **-15,260** | **-12,661** | **-14,826** | **-13,058** | **-14,045** | **-14,348** | **-14,899** | **-15,096** | **-14,692** | **-15,096** | **-404** | **-114,390** | **-114,193** | **197** |
| Depreciation | -7,773 | -648 | -648 | -538 | -607 | -607 | -607 | -604 | -604 | -648 | -604 | 44 | -5,182 | -4,862 | 319 |
| Dividend | -1,662 | -168 | -168 | -168 | -168 | -168 | -168 | -168 | -168 | -168 | -168 | 0 | -1,341 | -1,341 | 0 |
| Interest Payable | -3,944 | -329 | -329 | -421 | -378 | -365 | -364 | -364 | -364 | -329 | -364 | -35 | -2,629 | -2,913 | -283 |
| Interest Receivable | 25 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 0 | 2 | 0 | -2 | 17 | 15 | -1 |
| **Financing Total** | **-13,354** | **-1,141** | **-1,142** | **-1,124** | **-1,150** | **-1,138** | **-1,137** | **-1,134** | **-1,136** | **-1,142** | **-1,136** | **6** | **-9,136** | **-9,101** | **35** |
| **Grand Total** | **-7,745** | **-5,093** | **-2,927** | **-1,633** | **-841** | **-3,593** | **-1,415** | **-2,434** | **-1,340** | **775** | **-1,340** | **-2,115** | **-9,121** | **-19,277** | **-10,156** |

East and North Hertfordshire NHS
NHS Trust

**Agenda Item: 9.2**

# TRUST BOARD PART 1 – JANUARY 2018
## PERFORMANCE REPORT MONTH 8

| | |
|---|---|
| **PURPOSE** | To update the Finance and Performance Committee on:<br>• Progress against Monitor Compliance Framework, DH Operating Standards, Contractual standards and local performance measures.<br>• Exception reports outlining action take and next steps are provided for indicators that are either 'red' in month, or at risk year to date. |
| **PREVIOUSLY CONSIDERED BY** | **FPC** |
| **Objective(s) to which issue relates *** | ☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme.<br>☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations<br>☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.** |
| **Risk Issues**<br>(Quality, safety, financial, HR, legal issues, equality issues) | Delivery of financial, operational performance and strategic objectives, FT application, CQC ratings, Governance risk Rating, Contractual performance. |
| **Healthcare/ National Policy**<br>(includes CQC/Monitor) | Achievement of Monitor, CQC, DH Operating Framework and other national and local performance standards. |
| **CRR/Board Assurance Framework *** | ☑ **Corporate Risk Register** ☑ **BAF** |

**ACTION REQUIRED ***

| | | | |
|---|---|---|---|
| For approval | ☐ | For decision | ☐ |
| For discussion | ☑ | For information | ☐ |

| | |
|---|---|
| **DIRECTOR:** | CHIEF OPERATING OFFICER |
| **PRESENTED BY:** | CHIEF OPERATING OFFICER |
| **AUTHOR:** | DIRECTOR OPERATIONAL PERFORMANCE |
| **DATE:** | DECEMBER 2017 |

**We put our patients first We work as a team We value everybody We are open and honest**
**We strive for excellence and continuous improvement**

***** tick applicable box

# PERFORMANCE REPORT

## 1. Key Headlines

The following table shows the trust's summary position against the 3 key KPIs that had been agreed with NHSI for 2017/18. Achievement of the ED standard is linked to the STF funding.

November 18 (STF) KPI Performance

**RTT - 2017/18 Trajectory**

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
|---|---|---|---|---|---|---|---|---|
| | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% | 92.00% |
| | 92.16% | 90.49% | 88.93% | 87.43% | 85.68% | - | - | - |

**ED - 2017/18 Trajectory**

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
|---|---|---|---|---|---|---|---|---|
| | 84.50% | 84.60% | 85.64% | 87.07% | 88.62% | 90.19% | 90.97% | 91.82% |
| | 89.24% | 84.07% | 87.53% | 85.24% | 85.06% | - | 82.26% | 81.74% |

**Cancer - 2017/18 Trajectory**

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 |
|---|---|---|---|---|---|---|---|---|
| | 70.80% | 79.56% | 85.04% | 84.96% | 85.19% | 85.00% | 85.11% | 85.23% |
| Pre Breach Sharing | 75.00% | 70.60% | 64.50% | 71.20% | 69.30% | 73.20% | 76.80% | |
| Post Breach Sharing | 77.90% | 71.00% | 66.40% | 74.96% | 72.20% | 78.80% | 79.10% | |

**Comments**

Following Lorenzo 'go live' the trust is unable to report November's performance

November's performance is not finalise until 8th Janurary

## 2. RTT – 18 weeks

Following the migration to Lorenzo the trust is unable to report November's performance against the RTT standard.

### 2.1 RTT Reporting

Following discussions with NHS Elect and further assessment of our current position the trust is forecasting being able to submit February's RTT performance data before the closing date in March.

Significant validation of pathways continues using a team of contract validators, it is anticipated that team will be required until at least March 2018.

### 2.2 RTT PTL Reports

At the time of writing the trust is not in possession of a complete suite of PTL reports; the open pathway PTL has been partially developed although its operational application is limited because of the significant data quality issues, this links to the ongoing validation. An outpatient PTL is in the technical and user testing stages; however the operational teams are using a version of the report to support the booking of patient appointments.

The follow up, planned and diagnostic PTL's are still being developed, the process of development has highlighted a number of issues that were previously not known at the time of last month's report. These issues centre predominantly around the use of 'access plans' and fall into two broadly defined categories relating to the way the data was migrated / mapped across and also to user behaviour post 'go live'.

Operations and Information are working collaboratively to understand the full impact / issues and consequences. This is ongoing work and the executive will be kept updated via the three times per week 0800 huddles and DEC/ Exec's.

Since 'go live' the weekly trust Access Meeting has not been able to assess or provide an overview of waiting list management as the reports are not currently available, therefore at this time we are unable to provide assurance to the board that patients are being tracked appropriately and are being booked in order.

## 3. 4 Hour Performance

November's performance against the 4 hour standard was 81.796%, see table below.

| Month | % Performance | Quarterly Performance |
|---|---|---|
| **Nov-16** | 89.43% | |
| **Dec-16** | 85.41% | Q3 87.63% |
| **Jan-17** | 83.41% | |
| **Feb-17** | 83.82% | |
| **Mar-17** | 83.90% | Q4 84.22% |
| **Apr-17** | 89.24% | |
| **May-17** | 84.82% | |
| **Jun-17** | 87.53% | Q1 83.72% |
| **Jul-17** | 85.24% | |
| **Aug-17** | 85.06% | |
| **Sep-17** | No submission | |
| **Oct-17** | 82.26% | |
| **Nov-17** | 81.79% | |

Nerve Centre continues to pose operational challenges that are impacting on the trusts reported performance. The breach volumes are potentially overstated whilst the operational teams continue to embed new practices and behaviours.

## 4. Cancer

Cancer performance is reported retrospectively, October finalised position is shown below.

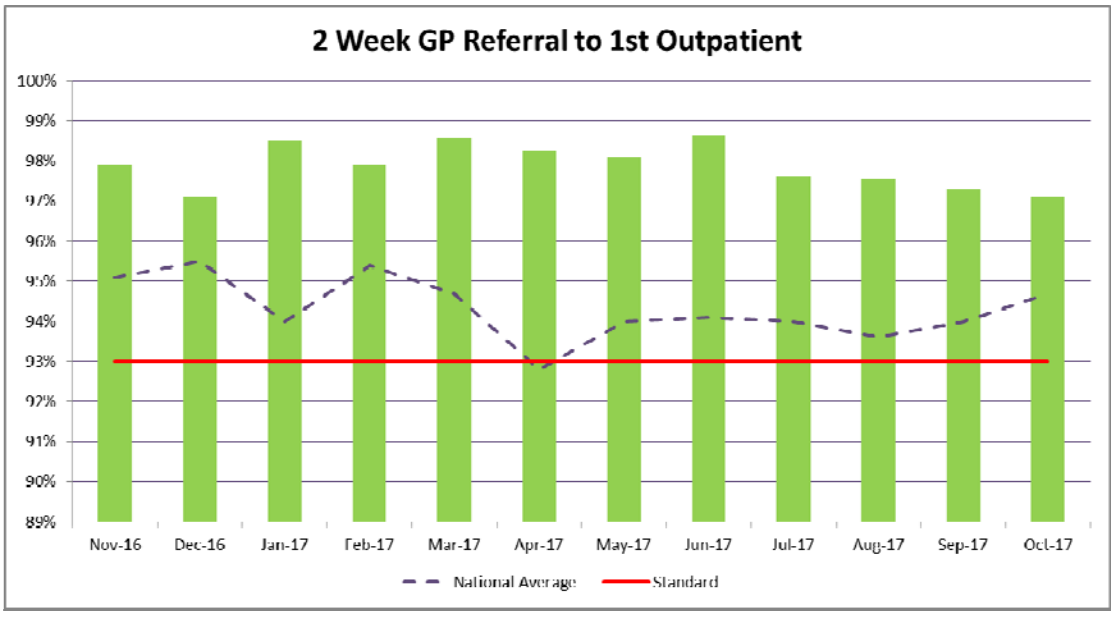
Performance October 2017

| Target | Goal | Threshold | 2016/17 | Month | Quarter 3 | Year 17/18 | Nat Average (Oct) | Nat Average Qtr (Q2) |
|---|---|---|---|---|---|---|---|---|
| **Target Referrals** | | | | | | | | |
| Cancer Referral to 1st Outpatient Appointment | < 14 Days | 93.0% | 97.4% | 97.1% ▼ | 97.1% ▼ | 97.8% ▲ | 94.7% | 93.9% |
| Referrals with Breast Symptoms (wef January 2010) | < 14 Days | 93.0% | 94.1% | 90.1% ▼ | 90.1% ▼ | 93.0% ▼ | 95.4% | 93.3% |
| **Cancer Treatments** | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for all Cancers | < 31 Days | 96.0% | 91.7% | 91.6% ▼ | 91.6% ▼ | 91.3% ▼ | 97.8% | 97.6% |
| Referral to Treatment from Consultant Upgrade | < 62 Days | 90.0% | 75.5% | 87.5% ▲ | 87.5% ▲ | 70.3% ▼ | 87.9% | 87.9% |
| Referral to Treatment from Screening (62 Day) | < 62 Days | 90.0% | 87.5% | 57.9% ▼ | 57.9% ▼ | 64.5% ▼ | 89.3% | 91.7% |
| Second or Subsequent Treatment (Anti Cancer Drug Treatments) | < 31 Days | 98.0% | 95.1% | 98.4% ▲ | 98.4% ▲ | 96.0% ▲ | 99.5% | 99.4% |
| Second or subsequent treatment (Radiotherapy Treatments) | < 31 Days | 94.0% | 91.9% | 89.5% ▲ | 89.5% ▼ | 89.0% ▼ | 97.1% | 97.0% |
| Second or subsequent treatment (Surgery) | < 31 Days | 94.0% | 85.8% | 74.1% ▼ | 74.1% ▼ | 85.3% ▼ | 95.6% | 95.8% |
| Urgent Referral to Treatment of All Cancers | < 62 Days | 85.0% | 69.3% | 76.8% ▲ | 76.8% ▲ | 71.3% ▲ | 82.2% | 82.1% |
| Urgent Referral to Treatment of All Cancers (following breach reallocation) | < 62 Days | 85.0% | 72.2% | ▼ | ▼ | - ▲ | - | - |

Performance by tumour site against the 31 and 62 day standards shown below.

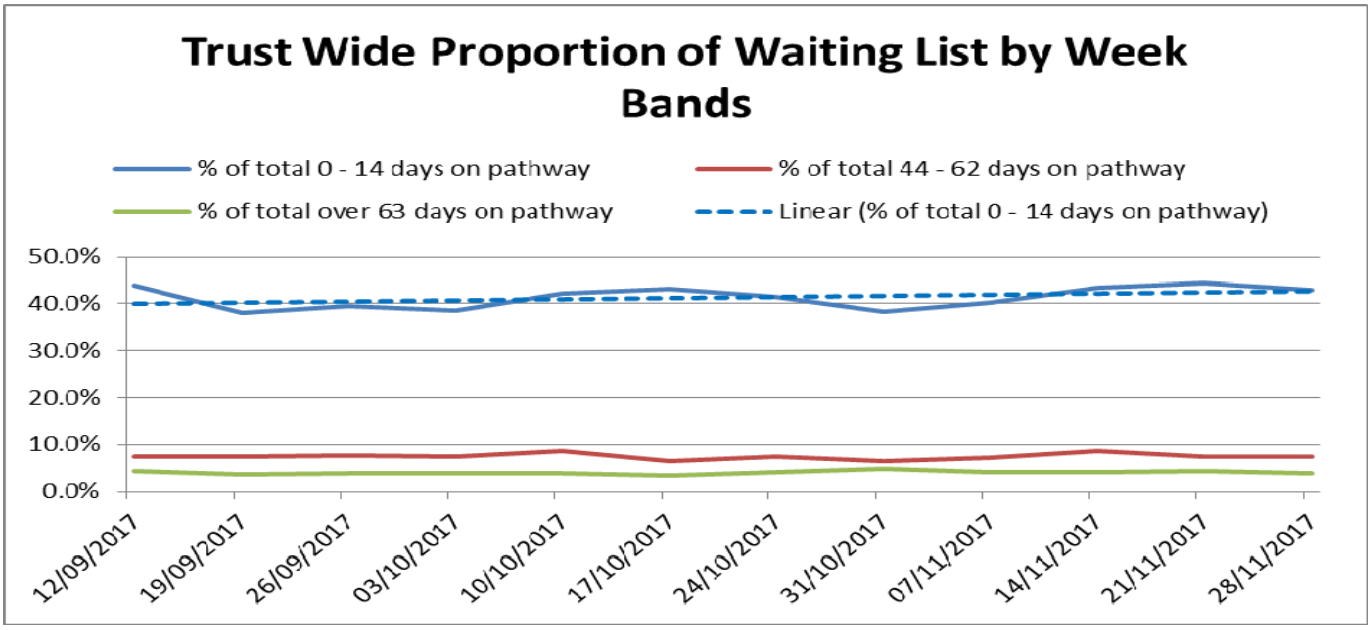
| By Tumour Group | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Breast Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Breast Cancer | <31Days | 96.0% | 98.8% | 96.7% | ▼ | 96.7% | ▼ | 98.3% | ▼ | 98.9% | 98.5% |
| Urgent Referral to Treatment of Breast Cancer | <62 Days | 85.0% | 89.6% | 84.6% | ▼ | 84.6% | ▼ | 87.5% | ▼ | 94.0% | 93.7% |
| **Colorectal Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Colorectal Cancer | <31Days | 96.0% | 96.6% | 90.9% | ▼ | 90.9% | ▼ | 91.4% | ▼ | 97.8% | 98.2% |
| Urgent Referral to Treatment of Colorectal Cancer | <62 Days | 85.0% | 48.3% | 60.9% | ▲ | 60.9% | ▲ | 51.9% | ▲ | 71.3% | 72.4% |
| **Gynae Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Gynae Cancer | <31Days | 96.0% | 93.9% | 100.0% | ▲ | 100.0% | ▲ | 97.0% | ▲ | 97.1% | 96.9% |
| Urgent Referral to Treatment of Gynae Cancer | <62 Days | 85.0% | 61.4% | 66.7% | ▼ | 66.7% | ▼ | 80.0% | ▲ | 81.0% | 76.6% |
| **Haematology Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Haematology Cancer | <31Days | 96.0% | 98.3% | 100.0% | ◀ | 100.0% | ▲ | 98.9% | ▲ | 99.7% | 99.5% |
| Urgent Referral to Treatment of Haematology Cancer | <62 Days | 85.0% | 74.5% | 66.7% | ▲ | 66.7% | ▼ | 65.0% | ▼ | 79.9% | 80.1% |
| **Head and Neck Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Head and Neck Cancer | <31Days | 96.0% | 91.8% | 100.0% | ▲ | 100.0% | ▲ | 90.7% | ▼ | 94.3% | 93.9% |
| Urgent Referral to Treatment of Head and Neck Cancer | <62 Days | 85.0% | 49.7% | 71.4% | ▲ | 71.4% | ▲ | 60.9% | ▲ | 64.9% | 64.8% |
| **Lung Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Lung Cancer | <31Days | 96.0% | 96.7% | 90.9% | ▼ | 90.9% | ▼ | 95.7% | ▼ | 98.3% | 98.5% |
| Urgent Referral to Treatment of Lung Cancer | <62 Days | 85.0% | 56.4% | 55.0% | ▲ | 55.0% | ▼ | 54.9% | ▼ | 71.5% | 70.6% |
| **Sarcoma, Brain & Other Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Sarcoma, Brain & Other Cancer | <31Days | 96.0% | 96.9% | 100.0% | ◀ | 100.0% | ▲ | 96.8% | ▼ | 100.0% | 99.1% |
| Urgent Referral to Treatment of Sarcoma, Brain & Other Cancer | <62 Days | 85.0% | 75.0% | 100.0% | ◀ | 100.0% | ▲ | 62.1% | ▼ | 78.6% | 70.7% |
| **Skin Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Skin Cancer | <31Days | 96.0% | 96.7% | 97.1% | ▲ | 97.1% | ▲ | 97.1% | ▲ | 97.9% | 97.5% |
| Urgent Referral to Treatment of Skin Cancer | <62 Days | 85.0% | 91.4% | 100.0% | ▲ | 100.0% | ▲ | 95.5% | ▲ | 94.9% | 95.5% |
| **UpperGI Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for UpperGI Cancer | <31Days | 96.0% | 96.5% | 91.7% | ▼ | 91.7% | ▼ | 95.2% | ▼ | 98.7% | 98.8% |
| Urgent Referral to Treatment of UpperGI Cancer | <62 Days | 85.0% | 73.9% | 100.0% | ▲ | 100.0% | ▲ | 67.8% | ▼ | 74.0% | 74.4% |
| **Urology Cancer** | | | | | | | | | | |
| Decision to Treat to 1st Definitive Treatment for Urology Cancer | <31Days | 96.0% | 73.4% | 78.1% | ▼ | 78.1% | ▲ | 73.9% | ▲ | 96.1% | 95.9% |
| Urgent Referral to Treatment of Urology Cancer | <62 Days | 85.0% | 58.0% | 68.0% | ▼ | 68.0% | ▲ | 60.7% | ▲ | 79.2% | 78.2% |

Although the trust performance against the 62 day standard remains below 85%, the trust can demonstrate consistent and sustained performance against the 2 Week GP Referral to 1st Outpatient performance compared with the national average.



### 4.1 Recovery

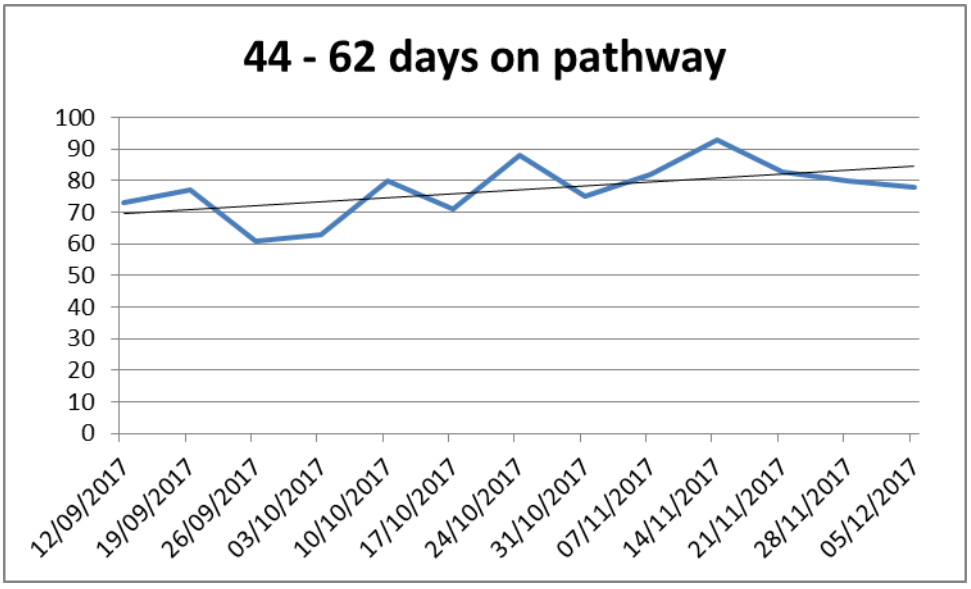
ENHT did not achieve the 62 day performance standard or achieve against the recovery trajectory, delivering 79.1%, post breach sharing, against an original trajectory of 85%. However the waiting list profile remains consistent with a sustainable recovery i.e. 41.6% of all patients on the waiting list have waited 0-14 days and 3.9% have exceeded 62 days.




The table below shows the actual numbers of patients split across 5 waiting zones.

| Date | 0 - 14 days on pathway | 15 - 28 days on pathway | 29 - 43 days on pathway | 44 - 62 days on pathway | Over 63 days on pathway |
|---|---|---|---|---|---|
| 12/09/2017 | 436 | 299 | 142 | 73 | 45 |
| 19/09/2017 | 393 | 357 | 168 | 77 | 38 |
| 26/09/2017 | 319 | 274 | 122 | 61 | 32 |
| 03/10/2017 | 332 | 300 | 134 | 63 | 33 |
| 10/10/2017 | 396 | 286 | 141 | 80 | 38 |
| 17/10/2017 | 477 | 364 | 153 | 71 | 39 |
| 24/10/2017 | 500 | 401 | 169 | 88 | 51 |
| 31/10/2017 | 441 | 396 | 183 | 75 | 58 |
| 07/11/2017 | 466 | 382 | 176 | 82 | 49 |
| 14/11/2017 | 475 | 301 | 181 | 93 | 47 |
| 21/11/2017 | 495 | 301 | 188 | 83 | 49 |
| 28/11/2017 | 464 | 343 | 153 | 80 | 42 |
| 05/12/2017 | 439 | 347 | 150 | 78 | 41 |

To deliver a sustainable waiting list the ideal profile will have more patients waiting at the earlier part of the pathway, as per the table below. Additionally the volume of patients in the 44-62 day cohort also needs to be stable, as increases in this cohort typically correlate to an increased volume of patients breaching the standard. The trust has more recently experienced an increased volume of patients in this area which is likely to have a detrimental impact on November's performance.




Since the implementation of the new PAS, the recorded number of confirmed cancer treatments has been below usual levels. Treatment numbers do not appear to be 'operationally' reduced therefore suggesting that some treatments are potentially not being captured from a data quality perspective and therefore potentially having an adverse impact on our reported performance.

Further clarity will be obtained as the trust continues to catch up with data input and improvements in data quality post Lorenzo implementation.

**4.2 Remedial Actions**

As the November performance is forecast to have deteriorated from the more recent improvement a number of actions have been implemented with immediate effect. New RAG rated trust wide cancer PTL's have been officially released, this enables to the divisions to see at a glance, the patients that are booked to achieved the standard, booked outside of the standard or not booked at all. Whilst much of this detail could be seen before the new PTL's make this more intuitive to use and is highly visible.

The cancer tracking team will be using these PTL's to book, track and chase decisions for patients on cancer pathway.

The trust wide Access monitoring process has been enhanced, implementing a three stage process, building on best practice; it is aimed at increasing senior divisional oversight at the different stages.

**4.2 Recovery Trajectory**

Organisations that were not forecasting achievement of the 62 day standard in December where required on 12th December to complete and submit a new trajectory to NHSI by 14th December, see appendix 1 for ENHT's updated trajectory.

In addition NHSI requires a letter from the Board that the trust is committing to the recovery trajectory and associated actions. NHSI requires this letter by 21st December. At the time of writing a detailed action plan is being developed and will be presented to the executives and CEO seeking approval on behalf of the board.

## 5. Stroke

October ’17 Stroke performance

| Metrics | Oct ’ 16 | Nov ’16 | Dec ‘16 | Jan ’ 17 | Feb ‘17 | Mar ‘17 | Apr ‘ 17 | May’17 | June’17 | July ‘17 | Aug ‘17 | Sept ‘ 17 | Oct ‘17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Trust SSNAP Grade** | B | B | A | A | A | A | A | A | A | A | | | |
| **Stroke Discharged with AF on anticoagulants (ASI 1)** | 88.9% | 75% | 86.7% | 72.2% | 88.2% | 91.7% | 54.5% | 90% | 92.3% | 62.5% | 100% | 62.5% | 62.5% |
| **Stroke – 4 hours direct to stroke unit from ED** | 80.9% | 76.1% | 76.6% | 71.8% | 76.4% | 73.4% | 82.5% | 76.6% | 77.6% | 78.6% | 71.7% | 71.6% | 71.2% |
| **No. Confirmed Strokes in Month** (figure excludes inpatient strokes & hospital transfers) | 47 | 66 | 77 | 78 | 72 | 79 | 40 | 36 | 67 | 42 | 53 | 67 | 73 |
| **Stroke – 80% of patients spent 90% of time on the stroke unit** | 93% | 84.3% | 85.7% | 86.9% | 83.3% | 92.5% | 88.9% | 91.4% | 88.5% | 88% | 83.9% | 88.9% | 79.7% |
| **Stroke – 60 min to scan from time of arrival – target 50%** | 51.9% | 40.9% | 47.6% | 51.2% | 46.2% | 51.3% | 52.4% | 55.1% | 57.5% | 70% | 59.6% | 56.9% | 51.9% |
| **Stroke 60 mins to scan for those patients deemed urgent** | 100% | 91.3% | 86.1% | 91.7% | 90% | 89.2% | 95.2% | 91.7% | 90% | 96.2% | 92.9% | 87.8% | 90.9% |
| **Stroke – scanned within 24 hrs (all strokes) targed 100%** | 98% | 100% | 98.8% | 100% | 98.7% | 100% | 100% | 98.6% | 100% | 100% | 100% | 100% | 100% |
| **Total Thrombolysis Rate for confirmed strokes** | 8.2% | 3.4% | 9.9% | 17.1% | 7.5% | 13.6% | 16.2% | 11.5% | 13.4% | 14.3% | 16.7% | 11.3% | 6.3% |
| **Stroke patients thrombolysed within 3hrs-4.5hrs** | 6.1% | 3.45% | 7.1% | 12% | 6% | 9.1% | 10.8% | 6.6% | 9% | 7.1% | 6.3% | 4.8% | 1.6% |
| **Stroke – discharged with JCP – target 80%** | 94.1% | 90.5% | 79.2% | 95.8% | 100% | 100% | 100% | 100% | 100% | 100% | 94.7% | 98% | 98% |
| **Stroke –discharged with ESD target 40%** | 27.5% | 39.6% | 36.5% | 42.1% | 42.4% | 40% | 54.5% | 26.5% | 48.1% | 50% | 33.3% | 34% | 35.8% |

## 6. Diagnostic Standard (DM01)

The trust has not been able to report the DM01 performance in November as a consequence of moving to the new PAS (Lorenzo).

**DM01**

| Month | Performance | Standard |
|---|---|---|
| Dec-16 | 99.23% | 99% |
| Jan-17 | 99.90% | 99% |
| Feb-17 | 99.68% | 99% |
| Mar-17 | 99.82% | 99% |
| Apr-17 | 99.72% | 99% |
| May-17 | 99.00% | 99% |
| Jun-17 | 99.60% | 99% |
| Jul-17 | 96.65% | 99% |
| Aug-17 | No submission | |
| Sep-17 | No submission | |
| Oct-17 | No submission | |
| Nov-17 | No submission | |

The trust expects to be able to report the DM01 performance for February, within the national reporting timeframes.

** End of document **

Appendix 1

East & North Herts

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Expected Monthly | Month | December | | | | January | | | | February | | | | March | | | | |
| | Expected 62 performance | 70.6% | | | | 75.2% | | | | 78.5% | | | | 81.0% | | | | |
| Expected Weekly | Week Ending | 08/12/2017 | 15/12/2017 | 22/12/2017 | 29/12/2017 | 05/01/2018 | 12/01/2018 | 19/01/2018 | 26/01/2018 | 02/02/2018 | 09/02/2018 | 16/02/2018 | 23/02/2018 | 02/03/2018 | 09/03/2018 | 16/03/2018 | 23/03/2018 | 30/03/2018 |
| | Expected 62 day backlog | 41 | 41 | 39 | 37 | 37 | 35 | 35 | 33 | 31 | 31 | 31 | 31 | 31 | 31 | 31 | 31 | 31 |
| Monthly additional activity | | 0 | | | | 0 | | | | 0 | | | | 0 | | | | |
| Key issues | | Since the Trust changed EPR system to Lorenzo in September 2017 there has been a decrease in the number of reported treatments against both the 31 day first treatment standard and the 62 day first treatment standard. The Trust continues to face challenges in delivering sufficient capacity for brachytherapy and chemotherapy treatments. The Trust has an ambition to implement the 4 timed pathways by the end of the financial year and to use best practice in other tumour sites. The Trust also continues to have challenges of providing sufficient radiology and histopathology capacity for cancer pathways. | | | | | | | | | | | | | | | | |
| Key actions (New/additional | | Implementation of a system change in Infoflex to capture that date an "all clear" diagnosis is given. This will enable the more complete review of pathways, gain an understanding of activity vs positive diagnosis and provide greater assurance about comprehensive treatment capture. Specific plans are in place to deliver the 4 timed pathways by the end of the financial year. Additionally the Trust has redesigned and launched new PTLs which RAG rate pathways against key milestones. The PTLs developed include 62 day first definitive treatment (incorporating the 31 day first treatment standard), 31 day second and subsequent treatments, 62 day referrals from screening programmes and an outgoing tertiary referral PTL. Use of these PTLs are the main tracking and reporting tool is anticipated to improve cancer performance and decease the number of pathways breaching the standards. The Trust is completing a demand and capacity review for radiology and histopathology with a specific focus on provision for cancer pathways. | | | | | | | | | | | | | | | | |
| Use of funds | | Funding has been allocated to the provision of additional brachytherapy sessions although the Trust has yet to secure an alternative provider. Funding has also been allocated for the provision of a locum Oncologist for 6 months to provide additional capacity. Funding has been allocated for an external provider to complete a review of the demand and capacity requirements for diagnostics for cancer pathways - there has been some delay in securing a cost effective provider. | | | | | | | | | | | | | | | | |

East and North Hertfordshire NHS
NHS Trust

**Agenda Item: 9.3**

# TRUST BOARD PART I – 10 JANUARY 2018

## Workforce & OD Board Report – Month 8

| | |
|---|---|
| **PURPOSE** | To present an update to the Trust Board on Workforce and OD issues. |
| **PREVIOUSLY CONSIDERED BY** | Monthly standing item<br>FPC |
| **Objective(s) to which issue relates *** | [√] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme.<br>[ ] 2. **Developing new services and ways of working** – delivered through working with our partner organisations<br>[ ] **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.** |
| **Risk Issues**<br><br>(Quality, safety, financial, HR, legal issues, equality issues) | Financial: increased workforce costs<br>HR: failure to meet agreed standards<br>Legal: failure to meet CQC and other national standards<br>Patient Safety: failure to maintain appropriately trained workforce |
| **Healthcare/ National Policy**<br><br>(includes CQC/Monitor) | |
| **CRR/Board Assurance Framework *** | [√] **Corporate Risk Register** [ ] **BAF** |

**ACTION REQUIRED ***

| | | | |
|---|---|---|---|
| For approval | [ ] | For decision | [ ] |
| For discussion | [√] | For information | [ ] |

| | |
|---|---|
| **DIRECTOR:** | Chief People Officer |
| **PRESENTED BY:** | Chief People Officer |
| **AUTHOR:** | Deputy Director of Workforce and Head of Workforce Planning, Information, and Performance |
| **DATE:** | January 2018 |

**We put our patients first We work as a team We value everybody We are open and honest**
**We strive for excellence and continuous improvement**

* tick applicable box

# Workforce Report

DECEMBER 2017

BASED ON MONTH 8 DATA

## Key Headlines

### Executive Summary

The trends for the Trust workforce report for month 7:

**Vacancy Rate** - The vacancy rate at the end of November 2017 was 8.2% which is a further improvement on the previous month and indicates positive improvement from the start of the year (11.9%). There was a net increase of 40.47 WTE in post in November bring the Trust to within 41.87 WTE of the year end target. Most notably nursing band 5 staff in post increased by 19.33 WTE.

**Agency Target -** The monthly agency ceiling target was achieved in month 8 with agency spend under by £104k, this was despite an increase in agency spend compared to the previous month. The Trust is under the ceiling target by £2,561k, year to date and with the controls in place it is expected that the Trust will remain under the target each month until the end of the financial year.

**Turnover rate** – In November 2017, the turn-over rate was at 13.02% which is a slight increase compared with prior months. This puts the Trust 0.85% away from the in month target and 1.02% away from the end of year target. However, plans are being developed as part of the NHSI led retention initiative which will re-set the target for the next 12 months.

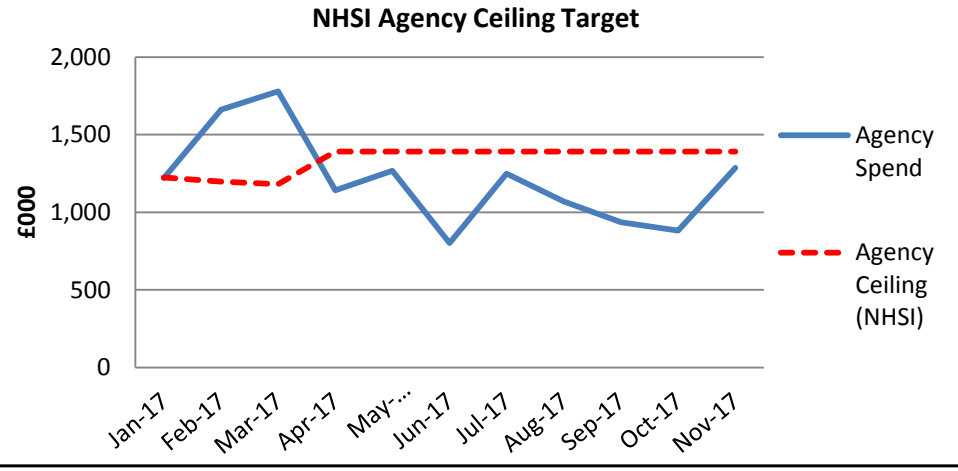
**Leadership Development -** The new Leadership, Management and Coaching Development Pathway (LMDCP) launches this month. It has redesigned modules that utilise up to date blended learning and new programmes such as ‘Quality & Service Improvement for Leaders’ and Essential Skills for Successful Projects’. The programmes are formally CPD accredited ensuring their quality and we are taking the regional lead in ADDS and Mary Seacole.

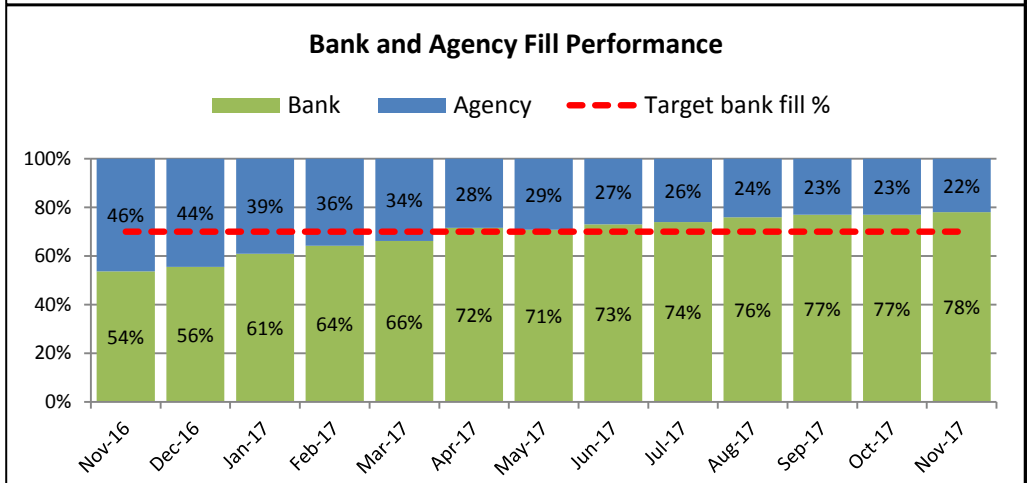
## Workforce Board Report

**Index**

## 1. Temporary Staffing

Strategy: To reduce agency pay costs and unit pricing through the Trust control environment and the management of agency suppliers. To improve the efficiency and performance of the temporary staffing service, ensuring that processes, policies and guidelines are adhered to for optimal service delivery and financial control.




**Headlines:**

The monthly agency ceiling target was achieved in month 8 with agency spend under by £104k. Month on month the agency spend increased by £464k and is the highest year to date. This increase in expenditure is not representative of the month on month booking information where agency hours have only marginally increased. The reason for the increase in multi-factorial including VAT benefits represented in M7 not relating to M8, late accruals being reported, retrospective agency expenditure relating to late finalisation of payments, early winter pressure activity, operational management and reporting measures and income recovery.

The Trust is under the ceiling target by £2,561k, year to date and with the controls in place it is expected that the Trust will remain under the target each month until the end of the financial year.

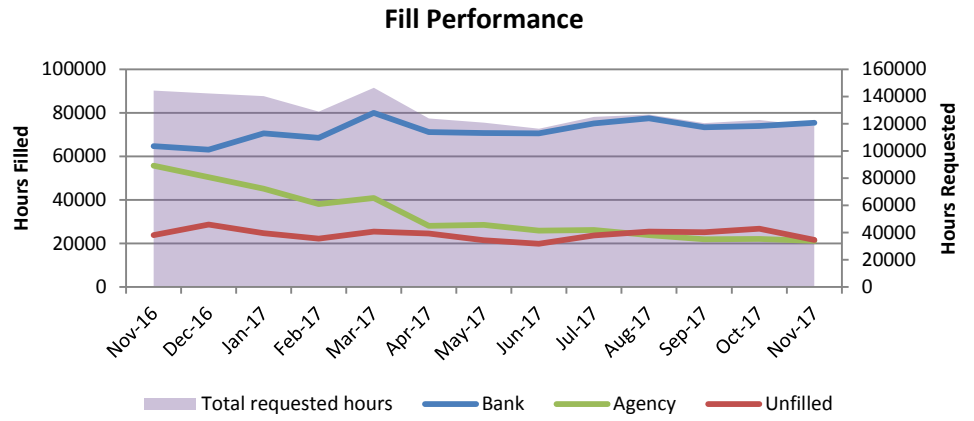
The composite of bank to agency fill showed a slight improvement with bank moving to 78% of filled hours which remains above target. Unfilled rates have started to improve through measures taken to improve bank fill and work with agencies to secure more workers.

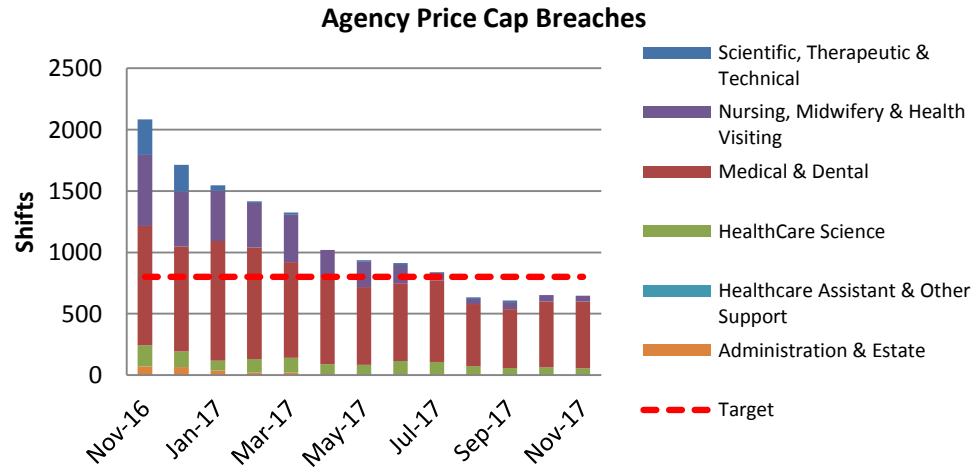
Year to date, compared to the previous year, the trust has reduced its agency shifts booked by 43%. The reduction in agency has been delivered through a comprehensive action plan focusing on key areas including agency controls, bank recruitment, regional collaboration, demand management and staff engagement.

**Shared bank**: With The Bank Network now embedded with 3 Hertfordshire Trusts the Trust is now reviewing how this could be expanded further including a review of the software available to facilitate this

## 1b. Temporary Staffing

Strategy: To reduce agency pay costs and unit pricing through the Trust control environment and the management of agency suppliers. To improve the efficiency and performance of the temporary staffing service, ensuring that processes, policies and guidelines are adhered to for optimal service delivery and financial control.




**Headlines:**

**Internal Temporary Staffing Office, Doctors (TSOD):** Six months since the launch of TSOD the performance metrics are showing some very positive results including reduction in retrospective bookings, increase in direct engagement, standardisation of bank rates and compliance with agency approvals. The team are now focusing on reducing the unit cost of agency as there has been a gradual increase over the last few months. There is currently work ongoing with the pan London procurement group to review the Hertfordshire ceiling rates with their rates for Doctors, with a plan of achieving some standardisation across the patch. Bank recruitment is very positive with a large number of doctors in the pipeline wanting to work for TSOD.

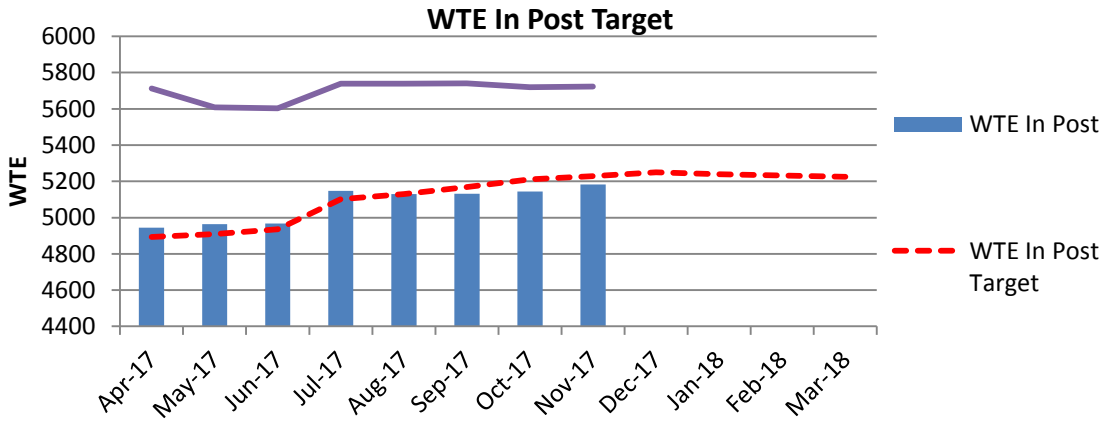
**Agency restrictions/agency free zones:** 'Padlocks', restricting agency, are automatically applied to all shifts for nursing and midwifery and are only removed with approval from the Director of Nursing. Direct booking of agency has been centralised and work is ongoing to secure staff number to support wards with significant short-falls.

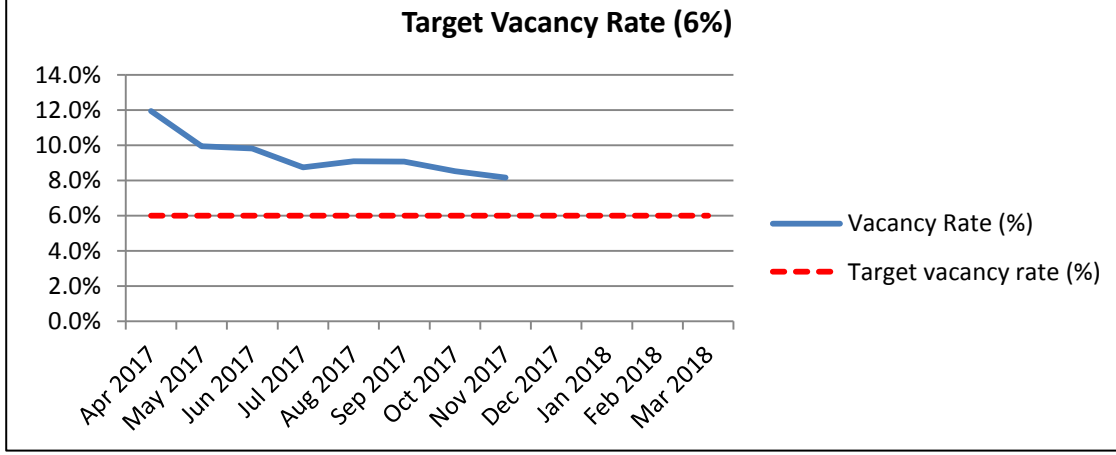
**Agency unit cost and price management:** All nursing critical care rate cards are now in line with NHSI price caps with the only area recording a breach being oncology. Focus is on reducing the agency bookings for doctors to minimise breaches and continue to achieve less than 800 per month.

**Demand control:** A new process has been established to review admin requests longer than two weeks to ensure that there is an approved vacancy for the post being covered. Further scrutiny is being applies to this through Grip and Control which has recently established a new agenda.

## 2. Resourcing

Strategy: To reduce the vacancy rate to 6% in order to support the Trust's People Strategy and the Safer Staffing agenda. The achievement of this strategy is reliant on new, innovative attraction, recruitment and retention projects.




**Headlines:**

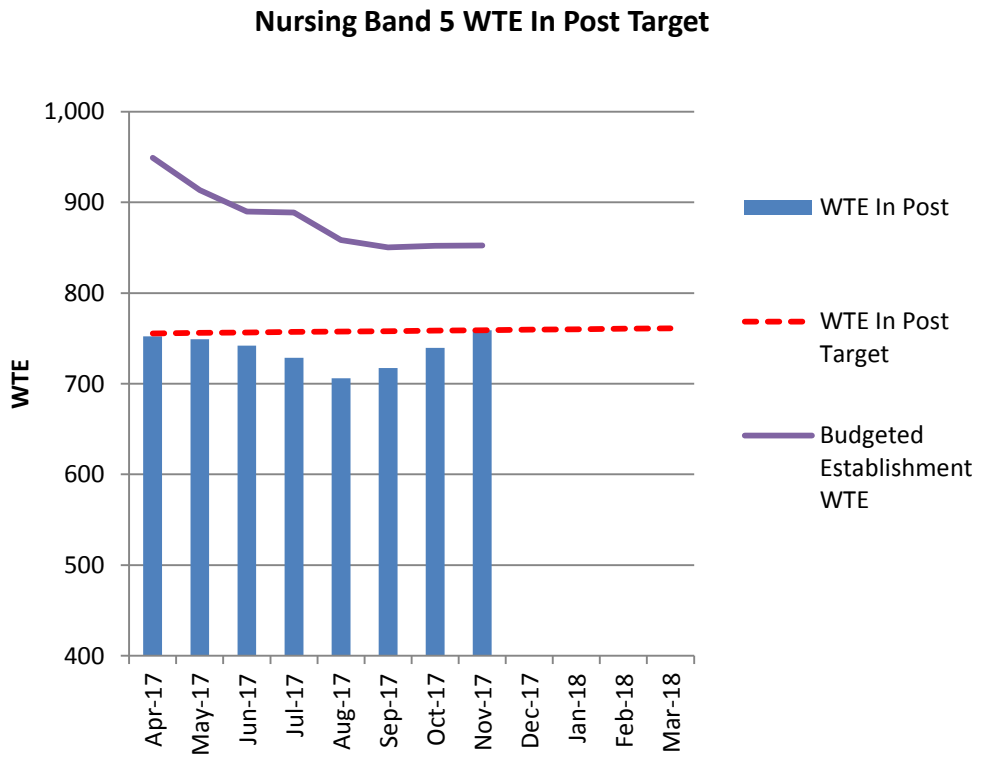
**Performance:** WTE in post increased in November to 5183.34 this indicates a positive movement by 39.77 WTE on October's figures. There was a total of 106.14 WTE starters in November against a total of 65.67 WTE leavers this is a net position of 40.47 WTE.

November's reported figures means the Trust was 45.03 WTE short from the in-month recruitment target and 41.87 WTE away from the end of year target. With an additional 10.5 WTE recruited per month until the end of March 2018 the target can be achieved. There are currently 303.48 WTE external candidates undergoing pre-employment checks or waiting to start with the Trust.

The vacancy rate at the end of November 2017 was 8.2% (429.93 WTE) which is a further improvement on the previous month and indicates positive improvement from the start of the year (11.9%). The vacancy rate is based on the posts actively being recruited, excluding bank and agency lines.

## 2b. Resourcing - Non-Medical Band 5 Registered Nurses

Strategy: To reduce the vacancy rate to 6% in order to support the Trust's People Strategy and the Safer Staffing agenda. The achievement of this strategy is reliant on new, innovative attraction, recruitment and retention projects.




**Headlines:**

The band 5 nurses in post increased by 19.33 WTE in November taking the total number of Band 5 nurses to 758.77. This meant the Trust was only 0.23 WTE away from the in-month target and 2.23 WTE away from the end of year target.

Taking into consideration average attrition of 10 WTE nurses leaving each month, to truly reach the net target WTE for nurses an additional 10.5 WTE will need to be recruited each month until the end of March 2018 to achieve the target.

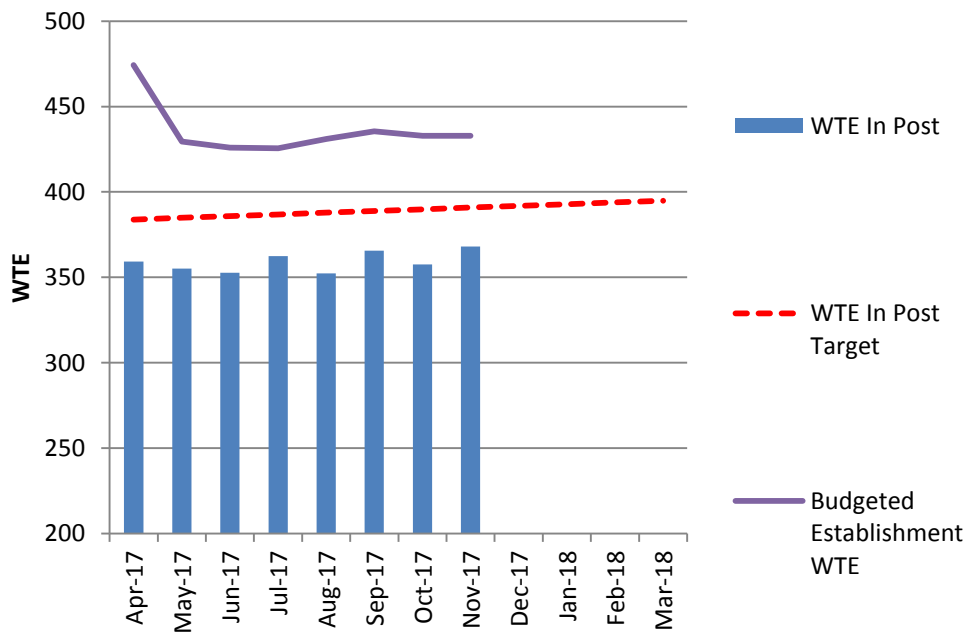
The Trust's vacant posts for band 5 registered nurses at the end of November was 93.81 WTE, this equates to a 11.0% vacancy rate which represents a decrease on October's reported 13.23% Band 5 nurse vacancy rate. The forward view recruitment trajectory for band 5 registered nurses, predicts a decrease in the vacancy rate to circa 12.0% by March 2018.

There are currently 110.92 WTE external band 5 qualified nurse candidates undergoing pre-employment checks or awaiting to start with the Trust.

The increase in band 5 deployment could in part be attributed to the timeline for international nurses to start which on average takes 6 months. Our latest cohort to be deployed started the process in June 17. The benefit of this is expected to continue in the new year with a large cohort due to start in January 18. In addition to this the resourcing team have been working to targets to fulfil pre-employment compliance at larger volumes within shorter timeframes. Divisional recruitment plans are on-going and monitored through Grip and Control meetings.

## 2c. Resourcing - Non-Medical CSW

Strategy: To reduce the vacancy rate to 6% in order to support the Trust's People Strategy and the Safer Staffing agenda. The achievement of this strategy is reliant on new, innovative attraction, recruitment and retention projects.




**Headlines:**

The band 2 Care Support Worker (CSW) WTE in post increased by 10.39 in November taking the total number to 367.99 WTE. This meant the Trust was 22.83 WTE away from the in month target and 26.81 WTE away from the end of year target. The trust now aims to recruit an additional 6.7 WTE per month until the end of the year to achieve the target.

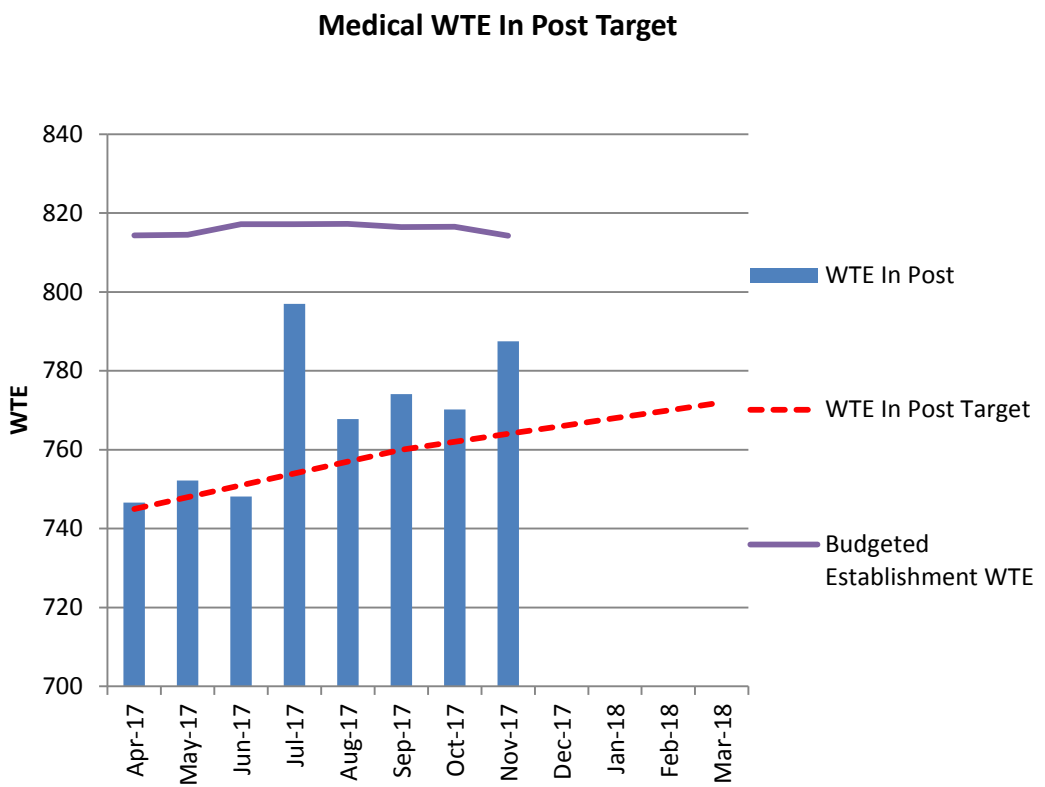
The Trust's number of vacant posts for Band 2 CSWs at the end of November 2017 was 64.80 WTE, equating to an overall vacancy rate of 14.97% for CSWs. There are currently 18 WTE CSW candidates going through pre-employment checks. It is projected 14 WTE band 2 will commence employment in January 2018 which based on current attrition should take us to our target level.

There are further assessment and recruitment events planned until the end of March 2018 with employment start dates in line with the Preparation to Practice Course which is now being scheduled every month as opposed to every 2 months.

Bespoke CSW recruitment days are to be rolled out in line with divisional recruitment plans to attract candidates for specialties. The cohort recruitment assessment days continue to be held every two weeks, to increase the pipeline. Further work is currently underway, exploring other avenues of candidate attraction and explaining the apprenticeship scheme in detail in order to determine candidate and job profile compatibility. A working group has been set up with Nursing and Temporary Staffing teams as part of a collaborative exercise to improve attraction and retention; and establish processes between teams which will improve the overall recruitment experience.

## 2d. Resourcing - Medical

Strategy: To increase contracted medical post holders, reducing vacancy to below 5% and minimising agency, through innovative and efficient recruitment methods and by enhancing the East and North Hertfordshire medical brand.




**Headlines:**

12.0 new WTE medical staff were appointed and in post in November and only 4.0 WTE medical staff left the Trust, giving a **+8** net increase . December 2017 is looking positive with 5.0 WTE new medical staff in the pipeline and only 1.0 WTE confirmed to leave. Going forward: there are a total of 28.0 WTE new starters in the pipeline, 20.0 WTE with agreed start dates, 8.0 WTE with start dates to be confirmed therefore the projection is positive. The current Trust vacancy rate for Medical Staffing is currently within target at 3.1% however this is over represented due to a number staff in training being counted that will not feature in M9.

**The key actions to ensure achievement of the target:** Acute and ED workshop: Identified as an area with significant challenges for recruitment and with high volumes of agency, the Trust has set up a working group with lead consultants to focus on recruitment activity. An action plan has been agreed, focusing on key areas including training opportunities, attraction package, marketing and networking. The objectives that are key are ED Consultant recruitment package, a marketing document including Consultant profiles is currently being finalised, this will supplement the December 2017 advert.

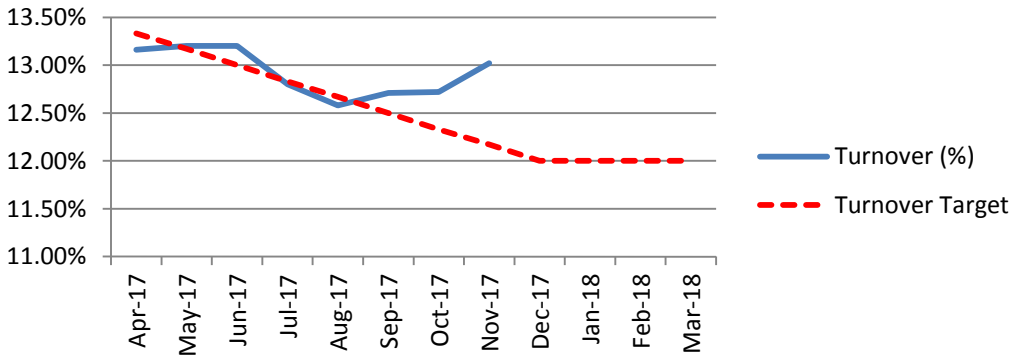
**Candidate attraction**: A promotional event was held at the AGM exhibition in November 2017 in London, this proved to be relatively successful with the recruitment team picking up several leads of potential candidates to follow up. An ongoing review to look at options for an enhanced promotional video and marketing material is currently taking place.

**Threats to target:** Increasingly the emphasis is on international recruitment to fill the gap in some specialties, this is an extensive process and complicated process regarding the Home Office and GMC requirements therefore impacting the overall Time to Hire.

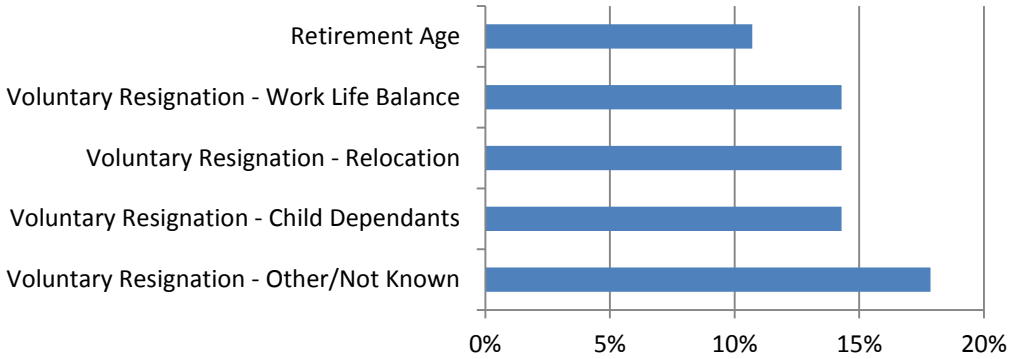
## 3. Staff Retention

Strategy: To develop and influence the organisational culture in order to create a working environment where staff want to attend work and feel happy, engaged, valued, supported and empowered to deliver effective and compassionate care.

**Turn-over Rate - Trust Target 12%**




**Top 5 Reasons for Leaving**




**Headlines:**

In November 2017, the turn-over rate was at 13.02% which is a slight increase compared with prior months. This puts the Trust 0.85% away from the in month target and 1.02% away from the end of year target.

73 individuals chose to leave the Trust voluntarily. This number excludes those individuals leaving as a result of a fixed term contract coming to an end or as a result of dismissal. The total number of leavers was 111. Of the 73 who left voluntarily; the most common reasons provided were work-life balance (14%), relocation to another area (14%) and child dependents (14%) followed by retirement (11%). Unfortunately, 18% of individuals chose not to give a reason for leaving. We continue to monitor leaver feedback and key points from the exit interviews can be found at Appendix 8.

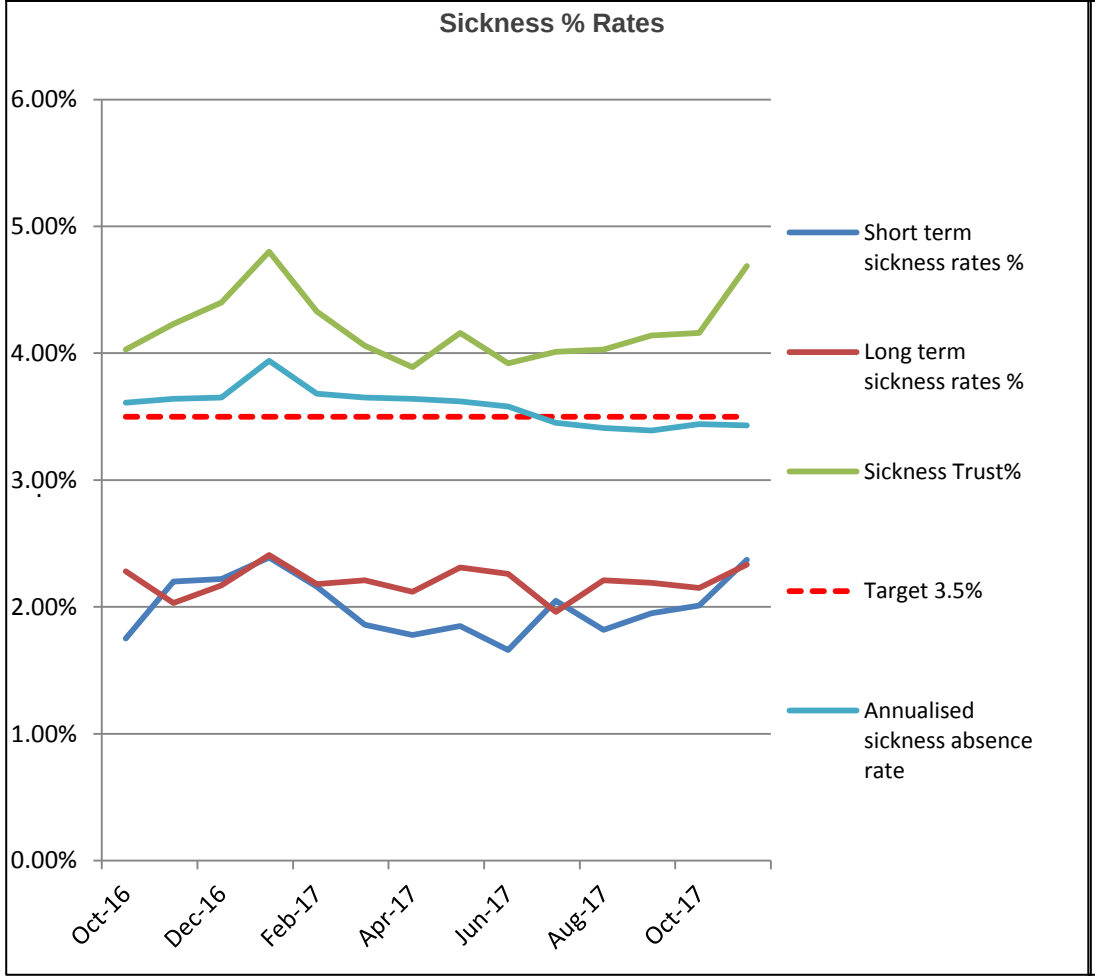
As part of the retention initiative which is part of cohort 2 of the NHSI programme the Trust is creating an action plan. The scoping exercise has picked up 5 main drivers for which actions will be worked up as part of a series of workshops through January:

- Increase contracted WTE in post – Targeting critical mass to ensure wards remain safely covered with contracted
- Management development training – improvements to clinical leadership to make the Trust a more desirable place to work due to the people you work for
- Career pathway – Develop and promote staff career and development pathways
- Staff benefits – Promotion of existing benefits and consider new opportunities
- Turn-over hot spots – concentrates efforts and bespoke plans for areas with high turn-over

Each element will have a target improvement trajectory applied and will be monitored and reported internally and externally.

## 4. ER Sickness Management

Strategy: To reduce the annualised sickness absence rate to 3.3% by March 2018. The approach to achieving this is by providing advice and support to both managers and employees to optimise health at work, reduce sickness absence and prevent work related ill health and injury therefore reducing the cost of sickness absence across the Trust.




**Headlines:**

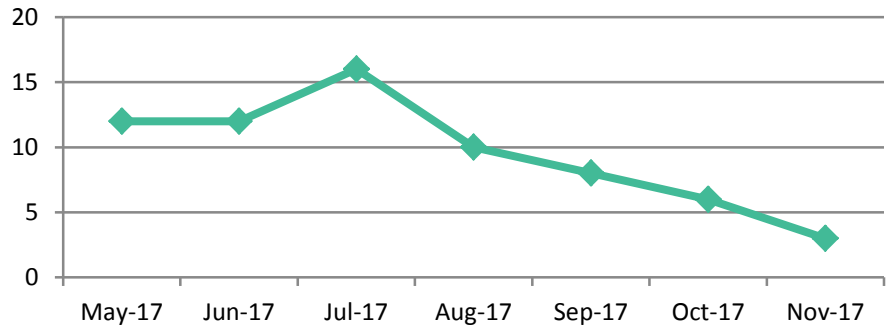
In November 2017 the in-month sickness absence rate has increased to 4.69% from 4.16% in October 2017. This reflects a similar increase between October and November in 2016 due to seasonal increases in sickness absence. Overall the annualised sickness absence rate has reduced from 3.44% in October to 3.43% in November and this reduction is in line with the overall trajectory and plan to reduce the annualised sickness absence rate to 3.3% by March 2018. There were 123 individuals absent due to long term sickness at the end of November 2017.

The key actions that have commenced in respect of the sickness absence cost saving plan are; Auto-enrolment of LTS cases, focus on hotspot areas, early intervention by Health at Work in respect of musculoskeletal and stress related sickness and direct communications with individuals reaching informal triggers in respect of STS absence. Future Actions to reduce sickness absence:

- Complete review of Sickness Absence Management Policy; amending existing reporting structure and triggers for the management of sickness absence which is due to be finalised January 2018.
- Re-launch of the Sickness Absence Policy with increased training and support from the Employee Relations Team from January 2017.
- Review of the Absence Assist Service. Service extended to the end of March 2018.

Strategy: to deliver a customer service focused ER function, providing both managers and staff with advice and support on all Employee Relations issues, managing of sickness and eradicating bullying and harassment.

**Bullying and Harassment Cases**




**Headlines:**

•In November, the percentage of employee relations cases within the Trust was 1.8% which sits within the target range of 1% and 3%.

•The overall number of live employee relations cases decreased from 116 in October to 107 in November 2017.

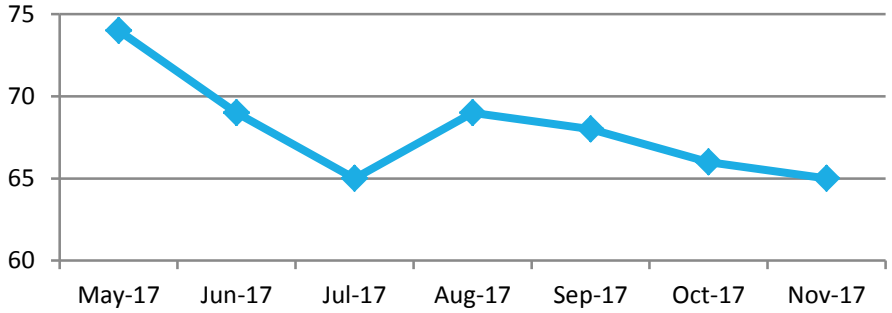
•There has been no increase of B&H cases, with 3 ongoing cases as at month end.

•A Bullying and Harassment Steering Group has now been established with a plan for open forums shared – the first drop-in session is due to take place on 15th January 2018.

•A re-launch of the Speak in Confidence Service will take place in January 2018: with all staff being auto-enrolled to allow for easier access and increased awareness.

•The overall number of suspended staff reduced to 4 as at the end of November 2017.

**Sickness Cases**




The number of sickness absence cases registered with ERAS for active support reduced to 65 as at the end of November 2017; it is expected that this figure will rise from January 2018 when the revised Sickness Absence Policy is launched across the Trust which provides a more robust and clear process for the management of sickness absence.

In accordance with the Trusts plans for reducing short term sickness absence; the ERAS team with HRBPs are targeting hotspots areas using metrics for the highest number of staff reaching a formal trigger point.

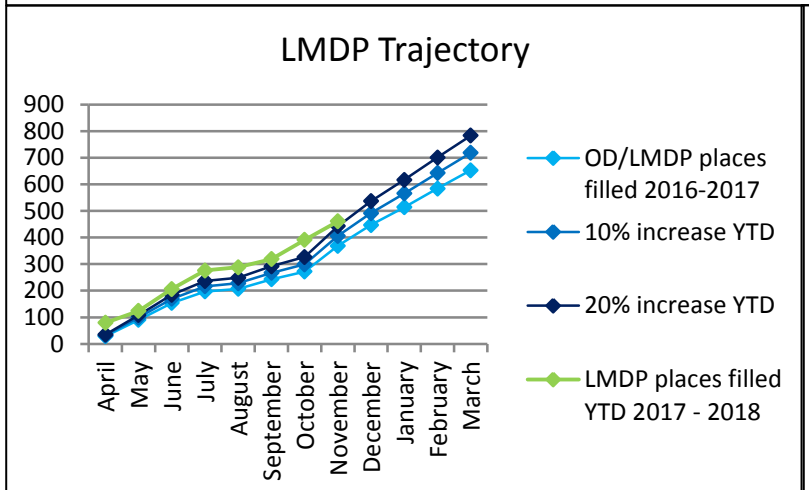
To ensure proactive and positive management of LTS; all cases over 6 Months are automatically registered with ERAS and an ER Advisor assigned for consistency.

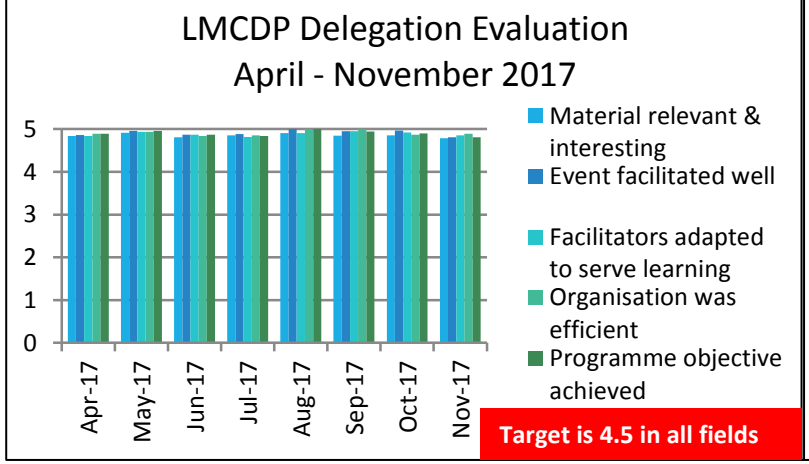
Case information is shared with the operational teams to ensure full oversight of the cases within each Division

**Policy Update:**

- Work ongoing to finalise Disciplinary Policy.
- Dignity and Respect at Work Policy, Capability Policy and Sickness Absence Policy at Review Stage.

Strategy: The Culture Programme aims to improve staff engagement so the Trust is amongst the top 20% of acute hospital Trusts within three years. This will be achieved by embedding a strong leadership culture, leading to improved patient and staff experience and improved customer satisfaction with our services; this will lead to sustained improvements in services.




**Target is 4.5 in all fields**

**Headlines:**

The new Leadership, Management and Coaching Development Pathway (LMDCP) launches this month. It has redesigned modules that utilise up to date blended learning and new programmes such as 'Quality & Service Improvement for Leaders' and Essential Skills for Successful Projects'. The programmes are formally CPD accredited ensuring their quality and we are taking the regional lead in ADDS and Mary Seacole. The 2018 programmes are taking shape and are being advertised from this month onwards.

Despite the many challenges faced in terms of resources and organisational change the number of staff attending development programmes is increasing (see green line of opposite chart). Those attending the programme are also experiencing a quality learning experience and feedback has been exceptional.

The latest addition to the pathway is the 'Essential Skills for Successful Projects'. This has been a joint programme between the OD Team and PMO and over 2 days the competence and confidence of staff was enhanced through an experiential and blended learning experience. The joint programme further highlights the potential of the ENHT Leadership Development Faculty is offering an organisational context to our learning experiences.

The PDG (People Development Group) agreed its terms of reference, group membership and significant first tasks. By January 2018 a sample of staff from each division will be mapped against their leadership and management development. This will allow divisional leaders sight of their people and the areas in which further development may be required.

ADDS nominees will be submitted by December and the latest cohort of the Mary Seacole will begin recruitment in January. Our expertise and success in delivering the Mary Seacole for the Leadership Academy has seen us take o the regional leadership of the programme.

## 7. Medical HR: Electronic Job Planning & Exception Reporting

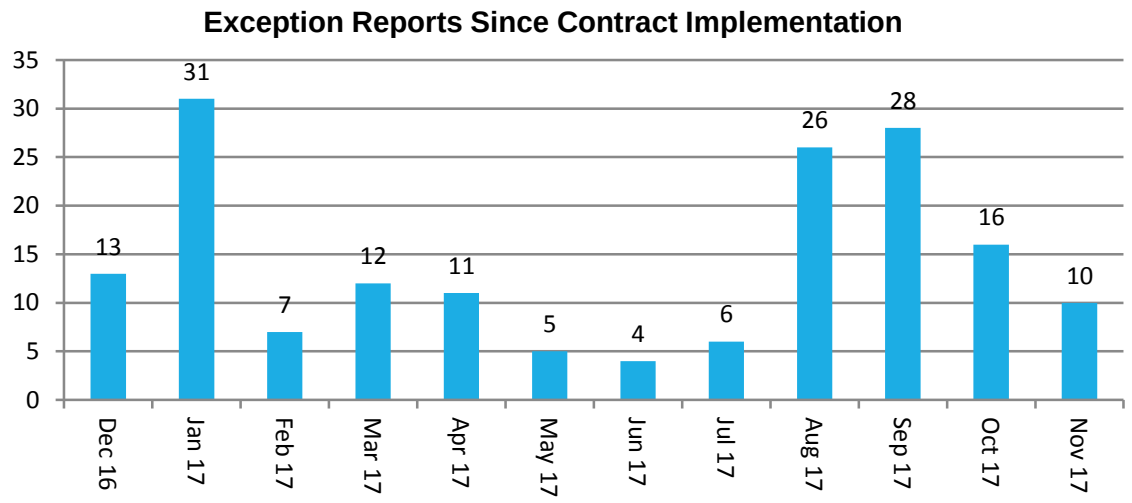
Strategy: To ensure full compliance with Medical Terms and Conditions to mitigate risks to the organisation.

**Headlines:**

**Electronic Job Planning:** For the 2017/18 financial year 326 Electronic Job Plans required sign off as part of the implementation of the system. At present 3 remain outstanding and are not fully signed off due to ongoing mediation / dispute resolution / discussion.

At present the intention is not to re-publish job plans for 2018/9 round as previously planned in December 2017 due to ongoing work around the Demand and Capacity Model which will result in Team Job Planning. Once this work is complete the Electronic Job Plans will be re-published for the next round of discussions. An exception is those who have job plan changes since 2017/118 sign off who are now able to have job plans published for updating. Currently there are 10 that have been published for this purpose.

The expectation is that once all job plans have been released that they are to be signed off before 1st April 2018, including the mediation processes etc.



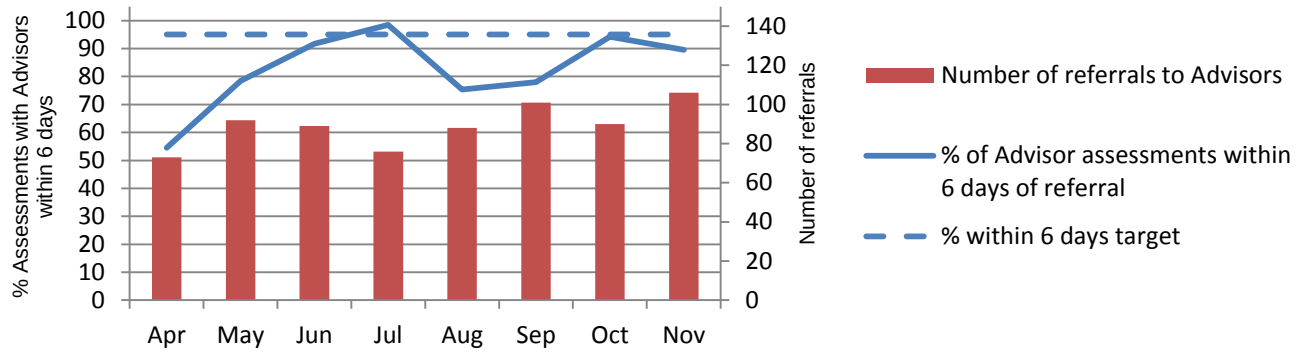

**Exception reporting:** Transition to the 2016 terms and conditions continues, in accordance with the nationally set timetable. As of September 2017, 93% of the Trust's doctor in training workforce is contracted to the new 2016 terms and conditions and all rotas are finalised as 'mixed economy'.

There has been an increase in the number of exception reports following the increase on juniors on the new contract from August 2017. A Divisional summary is provided at Appendix 2.

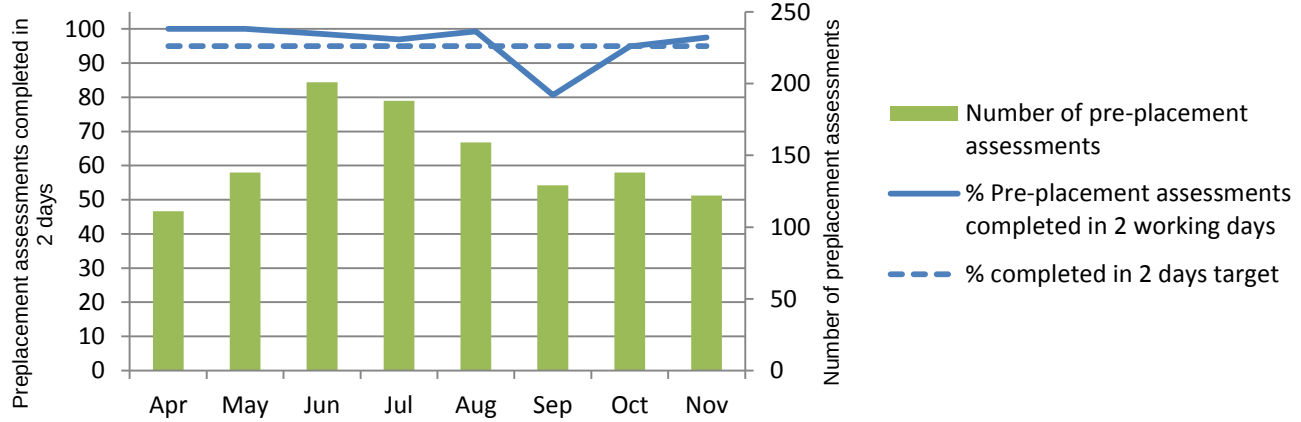
## 8. Staff Health and Well-being

Strategy: To achieve the staff health and well-being CQUIN goal, to improve the support available for staff to help promote their health and well-being.

Referrals from managers




Preplacement Assessments




**Headlines:**

**Referrals to the Health at Work Service**

Health at Work advice can be sought from managers and employees to support the improvement of health and wellbeing at work and reduce sickness absence.

The number of referral received continues to increase, 106 referrals were received from managers in November, 89.5% of employees were assessed by an Advisor within 6 days of referral. 98.8% of advice reports were sent to managers within 2 days of the assessment.

Self-referrals also increased, the previous average number of self referrals was 61, in November 80 employees telephoned the Health at Work Advice line to self-refer, all these staff were offered advice about strategies to optimise their health at work within 1 day of the call.

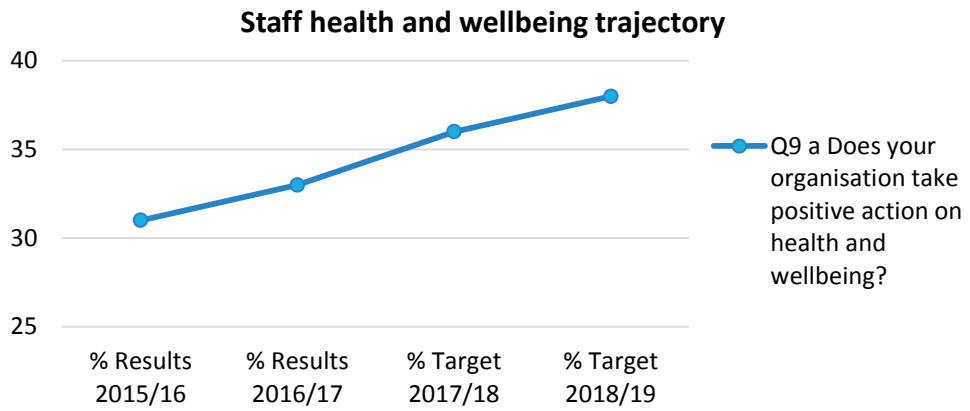
**Pre-placement health advice**

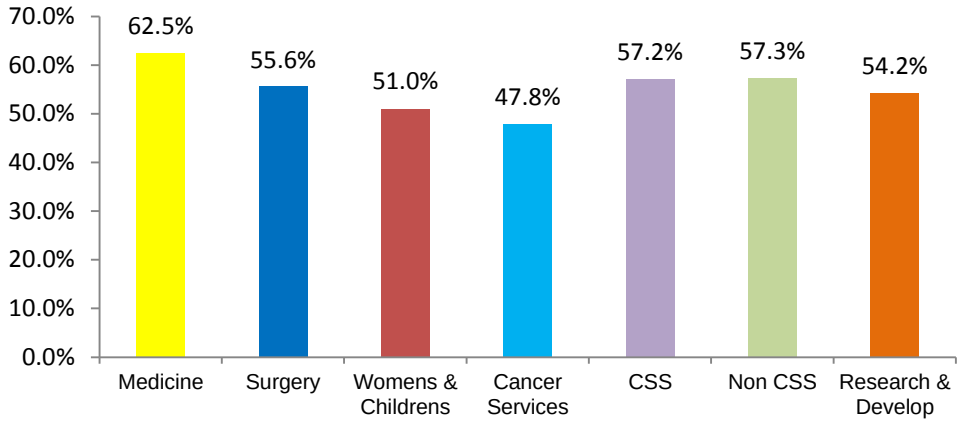
The Health at Work Service provides the Trust with fitness for work advice on all new employees following an offer of a post.

122 Preplacement health questionnaires were received in October, 97.5% of pre-placement health clearances were sent within 2 working days .

## 8b. Staff Health and Well-being

Strategy: To achieve the staff health and well-being CQUIN goal, to improve the support available for staff to help promote their health and well-being in order for them to remain healthy and well.




**Headlines:**

The Health at Work Service (H@W) are providing wellbeing initiatives and improving the support available for staff to help promote health and wellbeing.

**Trajectory:** To achieve a 5% improvement in two of the three NHS annual staff survey questions on health and wellbeing. To vaccinate 70% of frontline healthcare workers against flu between the end of September 2017 to February 2018

**Performance:** The Staff flu vaccine campaign began on the 2nd October 2017. Frontline healthcare workers play a pivotal role in helping to prevent the spread of influenza (flu) throughout the winter months. Flu immunisation is one of the most effective interventions to reduce harm from flu and pressures on health and social care services during the winter.

By the end of November 2597 (56.3%) frontline staff have received the vaccine. Drop in clinics have been held at Lister Community Hub, and roaming clinics have been held at Mount Vernon, QEII, Hertford County, Luton and Bedford Renal Units and Lister.

In total 3145 flu vaccines have been received, in addition to the frontline employees 236 non-frontline staff, 95 Medical students, 104 Nursing students, 61 bank staff and 52 G4S employees. Some employees have chosen not to have the flu vaccine, 320 frontline staff (6.9%) have completed a vaccine decline form.

In December winter wellness events are being held at Mount Vernon and Lister, during these events staff will be encouraged and supported to keep well this winter with a range of health checks, wellbeing advice and flu vaccines.

## 9. Workforce efficiency and capacity

Strategy: To deliver more efficient workforce models, within a reduced pay envelope to deliver financial stability and high quality patient care.

| | Revised plan of savings | Forecast (£) |
|---|---|---|
| **1** | Bank deep dive | 30000 |
| **2** | NWBN | 73000 |
| **3** | Overtime spend reduced | 18000 |
| **4** | Vacancy review | 60000 |
| **5** | Senior management role pause | 169300 |
| **6** | Medic efficiencies | 30000 |
| **7** | Consultancy and Interim reduced spend | 9000 |
| **8** | Direct Engagement | 35000 |
| **9** | MARS scheme savings | 67139 |
| **10** | Workforce effeciencies programme | 40000 |
| | **Total** | 531439 |

**Headlines:**

As part of the Trust's Transformation programme, supporting the Model hospital agenda and development of a leaner Trust organisation structure, a workforce efficiency programme will develop an organisational design to align the demand, capacity and income of the Trust with more efficient workforce models, within a reduced pay envelope to deliver financial stability and high quality patient care. The detail of the savings. The total the Workforce efficiency programme plan includes delivery of savings of £668k in 17-18 year and £3.2 million full year effect, and a 10% reduction in headcount.

**Overview of the Workforce efficiency programme**: A revised savings plan was required to deliver the savings of £668k as a result of a number of factors. The factors included the need to remodel options not requiring financial spend in this year, for example a severance scheme. Also the necessity of remodelling the Clinical administration teams (CATS), including the capture of metrics about reception staff and nurse led clinics, and the resource to support the bedding in of the new Lorenzo system. This resulted in a risk to the delivery of the original programme savings in 17-18 year, however a revised plan was delivered to ensure the original savings are protected:

**The Workforce efficiencies programme -** targets a 10% reduction of staff in scope. The programme includes an estimated reduction of substantive posts of 115 wte, the strategy to limit any potential redundancy is the active management of vacancies, fixed term contracts and turnover to reduce the risk to substantive staff and the implementation of a MARS scheme. **Milestone**: A revised plan is in place to deliver the savings of £531.4 in year 17-18, (see Fig 1). This includes a refocus on Bank spend, a pause on recruiting into Senior roles for the 17-18 year, a direct engagement model with Locum Clinicians and the Non Ward Based Nursing (NWBN) workstream. Progress to date is a delivery of £319k and detailed plans actions are in place to deliver the gap of £212k.

**Non Ward based Nursing -** The NWBN workstream aims to improve cost efficiency of Senior Nurses in roles not directly clinical facing. The savings plan for 17-18 year is 73k and a fye of £144k. This staff base will now benefit from an in-depth review to align the current workforce against the changing clinical and organisational requirements. This will be achieved through the use of the LENS analytical tool devised in conjunction with the Chair of Clinical Nursing Practice at the University of Hertfordshire. The review will also provide an analysis of training needs and will provide a framework for future succession planning.

**The A&C clinical pathway** will deliver co-located pods of staff supporting clinical delivery. **Milestone:** The revised plan is to deliver the new CAT teams next year with a full year effect savings of £1.6 million. Update in month 8 includes comparator information from Kingston Trust, to understand the issues and solutions; this review suggests a number of benefits across the pathway e.g. streamlined clinical financial cashing up, and more importantly improvements in patient experience. A further visit to Royal Berkshire is planned for January. To ensure input and engagement from Medics about the move to co-located staff, the programme team are presenting at Divisional Board and a full plan is in place to ensure consultant engagement.

## 11. Appendices

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1. ERAS Data
2. Medical Staffing Data
3. Appraisal Data
4. Training Data
5. Benchmarking
6. Exit Interview Feedback

## 11. Appendices

### 1. ERAS Data

| Source: ERAS | Total Live Cases as at 31-Oct--17 | Total Live Cases as at 30-Nov--17 | Surgery | Medicine | CSS | Women & Children | Cancer (inc R & D) | corporate |
|---|---|---|---|---|---|---|---|---|
| Headcount | 5895 | 5940 | 1372 | 1447 | 919 | 786 | 675 | 741 |
| Number of Disciplinary Cases (excluding medical cases) % = no of cases as % of headcount | 16 (0.3%) | 13 (0.2%) | 2 (0.1%) | 1 (0.1%) | 3 (0.3%) | 0 (N/A) | 4 (0.6%) | 3 (0.4%) |
| Number of Grievances | 7 | 6 | 1 | 4 | 1 | 0 | 0 | 0 |
| Number of Capability cases | 7 | 8 | 1 | 3 | 1 | 0 | 1 | 2 |
| Number of B&H, discrimination and victimisation cases | 6 | 3 | 0 | 0 | 0 | 0 | 1 | 2 |
| Number of formal short term sickness cases including cases under monitoring | 17 | 18 | 7 | 1 | 5 | 1 | 1 | 3 |
| Number of formal long term sickness cases | 49 | 47 | 12 | 12 | 6 | 8 | 3 | 6 |
| Number of *MHPS cases (Medical cases) | 2 | 1 | 0 | 1 | 0 | 0 | 0 | 0 |
| Total number of cases in progress | 104 | 96 | 23 | 22 | 16 | 9 | 10 | 16 |
| Number of suspensions/medical exclusions (inclusive of over six months) | 4 | 4 | 0 | 2 | 1 | 0 | 0 | 1 |
| Number of suspensions lasting 6 months or longer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Number of appeals | 4 | 3 | 2 | 0 | 0 | 0 | 0 | 1 |

11. Appendices

## 2. Medical HR

### Exception Report Division Summary Since August 2017 Changeover

| | No. submitted reports | Total Additional Hours | Paid Enhanced Hours | Paid Basic Hours | Total Pay | Total TOIL Hours |
|---|---|---|---|---|---|---|
| **Medicine Total** | **44** | **80** | **0** | **26.5** | **£406.68** | **23.75** |
| Complete | 23 | 51 | 0 | 26.5 | £406.68 | 23.75 |
| Pending | 15 | 20.5 | | | | |
| Waiting For Doctor Agreement | 4 | 4.5 | | | | |
| Unresolved | 2 | 4 | | | | |
| **Surgery Total** | **33** | **127.25** | **0** | **2** | **£25.52** | **38.75** |
| Complete | 8 | 40.75 | 0 | 2 | £25.52 | 38.75 |
| Pending | 23 | 82 | | | | |
| Unresolved | 2 | 4.5 | | | | |
| **W&C Total** | **3** | **2.75** | **0** | **0** | **£0.00** | **0** |
| Pending | 1 | 1.25 | | | | |
| Waiting For Doctor Agreement | 2 | 1.5 | | | | |
| **Grand Total** | **80** | **210** | **0** | **28.5** | **£432.20** | **62.5** |

## 11. Appendices

### 3. Appraisals

Appraisal compliance

| Compliance | Done | Not Done | Not due but require review* | Grand Total | Completion Rate % November |
|---|---|---|---|---|---|
| Cancer Services | 375 | 41 | 86 | 502 | **90.14%** |
| Clinical Support Services | 530 | 69 | 266 | 865 | **88.48%** |
| Medicine | 745 | 166 | 219 | 1130 | **81.78%** |
| Corporate | 457 | 118 | 131 | 706 | **79.48%** |
| Research & Development | 50 | 21 | 20 | 91 | **70.42%** |
| Surgery | 716 | 175 | 163 | 1054 | **80.36%** |
| Women's and Children's | 427 | 101 | 105 | 633 | **80.87%** |
| Grand Total | **3300** | **691** | **990** | **4981** | **82.69%** |

Appraisal by Payband Data

| Band | Done | Not Done | Not Due But require review | Grand Total | Completion rate% |
|---|---|---|---|---|---|
| Band 1 | 102 | 17 | 21 | 140 | **85.71%** |
| Band 2 | 542 | 90 | 235 | 867 | **85.76%** |
| Band 3 | 458 | 72 | 136 | 666 | **86.42%** |
| Band 4 | 332 | 77 | 82 | 491 | **81.17%** |
| Band 5 | 676 | 148 | 252 | 1076 | **82.04%** |
| Band 6 | 627 | 119 | 136 | 882 | **84.05%** |
| Band 7 | 381 | 90 | 67 | 538 | **80.89%** |
| Band 8A | 104 | 34 | 27 | 165 | **75.36%** |
| Band 8B | 35 | 19 | 9 | 63 | **64.81%** |
| Band 8C | 20 | 5 | 12 | 37 | **80.00%** |
| Band 8D | 11 | 7 | 3 | 21 | **61.11%** |
| Band 9 | 2 | 2 | 5 | 9 | **50.00%** |
| SMP | 8 | 11 | 2 | 21 | **42.11%** |
| Tupe | 2 | | 3 | 5 | **100.00%** |
| **Grand Total** | **3300** | **691** | **990** | **4981** | **82.69%** |

## 11. Appendices

### 4. Training

| Source: ESR | Trust MTH | Surgery | Medicine | CSS | W & C | Cancer | R and D | Corporate |
|---|---|---|---|---|---|---|---|---|
| Statutory and mandatory training full compliance (Incl M&D) | 65.05% | 61.54% | 56.37% | 69.86% | 66.49% | 72.76% | 76.34% | 74.44% |
| Statutory and mandatory training average compliance (Incl M&D) | 88.58% | 86.60% | 85.18% | 90.89% | 91.67% | 90.48% | 96.08% | 91.42% |

## 11. Appendices

### 5. Benchmarking

| Trust | Mandatory Training Rate Sept 17 | Appraisal Rate Sept 17 | Turnover Sept 17 | Vacancy Rate Sept 17 | In mth Sickness Sept 17 | Agency Sept 17 |
|---|---|---|---|---|---|---|
| Bedford Hospital | 84% | 82% | 14.94% | 8.20% | 2.12% | 6.40% |
| Herts Community | 90% | 88% | 14.60% | 11.90% | 3.58% | 7.76% |
| WHHT | 89% | 90% | 16.00% | 11.80% | 2.80% | 8.30% |
| East & North Herts | 86% | 81% | 12.70% | 8.90% | 4.14% | 4.3% |
| Luton & Dunstable FT | 80% | 79% | 15.29% | 11.20% | 3.14% | 7.80% |
| HPFT | 82% | 89% | 13.14% | 14.30% | 4.13% | 4.70% |
| ELF Bedford | 84% | 85% | 19.45% | 17.40% | 5.97% | 13.10% |
| ELF Luton | 92% | 95% | 18.88% | 16.90% | 6.87% | 9.30% |
| Princess Alexandra | 87% | 80% | 17.67% | 10.70% | 3.29% | 9.40% |
| Essex Partnership UT | 89% | 82% | 13.30% | 13.70% | 4.00% | 4.30% |
| Milton Keynes UFT | 89% | 86% | 12.86% | 14.30% | 4.04% | 6.90% |
| Central North West London FT | 96% | 91% | 17.50% | 14.90% | 3.04% | 4.00% |
| Average | 87% | 86% | 15.53% | 13% | 3.93% | 7.61% |

## 11. Appendices

**6. Exit Interview Feedback by Staff Group**

The following summarises the information collated through leaver questionnaires during November 2017 and provides some analysis of the key trends identified amongst the leavers. The main reasons cited for voluntary resignations were relocation, enhanced job opportunities, and retirement.

Staff Group (Administrative & Clerical)

· A band 4 left with 22 years' service as a result of feeling despondent with work place.; they stated that they have felt un-needed within their department.

· A band 2 left with 8 years' service as they stated they have felt it has been very challenging over the past few years, due to the red tape in the NHS. They cited staff changes, and lots of pressure as contributory factors. This individual felt that their department was not supportive of part time workers.

Staff Group (Healthcare Scientist)

· A band 6 left with 16 years' service because they felt that shift systems make them unwell. As there was alack of and consistency with shifts . In this particular response it was stated that people feel very uncomfortable with talking to the manager. Improvement suggested better communication between the management and the staff.

Staff Group (Nursing and Midwifery registered)

· A band 7 left with 7.5 years' service because they felt there were a lot of changes within hospital which made their role difficult to perform effectively. Examples given: Early discharge of patients not ready to go home therefore unable to give good symptom management and support. End of life patients are being moved on too quickly therefore not able to provide enough symptom control, support and end of life care on wards now. Being able to provide support and symptom management for patients and families and ensure peaceful deaths for patients and support for families/carers. Improvement suggested the job had adapted with some changes in the cancer centre - however with the pressure to move patients on so quickly it is difficult to fulfil the role and care feels compromised.

· A band 2 left with 13 years' service due to better hours, less stress and closer to home job opportunity. On this occasion the individual cited concerns regarding leadership in their department and raised concerns about bullying behaviour towards the team leading to poor morale.

· A band 8 left with 10 years' service due to seeking career development opportunities. They stated that they felt there had been a change in culture in the last year due to pressure over delivering CIPs. They described seeing staff struggle., financial pressure sand fighting for quality on the agenda. Improvement suggested - more value to nursing from other disciplines.

**Agenda Item: 10**

**TRUST BOARD PART 1 – 10 JANUARY 2018**

**RISK AND QUALITY COMMITTEE – MEETING HELD ON 19 DECEMBER 2017**
**EXECUTIVE SUMMARY REPORT**

| | |
|---|---|
| **PURPOSE** | To present to the Board the report from the RAQC meeting of 19 December 2017. |
| **PREVIOUSLY CONSIDERED BY** | N/A |
| **Objective(s) to which issue relates *** | ☑ 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme.<br>☐ 2. **Developing new services and ways of working** – delivered through working with our partner organisations<br>☐ **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.** |
| **Risk Issues**<br><br>(Quality, safety, financial, HR, legal issues, equality issues) | Key assurance committee reporting to the Board<br><br>Quality and safety risks as outlined in paper |
| **Healthcare/National Policy**<br><br>(includes CQC/Monitor) | Potential risk to CQC outcomes<br><br>Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards |
| **CRR/Board Assurance Framework *** | ☐ **Corporate Risk Register** ☑ **BAF** |

**ACTION REQUIRED ***

| | | | |
|---|---|---|---|
| For approval | ☐ | For decision | ☐ |
| For discussion | ☑ | For information | ☐ |

| | |
|---|---|
| **DIRECTOR:** | CHAIRMAN OF RAQC |
| **PRESENTED BY:** | CHAIRMAN OF RAQC |
| **AUTHOR:** | CORPORATE GOVERNANCE OFFICER/ COMPANY SECRETARY |
| **DATE:** | JANUARY 2018 |

**We put our patients first We work as a team We value everybody We are open and honest We strive for excellence and continuous improvement**

**RISK AND QUALITY COMMITTEE – MEETING HELD ON 19 DECEMBER 2017**

**SUMMARY REPORT TO TRUST BOARD – 10 JANUARY 2018**

The following Non-Executive Directors were present:
John Gilham (Chair), Val Moore, Bob Niven, Ellen Schroder (Trust Chair) and Nick Swift

The following core attendees were present:
Jude Archer, Nick Carver, Michael Chilvers and Liz Lees

**The following points are specifically highlighted to the Trust Board:**

**Nursing Establishment Review**

The Acting Director of Nursing presented the biannual review report for ward establishments. The report was in draft, awaiting financial information and the latest NQIs. The data collection for the period was undertaken in October 2017. Detail of the methodology of the review was included in the report. On balance, reviewing all available information, the review suggested that current funded establishments were appropriate to provide safe nursing care on most inpatient wards. However, based on the information in the report, the following recommendations were put forward for consideration:-

- Reduction of inpatient beds at MVCC to open a supportive care unit.
- Uplift of 1 band 2 CSW on late and night shift on Ashwell Ward
- Watch and Wait approach on SSU
- Watch and Wait approach and support ward improvement program on 10B and 8B
- Watch and Wait approach on Barley
- Staffing on Swift ward to remain higher to support elective programme during winter with a review in spring.
- Ward manager to remain supervisory 5 days per week on AMUW and to review in 6 months
- Review of Enhanced Nursing Care team and mental health requirement
- Prepare for the next cohort of TNA in April 2018
- Complete the NWBN project

The Committee endorsed the proposed changes in principle and recommended the report to Trust Board for approval.

The final report is available at agenda item 10.1.

**BAF Discussion – Capacity and Demand Review**

The Committee reviewed the latest position regarding capacity and demand, this having been the first topic discussed under the BAF discussion standing agenda item approximately one year ago. The Chief Operating Officer explained that since that time the Trust had commissioned an external company to undertake capacity and demand modelling. The Chief Operating Officer would be exploring the next steps to take with that data. The Committee were also informed of work taking place to look at improving patient flow at the ED front door which could be improved. It was also considered that the SAFER and Red 2 Green schemes were having a positive impact. It was considered that this remained a key area of risk and it was important that the forthcoming business planning process took steps to mitigate this risk using the data from the work completed to date.

**Outcomes:**

**Divisional Presentation – End of Life Care**

The Trust's Clinical Lead for End of Life Care presented to the RAQC regarding the service. Achievements that were highlighted in the presentation included the Butterfly project and work that had taken place in relation to carer support. The challenges that were identified in the presentation included the STP decision not to adopt the RESPECT model and also ongoing difficulties with engagement. The presentation included a recap of the previous CQC rating for EOLC and a self-assessment of the current position. Regarding future developments, it was proposed that providing regular feedback to the divisions from relatives/carers of EOLC patients could be an effective means of increasing engagement. The Committee thanked the Clinical Lead for End of Life Care for the presentation and noted that EOLC should be kept in mind whilst the Trust strategy is reviewed.

**Emergency Preparedness Quarterly Update**

The Committee received an update on Emergency Preparedness. The paper provided an update on the latest developments regarding the Emergency Planning, Resilience and Response Committee and provided detail of the EPRR work programme. It was reported that the Divisional Executive Committee had given approval for a full time role for EPRR (subject to funding being identified). It was noted that MVCC was working with The Hillingdon Hospitals NHS Foundation Trust to confirm that their site plans were fit for purpose and up to date. The Committee noted the report and plan but continued to hold concerns regarding resourcing.

**SI Report**

The Medical Director presented the Serious Incident Report. The number of SIs declared in the year to date was one case higher than the number reported in the same period in 2016 (56 in total for 2017 year to date). There were currently no Root Cause Analysis reports overdue to the CCG and no outstanding clarifications. It was noted that the last couple of months had seen a small increase in the number of SIs being declared. It was also noted that the Surgery Division had seen an increase in SIs in the last two months. There was some discussion regarding human factors as a contributory factor in SIs. The Committee noted the report.

**Safer Staffing Report**

The Committee received the latest Safe Staffing Report. The Unify submission for registered fill % increased in November with the average day fill % for registered nurses increasing from 92.6% in October to 96.3% in November. The RAQC had been closely monitoring the position following a challenging position at the end of the summer, but targeted work that had been undertaken since that time had helped to improve the situation. The Committee noted the report.

**Medical Staffing Establishment Report**

The RAQC received the first version of the Medical and Dental Establishment Review. This was a new report that the RAQC had previously requested. It was noted that, in comparison with Nursing and Midwifery workforce data, there was a lack, nationally, of accepted standards and therefore limited opportunities for benchmarking and comparison with other organisations. The purpose of the report was to provide a baseline for analysis and then development of a more robust planning methodology. The report included details of the funded establishment for each division and highlighted key areas where difficulties with recruitment existed. The Committee made some suggestions regarding the development of the report and agreed that the report should be provided on a six monthly basis.

**Clinical Effectiveness**

The Medical Director presented the half year (17/18) Clinical Effectiveness report, which summarised performance, developments and current risks. Performance remained moderately good and the Trust's process was being used an exemplar by the CCG for surrounding trusts. The Committee discussed the current position regarding Gap Analysis Action Plans. The Committee noted the report.

**Compliance and Regulation Report**

The RAQC received the Regulation and Compliance Report. The paper included updates on the risk register improvement work, external visits and reviews and CQC compliance and engagement. It was noted that the Trust had now received (and completed and returned) the Trust Provider information request. This indicated that the Trust inspection would be within 6 months (by end of May 18). The report also included details of recent correspondence between the Trust and the CCG regarding quality and safety. A Board to Board meeting had been scheduled to take place in January. The Committee noted the content of the report.

**Lorenzo and Nervecentre Stabilisation Update**

The Committee received updates regarding the Lorenzo and Nervecentre stabilisation work:

Nervecentre - With regard to reporting, progress was being made though some concerns remained regarding data quality. External feedback indicated that the Trust was not taking longer than usual to return to reporting following the switchover.
Lorenzo - Work continued to take place around training and to improve compliance. Validation work also remained ongoing.

The Committee were supportive of the stabilisation plans and requested to be kept updated regarding progress.

**Floodlight Scorecard Month 8**

The Committee noted the latest edition of the floodlight scorecard. It was noted that the report contained some errors.

**Stethoscope Tool Discussion**

The Committee had a brief discussion regarding the Stethoscope tool, which the Non-Executive Directors had received a demonstration of following the last RAQC meeting. The Committee discussed the possibility of using the tool to identify trends on a quarterly basis to be reviewed at RAQC, and of encouraging the use of the tool in the production of reports.

**The following reports were noted by the Committee:**

1. **Clinical Governance Strategy Committee**
   The Committee noted the latest update report from the Clinical Governance Strategy Committee.

2. **Infection Prevention and Control Monthly Report**
   The Committee noted the Infection Prevention and Control monthly update. There had been 1 Trust allocated case of MRSA bacteraemia in the year to date (against a target of 0 cases to year end). There had been 19 cases of C.diff in the year to date (against a target of 11 cases to year end), though 9 cases to date had been provisionally accepted by the CCG Appeals Panel for exemption against financial sanctions as there were no identified gaps in practice. Several further cases were due to be appealed at the next Appeal Panel meeting.

**John Gilham**
**December 2017**

East and North Hertfordshire NHS
NHS Trust

**Agenda Item: 10.1**

**Trust Board Part 1 - January 2018**

**Nursing and Midwifery Establishment Review**

| | |
|---|---|
| **PURPOSE** | To provide the Board with the bi-annual review report for ward establishments for October 2017 |
| **PREVIOUSLY CONSIDERED BY** | Elements of content previously considered by the Nursing and Midwifery Executive Committee (NMEC) and Ward Sisters and Matrons Committee and the Risk and Quality Committee (RAQC) |
| **Objective(s) to which issue relates *** | ☑ **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme.<br>☐ **Developing new services and ways of working** – delivered through working with our partner organisations<br>☐ **Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre** |
| **Risk Issues**(Quality, safety, financial, HR, legal issues, equality issues) | Poor quality patient experience<br>Impact on safety<br>Impact upon annual assessment ratings<br>Non-compliance with regulatory and legislative requirements<br>Trust reputation |
| **Healthcare/ National Policy** (includes CQC/Monitor) | CQC standards, NICE Guidance Safe Staffing for nursing in adult in patient wards in acute hospitals (2014). NICE Guidance Safe midwifery staffing for maternity settings (2015). National Quality Board – How to ensure the right people, with the right skills, are in the right place at the right time. (2013)<br>NHSI-Model Hospital Dashboard (2017) |
| **CRR/Board Assurance Framework *** <br>* tick applicable box | ☑ **Corporate Risk Register** ☐ **BAF** |
| **ACTION REQUIRED *** <br>For approval [x] For decision [ ] <br>For discussion [ ] For information [ ] | |
| **DIRECTOR:** | Director of Nursing and Patient Experience / DIPC |
| **PRESENTED BY:** | Director of Nursing and Patient Experience / DIPC |
| **AUTHOR:** | Acting Director of Nursing and Patient Experience / DIPC |
| **DATE:** | January 2018 |

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East and North Hertfordshire NHS
NHS Trust

# Nursing and Midwifery Establishment Review

# October 2017

**Nursing and Midwifery Establishment Review – Trust-wide**

## 1. Executive Summary

The data collection for the nursing and midwifery establishment review was undertaken in October 2017. Actual staffing, along with patient acuity and dependency data, was collected over a 20 day period. This was then analysed using a recognised evaluative framework, and was benchmarked against other Trusts - **Appendix 1.** Triangulation of this data along with nationally recognised recommendations are used to assess appropriate nurse staffing levels for each inpatient ward. The Trust uses a flexible and pragmatic approach to safe staffing, using evidence-based tools and appropriate skill mix to assess and meet the overall need in all departments. This establishment review outlines the work undertaken since the last review, provides an update on any continuous or on-going initiatives and outlines any future options to be undertaken in relation to maintaining safe and productive nurse staffing levels.

Summary of additional options reviewed:-

- Review of staffing shift plan and skill mix on Ashwell Ward
- Review of staffing shift plan and skill mix on the Short Stay Unit (SSU)
- Review of staffing and skill mix on Ward 10B
- Review of staffing and skill mix on Barley
- Review of staffing and skill mix in Critical Care
- Review of staffing and skill mix on Swift
- Review of staffing and skill mix on Bluebell
- Review of 5 day ward manager supervisory time on the Acute Medical Unit Ward (AMUW)
- Review of proposed introduction of a supportive care pathway at Mount Vernon Cancer Centre (MVCC)
- Update on non-ward based nursing (NWBN) project
- Update on Trainee Nurse Associates (TNA)
- Establishment alignment
- Enhanced nursing care team update

## 2. Introduction

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

The Nursing and Midwifery Council (NMC) sets out nurses responsibilities in relation to safe staffing levels. Demonstrating safe staffing is one of the six essential standards that all healthcare providers must meet to comply with the Care Quality Commission (CQC) regulation. This is also incorporated within the NICE guidelines 'Safe Staffing for nursing in adult inpatient wards in acute hospitals' (2014). The Carter report (2015) recommends the implementation of care hours per patient day (CHPPD) as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards.

Although not directly referenced within this report, other quality indicators have been taken into consideration, i.e. red flags, red triggered shifts and the Nursing and Midwifery Quality Indicators. These indicators are considered and reported within the monthly safe staffing report.

## 3. Purpose

This establishment review was undertaken for a number of reasons, including:-

- The need to provide assurance, both internally and externally, that ward establishments are appropriate to provide safe care to patients.
- To provide establishment data that will inform the Trust's Workforce Strategy and People Strategy 2014-19.
- To deliver Care Quality Commission requirements under the Essential Standards of Quality and Safety, including outcomes 13 (staffing) and 14 (supporting staff).
- To support implementation of the Trust's annual and strategic objectives, the Nursing and Midwifery Ambitions and Patient and Carer Experience Strategy.

## 4. Establishment review methodology

A full review of the data, collection processes and methodologies can be found in **Appendix 2.**

## 5. Current assumptions – Skill Mix and Registered Nurse to bed ratio

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

A full ward breakdown of the service model skill mix and the actual worked skill mix for the reference period can be found in **Appendix 3.**

The Royal College of Nursing (RCN) 'Mandatory Nurse Staffing Levels' (2012) and NICE 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014), suggest wards have a planned registered nurse to patient ratio of no more than 8 patients to one registered nurse on day shifts. Table 1 below indicates the service model average target 'registered nurse to patient' ratio for the Trust; the table indicates that no division has a model registered nurse to patient ratio of more than 1 to 8.

**Table 1**
**Registered Nurse to Patient ratio per division**

| Division | RN to Bed Ratio | | |
|---|---|---|---|
| | Early | Late | Night |
| **Medicine** | 1/6 | 1/6 | 1/7 |
| **Surgery (Excluding Critical Care)** | 1/7 | 1/6 | 1/7 |
| **Women's and Children's** | 2/9 | 2/9 | 2/9 |
| **Cancer** | 2/9 | 2/9 | 1/6 |

## 6. Data Triangulation

### 6.1 Care Hours per Patient Day (CHPPD)

At ENHT care hours per patient day (CHPPD) is a productivity model that has been used, in triangulation with other methods, to set the nursing and midwifery establishments.

The review of NHS productivity, chaired by Lord Carter, highlighted CHPPD as the preferred metric to provide NHS trusts with a single consistent way of recording and reporting deployment of staff working on inpatient wards. The methodology for calculating CHPPD used in this review can be found in **Appendix 4.**

CHPPD includes elements of care time that are categorised as direct and indirect clinical care time, these include:

| Direct patient care time | Indirect patient care time |
|---|---|
| ▪ All hands-on care (for example assistance with eating and drinking, patient hygiene, administering medication, taking clinical observations)<br>▪ Providing one-to-one observation or support to patients (for example, taking them to or from theatre)<br>▪ All direct communication with patients | ▪ Patient documentation<br>▪ Professional discussions to plan patient care<br>▪ Discharge planning<br>▪ Communication with patients relatives and friends<br>▪ Ordering investigations<br>▪ Shift handovers |

CHPPD is used prospectively to identify the likely care time required for expected patient type for a service; this can then be compared to the required CHPPD for actual patients using the service. This can then be compared to the actual CHPPD provided by staff on the ward to asses if wards were appropriately staffed for actual patients.

Table 2 below shows the three dynamics of the continuous linear CHPPD cycle. A full breakdown per ward can be seen in **Appendix 5.** The analysis of outlier wards are discussed further in this report.

**Table 2**
**Care Hours per Patient Day service model, required, and actual worked per division**

| Division | Service Model CHPPD | Required CHPPD | Actual worked CHPPD |
|---|---|---|---|
| **Medicine** | 5.80 | 6.82 | 6.13 |
| **Surgery (Excluding Critical Care)** | 5.21 | 5.73 | 5.32 |
| **Women's and Children's** | 6.96 | 6.94 | 8.50 |
| **Cancer** | 7.23 | 6.51 | 7.93 |

### 6.2 Safer Nursing Care Tool (SNCT)

The SNCT is an evidence-based tool developed to help NHS hospitals measure patient acuity and dependency to inform decision making on staffing and workforce, this tool has an expected 10% variation.

Table 3 below shows the occupancy information for each division for the sample period; the SNCT recommended establishment (whole time equivalent - WTE) adjusted to include 17% headroom, current recruitable establishment and the variance between the two metrics. The table shows the cumulative divisional position.

**Table 3**
**Divisional bed occupancy, SNCT, recruitable establishment and variance**

| Division | Bed Occupancy % | Recommended SNCT recruitable WTE based on occupancy (headroom adjusted to 17%) | Recruitable Establishment (17% headroom) | Variance from actual funded WTE |
|---|---|---|---|---|
| **Medicine** | 96% | 430.19 | 411.30 | -18.89 |
| **Surgery (Excluding Critical Care)** | 93% | 218.24 | 224.64 | 6.40 |
| **Women's and Children's** | 86% | 23.23 | 42.01 | 18.78 |
| **Cancer** | 76% | 38.73 | 67.11 | 28.38 |

As the SNCT has an expected variation of 10% Medicine and Surgery fall within this expected range. Women's and Children's and Cancer have variations of 45% and 42% respectively, this is further explored in section 9 below. A full breakdown of the data for each ward can be found in **Appendix 6.** When using this tool, other variables should also be taken into consideration:

- Clinical speciality
- Ward size and layout
- Staff capacity, capability, seniority and confidence
- Organisational support and support roles
- Ward manager supervisory time

The outlying variances are discussed per individual unit further in the report.

### 6.2.1 SafeCare

SafeCare has been used since October 2015 to provide the safer nursing care data for the establishment review. Acuity/dependency is measured on all inpatient wards three times a day and recorded on SafeCare. SafeCare allows nursing staff to capture actual patient numbers by acuity and dependency and asses if staffing levels are appropriate. SafeCare provides visibility across wards and areas transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards safety. SafeCare has been awarded an endorsement statement by NICE as an effective tool to support Safe Staffing. The Trust is a national leader in the use of SafeCare for safer staffing; having hosted over 50 Trusts to observe and share the Trusts practices and processes to ensure wards are staffed safely.

### 6.2.2 Data Validation

To validate data collection for the establishment review, the following actions were taken:

- Inter-rater reliability training - To ensure that the SNCT data is validated and consistent, inter-rater reliability exercises have been undertaken with the nursing teams to ensure consistent application of the acuity multipliers.
- Comparing recommended establishment for both CHPPD and SNCT **Appendix 6.**
- Matron Acuity Audits - Throughout the data collection period Matrons audited their wards on a weekly basis to validate data inputs. Any discrepancies in the acuity data scoring were corrected and Matrons worked with nurses to ensure consistent application of the tool.
- External benchmarking with other organisations using the NHS Improvement (NHSI) Model Hospital Dashboard.

### 6.2.3 Nursing and Midwifery Quality Indicators

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

Any indicator triggering above established threshold is subject to detailed analysis and an action plan developed where appropriate to improve patient safety and experience. A summary of the nursing and midwifery quality indicators for October 2017 can be seen in **Appendix 7.**

### 6.2.4 Red Triggered Shifts

The Trust monitors and reports shifts that fall below minimum staffing levels (red triggered shifts) on an on-going basis. **Appendix 8** shows the percentage of shifts that fell below minimum levels during the establishment review period. Proactive mitigating action is taken by nursing team to balance risk across the organisation.

Factors affecting red triggering shifts include:

- Patient numbers, dependency and acuity
- Staffing number and skill mix
- Temporary Staffing fill rate
- Vacancy Rate
- Sickness
- Enhanced Nursing Care requirements (Specialling)

## 7. Aligning budgets to clinical models

There is an on-going piece of work to align funded establishments to the safe staffing levels outlined in this paper. Although this work is not yet completed, there are some process improvements that have been identified that should prevent the misalignment of service requirement to budget. These are outlined below and will take immediate affect across the organisation:

- No change to clinical staffing budgets will be made without approval from the director of nursing or medical director.
- Where these areas are on e-roster any change must be identified on a shift plan and any budgetary change must align to the agreed shifts plan.
- Each shift plan must be signed by the clinical service lead, finance manager and appropriate clinical director before any service change or budget adjustment is made.
- An audit log of all changes must be included with each shift plan update.

## 8. Departmental Reviews

### 8.1 Critical Care

The Critical Care unit at East and North Hertfordshire NHS Trust (ENHT) has 20 beds spread over 3 areas, there are currently 93 staff in post in total equating to 88 whole time equivalent (WTE), and the unit currently has a 17.48% vacancy rate. The unit has a high degree of senior staff on duty with a band 7 overseeing each shift and band 6s working as nurse in charge of each patient area.

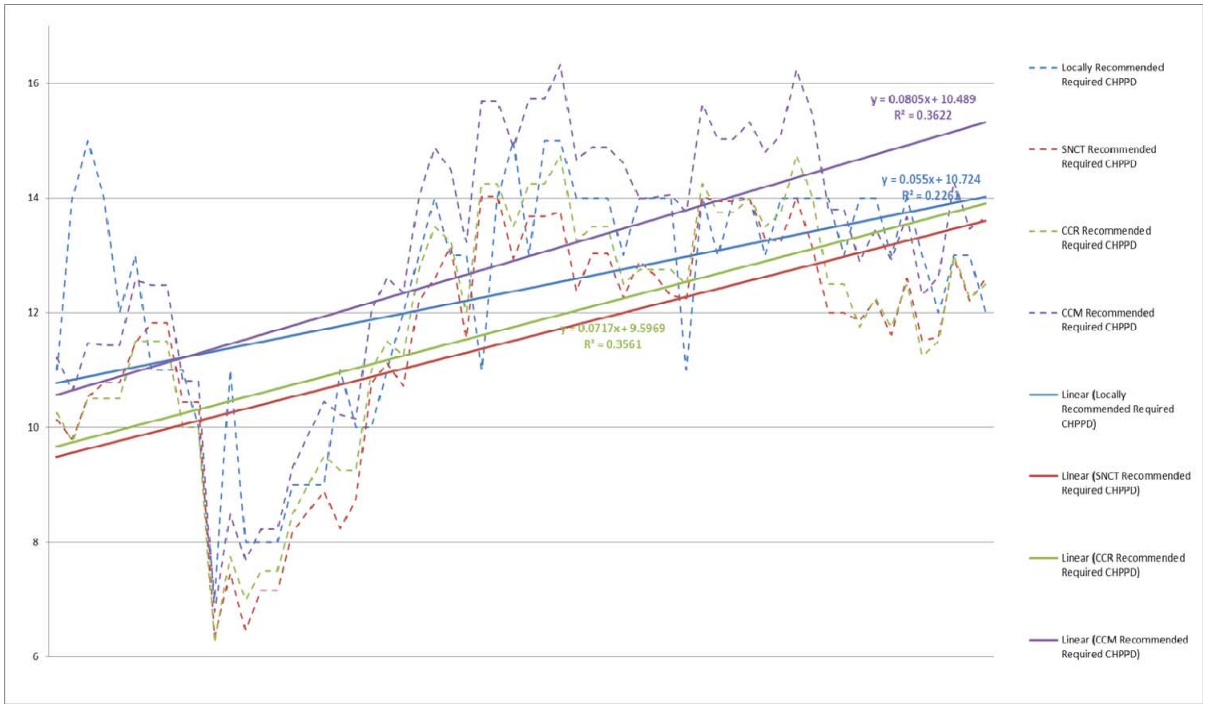
There are generally between 9-20 staff on shift at any time, this variation is due to the highly unpredictable nature of the demand. The unit plans staffing levels on expected activity at the time and flexes as service need dictates which is in line with the “Guidelines for the Provision of Intensive Care Services” (GPCIS) see **Appendix 9**. The unit cares for the most acutely ill patients which are broken down by patient levels, as per the GPCIS guidelines, these patients are scored according their acuity and dependency. Level 0 patients require the least clinical care, level 1 patients have a suggest 1 RN to 4 patient ratio, level 2 have a recommended 1 RN to 2 patients ratio and level 3 patients requiring constant 1-1 or 1-2 care. The patient profile and occupancy is subject to a high degree variation, making planning in the unit particularly complex.

Based on an extensive review carried out in the organisation earlier this year the unit had an average occupancy of 85.42%, with an expected range at 2 standard deviations of between 59.13% and 100% occupancy. The patient profiles for this research found that patients needed on average 18.13 care hours per patient day (Direct Clinical Care), for the acuity and dependency of the patients on the unit.

On this basis, factoring in the nurse in charge element outlined in GPCIS guidelines, the unit should have no less than 97.6 WTE and no more than 109 WTE establishment to provide the direct clinical care needs for patients.

The research carried out also reviewed how staff flexed based on the care needs of the patients in the department, comparing the locally recommended CHPPD levels to GPICS, SNCT and SafeCare recommended CHPPD. Chart 1 below shows the CHPPD comparison across the days of the review period, and suggests the ward does flex CHPPD based on patient need and was generally appropriately staffed to the recommended level. See chart 1 below.

**Chart 1**




This suggests that staffing levels are appropriate for the unit throughout the review.

To ensure the unit has the appropriate funded skills mix for the service, benchmarking of banding profile was carried with five other acute trusts. This data can be found in **Appendix 10**. This shows the critical care unit had a slightly lower level of senior nurses compared to other organisations.

Triangulating all the available data would suggest that the critical care department’s establishment is appropriate for the service and is flexed effectively based on patient need. The benchmarking data would suggest our banding profile is lower than surrounding trusts but the unit has indicated they do not feel this needs adjusting at this time.

### 8.2 Bluebell Children's Ward

Children's services have always flexed the nursing and support staff on Bluebell ward in relation to patient numbers and acuity. Bluebell ward works closely with the children's emergency department and outpatient services to support the whole paediatric unit ensuring all areas are safely staffed. From April 2017, operational beds on Bluebell ward have been reduced to 16 open beds/cots (from 20). This is for a number of reasons:

- Reduced bed occupancy over the summer period
- Vacancies across children's services
- Change in acuity and dependency of patients
- Staff in the pipeline starting in September 2017

The service has continued to monitor patient activity and has recruited into a number of posts successfully. The staffing shift plan for the winter period has been reviewed due to increased patient activity and acuity. Staffing levels continue to be flexed to support any reduction of inpatient numbers, staffing ratios remain within paediatric guidelines and the service is able to flex the team across the unit to maintain safe staffing levels.

### 8.3 Mount Vernon Cancer Centre (MVCC) - Wards 10 and 11

Following the reduction in inpatient bed numbers from 45 to 36 at the beginning of this year, there has been further scoping done at MVCC to review their models of care.

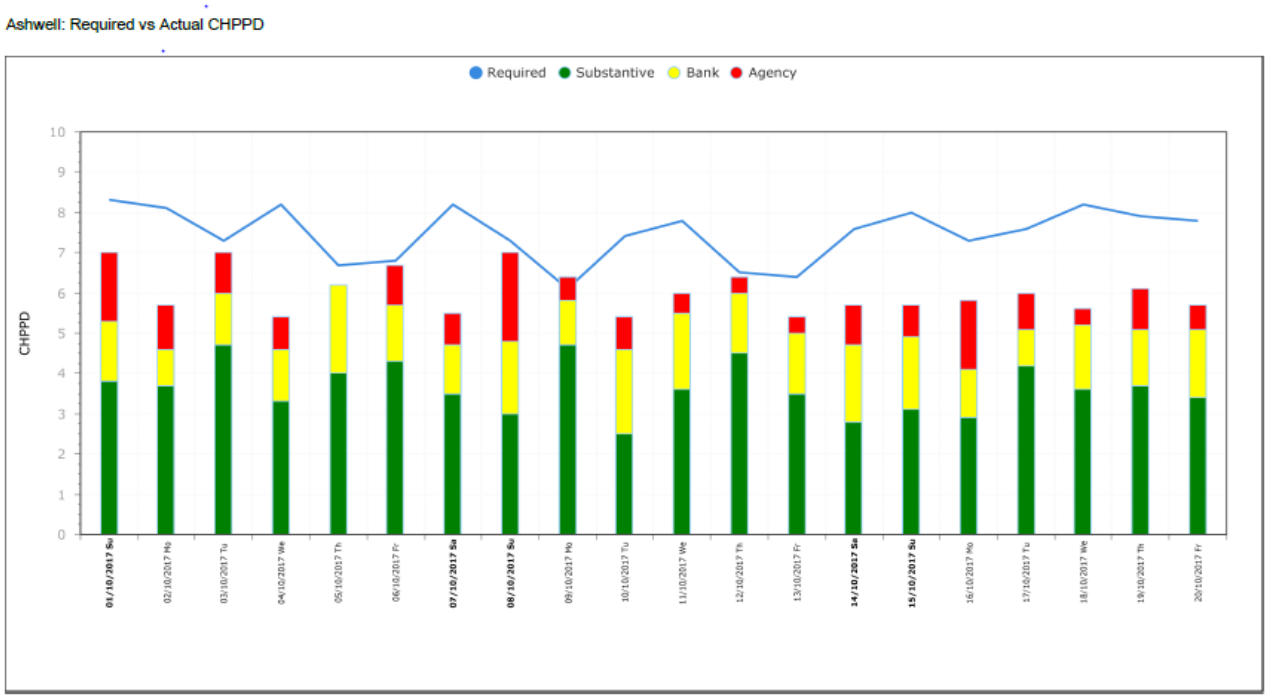
The proposed plan is to further reduce the inpatients beds down to 22 across both ward 10 and 11 and to create a Supportive Oncology Care Day Unit in the old Marie Curie Day Unit, which will be known as the John Bush Supportive Oncology Unit. This unit would be staffed Monday to Friday providing care on an outpatient basis to patients requiring assessment, observation, consultation, treatment, interventions and rehabilitation services. During the weekends, the 7 day elements of the supportive care model will be managed in a dedicated room on Ward 11 to ensure that the patient pathway remains consistent. This plan has been proposed by the Cancer Division and shared with operational, financial and nursing teams at an Executive level.

| Role | Total | Total | WTE Saving | Financial Saving |
|---|---|---|---|---|
| **Nurse band 7** | 2.00 | 2.00 | 0 | £0 |
| **Nurse band 6** | 14.84 | 14.07 | 0.77 | £39,660 |
| **Nurse band 5** | 13.47 | 12.60 | 0.87 | £35,830 |
| **Nurse band 4** | 1.16 | 1.16 | 0 | £0 |
| **Nurse band 3** | 4.26 | 3.48 | 0.78 | £24,420 |
| **Nurse band 2 (CSW)** | 7.91 | 7.13 | 0.78 | £22,260 |
| **Admin & Clerical band 2** | 1.69 | 1.69 | 0 | £0 |
| **Ancillary band 2** | 1.36 | 1.36 | 0 | £0 |
| Total | **47.70** | **43.49** | **3.2** | **£122,170** |

### 8.4 Ashwell Ward

Ashwell ward is a 24 bed frailty ward that flexes to 28 beds when escalation beds are required. The ward has been running at 28 beds and this plan will continue through to April 2018 when this will be reviewed. Chart 3 shows the CHPPD for Ashwell ward had less care hours than were required for the acuity and dependency of their patients.

## Chart 3 - Ashwell: Required vs Actual CHPPD




This ward had a higher than expected number of patients requiring enhanced care during the data collection period, which is reflected in the SNCT data.

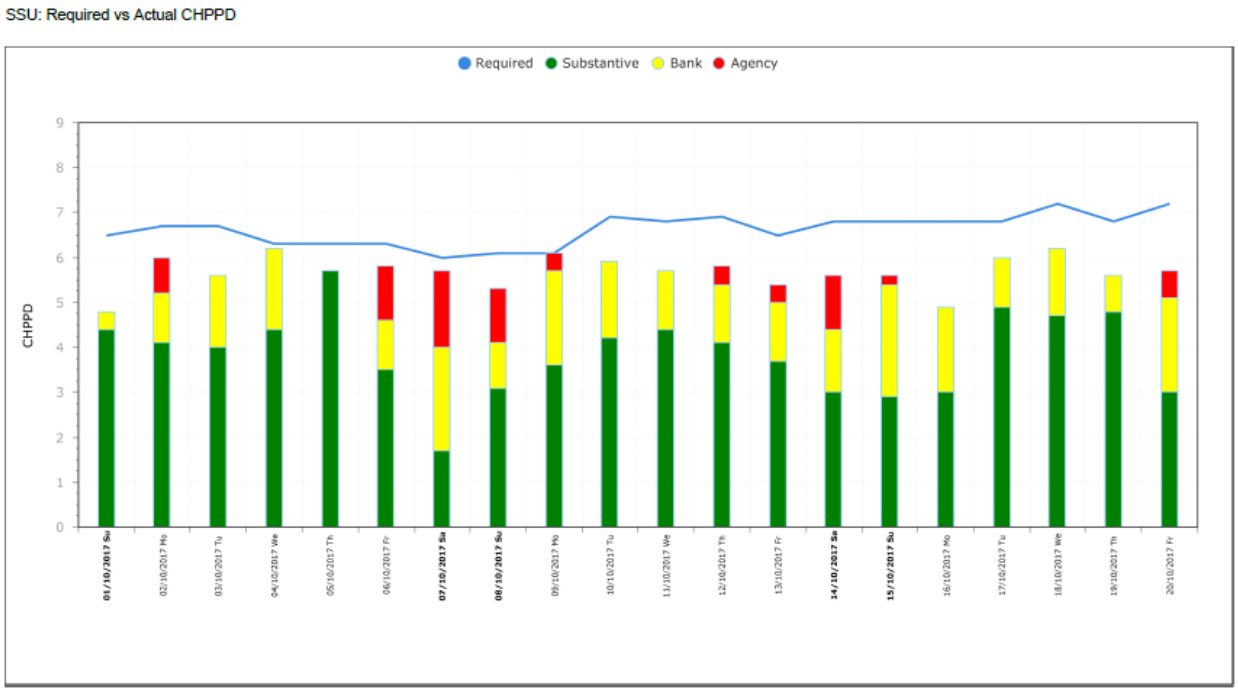
The previous review recommended a 'wait and watch' approach in Ashwell, using the flex and reactive support process. However it was highlighted that Ashwell required uplift prior to this review to support the acuity and dependency of patients on the ward. It was agreed that an additional band 2 CSW for the late and the night shift have been introduced and the ward will continue to be monitored.

| Skill Mix Change | Cost |
|---|---|
| Uplift 4.1 WTE Band 2 CSW | £99,780 |

## 8.5 Short Stay Unit (SSU)

SSU had a higher than expected number of patients requiring enhanced care for the data collection period. This ward also has frequently longer stay patients admitted due to continuing bed pressures within the trust. There will need to be some work done to look at the modelling for the short stay unit to ensure they are receiving the right patient group for the model of care. SSU will continue to be monitored, with continuing support for high acuity patients requiring 1-1 from the enhanced care team.

## Chart 4 - SSU: Required vs Actual CHPPD




This spike in acuity is not consistent with the continuous data collected over the last 6 months and therefore this review recommends a 'wait and watch' approach, focusing on acuity and dependency to ensure these results are not part of a trend change in the service.

### 8.6 10B

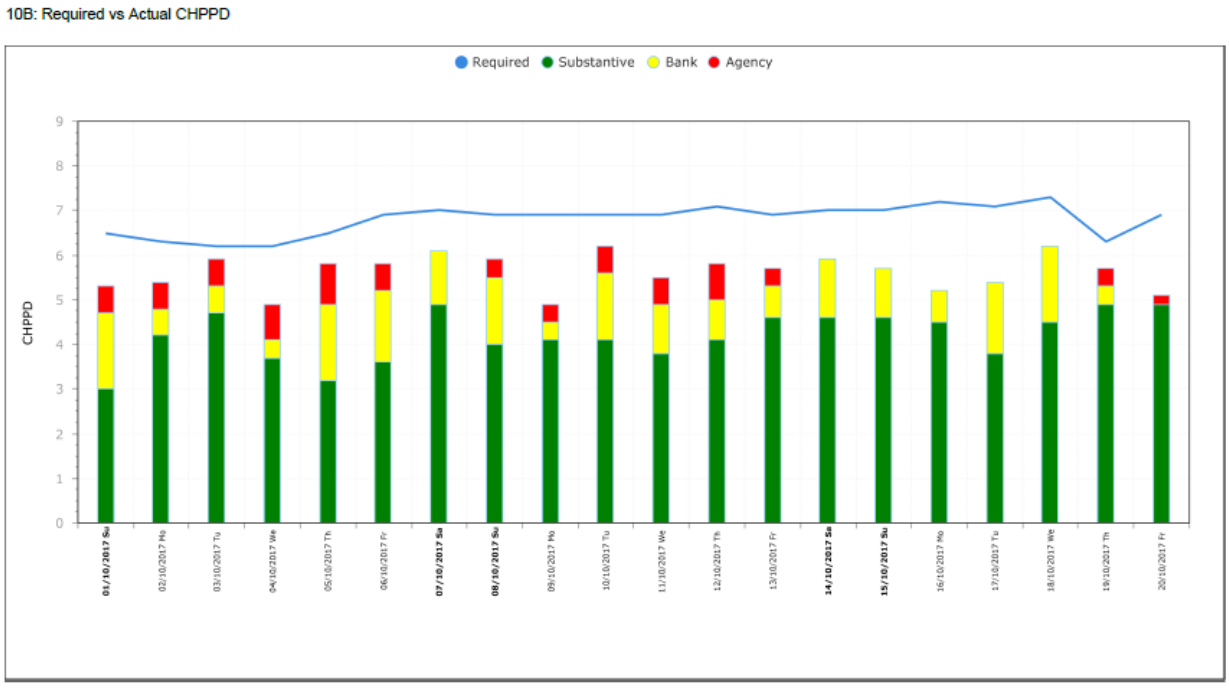
10B is a 30 bedded diabetic ward. The acuity and dependency shows on a daily basis that the care hours do not meet the required demand. Chart 5 shows the required care hours do not meet the actual care hours. This is for a number of reasons such as;

- High number of unfilled shifts
- High sickness levels
- Higher than expected patient acuity and dependency for the ward model.

A deep dive project is being undertaken into the patient type on the ward. Currently the ward receives repatriated neurological patients which are not reflected in the model of care for the ward. The ward also has a large number of patients with numerous co morbidities due to their diabetes and the nurses are required to deal with a high level of complex dressings and IV drug regimes. The ward has an action plan in place with the senior nursing team which includes;

- Ward improvement programme
- Nurse Education Support
- Long line Agency staff
- Ongoing Recruitment
- Extra support from Human Resources to manage sickness absence
- Consideration by the site team when placing complex patients
- Looking at new models of care

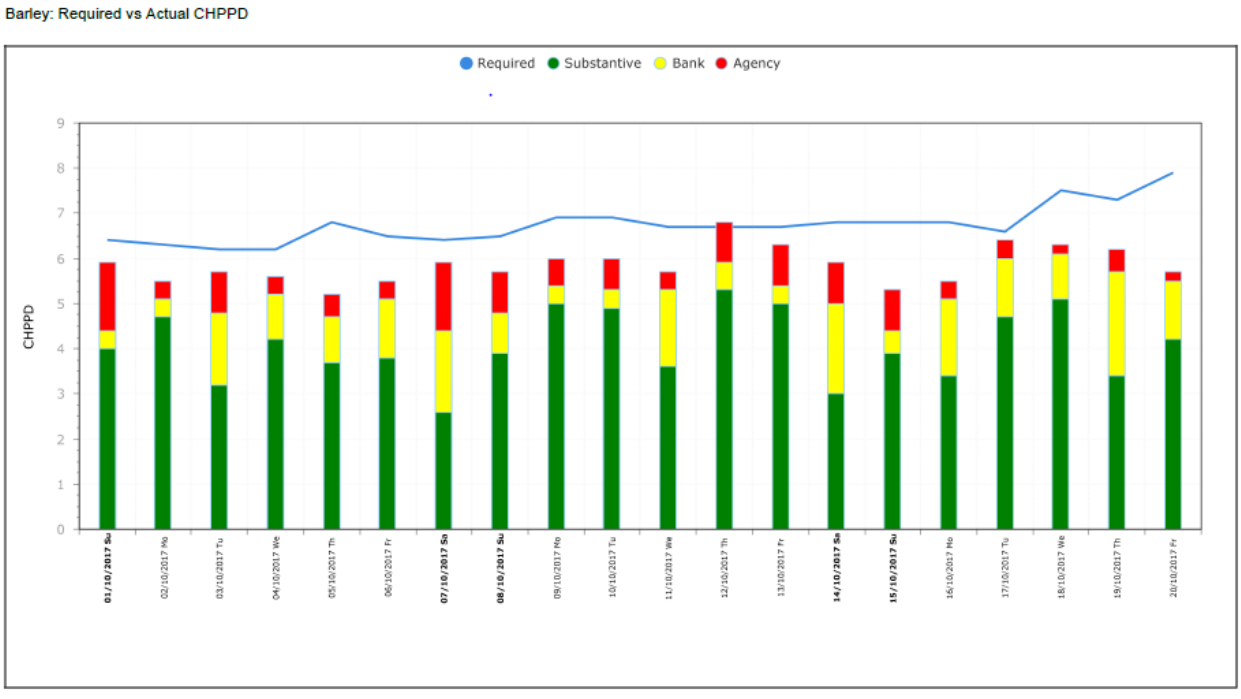
## Chart 5 10B: Required vs Actual CHPPD




## 8.7 Barley

Barley is a 26 bedded rehabilitation stroke ward and the acuity and dependency of patients on Barley therefore is often high. Chart 6 shows that the required CHPPD is lower than the actual worked. However therapists work on the stroke wards providing one hour of therapy for all stroke patients on a daily basis. This care is not included in the CHPPD for this ward. The CHPPD is also being impacted by the number of vacancies due to the challenges associated with unfilled temporary staffing shifts.

## Chart 6- Barley: Required vs Actual CHPPD



The stroke service is looking at new models of care and how therapists can be captured in care hours. Therefore it is recommended that Barley will be on a watch and wait review with support from:

- Long line Agency staff and focus on improving temporary staffing fill rates
- Matron acuity and dependency monitoring
- Human resources for ongoing Recruitment and retention support
- Looking at new models of care in the stroke unit

### 8.8 Acute Medical Unit Ward (AMUW)

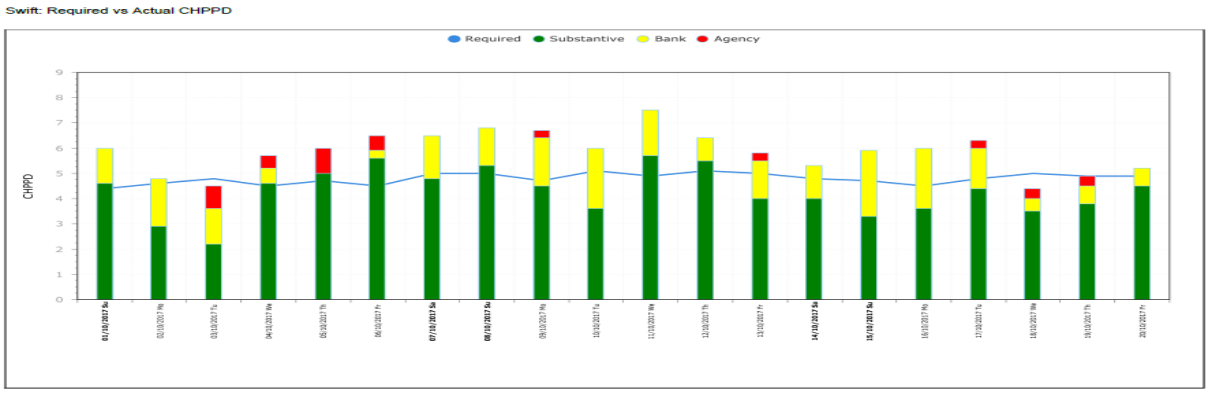
The risk assessment completed following the introduction of the TNA role, highlighted that the skill mix in this area, on the days that the ward manager is not supervisory, is not adequate. This is largely due to the admission criteria, high turnaround of patients and the geographical layout which consists of 100% side room accommodation. It is therefore recommended that the ward manager remains supervisory five days a week instead of three to ensure the unit is staffed safely. This will be reviewed again in six months.

| Skill Mix Change | Cost |
|---|---|
| Uplift 0.39 WTE Band 5 | £13,600 |

### 8.9 Swift

Swift is a 26 bedded elective Orthopaedic ward. The ward layout is over two areas and consists of all side rooms. This is not taken into account when using the SNCT so professional judgement needs to be used when looking at Swifts staffing levels. Due to their occupancy they remain over on their care hours shown in chart 7. This review recommends that Swift staffing remain the same over the winter period due to a plan to increase elective admission rates. If occupancy drops staff will be flexed to support other areas when required. This will be reviewed again in 6 months.

**Chart 7- Swift: Required vs Actual CHPPD**

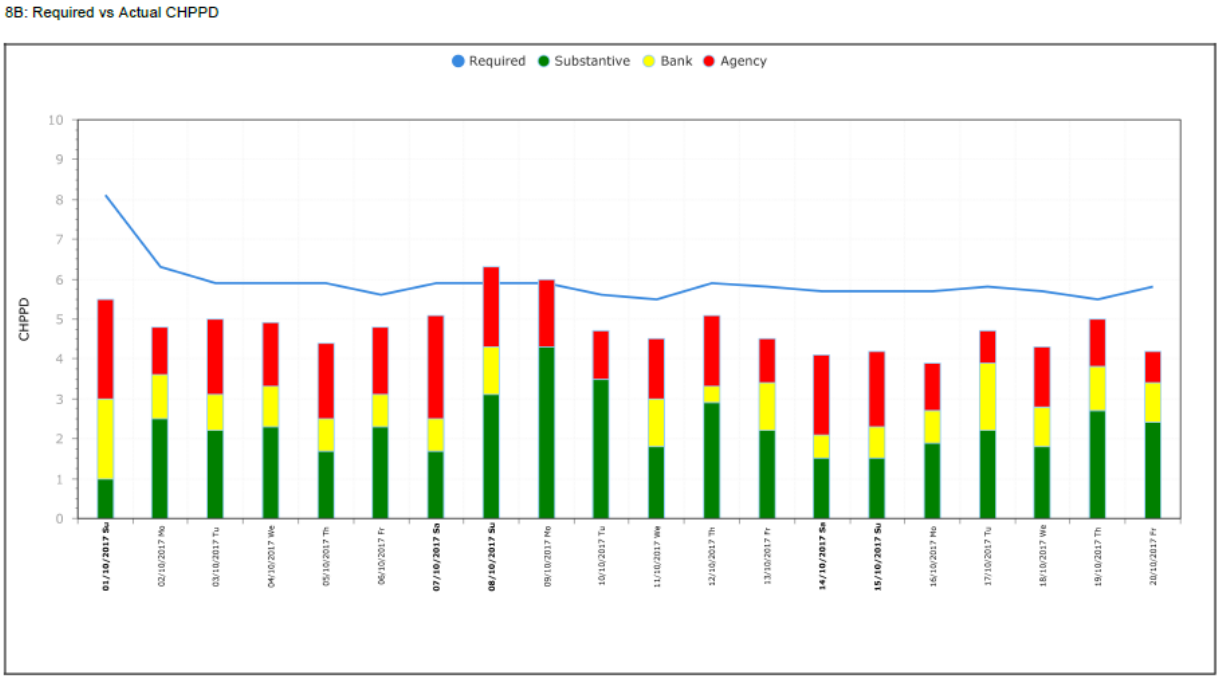



### 8.10 8B

8B is a 30 bed general surgical and vascular ward. During the establishment review the SCNT and CHPPD indicated the funded establishment was within the agreed parameters. The April 2017 review agreed that 8B would have an uplift of 1 band 2 CSW on a night shift. Chart 8 shows that the required CHPPD compared to the actual CHPPD is not meeting the requirement. This is for a number of reasons which were;

- High level of vacancy
- Shifts not being filled by temporary staffing
- Higher than average sickness levels

**Chart 8- 8B: Required vs Actual CHPPD**




This review therefore recommends the following actions:

- Ward improvement plan to replicate the work carried out on ward 10B
- Watch and wait approach
- Support from Human Resources with sickness management, recruitment and retention
- Introduce Agency long line staff and movement of skilled staff from other areas within the Surgical Division

## 9. Trainee Associate Nurse (TNA) Pilot

This new nursing support role works alongside healthcare support workers and registered nurses to deliver hands on care, ensuring patients continue to get the compassionate care they deserve. Nursing associates support nurses to spend more time using their specialist training to focus on clinical duties and take more of a lead in decisions about patient care.

The NMC (2017) stated “The intention is for nursing associates, who will have foundation degrees, to contribute to the delivery of patient care. The registered nurse will still have responsibility as the primary assessor, planner and evaluator of care. Nursing associates will support, not replace, registered nurses.” The NMC have agreed to regulate this role.

Hertfordshire and West Essex STP became a pilot site for the new Trainee Nursing Associate (TNA) programme. Across the STP 53 Trainees have commenced this programme, of which 17 are from ENHT. The TNA programme is a two year work based learning programme with one day a week attendance at University. The TNA works under supervision of the registered nurse delivering effective, safe and responsive care. On successful completion of the course the Nursing Associate will be able to work independently, within defined parameters of practice.

Our 17 TNA’s are progressing well and have completed their first external placement which provided learning experiences for the TNA’s in a variety of settings for a period of four weeks which included: the Mental Health Trust, Community, Private sector and an Acute Trust. Facilitated meetings take place monthly with the TNA’s and an in-house educational rolling programme will feature in these meetings commencing in 2018. Ward managers and mentors support sessions will also be commencing in 2018.

## 10. Enhanced Nursing Care Team

The Enhanced care team have embedded best practice for patients in our trust that require enhanced care (specialling).

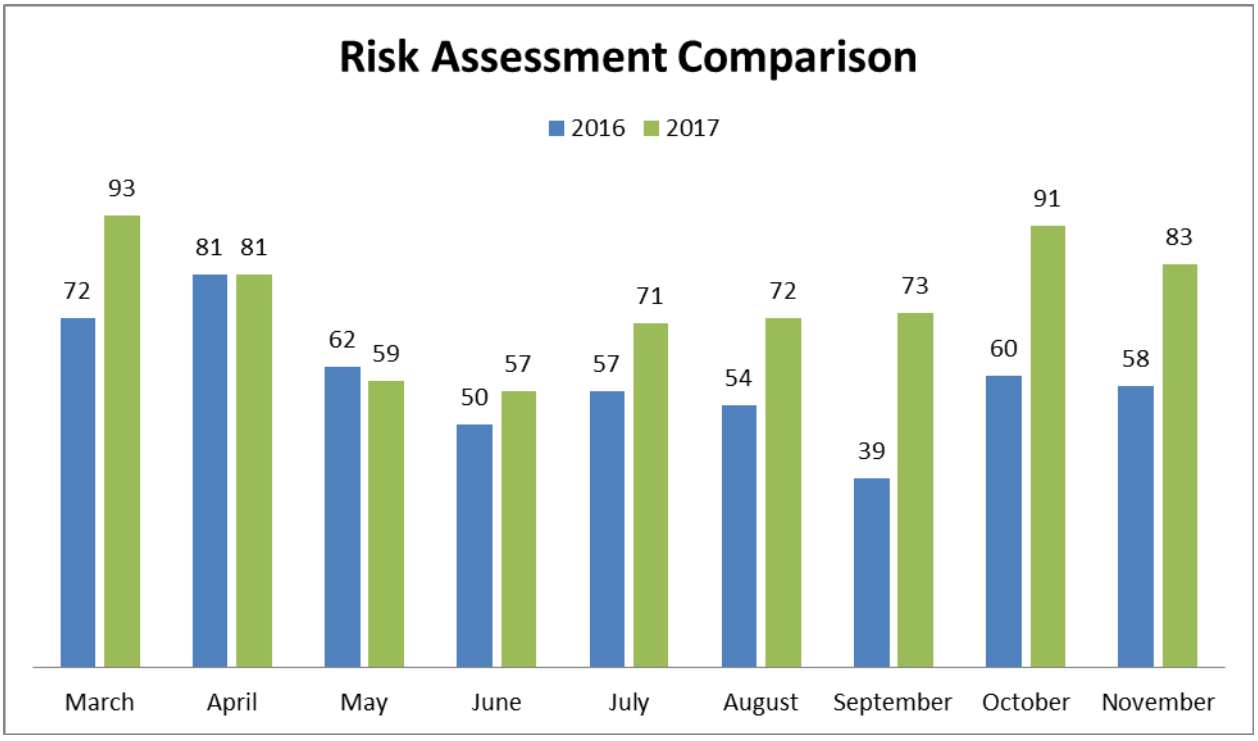
The team has contributed to the following benefits:

- More hours of care at reduced costs
- Reduction in agency spend
- Falls reduction
- Harms reduction
- Higher level of care for vulnerable patients
- Preventing deconditioning
- Robust process for enhanced care
- Rotation of staff to most high risk patients
- Specialist training
- Involving carers
- Promoting independence
- Reduced length of stay
- Improved compliance with MCA and DOLs
- Use of volunteers for enhanced care
- Least restrictive care requirement for vulnerable patients
- Introduction of Bay watch

The Enhanced Care Team has now introduced the band 4 shift leaders to manage and coordinate the team out of hours. In addition the team are working with Hertfordshire Partnership Foundation Trust (HPFT) supporting adult and paediatric mental health patients requiring enhanced care whilst in the acute trust. Additional training has been delivered to support this collaborative work.

The team is now supporting a much larger cohort of patients with varying care needs, demand continues to remain high; Chart 9 shows the risk assessments received for patients requiring enhanced care 2017 compared to 2016. The demand for the service has increased and temporary staff are being used to support the increased demand and ensure patient safety. The mental health enhanced care will be reviewed in December with a view for uplift in the team to support the mental health demand.

**Chart 9**



The team has received very positive feedback for the quality of care and support they are providing for patients. They have also hosted numerous visits to share the good practice with other Trusts who are keen to implement a similar model. The team have written a case study for NHSI about how the best practice team works. They have also won an Award for "care needs first" at the national Allocate awards in October 2017 and were finalists in the RCNI awards in May 2017.

## 11. Non Ward Based Nursing Project

Non-ward based staff form a large part of the organisation and have, historically, been developed through organic growth. This staff base can now benefit from an in-depth review to align the current workforce against the changing clinical and organisational requirements. The project was initiated in July 2017 with several qualitative and financial objectives. These included a review and evaluation of roles and activities, supporting ward activity, and maximising income generation.

The immediate aim was to support and contribute to the Trust CIP programme by delivering sufficient non-ward based staff shifts to wards to achieve a financial contribution target of £12k per month. This was achieved, as planned, in October of this year. August saw the launch of the diary exercise with the first tranche of over 50 diaries issued. These were reviewed collectively on return and contributed to the delivery of the financial target. Diaries continue to be issued in tranches with nearly 300 issued to date. These include a whole range of non-ward based services, with the final tranche to be issued to outpatients in November.

The culmination of the exercise will inform the proposed in-depth review of the roles and activities of non-ward based nurses, and will allow for a more objective approach to meeting the clinical and organisational demands.

## 12. Summary of proposed changes from establishment review

| WTE movement | MVCC Ward | Ashwell | AMUW | Total WTE Movement |
|---|---|---|---|---|
| Nurse band 7 | 0 | 0 | 0 | 0 |
| Nurse band 6 | -0.77 | 0 | 0 | -0.77 |
| Nurse band 5 | -0.87 | 0 | 0.39 | -0.48 |
| Nurse band 3 | -0.78 | 0 | 0 | -0.78 |
| Nurse band 2 (CSW) | -0.78 | 4.1 | 0 | 3.32 |
| Admin & Clerical band 2 | 0 | 0 | 0 | 0 |
| Ancillary band 2 | | 0 | 0 | 0 |
| Total | -3.2 | 4.1 | 0.39 | 1.29 |

| £ movement | MVCC Ward | Ashwell | AMUW | Total £ Movement |
|---|---|---|---|---|
| Nurse band 7 | 0 | 0 | 0 | 0 |
| Nurse band 6 | -39,660 | 0 | 0 | -39,660 |
| Nurse band 5 | -35,830 | 0 | 13,600 | -22,230 |
| Nurse band 3 | -24,420 | 0 | 0 | -24,420 |
| Nurse band 2 (CSW) | -22,260 | 99,780 | 0 | 77,520 |
| Admin & Clerical band 2 | 0 | 0 | 0 | 0 |
| Ancillary band 2 | 0 | 0 | 0 | 0 |
| Total | -122,170 | 99,780 | 13,600 | -8,790 |

## 13. Summary and Recommendations for Executive Approval

On balance, reviewing all available information, this review suggests that current funded establishments are appropriate to provide safe nursing care on most inpatient wards. However, based on the information in this report, the following recommendations should be considered:-

- Reduction of inpatient beds at MVCC to open a supportive care unit.
- Uplift of 1 band 2 CSW on late and night shift on Ashwell Ward
- Watch and Wait approach on SSU
- Watch and Wait approach and support ward improvement program on 10B and 8B
- Watch and Wait approach on Barley
- Staffing on Swift ward to remain higher to support elective programme during winter with a review in spring.
- Ward manager to remain supervisory 5 days per week on AMUW and to review in 6 months
- Review of Enhanced Nursing Care team and mental health requirement
- Prepare for the next cohort of TNA in April 2018
- Complete the NWBN project

## 14. Next Steps

The Board are asked to approve the recommendations in this report.

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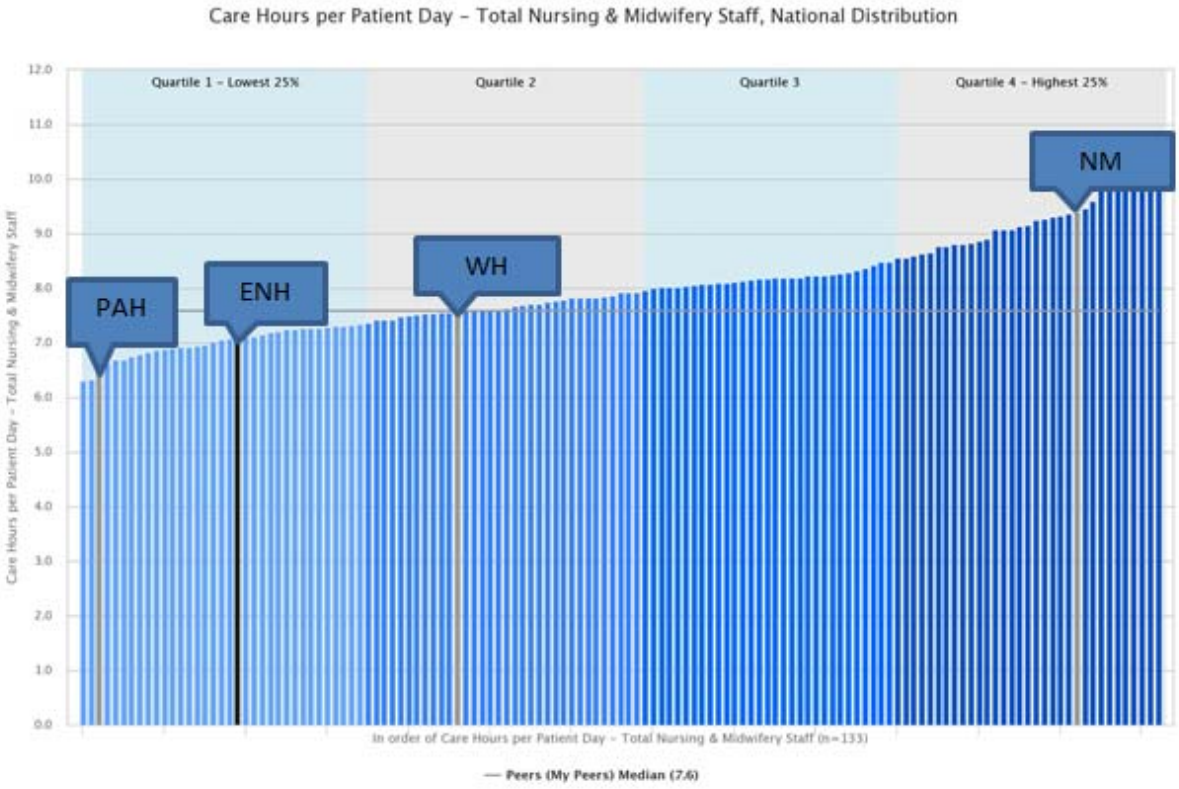
**References:**

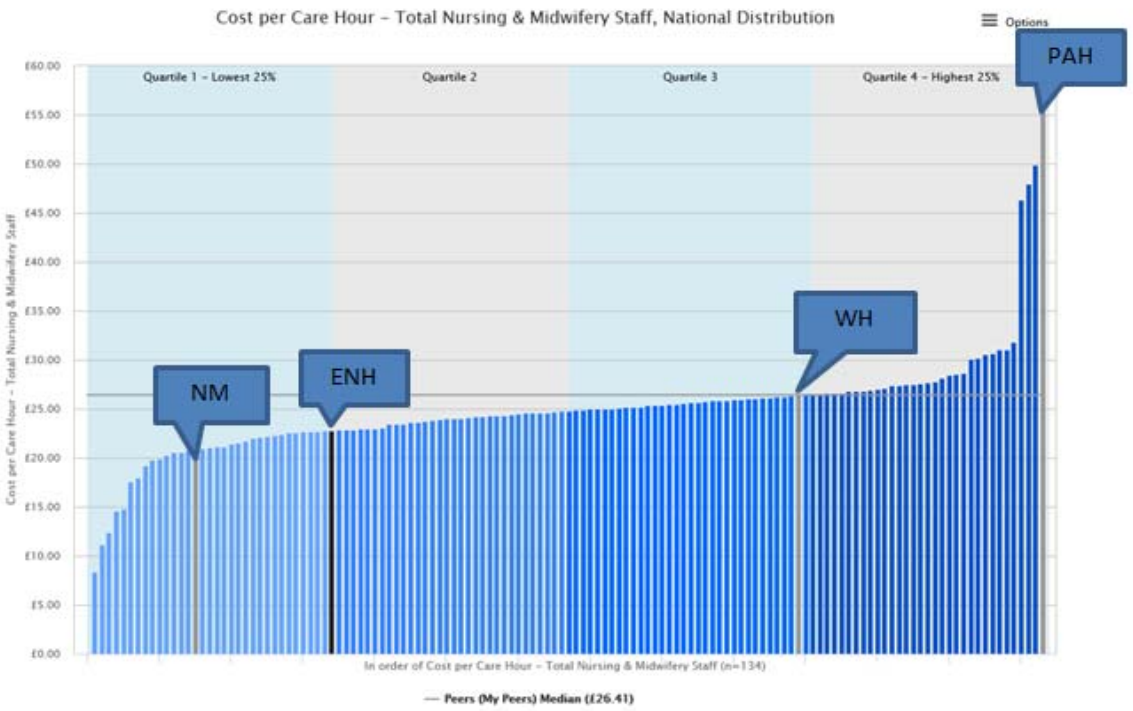
- Carter (2015). Productivity in NHS Hospitals. London: Department of Health.
- Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: Stationery Office
- NHS England (2016). Leading Change and Adding Value: A framework for nursing, midwifery and care staff. London: NHS England
- NICE (2013) Safe Staffing for nursing in adult inpatient wards in acute hospitals.

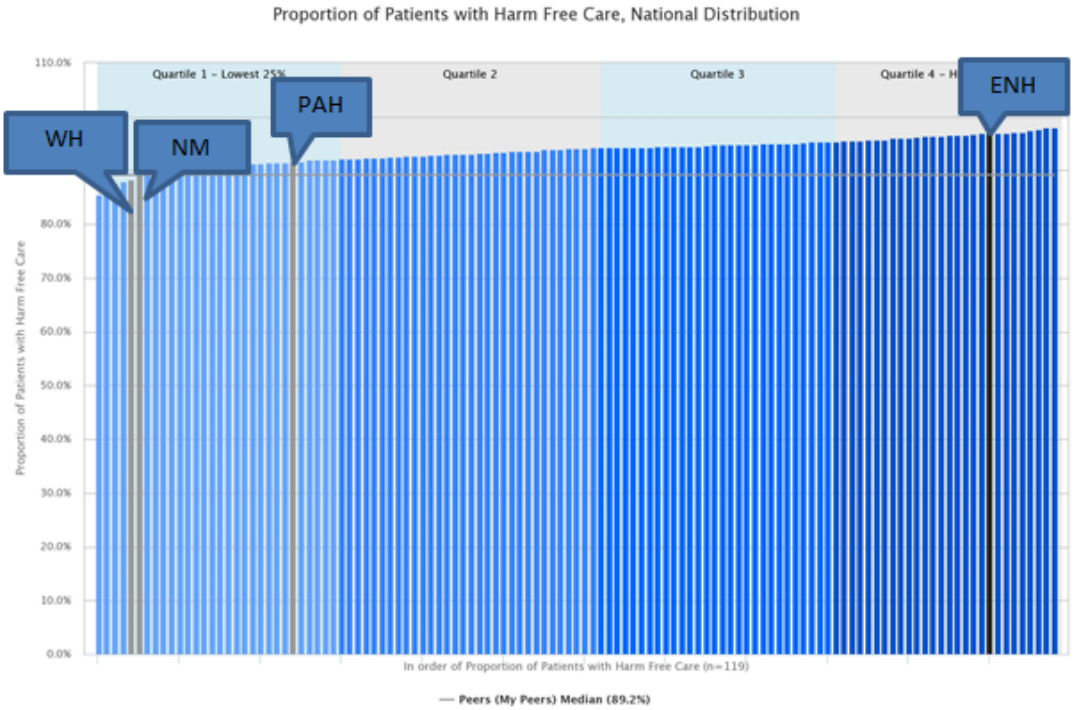
**Appendix 1**

## Benchmarking data comparing local peers From The NHSI Model Hospital Dashboard – latest data available August 2017

East & North Hertfordshire NHS Trust (ENH), Princess Alexandra Hospital (PAH), West Herts Hospitals Trust (WH) North Middlesex University Hospitals Trust (NM)




Cost per Care Hour – Total Nursing & Midwifery Staff, National Distribution
Options
Quartile 1 – Lowest 25%
Quartile 2
Quartile 3
Quartile 4 – Highest 25%
PAH
WH
ENH
NM
£60.00
£55.00
£50.00
£45.00
£40.00
£35.00
£30.00
£25.00
£20.00
£15.00
£10.00
£5.00
£0.00
Cost per Care Hour – Total Nursing & Midwifery Staff
In order of Cost per Care Hour – Total Nursing & Midwifery Staff (n=134)
Peers (My Peers) Median (£26.41)


Proportion of Patients with Harm Free Care, National Distribution
Quartile 1 – Lowest 25%
Quartile 2
Quartile 3
WH
NM
PAH
ENH
110.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Proportion of Patients with Harm Free Care
In order of Proportion of Patients with Harm Free Care (n=119)
Peers (My Peers) Median (89.2%)

## Methodology

The following information was also collected and reviewed; a review of all relevant literature and guidelines was undertaken prior to commencement of this review, these included:

- NICE Guidance on Safer Staffing for nursing in adult inpatient wards in acute hospitals (2012)
- Compassion in Practice, NHS England (2012)
- Safer Nursing Care Tool
- Nurse sensitive indicators
- Safer Staffing Guidance, Trust Development Authority (2015)
- Leading Change Adding Value (2016)
- Lord Carter Report (2016)
- Lord Willis Report (2015)

As part of this review all calculations were carried out in line with the national guidance associated with these tools. This document details the assumptions, methods of data collection, calculation and evaluation as applied in the establishment review. These are set out for each information process below:

### Skill Mix:

Data for this metric is collected from the approved shift plans defining each service model and actual hours worked on the roster system. It is assumed that the roster template is an accurate representation of the shift plan, that the shift plan is an accurate representation of the service model and that the hours worked on the roster are true reflection of what was worked. The calculations for this metric are:

**Service model skills mix:**

**Total number of clinical hours available on shift plan for registered/unregistered staff**

**/**

**Total number of clinical hours available on shift plan**

**Actual skills mix:**

**Total number of clinical hours worked for registered/unregistered staff for the reference period**

**/**

**Total number of clinical hours worked for the reference period**

### Registered nurse to bed ratio:

The data for this metric is collected from the daily staff sheet and the shift plan, it is assumed that the number of available beds on the daily staffing return is correct and the number of registered nurses on shift on the shift plan is an accurate representation of what could be rostered to work. The calculations for this metric are:

**Number of registered nurse on shift**

**/**

**Number of available beds for reference period**

**Care Hours per patient day (CHPPD)**

The data for this metric is collected from the service model shift plans, the Trusts e-roster system and SafeCare. It is assumed that the service model shift plan is an accurate representation of the service, the roster is an accurate reflection of the hours worked and SafeCare has accurate patient acuity and dependency scores input for each patient. As SafeCare uses an external formula to calculate the required and actual CHPPD values, it is assumed that this formula is correct and the Shelford Acuity and Dependency model is appropriate for the service. The calculations for this metric are:

**Service Model CHPPD:**

**Total service model care hours (clinical care hours for registered and unregistered staff)**

**/**

**Total beds**

**Required CHPPD:**

**Required hours of work based on standardised SNCT model**

**/**

**Average patients per 24 hours in reference period (Patient days)**

**Actual CHPPD:**

**Actual Hours Worked**

**/**

**Average patients per 24 hours in reference period (Patient days)**

**Cost of Care Hours per Patient Day:**

The data for this metric is taken from the same sources as detailed in CHPPD calculations above, along with financial information from the budgeted and actual cost in month for the reference period. In addition to the assumptions made in the CHPPD calculation, it is assumed that the financial information is an accurate account of what is spent in month and that the budget is representative of the nursing spend for inpatient activity.

**Target cost of care hours:**

**Budget per bed day (Total monthly budget/number of inpatient beds)**

**/**

**Service model CHPPD**

**Required cost of care hours:**

**Target cost of care hours**

**X**

**Variance factor of CHPPD (Target model CHPPD/Required CHPPD)**

**Actual cost of CHPPD:**

**Spend per bed day (Total monthly budget/number of inpatient beds)**

**/**

**Actual worked CHPPD**

**Cost distribution of CHPPD:**

This metric builds on the actual worked CHPPD and breaks this down by how it was funded, highlighting the substantive, bank and agency proportions of how CHPPD is provided.

**Safer Nursing Care Tool:**

Calculations for this metric follow the SNCT national guidelines; data collection for this metric is taken from the roster and SafeCare systems. It is assumed that the roster is an accurate reflection of the work carried out and that SafeCare has accurate patient acuity and dependency scores input for each patient. Calculations for this metric are:

**Bed Occupancy:**

**Total bed days in reference period**
**/**
**Total available beds in reference period**

**SNCT WTE required:**

**Sum of** [ **Total number of patient of a specific acuity** **X** **SNCT specific multiplier** ]

**Required SNCT is then adjusted to include 17% headroom**

**Variance from actual funded WTE:**

**Funded WTE – Adjusted SNCT Recommended WTE**

**Supervisory Shifts:**

Data for this metric is taken from the shift plans and the roster system, it is assumed that the shift plan accurately represents the number of supervisory days available for managers to work, and that the data in the roster system is correct. Calculations for this metric are:

**Supervisory hours worked**
**/**
**Supervisory hours available**

## Table 1

*The table below shows the registered and unregistered nurse % for each ward:*

| Div | Speciality | Ward | Service model registered nurse % | Service model unregistered nurse % | Actual registered nurse % | Actual unregistered nurse % |
|---|---|---|---|---|---|---|
| Medicine | Care of the Elderly | 9B | 60.00 | 40.00 | 56.40 | 43.60 |
| | | Ashwell | 54.00 | 46.00 | 47.30 | 52.70 |
| | | 9A | 57.00 | 43.00 | 53.70 | 46.30 |
| | Stroke | Pirton | 67.00 | 33.00 | 67.70 | 32.30 |
| | Stroke | Barley | 61.00 | 39.00 | 58.00 | 42.00 |
| | General | 6A | 56.00 | 44.00 | 54.90 | 45.10 |
| | General | 10B | 56.00 | 44.00 | 52.10 | 47.90 |
| | Respiratory | 11A | 71.00 | 29.00 | 70.00 | 30.00 |
| | | 7AN | | | | |
| | Cardiology | ACU | 67.00 | 33.00 | 74.60 | 25.40 |
| | Acute | AMU Ward | 56.00 | 44.00 | 49.90 | 50.10 |
| | | SSU | 60.00 | 40.00 | 62.00 | 38.00 |
| | Renal | 6B | 58.00 | 42.00 | 64.70 | 35.30 |
| Surgery | General | 8A | 59.00 | 41.00 | 58.70 | 41.30 |
| | | 8B | 63.00 | 37.00 | 69.70 | 30.30 |
| | Surgical Spec | 11B * | 55.00 | 45.00 | 57.40 | 42.60 |
| | | 7B | 64.00 | 36.00 | 66.80 | 33.20 |
| | T&O | 5A | 61.00 | 39.00 | 66.70 | 33.30 |
| | | Swift | 61.00 | 39.00 | 59.10 | 40.90 |
| | | 5B | 57.00 | 43.00 | 56.60 | 43.40 |
| | ATCC | Critical Care | 90.00 | 10.00 | 88.90 | 11.10 |
| W&C | Gynae | 10A Gynae* | 67.00 | 33.00 | 68.90 | 31.10 |
| | Paeds | Bluebell | 80.00 | 20.00 | 76.50 | 23.50 |
| Cancer | Inpatient | Ward 10 | 75.00 | 25.00 | 77.50 | 22.50 |
| | | Michael Sobell House | 59.00 | 41.00 | 61.60 | 38.40 |

## Table 2

*The table below shows the available staff on shift as per the agreed shift plan and the Registered Nurse to bed ratio*

| Div | Speciality | Ward | RN to Bed Ratio Early | Late | Night |
|---|---|---|---|---|---|
| Medicine | Care of the Elderly | 9B | 1/6 | 1/7 | 1/7 |
| | | Ashwell | 1/7 | 1/7 | 1/9 |
| | | 9A | 1/7 | 1/7 | 1/7 |
| | Stroke | Pirton | 2/9 | 2/9 | 1/7 |
| | Stroke | Barley | 1/5 | 1/6 | 1/9 |
| | General | 6A | 1/7 | 1/7 | 1/7 |
| | General | 10B | 1/7 | 1/7 | 1/7 |
| | Respiratory | 11A | 1/6 | 1/5 | 1/6 |
| | | 7AN | | | |
| | Cardiology | ACU | 1/5 | 1/5 | 1/5 |
| | Acute | AMU Ward | 1/8 | 1/5 | 1/5 |
| | | SSU | 1/7 | 1/7 | 1/7 |
| | Renal | 6B | 1/5 | 1/5 | 1/8 |
| Surgery | General | 8A | 1/7 | 1/7 | 1/7 |
| | | 8B | 1/6 | 1/7 | 1/7 |
| | Surgical Spec | 11B * | 1/7 | 1/5 | 1/7 |
| | | 7B | 1/7 | 1/7 | 1/7 |
| | T&O | 5A | 1/7 | 1/7 | 1/7 |
| | | Swift | 1/6 | 1/6 | 1/9 |
| | | 5B | 1/7 | 1/7 | 1/7 |
| | ATCC | Critical Care** | 6/7 | 6/7 | 8/9 |
| W&C | Gynae | 10A Gynae* | 1/5 | 1/5 | 1/5 |
| | Paeds | Bluebell | 1/4 | 1/4 | 1/4 |
| Cancer | Inpatient | Ward 10 | 1/4 | 1/4 | 1/5 |
| | | Michael Sobell House | 1/5 | 1/5 | 1/8 |

* Denotes the number of staff allocated to the inpatient ward areas

** Critical Care staffing is dependant on the patient number and acuity and therefore the available shifts is not representative of required staff

**Appendix 4**

## Care Hours per Patient Day service model, required, and actual worked

| Div | Speciality | Ward | Service Model CHPPD | Required CHPPD | Actual worked CHPPD |
|---|---|---|---|---|---|
| Medicine | Care of the Elderly | Ward 9B Elderly Care | 5.28 | 5.73 | 5.47 |
| | | Ashwell ward | 5.36 | 7.48 | 6.04 |
| | | Ward 9A Elderly Care | 5.29 | 6.8 | 5.94 |
| | Stroke | Pirton HASU | 6.18 | 6.94 | 6.7 |
| | Stroke | New Barley | 5.48 | 6.75 | 5.87 |
| | General | Ward 6A | 5.51 | 6.43 | 5.78 |
| | General | Ward 10B | 5.44 | 6.8 | 5.61 |
| | Respiratory | Ward 11A Respiratory | 6.07 | 6.78 | 6.12 |
| | | 7AN | | | |
| | Cardiology | Acute Cardiac Unit | 6.19 | 6.83 | 6.52 |
| | Acute | Acute Medical Unit | 7.08 | 8.74 | 7.75 |
| | | Short Stay Unit - SSU | 5.5 | 6.62 | 5.66 |
| | Renal | Ward 6B | 6.17 | 5.93 | 6.04 |
| Surgery | General | Gen Surgery Ward 8A | 5.12 | 5.56 | 5.01 |
| | | Gen Surgery Ward 8B | 5.12 | 5.88 | 4.75 |
| | Surgical Spec | Ward 11B Plastics & ENT | 6.09 | 5.99 | 5.9 |
| | | Urology Ward 7BN | 4.69 | 5.57 | 5 |
| | T&O | T&O Ward 5A | 5.05 | 5.64 | 4.95 |
| | | Swift Ward | 5.02 | 4.77 | 5.77 |
| | | T&O Ward 5B | 5.38 | 6.68 | 5.84 |
| | ATCC | Critical Care Unit | 23 | 18.11 | 19.05 |
| W&C | Gynae | Gynaecology Ward 10A | 6.79 | 5.09 | 7.69 |
| | Paeds | Children Bluebell Ward | 7.13 | 8.78 | 9.3 |
| Cancer | Inpatient | MV Ward 10 | 7.55 | 4.73 | 5.81 |
| | | MV M.S.H Inpatient Unit | 6.9 | 8.29 | 10.05 |

| Division | Service Model CHPPD | Required CHPPD | Actual worked CHPPD |
|---|---|---|---|
| Medicine | 5.80 | 6.82 | 6.13 |
| Surgery (Excluding Critical Care) | 5.21 | 5.73 | 5.32 |
| Women's and Children's | 6.96 | 6.94 | 8.50 |
| Cancer | 7.23 | 6.51 | 7.93 |

# Appendix 5

***The table below shows the recommended recruitable WTE based on the benchmark for the service and the average occupancy for the reference period compared to the actual funded recruitable WTE for the period***

| Div | Speciality | Ward | Bed Occupancy % | Recommended SNCT recruitable WTE based on occupancy (headroom adjusted to 17%) | Recruitable Establishment (17% headroom) | Variance from actual funded WTE |
|---|---|---|---|---|---|---|
| Medicine | Care of the Elderly | **9B** | 97.5% | 35.99 | 36.13 | 0.14 |
| | | **Ashwell** | 97.9% | 39.38 | 34.25 | -5.13 |
| | | **9A** | 98.2% | 34.50 | 36.18 | 1.68 |
| | Stroke | **Pirton** | 90.9% | 30.57 | 31.07 | 0.50 |
| | Stroke | **Barley** | 98.7% | 37.59 | 32.57 | -5.02 |
| | General | **6A** | 99.3% | 40.64 | 37.67 | -2.97 |
| | General | **10B** | 97.7% | 43.26 | 37.19 | -6.07 |
| | Respiratory | **11A** | 95.7% | 40.75 | 38.76 | -1.99 |
| | | **7AN** | | | | |
| | Cardiology | **ACU** | 86.1% | 28.37 | 31.12 | 2.75 |
| | Acute | **AMU Ward** | 98.8% | 28.75 | 26.49 | -2.26 |
| | | **SSU** | 98.8% | 39.83 | 35.14 | -4.69 |
| | Renal | **6B** | 95.4% | 30.56 | 34.73 | 4.17 |
| Surgery | **General** | **8A** | 96.0% | 34.72 | 35.05 | 0.33 |
| | | **8B** | 95.3% | 37.13 | 35.05 | -2.08 |
| | **Surgical Spec** | **11B *** | 99.0% | 19.60 | 21.05 | 1.45 |
| | | **7B** | 91.0% | 32.80 | 32.13 | -0.67 |
| | **T&O** | **5A** | 95.3% | 33.99 | 34.59 | 0.60 |
| | | **Swift** | 82.7% | 22.39 | 29.94 | 7.55 |
| | | **5B** | 89.3% | 37.61 | 36.83 | -0.78 |
| | **ATCC** | **Critical Care** | 79.3% | 62.67 | 100.78 | 38.11 |
| W&C | **Gynae** | **10A Gynae *** | 96.0% | 10.64 | 15.37 | 4.73 |
| | **Paeds** | **Bluebell** | 76.6% | 12.59 | 26.64 | 14.05 |
| Cancer | **Inpatient** | **Ward 10** | 89.0% | 22.05 | 43.21 | 21.16 |
| | | **Ward 11** | | | | |
| | | **Michael Sobell House** | 63.1% | 16.68 | 23.9 | 7.22 |

* Denotes the number of staff allocated to the inpatient ward areas

# Appendix 6

*The table below shows the CHPPD Benchmark Recommended WTE compared to the SNCT Recommended WTE.*

| Div | Speciality | Ward | CHPPD Bench Marking Data | | | SNCT Recommended Data | | |
|---|---|---|---|---|---|---|---|---|
| | | | Recommended CHPPD recruitable WTE based on occupancy | Recruitable Establishment Oct 2017 | Variance form actual funded WTE | SNCT recommended WTE | Recruitable Establishment Oct 2017 | Variance of operation establishment to SNCT recommended |
| Medicine | Care of the Elderly | 9B | 33.73 | 36.13 | 2.40 | 35.99 | 36.13 | 0.14 |
| | | Ashwell | 32.09 | 34.25 | 2.16 | 39.38 | 34.25 | -5.13 |
| | | 9A | 34.04 | 36.18 | 2.14 | 34.50 | 36.18 | 1.68 |
| | Stroke | Pirton | 26.99 | 31.07 | 4.08 | 30.57 | 31.07 | 0.50 |
| | Stroke | Barley | 30.71 | 32.57 | 1.86 | 37.59 | 32.57 | -5.02 |
| | General | 6A | 35.85 | 37.67 | 1.82 | 40.64 | 37.67 | -2.97 |
| | General | 10B | 34.82 | 37.19 | 2.37 | 43.26 | 37.19 | -6.07 |
| | Respiratory | 11A | 36.79 | 38.76 | 1.97 | 40.75 | 38.76 | -1.99 |
| | | 7AN | | | | | | |
| | Cardiology | ACU | 25.61 | 31.12 | 5.51 | 28.37 | 31.12 | 2.75 |
| | Acute | AMU Ward | 24.44 | 26.49 | 2.05 | 28.75 | 26.49 | -2.26 |
| | | SSU | 33.23 | 35.14 | 1.91 | 39.83 | 35.14 | -4.69 |
| | Renal | 6B | 32.14 | 34.73 | 2.59 | 30.56 | 34.73 | 4.17 |
| Surgery | General | 8A | 32.20 | 35.05 | 2.85 | 34.72 | 35.05 | 0.33 |
| | | 8B | 31.97 | 35.05 | 3.08 | 37.13 | 35.05 | -2.08 |
| | Surgical Spec | 11B * | 19.75 | 21.05 | 1.30 | 19.60 | 21.05 | 1.45 |
| | | 7B | 27.96 | 32.13 | 4.17 | 32.80 | 32.13 | -0.67 |
| | T&O | 5A | 31.53 | 34.59 | 3.06 | 33.99 | 34.59 | 0.60 |
| | | Swift | 23.57 | 29.94 | 6.37 | 22.39 | 29.94 | 7.55 |
| | | 5B | 31.48 | 36.83 | 5.35 | 37.61 | 36.83 | -0.78 |
| | ATCC | Critical Care | 79.67 | 100.78 | 21.11 | 62.67 | 100.78 | 38.11 |
| W&C | Gynae | 10A Gynae * | 14.24 | 15.37 | 1.13 | 10.64 | 15.37 | 4.73 |
| | Paeds | Bluebell | 19.08 | 26.64 | 7.56 | 12.59 | 26.64 | 14.05 |
| Cancer | Inpatient | Ward 10 | 24.15 | 43.21 | 19.06 | 22.05 | 43.21 | 21.16 |
| | | Michael Sobell House | 15.21 | 23.9 | 8.69 | 16.68 | 23.9 | 7.22 |

* Denotes the number of staff allocated to the inpatient ward areas

| Division | CHPPD Bench Marking Data | | | SNCT Recommended Data | | |
|---|---|---|---|---|---|---|
| | Recommended CHPPD recruitable WTE based on occupancy | Recruitable Establishment Oct 2017 | Variance form actual funded WTE | SNCT recommended WTE | Worked WTE | Variance of operation establishment to SNCT recommended |
| Medicine | 31.70 | 34.28 | 2.57 | 35.85 | 34.28 | -1.57 |
| Surgery (Excluding Critical Care) | 28.35 | 32.09 | 3.74 | 31.18 | 32.09 | 0.91 |
| Women's and Children's | 16.66 | 21.01 | 4.35 | 11.62 | 21.01 | 9.39 |
| Cancer | 19.68 | 33.56 | 13.88 | 19.37 | 33.56 | 14.19 |

**Appendix 7**

## NURSING & MIDWIFERY QUALITY INDICATORS: Oct 17

East and North Hertfordshire NHS NHS Trust

*** Bed Totals & Occupancy figures taken from SafeCare data*

| SUMMARY | | Trust | Medicine | Surgery | Women & Children | Cancer |
|---|---|---|---|---|---|---|
| Beds | Total Beds (based on Wards within this report) | 606 | 317 | 211 | 26 | 52 |
| | Bed occupancy % (at Midnight) | 89.78 | 95.80 | 90.21 | 78.04 | 54.34 |
| e-Rostering | % E-roster Deadline Met | 0.7 | 0.5 | 0.8 | 0.9 | 0.4 |
| | Net Hours % | 0.0 | 0.4 | -0.4 | -0.7 | 0.3 |
| | Net Hours Position | -795.4 | 19.5 | -20.9 | -30.6 | 7.9 |
| | % of Actual Annual Leave | 12.6 | 11.5 | 12.2 | 12.6 | 7.7 |
| Staffing | Funded WTE | 1702.3 | 710.3 | 406.7 | 350.0 | 74.5 |
| | Actual WTE | 1265.8 | 505.0 | 281.5 | 280.8 | 57.8 |
| | Vacancy rate % | 13.6 | 13.5 | 19.3 | 11.5 | 13.4 |
| | RN Fill Rate (day shifts) | 92.6 | 93.2 | 93.2 | 93.9 | 57.3 |
| | Sickness % | 6.5 | 5.5 | 7.7 | 7.9 | 9.0 |
| | Agency usage % | 5.1 | 6.8 | 10.0 | 2.6 | 0.7 |
| | Bank usage % | 15.2 | 15.4 | 15.1 | 12.4 | 4.1 |
| | Staff Appraised % (rolling 12 months) | 73.0 | 70.5 | 77.4 | 68.6 | 88.9 |
| | Nursing Overtime | 0.6 | 0.0 | 0.0 | 0.6 | 0.0 |
| | Statutory Mandatory Training Overall Coverage % | 58.0 | 49.6 | 54.1 | 62.3 | 69.0 |
| | % Shifts Triggered Red in Month - Initial | 12.2 | 14.9 | 13.4 | 7.8 | 1.6 |
| | % Shifts Triggered Red in Month - Final | 0.8 | 1.2 | 0.2 | 1.1 | 0.0 |
| Patient Safety | Inpatient falls (rate per 1000 bed days) | 4.21 | 4.27 | 4.89 | 2.48 | 1.86 |
| | Inpatient falls resulting in harm (rate per 1000 bed days) | 0.00 | 0.20 | 0.15 | 0.00 | 0.00 |
| | Hospital Acquired Pressure Ulcers (rate per 1000 bed days) | 0.11 | 0.00 | 0.15 | 1.24 | 0.00 |
| | % News Score Completion | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| | News Escalation | Not Applicable | Not Applicable | Not Applicable | Not Applicable | Not Applicable |
| | No. Medication Reported errors | 58 | 23 | 19 | 14 | 2 |
| | % Medication administered as prescribed | 98.0 | 99.6 | 95.5 | 100.0 | Not Provided |
| | % Analgesia administered as prescribed | 97.0 | 96.0 | 99.3 | 100.0 | Not Provided |
| | Intentional rounding completed | 94.0 | 98.3 | 90.5 | 100.0 | Not Provided |
| | Patient Identification | 93.0 | 96.5 | 93.8 | 95.0 | Not Provided |
| | Safety Thermometer Patients with harm | 31 | 22 | 6 | 2 | 1 |
| | % of Compliance with Hand Hygiene | 96.1 | 97.2 | 98.5 | 89.2 | 99.4 |
| Patient Experience | % Response to Inpatient Survey | 39.5 | 53.3 | 50.9 | 26.1 | 18.4 |
| | Help to eat meals/Infant Feeding | 93 | 94.2 | 88.6 | 93.0 | 96.5 |
| | Enough nurses on duty | 77 | 73.6 | 76.3 | 92.7 | 90.5 |
| | Respond to call bell | 89 | 88.9 | 85.9 | 80.0 | 100.0 |
| | Pain Control | 94 | 94.8 | 92.5 | 93.0 | 100.0 |
| | Understand answers from nurses | 92 | 91.9 | 90.4 | 95.3 | 98.0 |
| | Someone to talk to about worries and fears | 86 | 85.4 | 82.3 | 78.3 | 98.0 |
| | Enough emotional support from staff | 89 | 88.8 | 86.5 | 93.5 | 96.0 |
| | Know named nurse | 80 | 82.0 | 80.0 | 84.3 | 99.0 |
| | Inpatient FFT - % of patients would recommend | 97.0 | 97.0 | 97.2 | 94.8 | 97.2 |
| | Inpatient FFT - % of patients would not recommend | 0.6 | 0.7 | 0.5 | 1.7 | 0.0 |
| | FFT Response Rate % | 46.0 | 58.9 | 43.7 | 37.8 | 32.7 |
| | No.of Complaints | 16 | 7 | 8 | 1 | 0 |

# Appendix 8

| Period | 01/10/17-20/10/17 | Days in Month | 20 |
|---|---|---|---|

| Division | Speciality | Ward | INITIAL REDS | | | | | | FINAL REDS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Total no. of shifts available | Early | Late | Night | Number of shifts where staffing initially fell below agreed levels | % of shifts where staffing fell below agreed levels and triggered a Red rating | Early | Late | Night | Number of shifts where staffing initially fell below agreed levels | % of shifts where staffing fell below agreed levels and triggered a Red rating |
| Medicine | Care of the Elderly | 9A | 60 | 5 | 6 | 0 | 11 | 18.33 | 0 | 0 | 0 | 0 | 0.00 |
| | | 9B | 60 | 3 | 4 | 0 | 7 | 11.67 | 0 | 0 | 0 | 0 | 0.00 |
| | Stroke | Barley | 60 | 7 | 5 | 0 | 12 | 20.00 | 0 | 0 | 0 | 0 | 0.00 |
| | | Pirton | 60 | 1 | 5 | 2 | 8 | 13.33 | 0 | 0 | 1 | 1 | 1.67 |
| | General | 6A | 60 | 3 | 4 | 0 | 7 | 11.67 | 0 | 0 | 0 | 0 | 0.00 |
| | | 10B | 60 | 8 | 4 | 1 | 13 | 21.67 | 0 | 0 | 0 | 0 | 0.00 |
| | Respiratory | 11A | 60 | 4 | 3 | 0 | 7 | 11.67 | 0 | 0 | 0 | 0 | 0.00 |
| | | 7AN | 60 | 0 | 0 | 0 | 0 | 0.00 | 0 | 0 | 0 | 0 | 0.00 |
| | Cardiology | ACU | 60 | 3 | 10 | 1 | 14 | 23.33 | 0 | 0 | 0 | 0 | 0.00 |
| | Acute | AMU-A | 60 | 2 | 3 | 0 | 5 | 8.33 | 0 | 0 | 0 | 0 | 0.00 |
| | | SSU | 60 | 2 | 3 | 0 | 5 | 8.33 | 0 | 0 | 0 | 0 | 0.00 |
| | | AMU-W | 60 | 8 | 2 | 0 | 10 | 16.67 | 0 | 0 | 0 | 0 | 0.00 |
| | Renal | 6B | 60 | 1 | 6 | 0 | 7 | 11.67 | 0 | 0 | 0 | 0 | 0.00 |
| | DTOC / gastro | Ashwell | 60 | 10 | 9 | 3 | 22 | 36.67 | 0 | 0 | 0 | 0 | 0.00 |
| | ED | A&E | 60 | 3 | 3 | 1 | 7 | 11.67 | 0 | 1 | 1 | 2 | 3.33 |
| | | UCC | 60 | 0 | 0 | 0 | 0 | 0.00 | 0 | 0 | 0 | 0 | 0.00 |
| **Total** | | | **960** | **60** | **67** | **8** | **135** | **14.06** | **0** | **1** | **2** | **3** | **0.31** |
| Surgery | General | 8A | 60 | 4 | 5 | 0 | 9 | 15.00 | 0 | 0 | 0 | 0 | 0.00 |
| | | 8B | 60 | 7 | 7 | 6 | 20 | 33.33 | 0 | 0 | 0 | 0 | 0.00 |
| | | SAU | 60 | 2 | 10 | 1 | 13 | 21.67 | 0 | 0 | 0 | 0 | 0.00 |
| | Surgical Spec | 11B | 60 | 2 | 1 | 0 | 3 | 5.00 | 0 | 0 | 0 | 0 | 0.00 |
| | | 7B | 60 | 5 | 4 | 2 | 11 | 18.33 | 0 | 0 | 0 | 0 | 0.00 |
| | T&O | 5A | 60 | 5 | 0 | 1 | 6 | 10.00 | 0 | 0 | 0 | 0 | 0.00 |
| | | 5B | 60 | 4 | 4 | 0 | 8 | 13.33 | 0 | 0 | 0 | 0 | 0.00 |
| | | Swift | 60 | 5 | 5 | 3 | 13 | 21.67 | 0 | 0 | 0 | 0 | 0.00 |
| | ATCC | Critical Care 1 | 60 | 0 | 0 | 1 | 1 | 1.67 | 0 | 0 | 0 | 0 | 0.00 |
| | | ASCU | 60 | 0 | 0 | 0 | 0 | 0.00 | 0 | 0 | 0 | 0 | 0.00 |
| **Total** | | | **600** | **34** | **36** | **14** | **84** | **14.00** | **0** | **0** | **0** | **0** | **0.00** |
| Women's & Children | Gynae | 10A Gynae | 60 | 4 | 8 | 2 | 14 | 23.33 | 0 | 0 | 0 | 0 | 0.00 |
| | Paeds | Bluebell | 60 | 0 | 0 | 2 | 2 | 3.33 | 0 | 0 | 0 | 0 | 0.00 |
| | | Child A&E | 60 | 0 | 1 | 1 | 2 | 3.33 | 0 | 0 | 0 | 0 | 0.00 |
| | | NICU | 60 | 0 | 0 | 0 | 0 | 0.00 | 0 | 0 | 0 | 0 | 0.00 |
| | Maternity | Dacre | 60 | 0 | 1 | 0 | 1 | 1.67 | 0 | 0 | 0 | 0 | 0.00 |
| | | Gloucester | 60 | 1 | 5 | 0 | 6 | 10.00 | 0 | 0 | 0 | 0 | 0.00 |
| | | Mat MLU | 60 | 0 | 0 | 0 | 0 | 0.00 | 0 | 0 | 0 | 0 | 0.00 |
| | | Mat CLU 1 | 60 | 3 | 5 | 3 | 11 | 18.33 | 0 | 0 | 1 | 1 | 1.67 |
| **Total** | | | **480** | **8** | **20** | **8** | **36** | **7.50** | **0** | **0** | **1** | **1** | **0.21** |
| Cancer | Inpatient | Ward 10 | 60 | 0 | 0 | 0 | 0 | 0.00 | 0 | 0 | 0 | 0 | 0.00 |
| | | Michael Sobell House | 60 | 2 | 1 | 0 | 3 | 5.00 | 0 | 0 | 0 | 0 | 0.00 |
| **Total** | | | **120** | **2** | **1** | **0** | **3** | **2.50** | **0** | **0** | **0** | **0** | **0.00** |
| | | **TRUST TOTAL** | **2160** | **104** | **124** | **30** | **258** | **11.94** | **0** | **1** | **3** | **4** | **0.19** |

| | Total no. of shifts available | Early | Late | Night | Number of shifts where staffing initially fell below agreed levels | % of shifts where staffing fell below agreed levels and triggered a Red rating | Early | Late | Night | Number of shifts where staffing initially fell below agreed levels | % of shifts where staffing fell below agreed levels and triggered a Red rating |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medicine** | 960 | 60 | 67 | 8 | 135 | 14.06% | 0 | 1 | 2 | 3 | 0.31% |
| **Surgery (Excluding Critical Care)** | 600 | 34 | 36 | 14 | 84 | 14.00% | 0 | 0 | 0 | 0 | 0.00% |
| **Women's and Children's** | 480 | 8 | 20 | 8 | 36 | 7.50% | 0 | 0 | 1 | 1 | 0.21% |
| **Cancer** | 120 | 2 | 1 | 0 | 3 | 2.50% | 0 | 0 | 0 | 0 | 0.00% |

**Appendix 9**

Critical Care Guidelines

| Standard | | Additional rationale/consideration | References |
|---|---|---|---|
| 1.2.1 | Level 3 patients (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum 1:1 to deliver direct care | A greater ratio than 1:1 may be required to safely meet the needs of some critically ill patients, such as unstable patients requiring various simultaneous nursing activities and complex therapies used in supporting multiple organ failure.<br><br>Enhanced Level 3 patient status takes in to account severity of illness and the related nursing demands | Williams G, Schmollgruber S, Alberto L. *Crit Care Clin.* 2006 Jul;22(3):393-406<br><br>The European Federation of Critical Care Nursing Associations, 2007 |
| 1.2.2 | Level 2 patients (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum 1:2 to deliver direct care | The 1:2 ratios may need to be increased to 1:1 to safely meet the needs of critically ill patients, such as those who are confused/delirious requiring close monitoring and/or those being nursed in single rooms. | The European Federation of Critical Care Nursing Associations, 2007 |
| 1.2.3 | Each designated Critical Care Unit will have a identified Lead Nurse who is formally recognised with overall responsibility for the nursing elements of the service e.g. Band 8a Matron | This person must be an experienced critical care nurse with detailed knowledge and skills to undertake the operational management and strategic development of the service.<br><br>This person will have:<br>• undertaken leadership/management training<br>• be in possession of a post registration award in Critical Care Nursing<br>• be in possession or working towards post graduate study in relevant area<br><br>This person will be supported by a tier of Band 7 sisters/charge nurses who will collectively manage human resources, health & safety, equipment management, research, audit, infection prevention & control, quality improvement and staff development. | Williams G, Schmollgruber S, Alberto L. *Crit Care Clin.* 2006 Jul;22(3):393-406 |

Critical Care Staffing and skill mix benchmarking data

Trust A = Bedford Hospital NHS Trust
Trust B = Epsom and St Hellier University Hospitals NHS Trust
Trust C = East Sussex Hospitals NHS Trust
Trust D = Cambridge University Hospitals NHS Foundation Trust
Trust E = West Hertfordshire Hospitals NHS Trust

| | Trust A | Trust B | Trust C | Trust D | Trust E | Average for Bench Mark | ENHT | Var from Benchmark |
|---|---|---|---|---|---|---|---|---|
| **Band 8** | 1.74% | 0.96% | 0.94% | | 1.04% | 1.17% | 0.98% | -0.19% |
| **Band 7** | 10.45% | 15.45% | 20.77% | 7.11% | 7.33% | 12.22% | 7.83% | -4.39% |
| **Band 6** | 25.55% | 42.80% | 26.67% | 9.23% | 22.02% | 25.26% | 14.48% | -10.77% |
| **Band 5** | 53.13% | 34.36% | 43.31% | 73.64% | 62.34% | 53.36% | 69.86% | 16.51% |
| **Band 4** | | | | | | | | |
| **Band 3** | | 6.43% | 5.48% | | | 5.95% | | -5.95% |
| **Band 2** | 9.13% | | 2.83% | 10.01% | 6.24% | 7.05% | 6.85% | -0.20% |

East and North Hertfordshire NHS Trust

**Agenda Item: 11**

**TRUST BOARD PART I – 10 JANUARY 2018**

**CHARITY TRUST COMMITTEE – 4 DECEMBER 2017**
**EXECUTIVE SUMMARY REPORT**

| | |
|---|---|
| **PURPOSE** | To present to the Trust Board the report from the Charity Trust Committee meeting of 4 December 2017 |
| **PREVIOUSLY CONSIDERED BY** | N/A |
| **Objective(s) to which issue relates *** | [x] 1. **Keeping our promises about quality and value** – embedding the changes resulting from delivery of Our Changing Hospitals Programme.<br>[x] 2. **Developing new services and ways of working** – delivered through working with our partner organisations<br>[ ] **3. Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.** |
| **Risk Issues**<br>(Quality, safety, financial, HR, legal issues, equality issues) | Key assurance committee reporting to the Board<br>Financial risks as outlined in paper |
| **Healthcare/National Policy**<br>(includes CQC/Monitor) | Potential risk to CQC outcomes<br>Key statutory requirement under SFIs, SOs. Healthcare regulation, DH Operating Framework and other national performance standards |
| **CRR/Board Assurance Framework *** | [ ] **Corporate Risk Register** [✓] **BAF** |

**ACTION REQUIRED ***

| | | | |
|---|---|---|---|
| For approval | [ ] | For decision | [ ] |
| For discussion | [✓] | For information | [ ] |

| | |
|---|---|
| **DIRECTOR:** | Chairman of CTC |
| **PRESENTED BY:** | Chairman of CTC |
| **AUTHOR:** | Company Secretary |
| **DATE:** | December 2017 |

**We put our patients first We work as a team We value everybody We are open and honest We strive for excellence and continuous improvement**

**CHARITY TRUSTEE COMMITTEE MEETING HELD 4 DECEMBER 2017**

**SUMMARY REPORT TO BOARD – 10 JANUARY 2018**

The following members were present: Bob Niven (Committee Chairman), Val Moore (NED), Kate Lancaster (Director of Strategy), Carolyn Fowler (on behalf of Director of Nursing), Jude Archer (Company Secretary)

**Key Decisions made under delegated authority:**

The Charity Trustee Committee (CTC) made the following decisions on behalf of the Trust under the authority delegated to it within its terms of reference:

**Charity Strategy**
The Committee received the final draft Strategy for the Charity for 2017-2020 and fully supported the ambition and vision to transform the Charity to a best in class £3m+ hospital charity by 2020. There will be a detailed operational delivery plan to support the delivery of the strategy.

Subject to minor amendments the Charity Strategy is recommended to the Board as Corporate Trustee for final approval. **See appendix 1**

**Charity Funding Education and Training**
The Committee discussed the draft procedure for Nursing and Midwifery Staff to access charitable funds for education and training. This was a decision making tool to ensure a clear process was in place to identify what must be provided by the NHS and what could be provided through charitable funds. The Committee was clear the Charity has a responsibility to spend money in a charitable way and for the benefit of patients and staff. Following minor amendments the Committee agreed to pilot the process and form and re-evaluate in 6 months.

**Approvals for expenditure over £5,000**
The Committee did not receive any approvals for expenditure over £5,000 for consideration. This was due to the quality of the application paperwork received by the CMT for scrutiny prior to CTC. The new Head of Charity, Eloise Huddleston, and Financial Controller are working directly with the teams to ensure this is addressed.

**Other outcomes:**

**Investment Portfolio Update**
The CTC received an update report from the investment advisors (Rathbones) for the period to 31 October 2017. The portfolio is managed within a medium risk profile and with a long term investment horizon. The portfolio returned 15.4% compared to the benchmark of 14.2%.

**Investment Policy**
The Financial Controller proposed a full review of the Investment Policy and suggested this is incorporated into the Management of Charitable Funds Policy. This was welcomed by the Committee. This Investment review will include:

a. The 'portfolio mix' on types of investments
b. 'Ethical' investment considerations
c. The appropriateness of benchmarking data and investment performance

**Surgery Division Fund Management Report**
The Divisional Director presented the current position on charity funds for the surgery division. It was noted a number of funds required rationalising. He confirmed he would be working to streamline these to support the ability to spend these more flexibility and was in discussion with the teams regarding the spending plans for 2018/19. It was agreed to develop a standardised template to support the Divisions reporting.

**Charity Management Team Update**
The Head of Engagement presented the Charity Management Team Update and welcomed the New Head of Charity. The restructure and relaunch of the Charity Management Team operation has now commenced. The new CMT is chaired by the Director of Strategy and includes Divisional Directors as well as the Trust's Associate Director of Research and Development. One of the key terms of reference for the new CMT will be to provide more strategic direction for charitable activities as well as continuing to improve the associated financial and compliance processes.

**Charity Finance Report**
The CTC received a report regarding the financial performance of the Charity to 31 October 2017 (Month 7) and a verbal update for Month 4. The Charity is reporting income above expenditure at the end of month 7, year to date £115k which is £190K ahead of plan. The Committee noted the report and the further worked planned.

**GDPR Preparation**
The Committee received the Charity action plan to ensure it is compliant with the new General Data Protection Regulation (GDPR) prior to the deadline (May 2018). The Committee was assured by the progress made to date and endorsed the draft privacy notice subject to final scrutiny by the Trust Information Governance Manager.

**Bob Niven**
**CTC Chair**

December 2017

East & North Herts Hospitals Charity

# Strategy 2017-2020

# Contents

# Foreword

Our hospitals are held in high regard by our patients and local communities. Feedback on the quality of our patient care is overwhelmingly positive. Our patients, families, carers and citizens often want to support our hospitals and enhance the experience of others. We want to develop our hospitals Charity to improve this opportunity to provide the very best experience for our patients and carers.

Around 250 NHS Charities provide £321M additional funding to the NHS each year. In 2016/17 the East and North Herts Hospitals Charity fundraising performance was worth c£1.15M, providing income to enhance care for our patients. There is good potential for this to increase significantly over the next three years to allow us to provide more support to our patients, their families and our staff.

I believe this strategy marks a turning-point for our Charity.

**Kate Lancaster**
Director of Strategy


# Introduction

Our stakeholder engagement to develop our strategy resulted in the identification of strengths, weaknesses, opportunities and threats:

| Strengths | Weaknesses |
|---|---|
| • Four very different and unique hospital sites providing great potential for growth<br>• Mount Vernon Cancer Centre is a regional / tertiary centre of excellence, known and supported by the local community<br>• Lynda Jackson Macmillan Centre has an established donor base<br>• Successful appeals run at the Lister Hospital<br>• Dedicated staff team | • Discontinuity and lack of support for fundraisers<br>• High reserves<br>• Lack of internal awareness / reputation<br>• Financial systems and processes<br>• Confused, split branding<br>• Lack of project pipeline |
| **Opportunities** | **Threats** |
| • Untapped income streams<br>• Sustainability & Transformation Plan (STP) may mean larger more scaleable projects<br>• Many corporate head offices across Hertfordshire and North London | • Charity competition on Mount Vernon Cancer Centre site<br>• Complexity of estate management at Mount Vernon Cancer Centre |

From discussions with donors, trustees, fundraisers, fund managers and accountants, there are some things we know we can do better, including:

- establish and communicate a compelling vision and purpose for our charitable activities;
- provide clearer, more effective leadership and direction;
- improve the range and quality of fundraising and donor management;
- provide better access to and management of charitable funds;
- promote and market the Charity effectively across our hospitals and communities.

Despite these areas for development, we increased income for the first time for many years in 2016/17 as our team of fundraisers settled and started to work more effectively together to focus on higher return on investment (ROI) fundraising activities with some success. We also now have Charity Trustees with more directly relevant skills, knowledge and experience to oversee the strategic and operational development of the Charity and provide greater leadership capacity.

In just three years our fundraising will be achieving over £3M income to spend on a growing range of charitable projects to help our patients.

## Ambition and Vision

We want to grow to become the preeminent NHS Charity for residents and communities in Hertfordshire, West Essex and Bedfordshire, dedicated to making a real positive difference to the care and experience of our patients and carers, by:

- enhancing the care environment for patients, including our new services and ways of caring;
- providing access to the latest and best equipment for patient diagnosis and treatment, helping deliver both value and quality;
- supporting research to improve care for patients;
- enhancing training and development of staff, in line with donor wishes, to deliver the best care for patients.

To achieve this we will transform to work as one, coherent and efficient Charity capable of deploying skilled fundraisers effectively across all our sites to maximise income. We will make better use of our assets and build a philanthropic culture to mature into an effective, fully-functioning charitable enterprise in support of our hospitals and patients.

**In 2017/18** we will put the building blocks in place to deliver a more robust, effective charitable operation. We will build our capacity and expertise and this will increase confidence in our Charity across all stakeholders.

**In 2018/19 and 2019/20** we will complete the transformation of our operation into a best-in-class £3M+ hospital charity.

## PART 1 ~ Building capacity and confidence

2017/18 will be about laying the foundations for a successful, effective charitable operation.

We will recruit an excellent Head of Charity to deliver the change – they will be supported to have significant impact in taking our Charity to the next level.

We will focus on getting our governance working to the highest standards giving confidence to all our stakeholders including the Charity Commission, fund managers and donors.

We will develop a much stronger presence across our hospitals and communities: inspiring staff to identify causes and projects to fundraise for; and attracting a wide range of donors to want to give.

We will make the most of our professionalism by recruiting a high profile patron to give us the kudos, presence and reach to continue to grow and improve our ROI. In addition, we will recruit and develop ambassadors and champions for the Charity to front, promote and showcase our work to a wide audience of stakeholders and potential donors.

# Governance and Administration

We will ensure fit-for-purpose, robust processes are in place to meet the requirements of our Charity Commission regulatory framework and General Data Protection Regulations to inspire confidence in all our stakeholders.
Reviewing and improving our business processes will enable us to develop better working relationships with hospital services and fund managers so they see that we can quickly help them transform their fundraising ideas into enhanced care for patients.

In 2017/18 we will:

- Develop new monthly financial management reports that accurately and reliably present income and expenditure activity in a way that is clear, intelligible and conclusive for our stakeholders -
  - profile targets by income stream for each fundraiser to enable effective management of ROI;
  - ensure robust and consistent differentiation between costs of raising income and charitable expenditure;
  - manage our overheads ratio down to charitable sector good practice at 25%.
- Revamp the application process for charitable funds to enable fast but appropriate access for fund managers and other Trust managers -
  - design and implement one end-to-end process and form for applying for charitable funds to identify all costs associated with schemes and provide appropriate management sign-off.
- Review the effective management of our resources -
  - monitor investment portfolio;
  - manage levels of reserves;
  - reduce managed funds
  - utilise undesignated funds to secure appeals and grow charity
  - ensure all designated funds have a plan to spend in line with trust priorities

## Key Performance Indicators

- Overhead ratio down to 25% by 31 March 2018;
- Fewer managed funds in operation by 31 March 2018;
- Investment performance;
- Ratio of reserves to income;
- Improve user satisfaction for accessing funds.

# Reputation and Profile

As our efficiency and performance improves we will raise more income year-on-year. We aim to be generating over £3M income in 2019/20. To operate effectively at this level we must nurture the reputation and profile of the Charity through strong branding and a system of patronage and philanthropic support.

We will design and implement effective marketing and promotion for the Charity to attract both new and existing donors and specific to the needs of each of our hospitals and their local context:

We will take advantage of our professionalism and growing reputation by developing a system of ambassadors and champions to promote the Charity and so further build reputation and lever success.
We will appoint an eminent, high profile patron to give us the credibility and status to sustain our £3M+ income performance.

In 2017/18 we will:

- design a range of attractive new, branded material promoting our Charity;
- develop a modern, attractive, best-in-class website for our Charity;
- deploy a marketing campaign to raise visibility of Charity in our hospitals and local communities and businesses;
- select a high profile patron to adopt our work;
- recruit special ambassadors to lever opportunity;
- roll-out community champions.

## Key Performance Indicators

- New brand and website implemented by 31 March 2018;
- Appointment of Charity patron by 31 March 2018;
- Growing numbers of ambassadors and champions, year-on-year from March 2018;
- Measure(s) of brand recognition.

# PART II ~ Transforming our operation

Our capacity-building in 2017/18 will deliver:

- robust, effective processes;
- growing confidence in the Charity articulated by donors and stakeholders proud to be associated with us;

2018/19 and 2019/20 will be about realising the benefits.

We will reorganise how our fundraisers work across hospital sites and funding streams to become more flexible and target-focussed in the way we work. We will ensure appropriate training and development supports our fundraisers to maximise income and return on investment.

We will grow a broad range of projects and appeals that better meet the needs of our hospitals to provide enhanced care for our patients. The NHS operates in the context of increasing financial challenges. It makes sense to transform our Charity to step-up to provide greater financial support for the enhancements that make all the difference to patient care.

We will identify and work towards achieving best practice donor management to ensure we report the outcomes and impact of donations in an effective, timely and innovative way.

## Fundraising

We will fund a more ambitious range of charitable activities to support the Trust in line with our ambition and vision. We will formulate a more considered and expertise-based approach to fundraising to identify new opportunities for income generation and develop our fundraisers accordingly. We will win the confidence of more hospital staff to want to involve fundraisers at the formative stage of projects to build-in original and innovative fundraising. We will up-skill our fundraisers and deploy them more flexibly across all our hospitals.

In 2018/19 & 2019/20 we will:

Implement an ambitious fundraising strategy to take our performance to the next level to deliver more charitable support for our hospitals and patients:

- up-skill fundraisers and implement new, flexible working patterns;
- build capacity and develop working practice to achieve potential;
- deliver growth across all income streams;
- develop and implement a legacy stewardship and marketing plan
- utilise digital opportunities for donor engagement

### Key Performance Indicators

- £3M+ income achieved by March 2020;
- Income (growth) targets for all fundraisers and income streams;
- Improve user satisfaction for accessibility and attractiveness from donors.
- Trust staff has increased confidence in charity and act as ambassadors
- Fundraising activity and messaging enables unrestricted income generation, to cover charity operating costs
- Increase social media profile

# Appeals and Projects

We will secure and schedule a pipeline of inspiring appeals and projects to deliver the charitable expenditure that best supports our hospitals and patients. These schemes will stretch our fundraisers to achieve their potential and so help us start to achieve our ambition and vision by providing maximum benefit to patients and carers.

In 2018/19 & 2019/20 we will:

- systematically engage service and fund managers across all our sites to develop the very best fundraising ideas;
- schedule and deliver a pipeline of fundraising projects to ensure year-on-year growth in charitable expenditure;
- launch new capital appeals at the Lister hospital and Mount Vernon Cancer Centre.

## Key Performance Indicators

- £3M achieved in 2019/20;
- deliver annual appeals in line with trust priorities
- clear donor messaging around how charity income is spent

# Donor Management

We will develop a systematic, 'best practice' approach to looking after our patients and donors to demonstrate the impact of our work and secure new and repeat gifts. We want to develop a reputation across the sector for looking after donors and delivering the outcomes for patients they seek.

In 2018/19 & 2019/20 we will:

Identify what 'best practice' donor management looks like and start to put in place the building blocks to achieve excellence, to include:

- maintain an accurate and up-to-date contact management system;
- develop a forward plan for proactive reporting of charitable outcomes for patients;
- revamp our reporting to demonstrate value-for-money, impact and public benefit.


## Key Performance Indicators

- Retain existing donors
- Grow supporter base and widen reach
- Increase lifetime value of donors
- Deliver best practise donor journeys consistently at all sites

# Contact Us

If you would like to know more about the Charity or have some ideas for fundraising to support patients, staff and visitors to our four hospitals, please contact us:

East & North Herts Hospitals Charity, Charity Office, L96, Lister Hospital, Coreys Mill Lane, Stevenage, SG1 4AB

T: 01438 285182

E: charity.enh-tr@nhs.net

W: www.enh-tr.nhs.net/get-involved/our-charity

Or find us on social media by searching for ENHHCharity

East & North Herts Hospitals Charity is the working name for East and North Hertfordshire NHS Trust Charitable Fund. Charity registered in England and Wales number 1053338.

**Eloise Huddleston - Head of Charity**

*T: 01438 285541*

eloise.huddleston@nhs.net

**Fiona Hussey - Fundraiser**

*T: 020 3826 2250*

fiona.hussey@nhs.net

**Sam Skipp - Fundraiser**

*T: 01438 285182 | Ext: 5182 | M: 07496760472*

sam.skipp@nhs.net

**Marianne Louca - Fundraiser**

*T: 020 3826 2516 | M: 07747 184979*

marianne.louca@nhs.net

# DATA PACK

## Contents

# 1. Data & Exception Reports:

FFT

Health & Safety Indicators

# Friends and Family Test - November 2017

| Inpatients & Day Case | % Would recommend | % Would not recommend | Extremely Likely | Likely | Neither Likely/ Unlikely | Unlikely | Extremely Unlikely | Don't Know | Total responses | No. of Discharges | Total % response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 5A | 91.46 | 0.00 | 48 | 27 | 7 | 0 | 0 | 0 | 82 | 94 | 87.23 |
| 5B | 96.88 | 0.00 | 24 | 7 | 1 | 0 | 0 | 0 | 32 | 48 | 66.67 |
| 7B | 95.24 | 1.90 | 70 | 30 | 1 | 2 | 0 | 2 | 105 | 198 | 53.03 |
| 8A | 85.00 | 3.33 | 31 | 20 | 6 | 1 | 1 | 1 | 60 | 109 | 55.05 |
| 8B | 89.04 | 1.37 | 40 | 25 | 6 | 0 | 1 | 1 | 73 | 103 | 70.87 |
| 11B | 95.35 | 1.16 | 53 | 29 | 2 | 0 | 1 | 1 | 86 | 110 | 78.18 |
| Swift | 93.00 | 1.00 | 69 | 24 | 5 | 0 | 1 | 1 | 100 | 172 | 58.14 |
| ITU/HDU | 100.00 | 0.00 | 6 | 0 | 0 | 0 | 0 | 0 | 6 | 19 | 31.58 |
| Day Surgery Centre, Lister | 98.47 | 0.38 | 205 | 52 | 2 | 0 | 1 | 1 | 261 | 391 | 66.75 |
| Day Surgery Treatment Centre | 98.71 | 0.00 | 191 | 39 | 3 | 0 | 0 | 0 | 233 | 585 | 39.83 |
| Endoscopy, Lister | 97.86 | 1.42 | 254 | 21 | 0 | 1 | 3 | 2 | 281 | 948 | 29.64 |
| Endoscopy, QEII | 98.63 | 0.00 | 67 | 5 | 1 | 0 | 0 | 0 | 73 | 289 | 25.26 |
| **SURGERY TOTAL** | 96.05 | 0.86 | **1058** | **279** | **34** | **4** | **8** | **9** | **1392** | **3066** | 45.40 |
| SSU | 83.33 | 3.33 | 13 | 12 | 4 | 0 | 1 | 0 | 30 | 151 | 19.87 |
| AMU | 93.75 | 0.00 | 41 | 4 | 3 | 0 | 0 | 0 | 48 | 130 | 36.92 |
| Pirton | 77.78 | 0.00 | 12 | 2 | 3 | 0 | 0 | 1 | 18 | 53 | 33.96 |
| Barley | 100.00 | 0.00 | 18 | 2 | 0 | 0 | 0 | 0 | 20 | 23 | 86.96 |
| 6A | 100.00 | 0.00 | 28 | 12 | 0 | 0 | 0 | 0 | 40 | 65 | 61.54 |
| 6B | 100.00 | 0.00 | 19 | 13 | 0 | 0 | 0 | 0 | 32 | 52 | 61.54 |
| 11A | 100.00 | 0.00 | 52 | 6 | 0 | 0 | 0 | 0 | 58 | 73 | 79.45 |
| ACU | 100.00 | 0.00 | 40 | 13 | 0 | 0 | 0 | 0 | 53 | 102 | 51.96 |
| 10B | 83.33 | 5.56 | 9 | 6 | 2 | 1 | 0 | 0 | 18 | 60 | 30.00 |
| Ashwell | 100.00 | 0.00 | 25 | 3 | 0 | 0 | 0 | 0 | 28 | 28 | 100.00 |
| 9B | 96.51 | 0.00 | 58 | 25 | 2 | 0 | 0 | 1 | 86 | 86 | 100.00 |
| 9A | 100.00 | 0.00 | 23 | 4 | 0 | 0 | 0 | 0 | 27 | 54 | 50.00 |
| Cardiac Suite | 100.00 | 0.00 | 56 | 7 | 0 | 0 | 0 | 0 | 63 | 109 | 57.80 |
| **MEDICINE TOTAL** | 96.55 | 0.38 | **394** | **109** | **14** | **1** | **1** | **2** | **521** | **986** | 52.84 |
| 10AN Gynae | 92.75 | 1.45 | 45 | 19 | 4 | 1 | 0 | 0 | 69 | 83 | 83.13 |
| Bluebell ward | **94.00** | 0.00 | 27 | 20 | 1 | 0 | 0 | 2 | 50 | 193 | 25.91 |
| Bluebell day case | 100.00 | 0.00 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 11 | 9.09 |
| Neonatal Unit | 100.00 | 0.00 | 22 | 1 | 0 | 0 | 0 | 0 | 23 | 38 | 60.53 |
| **WOMEN'S/CHILDREN TOTAL** | 94.41 | 0.70 | **95** | **40** | **5** | **1** | **0** | **2** | **143** | **325** | 44.00 |
| Michael Sobell House | 100.00 | 0.00 | 48 | 0 | 0 | 0 | 0 | 0 | 48 | 53 | 90.57 |
| 10 | 100.00 | 0.00 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 27 | 3.70 |
| 11 | 100.00 | 0.00 | 69 | 45 | 0 | 0 | 0 | 0 | 114 | 118 | 96.61 |
| **CANCER TOTAL** | 100.00 | 0.00 | **117** | **46** | **0** | **0** | **0** | **0** | **163** | **198** | 82.32 |
| **TOTAL TRUST** | 96.35 | 0.68 | **1664** | **474** | **53** | **6** | **9** | **13** | **2219** | **4575** | 48.50 |

**Continued over …..**

| Inpatients/Day by site | % Would recommend | % Would not recommend | Extremely Likely | Likely | Neither Likely/ Unlikely | Unlikely | Extremely Unlikely | Don't Know | Total responses | No. of Discharges | Total % response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Lister | 95.94 | 0.75 | 1491 | 421 | 53 | 6 | 9 | 13 | 1993 | 4268 | 46.70 |
| QEII | 100.00 | 0.00 | 56 | 7 | 0 | 0 | 0 | 0 | 63 | 109 | 57.80 |
| Mount Vernon | 100.00 | 0.00 | 117 | 46 | 0 | 0 | 0 | 0 | 163 | 198 | 82.32 |
| **TOTAL TRUST** | **96.35** | **0.68** | **1664** | **474** | **53** | **6** | **9** | **13** | **2219** | **4575** | **48.50** |

| Accident & Emergency | % Would recommend | % Would not recommend | Extremely Likely | Likely | Neither Likely/ Unlikely | Unlikely | Extremely Unlikely | Don't Know | Total responses | No. of Discharges | Total % response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Lister A&E/Assesment | 90.20 | 4.39 | 188 | 79 | 15 | 4 | 9 | 1 | 296 | 9909 | 2.99 |
| QEII UCC | 91.18 | 5.88 | 47 | 15 | 2 | 2 | 2 | 0 | 68 | 3524 | 1.93 |
| **A&E TOTAL** | **90.38** | **4.67** | **235** | **94** | **17** | **6** | **11** | **1** | **364** | **13433** | **2.71** |

| Maternity | % Would recommend | % Would not recommend | Extremely Likely | Likely | Neither Likely/ Unlikely | Unlikely | Extremely Unlikely | Don't Know | Total responses | No. of Discharges | Total % response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Antenatal | 100.00 | 0.00 | 6 | 4 | 0 | 0 | 0 | 0 | 10 | 472 | **2.12** |
| Birth | 95.98 | 1.34 | 163 | 52 | 1 | 2 | 1 | 5 | 224 | 465 | **48.17** |
| Postnatal | 90.18 | 3.13 | 124 | 78 | 11 | 4 | 3 | 4 | 224 | 465 | **48.17** |
| Community Midwifery | 66.67 | 0.00 | 0 | 2 | 1 | 0 | 0 | 0 | 3 | 675 | **0.44** |
| **MATERNITY TOTAL** | **93.06** | **2.17** | **293** | **136** | **13** | **6** | **4** | **9** | **461** | **2077** | **22.20** |

| Outpatients | % Would recommend | % Would not recommend | Extremely Likely | Likely | Neither Likely/ Unlikely | Unlikely | Extremely Unlikely | Don't Know | Total responses |
|---|---|---|---|---|---|---|---|---|---|
| Lister | 91.92 | 3.56 | 280 | 107 | 14 | 5 | 10 | 5 | 421 |
| QEII | 95.66 | 0.95 | 507 | 199 | 21 | 4 | 3 | 4 | 738 |
| Hertford County | 92.58 | 1.56 | 155 | 82 | 9 | 1 | 3 | 6 | 256 |
| Mount Vernon CC | 98.54 | 0.00 | 165 | 37 | 3 | 0 | 0 | 0 | 205 |
| Satellite Dialysis | 96.63 | 0.00 | 69 | 17 | 3 | 0 | 0 | 0 | 89 |
| **OUTPATIENTS TOTAL** | **94.68** | **1.52** | **1176** | **442** | **50** | **10** | **16** | **15** | **1709** |

| Trust Targets | % Would recommend | % response rate |
|---|---|---|
| Inpatients/Day Case | 96%> | 40%> |
| A&E | 90%> | 10%> |
| Maternity (combined) | 93%> | 30%> |
| Outpatients | 95%> | N/A |

| Key Performance Indicators Reported to RAQC | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2017/18 | Financial Year 2017-18 | | | | | | | | | | | | |
| | | April | May | June | July | August | September | October | November | December | January | February | March | Current Position YTD |
| Patient Incidents | RIDDOR incidents | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 0 |
| | H&S public liability claims | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 0 |
| | Slips, Trips & Falls (not including inpatient falls) | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | | | | 2 |
| | Physical assault | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | | | | 2 |
| Visitor Incidents | RIDDOR incidents | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 0 |
| | H&S public liability claims | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | | | | 4 |
| | Slips, Trips & Falls | 2 | 2 | 4 | 3 | 4 | 0 | 2 | 0 | 3 | | | | 20 |
| The Workforce (Including Contractors) Incidents | RIDDOR incidents | 2 | 3 | 5 | 4 | 4 | 2 | 3 | 2 | 6 | | | | 31 |
| | Slips, Trips & Falls | 1 | 5 | 7 | 6 | 5 | 5 | 8 | 2 | 12 | | | | 51 |
| | Employer liability claims | 0 | 2 | 1 | 1 | 0 | 0 | 1 | 0 | 2 | | | | 7 |
| | Sharps incidents | 11 | 7 | 12 | 12 | 15 | 13 | 9 | 24 | 13 | | | | 116 |
| | Workplace stress | 6 | 2 | 1 | 3 | 7 | 3 | 4 | 4 | 2 | | | | 32 |
| | Contact dermatitis/latex | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | 0 |
| | Musculoskeletal injuries | 5 | 3 | 8 | 3 | 8 | 5 | 8 | 3 | 0 | | | | 43 |
| | Physical assault | 4 | 0 | 10 | 9 | 12 | 9 | 6 | 15 | 11 | | | | 76 |
| | H & S training (Compliance) (YTD = Latest Available Position) | 89% | 88% | 88% | 87% | 88% | 86% | 91% | 91% | | | | | 91% |
| | Significant workplace fires | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | 2 |
| | Total Staff | 5514 | 5529 | 5532 | 5574 | 5562 | 5881 | 5895 | 5940 | | | | | 45427 |

# Key Performance Indicators Reported to RAQC

**Floodlight Health & Safety Metrics**

**The Rate is the percentage of incident per 1000 employees.**

**Green is the output rate from last years figures, Amber is plus 5% and red is plus 10%**

| H & S Indicator | | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Average monthly total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **RIDDOR Incidents** | | 2 | 3 | 5 | 4 | 4 | 2 | 3 | 2 | 6 | 0 | 0 | 0 | 31 |
| RATE % | Red < 0.36<br>Amber 0.36-0.33<br>Green > 0.33 | 0.363 | 0.543 | 0.904 | 0.718 | 0.719 | 0.340 | 0.509 | 0.337 | | 0.000 | 0.000 | 0.000 | 0.682 |
| Slips, Trips and Falls | | 1 | 5 | 7 | 6 | 5 | 5 | 8 | 2 | 12 | 0 | 0 | 0 | 51 |
| RATE % | Red <0.86<br>Amber 0.86 - 0.78<br>Green >0.78 | 0.181 | 0.904 | 1.265 | 1.076 | 0.899 | 0.850 | 1.357 | 0.337 | | 0.000 | 0.000 | 0.000 | 1.123 |
| Sharps Injuries | | 11 | 7 | 12 | 12 | 15 | 13 | 9 | 24 | 13 | 0 | 0 | 0 | 116 |
| RATE % | Red < 2.56<br>Amber 2.56-2.33<br>Green > 2.33 | 1.995 | 1.266 | 2.169 | 2.153 | 2.697 | 2.211 | 1.527 | 4.040 | | 0.000 | 0.000 | 0.000 | 2.554 |
| Mgr Referrals to OH for Stress | | 6 | 2 | 1 | 3 | 7 | 3 | 4 | 4 | 2 | 0 | 0 | 0 | 32 |
| RATE % | Red < 0.96<br>Amber 0.96-0.87<br>Green > 0.87 | 1.088 | 0.362 | 0.181 | 0.538 | 1.259 | 0.510 | 0.679 | 0.673 | | 0.000 | 0.000 | 0.000 | 0.704 |
| Work related Musculosketal Injuries | | 5 | 3 | 8 | 3 | 8 | 5 | 8 | 3 | 0 | 0 | 0 | 0 | 43 |
| RATE % | Red < 1.11<br>Amber 1.11-1.01<br>Green > 1.01 | 0.907 | 0.543 | 1.446 | 0.538 | 1.438 | 0.850 | 1.357 | 0.505 | | 0.000 | 0.000 | 0.000 | 0.947 |
| Physical Assault | | 4 | 0 | 10 | 9 | 12 | 9 | 6 | 15 | 11 | 0 | 0 | 0 | 76 |
| RATE % | Red < 1.45<br>Amber 1.45-1.32<br>Green > 1.32 | 0.725 | 0.000 | 1.808 | 1.615 | 2.157 | 1.530 | 1.018 | 2.525 | | 0.000 | 0.000 | 0.000 | 1.673 |
| Total Staff | | 5514 | 5529 | 5532 | 5574 | 5562 | 5881 | 5895 | 5940 | 0 | 0 | 0 | 0 | 45427 |

# 2. Performance Data:

CQC Outcomes Summary

## Our CQC Registration and recent Care Quality Commission Inspection

The Care Quality Commission (CQC) inspected the Trust as part of a comprehensive inspection programme, which took place on trust sites during 20 to 23 October 2015 with three unannounced inspections on 31 October, 6 and 11 November 2015. Following their initial visit, inspection chair, Sir Norman Williams, said that the Trust was, ”An organisation on an upward trajectory.”

Overall the CQC rated the Trust as ‘**requires improvement**’ with ‘**good**’ for caring. This does not reflect the whole picture:

- *Good* ratings were received for surgery, critical care, outpatients and diagnostics (all hospital sites), children and young person’s community services and radiotherapy at the Mount Vernon Cancer Centre.
- 19 areas of outstanding practice across the Trust were recognised.
- Six areas where improvement had to be made were identified.
- The Lister’s urgent and emergency services, along with the medical care pathway at the Mount Vernon Cancer Centre were rated as *inadequate* – actions were taken in October 2015 in to address the concerns raised by the CQC, including the development of an emergency services pathway steering board to support improvements across the whole pathway.

The areas of improvement, regulatory actions, were applied in March 2016. These are:

- Lister Hospital regarding compliance with regulations 12, 17 and 18. In brief the Trust must:
  - Ensure that the triage process accurately measures patient need and priority in both the emergency department and maternity services ***(Actions taken and internal monitoring in place)***
  - Ensure records and assessments are completed in accordance with Trust Policy ***(Actions taken and internal monitoring in place)***
  - Ensure that there are effective governance systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients ***(Actions taken and internal monitoring in place)***
  - Ensure that all staff in all services complete their mandatory training ***(Closed and internal monitoring)***

- Mount Vernon Cancer Centre regarding compliance with regulations 12 and 17. In brief the Trust must:
  - Ensure that patients requiring urgent transfer from Mount Vernon Cancer Centre have their needs met to ensure safety and that there are effective process to handover continuing treatment ***(Closed and internal monitoring)***
  - Ensure there is oversight and monitoring of all transfers ***(Closed and internal monitoring)***

A number of the actions have now been completed and are being monitored to ensure they are sustained. The aim was for all actions to be delivered by end of September 2016; these are in the process of being tested and audited to ensure consistency prior to closure. Progress in complying with these regulatory actions is monitored through action plans owned by the teams reporting to the Quality Development Board which reports in to the Trust Risk and Quality Committee and the Trust Board. Quality Workshops have been established with the Matrons and Sisters to support embedding quality improvement and our CCG have undertaken some quality visits which helps to provide us with external assurance.

The CQC revisited the Trust in May 2016 and undertook an unannounced inspection in Lister emergency department and the children’s’ ward. The report confirms significant progress made in both areas.

The Director of Nursing and Company Secretary are developing a Quality Improvement Programme to ensure and support continuous improvement. The new CQC Insight was released in July 17 and this in now being used across the divisions and corporate directorates to support monitoring.

## Summary of the latest Inspection Outcome






## Summary of the Trust's CQC Registration Status across all locations.

| Regulatory Activity | Lister Hospital* | New QEII | MVCC | Hertford | Bedford Renal Unit | Harlow Renal Unit |
|---|---|---|---|---|---|---|
| Treatment of disease, disorder or injury | Registered with regulatory action | Registered | Registered with regulatory action | Registered | Registered | Registered |
| Surgical Procedures | Registered | Registered | Registered with regulatory action | | | |
| Maternity and midwifery services | Registered with regulatory action | Registered | | Registered | | |
| Diagnostic and Screening procedures | Registered | Registered | Registered with regulatory action | Registered | Registered | |
| Termination of Pregnancies | Registered | Registered | | | | |
| Family Planning Services | Registered | Registered | | Registered | | |
| Assessment or medical treatment of people detained under the Mental Health Act 1983 | Registered | Registered | Registered | | | |

*** Lister Hospital's registration includes the registrations for renal satellite units in St Albans Hospital and Luton and Dunstable Hospital.**

# 3. Risk and Quality Committee Reports:

Safer Staffing

Infection Control Data

East and North Hertfordshire NHS Trust

# Safe Nurse Staffing Levels

## November 2017

**Executive Summary**

The purpose of this report is:

1. To provide an assurance with regard to the management of safe nursing and midwifery staffing for the month of November 2017.
2. To provide a summary report of quality metrics for the month of November 2017 as indicators of patient safety
3. To provide context for the Trust Board on the UNIFY safer staffing submission for the month of November 2017.

East and North Hertfordshire NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Clinical Support Workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care. These staffing levels are viewed along with reported outcome measures, 'registered nurse to patient ratios', the percentage skill mix ratio of registered nurses to CSWs, and the number of staff per shift required to provide safe and effective patient care.

| No | Topic | Measure | Summary | RAG |
|---|---|---|---|---|
| 1. | **Patient safety is delivered though consistent, appropriate staffing levels for the service.** | Unify RN fill rate | The Unify submission for registered fill % increased in November with the average day fill % for registered nurses increasing from 92.6% in October to 96.3% in November. | |
| | | Care hours per Patient Day - CHPPD | Overall CHPPD decreased from 7.3 in October to 7.0 in November. | |
| 2. | **Staff are supported in their decision making by effective reporting.** | % of Red triggered shifts | The percentage of Red Triggered shifts decreased from 12.16% in October to 9.07%. | |
| | | % of shifts that remained partially mitigated | Out of the shifts triggering red, 6 of the 302 that initially triggered red (0.18%) remained only partially mitigated. This is a decrease in the number of partially mitigated shifts from 28 in October | |
| 3. | **Staffing risks are effectively escalated to an appropriate person** | Red flag reportable events and DATIX report | Red flags continue to be used to escalate staffing issues in the organisation. | |
| 4. | **Patient Safety incidents** | | In November 2017 2.3% of patients were identified with harm, a decrease from 5.2% in October 2017. | |
| 5. | **The Board are assured of safe staffing for nursing** | Board reports and discussion covering overview of safe staffing levels | The overall RN and CSW fill rate increased due to an increase in temporary staffing bank fill and slight decrease in demand. The CHPPD delivered in November has however decreased slightly. | |

## 1. Patient safety was delivered though consistent, appropriate staffing levels for the service.

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

### 1.1 Unify Safer Staffing Return

The Trust's safer staffing submission will be submitted to Unify for November within the Unify data submission deadline. SafeCare has been used as the data source for patients as at 23:59 in the absence of patient data reports from Lorenzo. The Maternity units have been capturing their patient data on SafeCare from the 1st November and will be included in this month's CHPPD submission. Table 1 below shows the summary of overall fill %, the full table of fill % can be seen in Appendix 1:

**Table 1 – Overall Unify Return fill rate**

| Day | | Night | |
|---|---|---|---|
| Average fill rate + registered nurses/midwives (%) | Average fill rate + care staff (%) | Average fill rate + registered nurses/midwives (%) | Average fill rate + care staff (%) |
| 96.3% | 90.0% | 96.7% | 109.2% |

The Unify submission for registered fill % increased in November with the average day fill % for registered nurses increasing from 92.6% in October to 96.3% in November.

**Factors affecting Planned vs. Actual staffing**

- Ashwell was escalated above their planned 24 beds to 28 beds for the whole month of November; their planned staffing level for the Unify return is reflective of their 28 bed shift plan.

There are a number of other contributory factors which affect the fill rate for November. This, along with the summary of key findings by ward, can be seen below:

- **Senior Nurses, Matrons and Specialist Nurses** – Senior Nurses, Matrons and Specialist nurses worked clinically to support wards where staffing fell below the minimum safe levels.
- **10B, 11A, 5A, 5B, 6A, 6B, 7B, 8A, 9A, 9B, AMU-W, Ashwell, Barley, Bluebell, Pirton and SSU -** The demand for enhanced care remained high during November especially across each of these areas. This could not always be covered by the enhanced nursing care team and therefore shifts were put out to temporary staffing to support this need. However CSW fill rates for November fell below 90% for some areas and senior nurses are working with nurse education, HR and NHSP to explore ways in which recruitment and fill rates can be improved.
- **AMU-A –** RN Night fill fell below 90% at 88.4% in November. Staffing was however deemed to be either Green or Amber at Night based on patient acuity.
- **Pirton –** RN day fill is recorded as 89.9% in November. The average bed occupancy was 82.12% as at the 23:59 census period. Staffing levels were managed appropriately to reflect the bed occupancy as the delivered CHPPD of 7.43 is within the required service model. In addition to the planned ward staff, the Stroke wards have support from the specialist Stroke Nurses and work is on-going to capture the care hours provided by the Stroke Nurses and Therapists on this ward.
- **Swift** - the average bed occupancy was 76.15% as at the 23:59 census period. Staffing levels were managed appropriately to the occupancy. CHPPD is 5.93 which is in line with the planned service model therefore we are assured that staffing is maintained

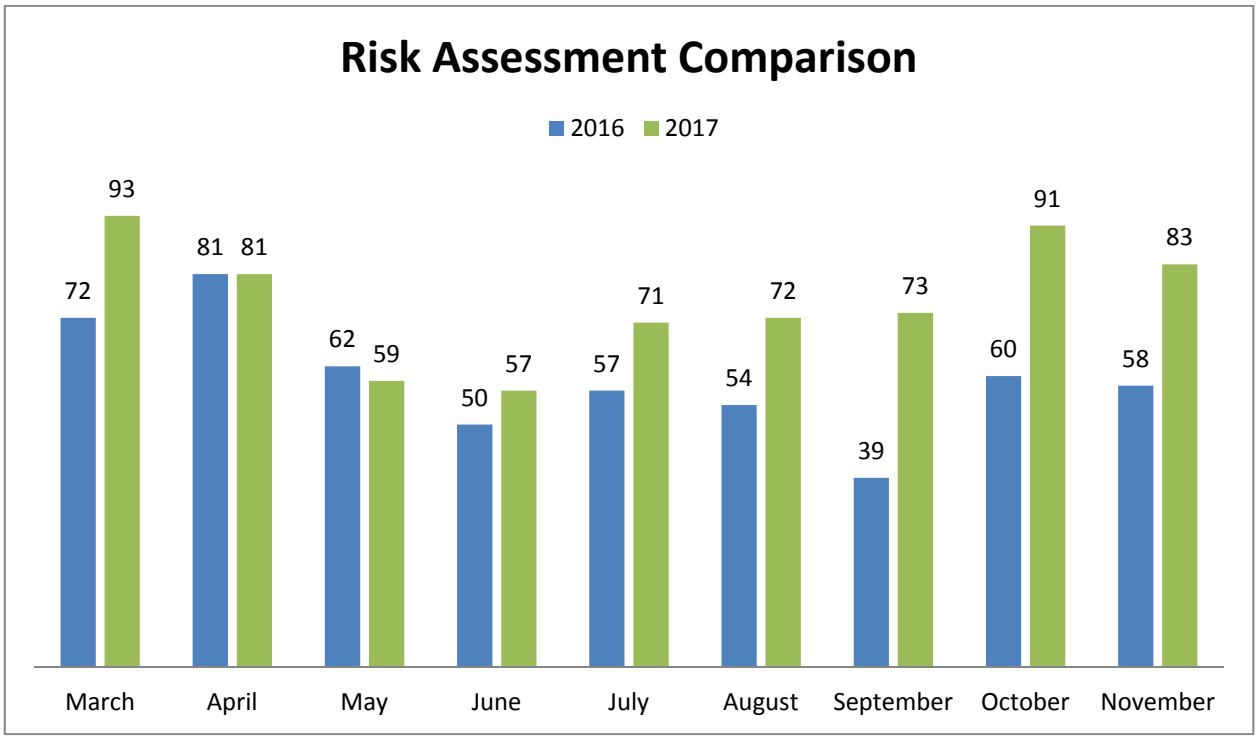
appropriately. Due to lower planned staffing levels at night there is less flexibility to reduce staffing at night in line with occupancy.

- **Ward 11** – The wards at Mount Vernon were merged in April following a review of the service model for these wards. The combined Oncology ward is referred to Ward 11 for the purposes of this report. Ward 11 ran below their planned patient numbers in November with their night occupancy at 49.26% therefore although their fill rate was below 90% staff flexed across the service, the AOS nurse and Matrons supported the service as required. Work is underway to differentiate between the ambulatory and inpatient nursing requirements of the combined Oncology ward as detailed in the October Establishment Review.
- **New Starters –** In addition to the clinical hours of work recorded for the Unify return, the wards were supported by in excess of over 2500 hours of Supernumerary staff on the wards in October, 1700 hours of RN and 808 hours CSW time.

**The Enhanced Nursing care team (ENCT)**

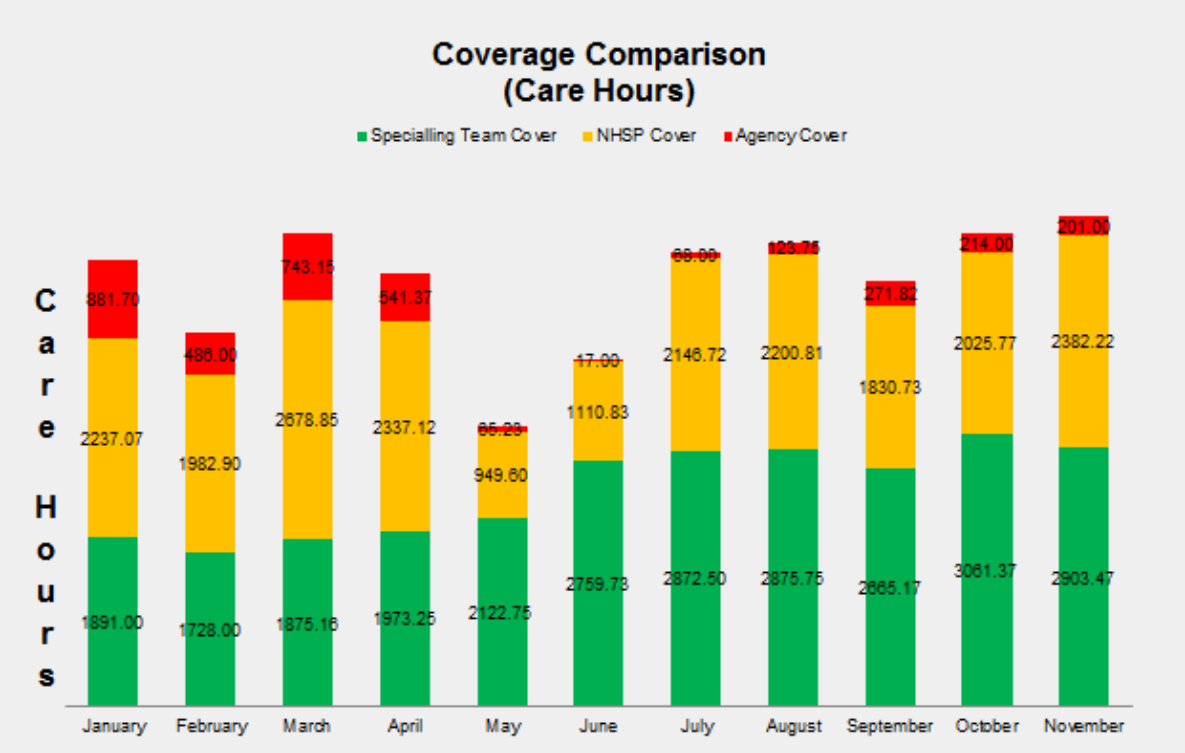
The ENCT have streamlined the service for patients needing enhanced care and the team review the level of care requirement on each ward on a daily basis. Chart 1 show that demand for enhanced care has decreased with 8 less risk assessments received for enhanced care needs from the previous month. However it also shows that there is a much higher demand for enhanced care for the same period 2016 which has been the trend over the previous 5 months.

**Chart 1**




The Enhanced Nursing Care Team (Specialling team) continues to mitigate the risk and reduce the need to cover those patients requiring enhanced care with temporary staff, providing a higher level of care for less cost. The team has recruited 4 band 4 team leaders to manage the team out of hours and continue to streamline the service. There is ongoing band 3 recruitment to bring the team up to full establishment by January 2018. The impact in terms of care hours delivered by the Specialling Team has reduced reliance on Agency staff can be seen in the Chart 2 below. The need to use Agency staff to support in November was a result of high level of sick leave within the team, reduced temporary staffing fill rates and an increased demand for enhanced care.

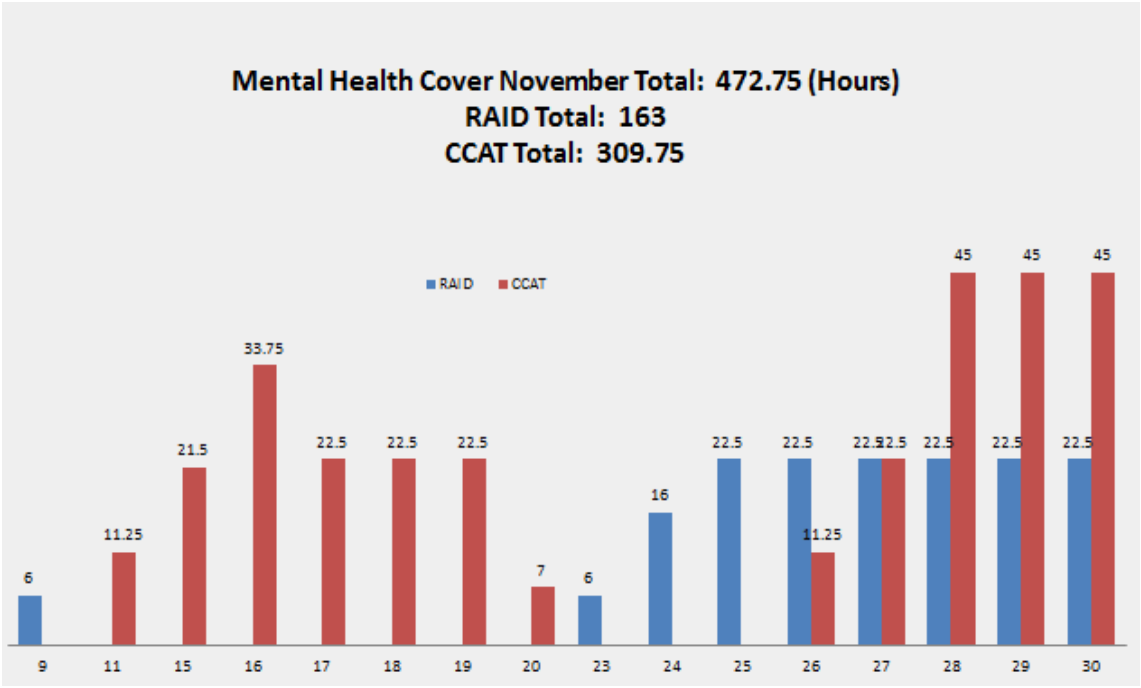
**Chart 2**




The ENCT review all patients requiring enhanced care on a daily basis and determine the requirement needed, reviewing behavioural charts and liaising with ward staff, patients and carers. This means that they can cover parts of shifts with less staff and working with carers and volunteers to help support the care requirement. If they are unable to support a ward with the team, the shift will be sent to temporary staffing to be filled. The team are now working collaboratively with Hertfordshire Partnership Foundation Trust (HPFT) who have funded 1 WTE band 3 CSW. HPFT have provided training for the team to support mental health patients requiring enhanced care in our trust. Demand for enhanced care seen an increase for the month; therefore additional duties were requested to support the rise in requirement.

Chart 3 below shows the number of care hours that have been covered by the ENCT for mental health patients. This requirement will be reviewed in January with a view to increase the funding from HPFT to cover the mental health patients.

**Chart 3**




### 1.2 UNIFY Care Hours Per Patient Day (CHPPD)

From 1 May 2016 each Trust is required to report the number of Care Hours per Patient Day (CHPPD). This figure is calculated:

**The total number of patient days over the month**
**(Sum of actual number of patients on the ward at 23:59 each day)**
**/**
**Total hours worked in month**
**(Total hours worked for registered staff, care staff and then combined)**

This is a standard calculation indicating the number of care hours provided to each patient over a 24 hour period. The table below shows the CHPPD for October, this indicates overall CHPPD decreased from 7.3 in October to 7.0 in November.

Following Lorenzo and Nerve Centre "Go Live" in September 2017 the Information Department are not yet able to provide patient data as work is on-going to update the bed data in the new data warehouse. To calculate the CHPPD for November the patient days over the month have been taken from an alternative data source of SafeCare.

**Table 2 – Average Care Hours Per Patient Day**

| Trust-wide | Care Hours Per Patient Day (CHPPD) | | |
|---|---|---|---|
| | Registered midwives/ nurses | Care Staff | Overall |
| **Total** | **4.5** | **2.5** | **7.0** |

CHPPD is used to inform the bi-annual establishment reviews and the results are reported monthly on the Unify return. When benchmarked against similar trusts the CHPPD for the Trust fall within expected thresholds. A full list of CHPPD by ward can be seen in Appendix 2 of this report.

The NHS Improvement Model Hospital Portal includes the CHPPD metric and was used to Benchmark CHPPD against other Trusts for the October Establishment Review.

## 2. Staff were supported in their decision making by effective reporting

### 2.1 Daily process to support operational staffing

Three daily staffing meetings and twice weekly look ahead meetings continue to support the organisation in balancing staffing risk across the Trust. Each ward is rated as red, amber or green for each of the early, late and night shifts. This record is held electronically in the Staffing Hub which provides a central point to access the E-Roster and NHSP teams. The record is also shared with the Operations Centre and provides assurance on nurse staffing levels in the organisation.

### 2.2 Staffing levels and shifts that trigger red

The number of shifts initially triggering red decreased from 407 in October to 302 in November. The percentage of Red Triggered shifts decreased from 12.16% in October to 9.07%. Table 3 below shows the % of shifts that triggered red in month.

**Table 3 – % of shifts triggering red**

| Month | % of shifts that triggered red in Month |
|---|---|
| **Nov-16** | 4.35% |
| **Dec-16** | 6.02% |
| **Jan-17** | 5.32% |
| **Feb-17** | 6.40% |
| **Mar-17** | 7.44% |
| **Apr-17** | 5.91% |
| **May-17** | 6.13% |
| **Jun-17** | 6.51% |
| **Jul-17** | 8.24% |
| **Aug-17** | 8.90% |
| **Sep-17** | 10.62% |
| **Oct-17** | 12.16% |
| **Nov-17** | 9.07% |

Comparison of red triggered shifts between November 2016 and November 2017 shows an increase of 4.72% in the number of shifts triggering red in month.

Out of the shifts triggering red, 6 of the 302 that initially triggered red (0.18%) remained only partially mitigated. This is a decrease in the number of partially mitigated shifts from 28 in October. Shifts triggering red, and those that remained a challenge to mitigate, are explored below.

Chart 4 below shows the % of shifts triggering red in month; the % shifts triggering red has shown a linear increase. This is multifactorial and the reasons include sustained levels of vacancies and sickness, controlled use of agency and unfilled temporary staffing shifts. These are discussed in section 2.3.

**Chart 4**

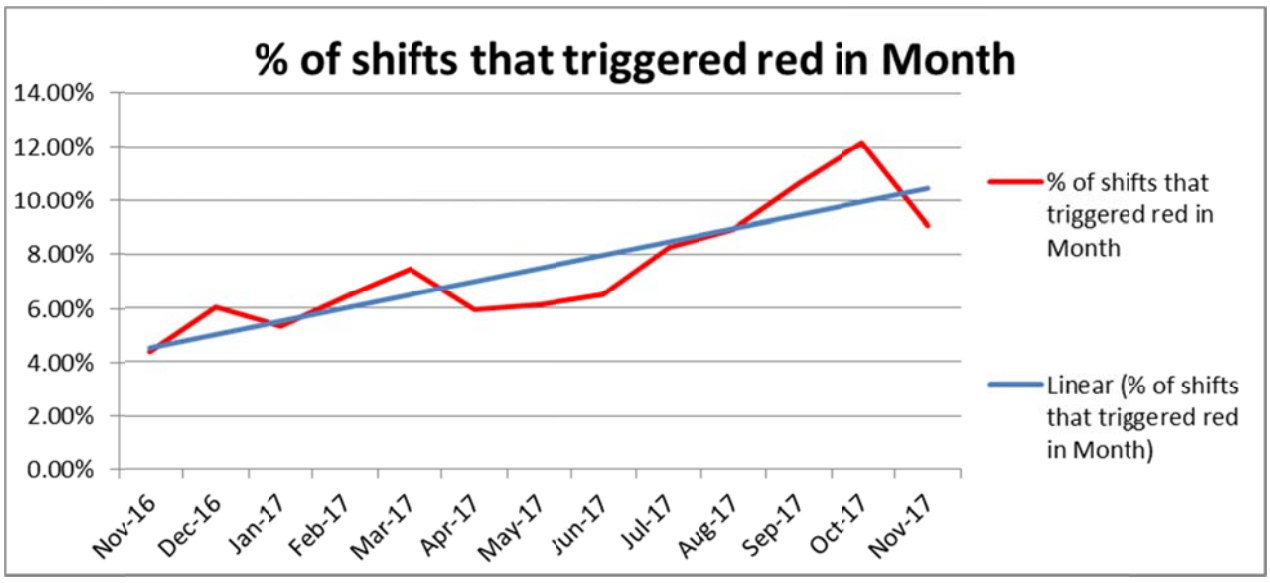
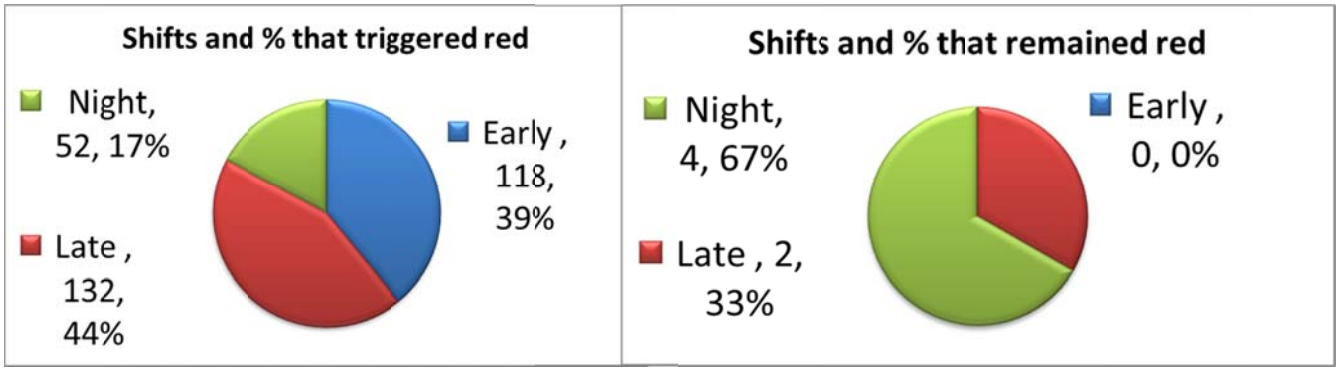



Chart 5 below shows the number and % distribution of red triggered shifts and those shifts that remained red after mitigating action was taken.

**Chart 5 – Shifts initially triggering red & remained red**




A list of all the shifts triggering red can be found in Appendix 3. 15 wards triggered red on 10% or more of the shifts in November which is a decrease from 22 wards in October.

Generally, red shifts are mitigated by moving staff between wards to balance staff numbers and skill mix. Table 4 below shows the shift breakdown for each of these wards.

**Table 4 – Wards triggering high number of red shifts**

| | INITIAL REDS | | | | |
|---|---|---|---|---|---|
| Ward | Early | Late | Night | Number of shifts where staffing initially fell below agreed levels | % of shifts where staffing fell below agreed levels and triggered a Red rating |
| 9A | 12 | 4 | 2 | 18 | 20.00 |
| 9B | 9 | 6 | 3 | 18 | 20.00 |
| Barley | 15 | 8 | 1 | 24 | 26.67 |
| 6A | 3 | 5 | 3 | 11 | 12.22 |
| 10B | 9 | 11 | 6 | 26 | 28.89 |
| 11A | 7 | 4 | 4 | 15 | 16.67 |
| ACU | 3 | 4 | 2 | 9 | 10.00 |
| SSU | 3 | 10 | 2 | 15 | 16.67 |
| AMU-W | 8 | 9 | 1 | 18 | 20.00 |
| 6B | 3 | 7 | 0 | 10 | 11.11 |
| Ashwell | 10 | 7 | 6 | 23 | 25.56 |
| 8A | 7 | 4 | 2 | 13 | 14.44 |
| 8B | 4 | 10 | 3 | 17 | 18.89 |
| 5A | 4 | 4 | 1 | 9 | 10.00 |
| 5B | 7 | 7 | 2 | 16 | 17.78 |

In addition to the reactive daily support, this information is provided to ward managers and matrons to ensure proactive robust supportive measures can be put in place moving forward.

### 2.3 Summary of factors affecting red triggering shifts

Several key factors have impacted the incidence of red shifts, these include:

- Temporary Staffing Fill – Temporary staffing demand decreased slightly in November, agency filled hours remained static at 18%, bank filled hours increased by 3.7%. The percentage of unfilled hours decreased from 27.3% in October to 23.7% in November. Overall fill rate in temporary staffing increased by 3.6% from 72.7% to 76.3%. See Appendix 5.
- Sickness – The sickness rate increased to 7.4% in November from 6.7% in October (taken from e-Roster) and remains above the 4% budget position.
- Specialling requirements impact on the care hours required on a ward on a shift by shift basis. If the specialling needs are not covered this may cause the ward to trigger red

To ensure some stability in staffing levels 18 long line agency nurses have been sourced to date and allocated to the most appropriate wards in line with operational shortfall. These placements are initially for three months and work is underway to ensure that these staff are trained and competent to trust standards of care and quality.

## 3. Staffing risks were effectively escalated to an appropriate person

Shifts that fall below minimum staffing levels are escalated to the divisional staffing bleep holder who moves staff to balance risk across the division. Where the individual division is unable to mitigate independently this is escalated to the Divisional Heads of Nursing to balance risk across the organisation.

### 3.1 Red Flags

Red flags are NICE recommended nationally reportable events that require an immediate response from the Senior Nurse Team. "Red flag events" signal to the Senior Nurse Team an urgent need for review of the numbers of staff, skill mix and patient acuity and numbers. These events are considered as indicators of a ward requiring an intervention e.g. increasing staffing levels, facilitating patient discharge or closing to admissions for a temporary period following discussion and agreement with the operations centre and the executive on call.

Red flag notifications are completed in SafeCare and sent to a centralised staffing e-mail address. These notifications are then escalated at each of the three daily staffing meetings and closed once actions to mitigate are in place. The nurse in charge of the ward will try to resolve Red Flags with the help of the Divisional bleep holders who will act on escalated 'open' issues to help resolve them. Feedback from the wards has found the red flags appropriate to the staffing challenges they need to escalate on a shift.

Chart 6 below shows the distribution of red flags by type. Total red flags raised decreased from 273 in October to 220 in November. This chart shows that Shortfall in Care Hours and Registered Nurse to Patient Ratio were the most commonly raised red flags. Matrons are expected to visit any ward that has raised a red flag within an hour to ensure any risk is mitigated.

**Chart 6 – Red Flags raised by Type**

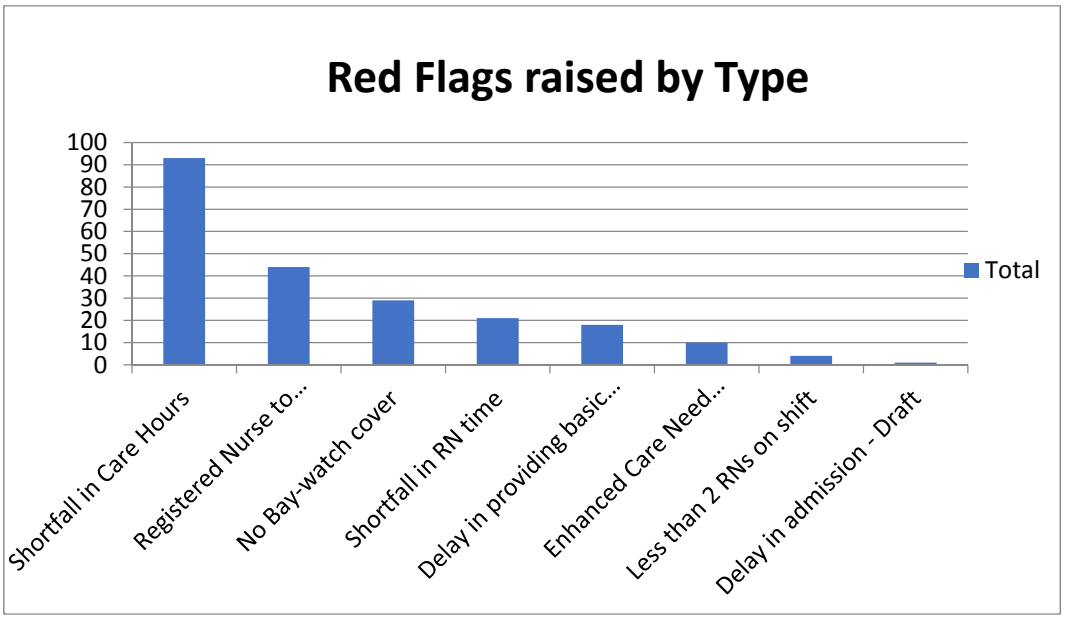
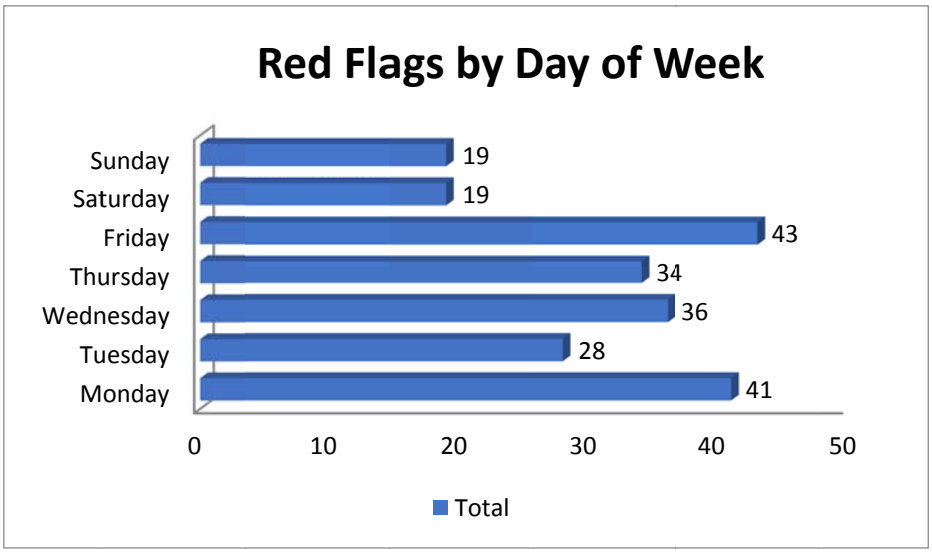



Chart 7 below indicates the red flags by day of the week; this shows that Mondays, and Fridays had the highest number of red flags raised in November. This mirrors the days on which there is a higher number of unfilled shifts. Work is underway to review the reasons behind the staffing challenges faced on these days of the week and is focusing on the actions required to minimise the risk accordingly.

**Chart 7 - Red Flags Day of Week**




## 4. Patient Safety incidents

### 4.1 Safety Thermometer

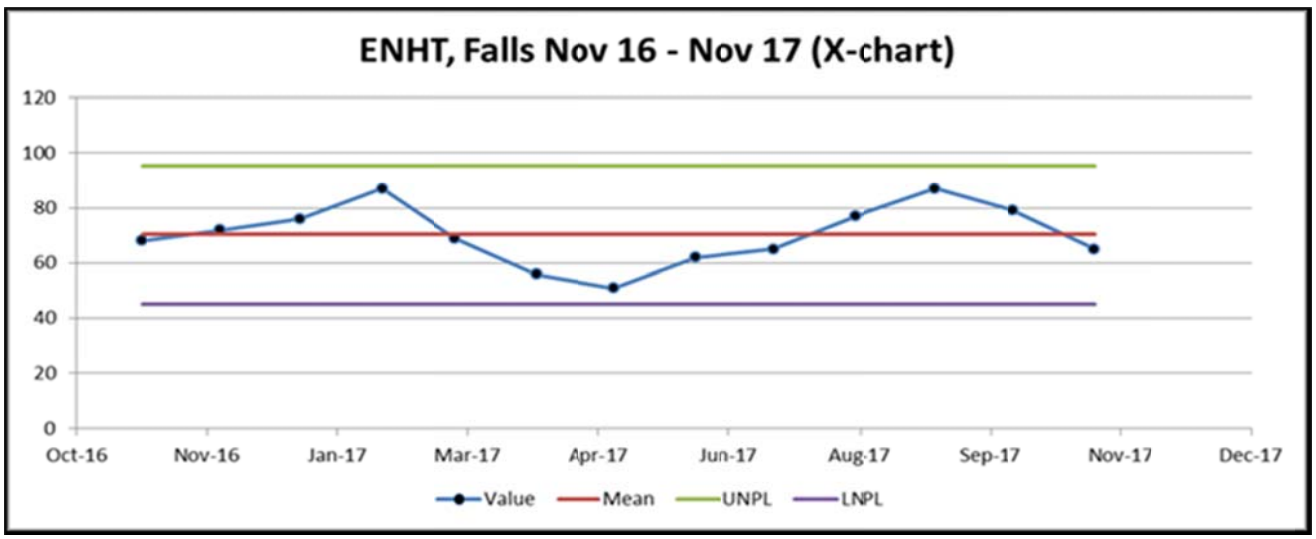
The NHS Safety Thermometer audit provides a 'temperature check' on levels of harm and enables the measurement of 'harm free care'. Harm free care is defined by the absence of pressure ulcers (community and hospital acquired), harm from a fall in hospital, urine infection (in patients with a catheter) and new VTE.

Despite the increased bed capacity and higher number of patients requiring enhanced nursing care the proportion of patients with harm identified within the classic safety thermometer audit remains low. In November 2017 2.3% of patients were identified with harm, a decrease from 5.2% in October 2017.

### 4.2 Falls

65 inpatient falls were recorded in the Trust during November. Chart 5 shows the Trust is currently 3 incidents below the reduction trajectory set for 2017/18.

**Chart 5**

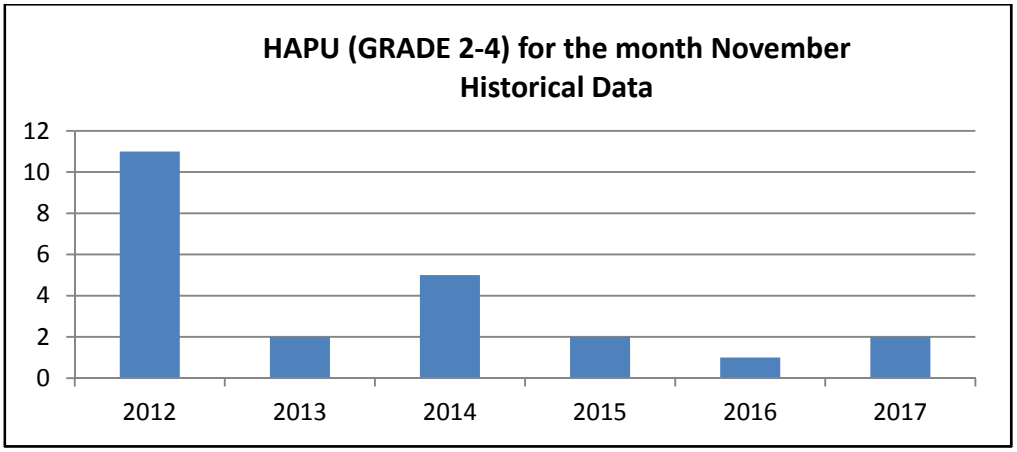


Year to date the Trust is reporting a 3.7% decrease in falls when compared to the same period in 2016/17. Ashwell, 10B and MSH are demonstrating significant reductions in falls when compared to the same period in 2016. Pirton, 9B, 9A and 8A are showing significant increases in incidents, all clinical areas are required to focus on achieving a year on year reduction in falls. The impact of safety huddles, Baywatch and the enhanced nursing care team have all had a positive impact in the reduction of falls in the trust.

## 4.2 Pressure Ulcers

For the month of November 2017, 2 avoidable hospital acquired pressure ulcers grade 2-4 were recorded. Chart 7 demonstrates the number of pressure ulcers in the month of November since 2012. In addition there were 2 hospital acquired avoidable suspected deep tissue injuries, (STDI)

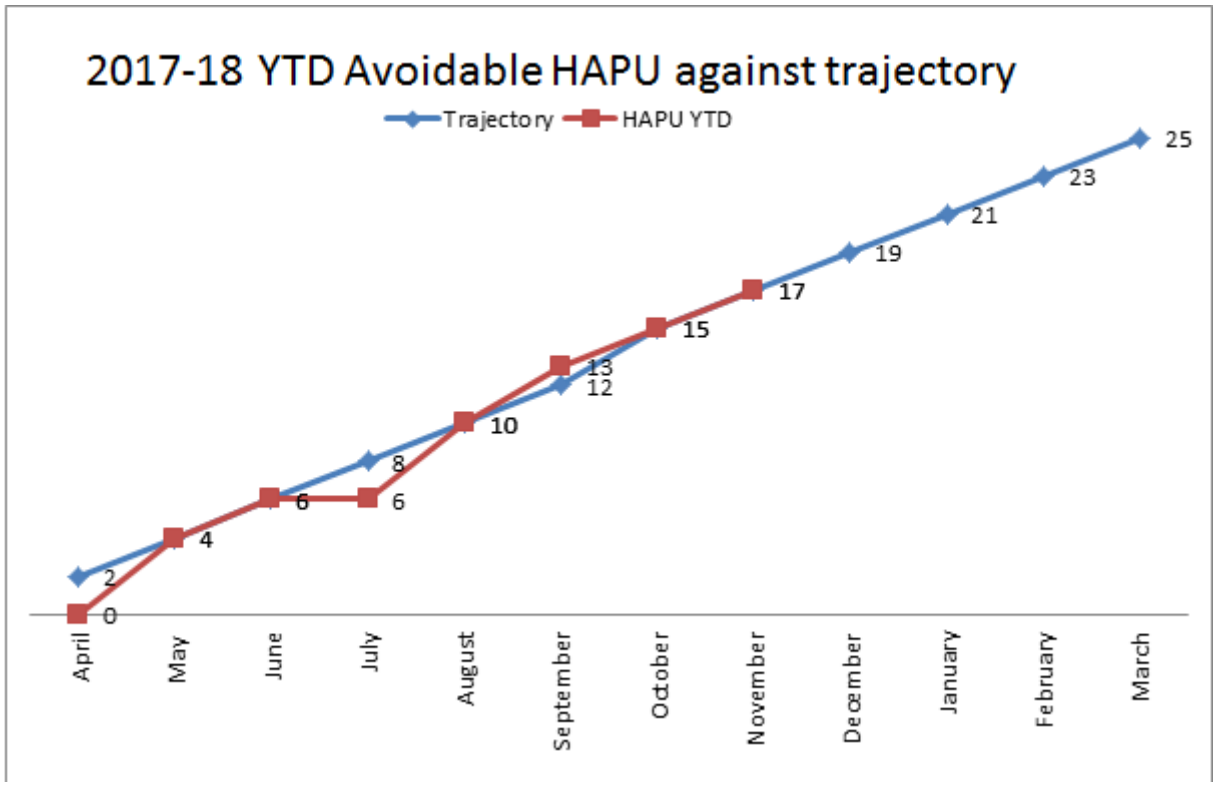
**Chart 7**




The outcomes of the investigations suggest that the omissions were lack of documentation and pressure relieving equipment.

The trust has launched the" end pyjama paralysis" a national campaign, to encourage patients to get dressed and out of bed to encourage mobility and prevent deconditioning. This is having a positive impact on pressure ulcer prevention and improving patient deconditioning. Chart 8 shows the Trust is on target to meet the trajectory for 2017-2018.

**Chart 8**




## 5. The Board are assured of safe staffing for nursing across the organisation

The overall RN and CSW fill rate increased due to an increase in temporary staffing bank fill and slight decrease in demand. The CHPPD delivered in November has however decreased slightly. The maintenance of safe staffing levels on wards in November was supported by:

- Continued daily monitoring and ward RAG rating of staffing levels across inpatient wards
- Matrons review and response to Red Flag events at the three Daily Staffing meetings with mitigations fed back to the wards via SafeCare in real time
- Regular patient acuity audits completed by Matrons
- Working with cap compliant agencies
- Working with agencies to identify long line agencies to support areas with high vacancies
- Controlled release of unfilled shifts to agencies
- Additional support provided by e-Roster, NHSP and Temporary Staffing management to assist wards with staffing challenges
- Active management by the Divisional / Duty Matron and support from Matrons and Heads of Nursing within the Divisions to review staffing requirements on a daily basis for identified wards
- Divisional Heads of Nursing, Matrons, Specialist Nurses and the Education Team working clinically where needed
- The introduction of the e-Roster operational support service in the evening to cover the handover of the night shift and support the Duty Matron with the mitigation of red shifts at night
- The e-Roster team contacting all Red wards to ensure that the planned mitigations have taken place and escalate to Matrons where appropriate

## Appendix 1

| | Day | | Night | |
|---|---|---|---|---|
| Ward name | Average fill rate + registered nurses/midwives (%) | Average fill rate + care staff (%) | Average fill rate + registered nurses/midwives (%) | Average fill rate + care staff (%) |
| 10B | 96.7% | 101.4% | 98.7% | 126.8% |
| 11A | 94.5% | 95.9% | 100.0% | 123.6% |
| 11B | 93.5% | 81.5% | 100.6% | 107.0% |
| 5A | 97.8% | 85.6% | 99.2% | 118.7% |
| 5B | 94.6% | 92.8% | 92.9% | 128.6% |
| 6A | 97.0% | 96.1% | 100.9% | 113.6% |
| 6B | 97.0% | 87.5% | 100.1% | 115.9% |
| 10A Gynae | 105.5% | 87.4% | 97.0% | 93.3% |
| 7B | 96.3% | 87.1% | 95.6% | 115.9% |
| 8A | 97.3% | 91.1% | 97.8% | 107.7% |
| 8B | 92.1% | 83.0% | 91.7% | 83.7% |
| 9A | 97.7% | 91.1% | 98.5% | 122.7% |
| 9B | 97.8% | 102.4% | 95.1% | 128.5% |
| ACU | 93.8% | 96.6% | 94.7% | 63.9% |
| AMU-A | 92.6% | 85.0% | 88.4% | 96.2% |
| AMU-W | 96.2% | 78.9% | 94.6% | 105.4% |
| Ashwell | 100.2% | 97.0% | 102.7% | 114.0% |
| Barley | 104.5% | 101.1% | 99.0% | 139.8% |
| Bluebell | 99.4% | 120.5% | 100.5% | #DIV/0! |
| Critical Care 1 | 100.0% | 100.0% | 100.0% | 100.0% |
| Dacre | 103.1% | 85.2% | 100.0% | #DIV/0! |
| Gloucester | 93.8% | 83.7% | 99.8% | 88.6% |
| CLU | 94.7% | 89.9% | 98.4% | 93.8% |
| Mat MLU | 103.6% | 92.2% | 103.7% | 87.7% |
| Michael Sobell House | 94.8% | 67.9% | 100.3% | 100.2% |
| Pirton | 89.9% | 102.4% | 98.2% | 122.0% |
| SAU | 90.5% | 76.8% | 97.8% | 92.9% |
| SSU | 105.4% | 99.3% | 98.7% | 125.0% |
| Swift | 86.2% | 97.4% | 82.5% | 97.6% |
| Ward 11 | 93.0% | 53.2% | 78.4% | #DIV/0! |
| **Total** | **96.3%** | **90.0%** | **96.7%** | **109.2%** |

## Appendix 2

| Ward name | Care Hours Per Patient Day (CHPPD) | | |
|---|---|---|---|
| | Registered midwives/ nurses | Care Staff | Overall |
| 10B | 3.01 | 2.70 | 5.71 |
| 11A | 4.11 | 1.92 | 6.03 |
| 11B | 3.62 | 2.47 | 6.10 |
| 5A | 3.20 | 1.92 | 5.12 |
| 5B | 3.22 | 2.67 | 5.89 |
| 6A | 3.09 | 2.49 | 5.58 |
| 6B | 3.68 | 2.61 | 6.29 |
| 10A Gynae | 5.24 | 2.34 | 7.57 |
| 7B | 3.26 | 1.76 | 5.02 |
| 8A | 3.10 | 2.15 | 5.25 |
| 8B | 3.07 | 1.63 | 4.70 |
| 9A | 2.98 | 2.33 | 5.31 |
| 9B | 3.04 | 2.30 | 5.35 |
| ACU | 4.52 | 1.92 | 6.44 |
| AMU-A | 5.16 | 3.19 | 8.34 |
| AMU-W | 3.94 | 2.96 | 6.90 |
| Ashwell | 3.03 | 3.28 | 6.31 |
| Barley | 3.41 | 2.57 | 5.98 |
| Bluebell | 7.50 | 2.56 | 10.06 |
| Critical Care 1 | 14.70 | 1.95 | 16.64 |
| Dacre | 7.83 | 1.11 | 8.94 |
| Gloucester | 4.74 | 3.86 | 8.60 |
| CLU | 29.68 | 6.48 | 36.16 |
| Mat MLU | 27.99 | 8.09 | 36.08 |
| Michael Sobell House | 4.57 | 2.47 | 7.04 |
| Pirton | 4.63 | 2.80 | 7.43 |
| SAU | 4.54 | 1.76 | 6.30 |
| SSU | 3.78 | 2.67 | 6.44 |
| Swift | 3.38 | 2.54 | 5.93 |
| Ward 11 | 5.34 | 1.51 | 6.85 |
| **Total** | **4.5** | **2.5** | **7.0** |

# Appendix 3

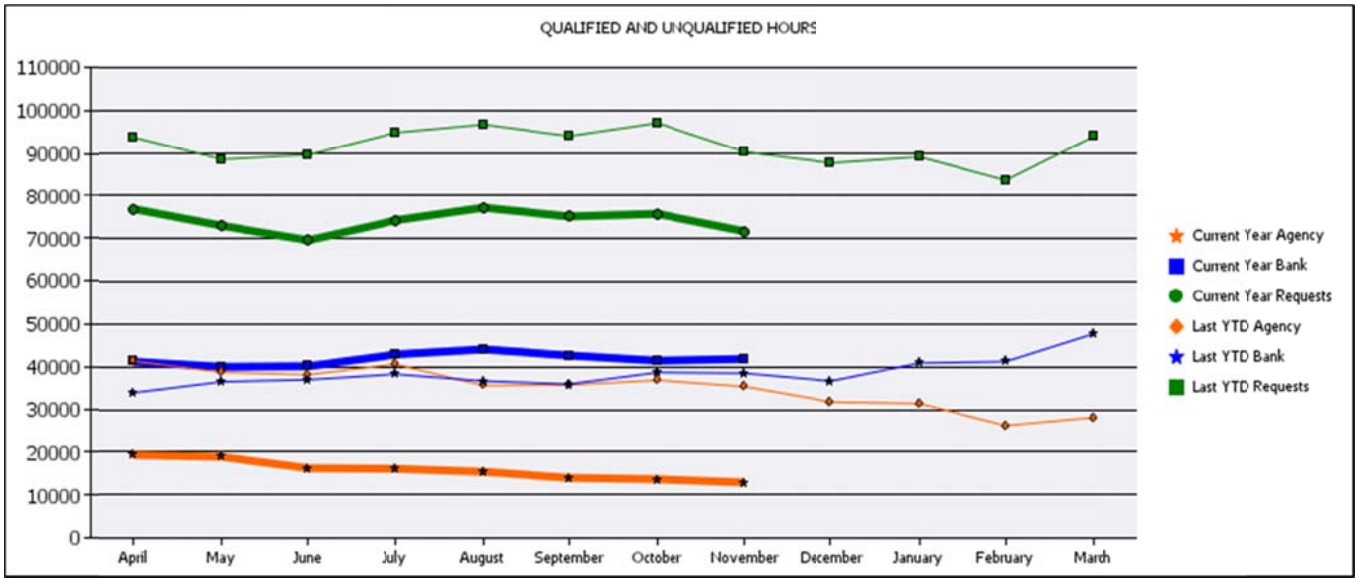
| Speciality | Ward | INITIAL REDS | | | | |
|---|---|---|---|---|---|---|
| | | Early | Late | Night | Number of shifts where staffing initially fell below agreed levels | % of shifts where staffing fell below agreed levels and triggered a Red rating |
| Care of the Elderly | 9A | 12 | 4 | 2 | 18 | 20.00 |
| | 9B | 9 | 6 | 3 | 18 | 20.00 |
| Stroke | Barley | 15 | 8 | 1 | 24 | 26.67 |
| | Pirton | 1 | 4 | 0 | 5 | 5.56 |
| General | 6A | 3 | 5 | 3 | 11 | 12.22 |
| | 10B | 9 | 11 | 6 | 26 | 28.89 |
| Respiratory | 11A | 7 | 4 | 4 | 15 | 16.67 |
| | 7AN | 0 | 0 | 0 | 0 | 0.00 |
| Cardiology | ACU | 3 | 4 | 2 | 9 | 10.00 |
| Acute | AMU-A | 1 | 6 | 0 | 7 | 7.78 |
| | SSU | 3 | 10 | 2 | 15 | 16.67 |
| | AMU-W | 8 | 9 | 1 | 18 | 20.00 |
| Renal | 6B | 3 | 7 | 0 | 10 | 11.11 |
| DTOC / gastro | Ashwell | 10 | 7 | 6 | 23 | 25.56 |
| ED | A&E | 2 | 4 | 0 | 6 | 6.67 |
| | CDU | 3 | 1 | 0 | 4 | 4.44 |
| | UCC | 0 | 0 | 0 | 0 | 0.00 |
| | | **89** | **90** | **30** | **209** | **13.66** |
| General | 8A | 7 | 4 | 2 | 13 | 14.44 |
| | 8B | 4 | 10 | 3 | 17 | 18.89 |
| | SAU | 0 | 3 | 1 | 4 | 4.44 |
| Surgical Spec | 11B | 0 | 1 | 3 | 4 | 4.44 |
| | 7B | 2 | 0 | 1 | 3 | 3.33 |
| T&O | 5A | 4 | 4 | 1 | 9 | 10.00 |
| | 5B | 7 | 7 | 2 | 16 | 17.78 |
| | Swift | 0 | 2 | 5 | 7 | 7.78 |
| ATCC | Critical Care 1 | 0 | 0 | 1 | 1 | 1.11 |
| | ASCU | 0 | 0 | 0 | 0 | 0.00 |
| | | **24** | **31** | **19** | **74** | **8.22** |
| Gynae | 10A Gynae | 2 | 3 | 1 | 6 | 6.67 |
| Paeds | Bluebell | 0 | 0 | 0 | 0 | 0.00 |
| | Child A&E | 1 | 0 | 1 | 2 | 2.22 |
| | NICU | 0 | 0 | 0 | 0 | 0.00 |
| Maternity | Dacre | 0 | 1 | 0 | 1 | 1.11 |
| | Gloucester | 0 | 5 | 0 | 5 | 5.56 |
| | Mat MLU | 0 | 0 | 0 | 0 | 0.00 |
| | Mat CLU 1 | 0 | 0 | 1 | 1 | 1.11 |
| | | **3** | **9** | **3** | **15** | **2.08** |
| Inpatient | Ward 10 | 1 | 1 | 0 | 2 | 2.22 |
| | Michael Sobell House | 1 | 1 | 0 | 2 | 2.22 |
| | | **2** | **2** | **0** | **4** | **2.22** |
| | **TRUST TOTAL** | **118** | **132** | **52** | **302** | **9.07** |

# Appendix 4

| Speciality | Ward | FINAL REDS | | | | |
|---|---|---|---|---|---|---|
| | | Early | Late | Night | Number of shifts where staffing initially fell below agreed levels | % of shifts where staffing fell below agreed levels and triggered a Red rating |
| Care of the Elderly | 9A | 0 | 0 | 0 | 0 | 0.00 |
| | 9B | 0 | 0 | 0 | 0 | 0.00 |
| Stroke | Barley | 0 | 0 | 0 | 0 | 0.00 |
| | Pirton | 0 | 0 | 0 | 0 | 0.00 |
| General | 6A | 0 | 0 | 0 | 0 | 0.00 |
| | 10B | 0 | 0 | 0 | 0 | 0.00 |
| Respiratory | 11A | 0 | 0 | 0 | 0 | 0.00 |
| | 7AN | 0 | 0 | 0 | 0 | 0.00 |
| Cardiology | ACU | 0 | 0 | 0 | 0 | 0.00 |
| Acute | AMU-A | 0 | 0 | 0 | 0 | 0.00 |
| | SSU | 0 | 0 | 0 | 0 | 0.00 |
| | AMU-W | 0 | 0 | 0 | 0 | 0.00 |
| Renal | 6B | 0 | 0 | 0 | 0 | 0.00 |
| DTOC / gastro | Ashwell | 0 | 0 | 1 | 1 | 1.11 |
| ED | A&E | 0 | 0 | 0 | 0 | 0.00 |
| | CDU | 0 | 0 | 0 | 0 | 0.00 |
| | UCC | 0 | 0 | 0 | 0 | 0.00 |
| | | **0** | **0** | **1** | **1** | **0.07** |
| General | 8A | 0 | 0 | 0 | 0 | 0.00 |
| | 8B | 0 | 0 | 0 | 0 | 0.00 |
| | SAU | 0 | 0 | 0 | 0 | 0.00 |
| Surgical Spec | 11B | 0 | 0 | 0 | 0 | 0.00 |
| | 7B | 0 | 0 | 0 | 0 | 0.00 |
| T&O | 5A | 0 | 0 | 0 | 0 | 0.00 |
| | 5B | 0 | 1 | 0 | 1 | 1.11 |
| | Swift | 0 | 0 | 0 | 0 | 0.00 |
| ATCC | Critical Care 1 | 0 | 0 | 1 | 1 | 1.11 |
| | ASCU | 0 | 0 | 0 | 0 | 0.00 |
| | | **0** | **1** | **1** | **2** | **0.22** |
| Gynae | 10A Gynae | 0 | 0 | 0 | 0 | 0.00 |
| Paeds | Bluebell | 0 | 0 | 0 | 0 | 0.00 |
| | Child A&E | 0 | 0 | 1 | 1 | 1.11 |
| | NICU | 0 | 0 | 0 | 0 | 0.00 |
| Maternity | Dacre | 0 | 0 | 0 | 0 | 0.00 |
| | Gloucester | 0 | 0 | 0 | 0 | 0.00 |
| | Mat MLU | 0 | 0 | 0 | 0 | 0.00 |
| | Mat CLU 1 | 0 | 0 | 1 | 1 | 1.11 |
| | | **0** | **0** | **2** | **2** | **0.28** |
| Inpatient | Ward 10 | 0 | 0 | 0 | 0 | 0.00 |
| | Michael Sobell House | 0 | 1 | 0 | 1 | 1.11 |
| | | **0** | **1** | **0** | **1** | **0.56** |
| | **TRUST TOTAL** | **0** | **2** | **4** | **6** | **0.18** |

## Appendix 5

# NHSP hours YTD report

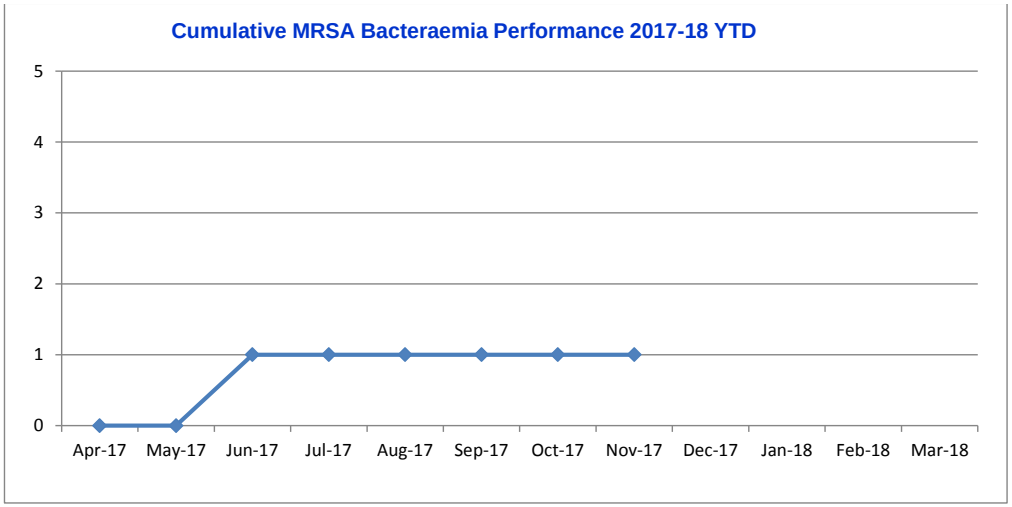


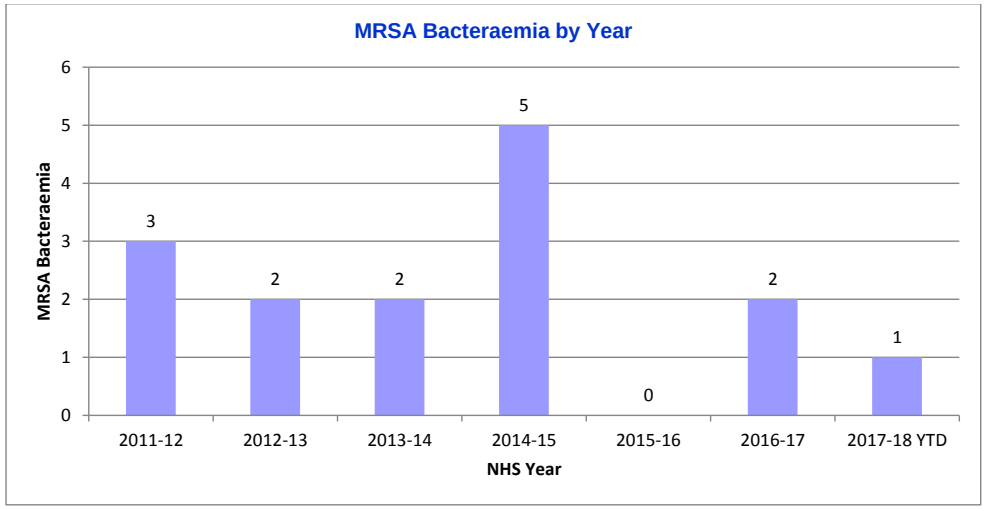
## Infection Prevention and Control Board Report Objectives & Outcomes: November 2017

| | | | |
|---|---|---|---|
| HCAI SURVEILLANCE | MRSA bacteraemias | 0 hospital associated MRSA bacteraemias in November.<br>Year to date position is 1 Trust allocated case, (target 0 cases to year end) | Red |
| | *C.difficile* | 2 Trust allocated *C.difficile* cases in November. Both cases to be appealed due to no lapses in care contributing to acquisition of infection.<br>Year to date position is 19 reported cases, of which 9 have been provisionally accepted by the CCG Appeals Panel for exemption against financial sanctions. Therefore, current position for the purpose of potential financial sanctions is 10 cases against the ceiling target of 11 cases to year end. Several further cases to be appealed at the next Appeal Panel meeting.<br>Recorded cases in the Trust have increased since 2016 – see September report for further details. | Amber |
| | MSSA bacteraemias | 1 Trust allocated MSSA bacteraemia in November.<br>Year to date position is 12 cases (no target set) | Green |
| | Gram negative bacteraemia:<br>National monitoring and reduction programme for E.*coli, Pseudomonas aeruginosa, Klebsiella species* – see page 9. | 1 Trust associated E.*coli* bacteraemia in November<br>Year to date position is 26 cases (no Trust target set) | Green |
| | | 0 Trust associated *Pseudomonas aeruginosa* bacteraemias in November<br>Year to date position tbc (no Trust target set) | Green |
| | | 1 Trust associated *Klebsiella species* bacteraemia in November<br>Year to date position tbc (no Trust target set) | Green |
| | Carbapenemase Producing Organisms (CPO) | 0 new inpatient cases and 0 outpatient cases identified in November.<br>Year to date position is 7 inpatient cases and 3 outpatient cases (no target set) | Green |
| | | A known CPO positive patient was not isolated on readmission to the Renal Ward. All patients on the ward are being screened as a precautionary measure. There have been at least two other incidents of known CPO positive patients being readmitted without their infectious status being recognised by the admitting team. This is likely to reoccur due to limitations of current manual surveillance process which cannot flag up such patients to the IP&C Team. | Amber |
| | Outbreaks / Periods of Increased Incidence | No outbreaks or periods of increased incidence were identified in November. | Green |
| | Surgical Site Infection | The Trust was identified as a high outlier for 2014-15 in all 3 categories monitored. Figures for 2015-17 to date indicate overall improvement, but the Trust remains a high outlier for Total Knee Replacement and Total Hip Replacement – see page 11 for detailed figures. | Amber |

| | | | |
|---|---|---|---|
| CQUINs | Antimicrobial stewardship | 7.3% reduction ytd (Apr-Nov) in total antibiotic consumption (target 2% reduction on baseline data Jan-Dec 2016)<br>52.7% reduction ytd (Apr-Nov) in piperacillin-tazobactam (target 2% reduction on baseline data Jan-Dec 2016)<br>36.9% reduction ytd (Apr-Nov) in carbapenems (target 2% reduction on baseline data Jan-Dec 2016) | Green |
| | | Review of sepsis patients on antibiotics who are still inpatients at 72 hrs.<br>Q1: 75% of cases reviewed within 72 hrs (target 25%)<br>Q2: 78% of cases reviewed within 72 hrs (target 50%)<br>Q3 to date: 83% of cases reviewed within 72 hrs (target 75%) | Green |
| AUDITS | High Impact Interventions (HII) | HII audit scores in November were above 95% with the exception of Hand Hygiene and Renal Environment. | Amber |
| SURVEILLANCE PROCESSES | ICNet | Potential solutions to resolve ongoing ICNet/TPP interface issue were presented to the IM&T Strategy Board in December 2016 and an outline business case for the reinstatement of the ICNet system has been prepared and is awaiting consideration. On Risk Register.<br>Several incidences have been identified of patients known to have CPE being readmitted to the hospital without their infectious status being recognised by the admitting team (see CPE above). The IP&C Team currently lack an automated process to alert them to the readmission of patients with transmissible organisms. | Red |
| | Infection in Critical Care Quality Improvement Programme (ICCQIP) | CCU are participating in the voluntary national surveillance programme which commenced in 2017 for blood stream infections in intensive care units, with the aim of reducing the number of such infections. Data will be presented quarterly from December. | Green |

# MRSA BACTERAEMIA – POST 48 HRS




## MRSA Bacteraemia by Division

| Division | 2016-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2017-18 YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| Medicine | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | | 1 |
| Surgical | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| Women & Children | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| **Grand Total** | **2** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **0** | | | | | **1** |

MRSA – PHE Benchmarking Data (October 2017)

Public Health England

# MRSA

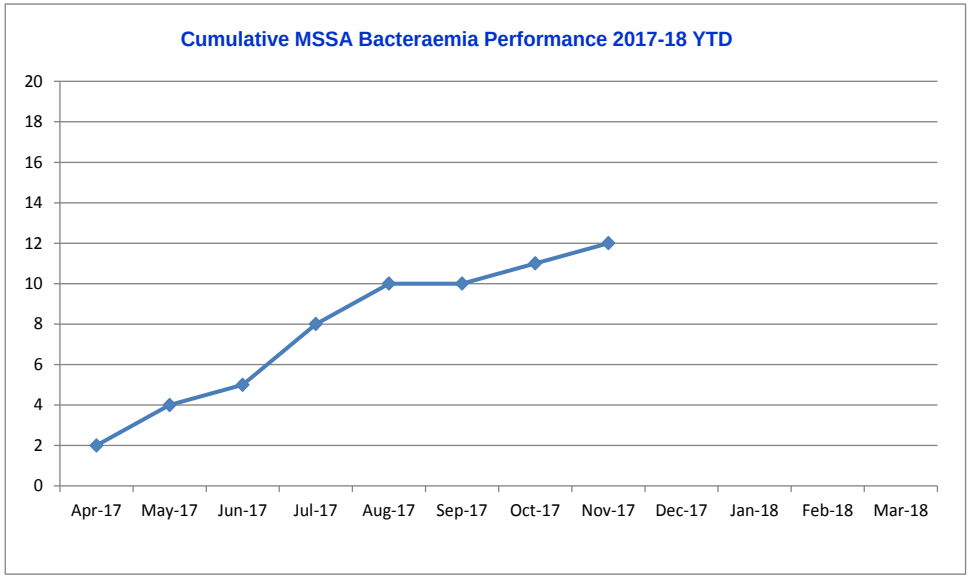
**Count of trust PIR assigned cases per month**

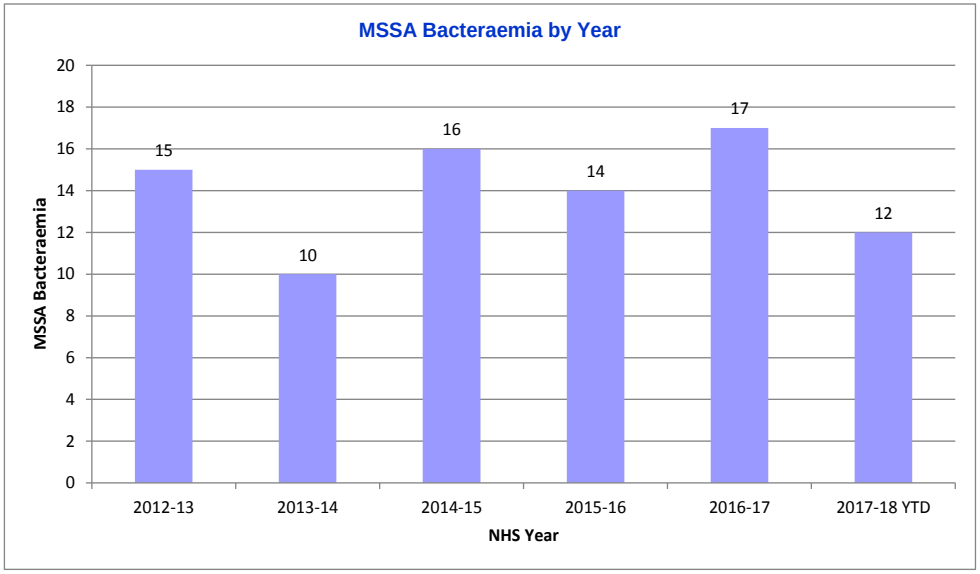
| Trust Code | Acute Trust Name | Trajectory | 2017 | | | | | | | | | 2018 | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | |
| RDD | Basildon & Thurrock University Hospitals NHS Foundation Trust | N/A | 0 | 0 | 0 | 2 | 2 | 0 | 0 | | | | | | 4 |
| RC1 | Bedford Hospitals NHS Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| RDE | Colchester Hospitals University NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| RWH | East & North Hertfordshire NHS Trust | N/A | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | | | 1 |
| RGQ | Ipswich Hospital NHS Trust | N/A | 0 | 1 | 0 | 0 | 0 | 0 | 1 | | | | | | 2 |
| RGP | James Paget University Hospitals NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| RC9 | Luton & Dunstable Hospital NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| RQ8 | Mid Essex Hospital Services NHS Trust | N/A | 2 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 2 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | N/A | 0 | 0 | 1 | 0 | 1 | 0 | 0 | | | | | | 2 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| RGN | North West Anglia NHS Foundation Trust | N/A | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 1 |
| RGM | Papworth Hospital NHS Foundation Trust | N/A | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | | | | | 2 |
| RQW | Princess Alexandra Hospital NHS Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| RAJ | Southend University Hospital NHS Foundation Trust | N/A | 1 | 0 | 0 | 1 | 2 | 0 | 0 | | | | | | 4 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| RWG | West Hertfordshire Hospitals NHS Trust | N/A | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | | | | | 1 |
| RGR | West Suffolk Hospitals NHS Trust | N/A | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | 0 |
| | **East of England Total** | **N/A** | **4** | **1** | **2** | **4** | **5** | **1** | **2** | | | | | | **19** |
| | **England Total** | **N/A** | **32** | **29** | **26** | **23** | **29** | **21** | **22** | | | | | | **182** |

**Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)**

| Trust Code | Acute Trust Name | Trajectory | 2017 | | | | | | | | | 2018 | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | |
| RDD | Basildon & Thurrock University Hospitals NHS Foundation Trust | N/A | 0.00 | 0.00 | 0.00 | 10.44 | 10.44 | 0.00 | 0.00 | | | | | | 3.03 |
| RC1 | Bedford Hospitals NHS Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| RDE | Colchester Hospitals University NHS Foundation Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| RWH | East & North Hertfordshire NHS Trust | N/A | 0.00 | 0.00 | 6.01 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.84 |
| RGQ | Ipswich Hospital NHS Trust | N/A | 0.00 | 5.89 | 0.00 | 0.00 | 0.00 | 0.00 | 5.89 | | | | | | 1.71 |
| RGP | James Paget University Hospitals NHS Foundation Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| RC9 | Luton & Dunstable Hospital NHS Foundation Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| RQ8 | Mid Essex Hospital Services NHS Trust | N/A | 14.07 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 1.97 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | N/A | 0.00 | 0.00 | 7.95 | 0.00 | 7.69 | 0.00 | 0.00 | | | | | | 2.23 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| RGN | North West Anglia NHS Foundation Trust | N/A | 4.90 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.69 |
| RGM | Papworth Hospital NHS Foundation Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 18.96 | 18.35 | | | | | | 5.32 |
| RQW | Princess Alexandra Hospital NHS Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| RAJ | Southend University Hospital NHS Foundation Trust | N/A | 7.17 | 0.00 | 0.00 | 6.94 | 13.88 | 0.00 | 0.00 | | | | | | 4.02 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| RWG | West Hertfordshire Hospitals NHS Trust | N/A | 0.00 | 0.00 | 0.00 | 5.16 | 0.00 | 0.00 | 0.00 | | | | | | 0.75 |
| RGR | West Suffolk Hospitals NHS Trust | N/A | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 0.00 |
| | **East of England Total** | **N/A** | **1.43** | **0.35** | **0.71** | **1.38** | **1.73** | **0.36** | **0.69** | | | | | | **0.95** |
| | **England Total** | **N/A** | **0.91** | **0.82** | **0.74** | **0.65** | **0.82** | **0.59** | **0.62** | | | | | | **0.74** |

# MSSA BACTERAEMIA - POST 48 HRS




**Hospital acquired MSSA Bacteraemia by Division**

| Division | 2016-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2017-18 YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| Medicine | 10 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | | | | | 3 |
| Surgical | 5 | 0 | 1 | 0 | 1 | 2 | 0 | 0 | 1 | | | | | 5 |
| Women & Children | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | | 2 |
| MVCC | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | | 2 |
| Grand Total | 17 | 2 | 2 | 1 | 3 | 2 | 0 | 1 | 1 | | | | | 12 |

MSSA – PHE Benchmarking Data (October 2017)

Public Health England

# MSSA

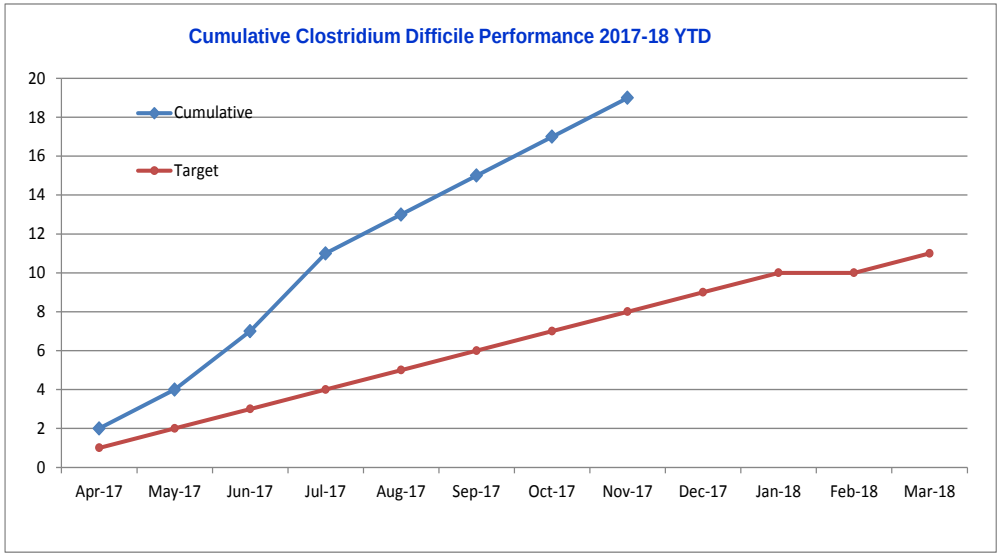
**Count of all cases identified by acute trust per month**

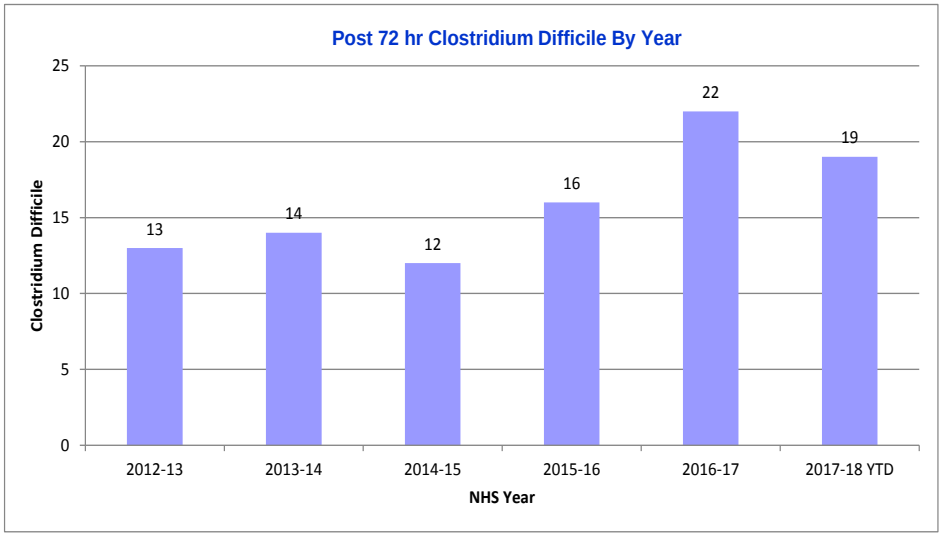
| Trust Code | Acute Trust Name | Trajectory | 2017 | | | | | | | | | 2018 | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | |
| RDD | Basildon & Thurrock University Hospitals NHS Foundation Trust | N/A | 1 | 2 | 4 | 1 | 1 | 1 | 2 | | | | | | 12 |
| RC1 | Bedford Hospitals NHS Trust | N/A | 0 | 0 | 1 | 1 | 0 | 1 | 0 | | | | | | 3 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | N/A | 2 | 0 | 1 | 0 | 1 | 5 | 2 | | | | | | 11 |
| RDE | Colchester Hospitals University NHS Foundation Trust | N/A | 1 | 2 | 2 | 2 | 2 | 1 | 0 | | | | | | 10 |
| RWH | East & North Hertfordshire NHS Trust | N/A | 2 | 2 | 1 | 3 | 2 | 0 | 1 | | | | | | 11 |
| RGQ | Ipswich Hospital NHS Trust | N/A | 1 | 0 | 1 | 0 | 3 | 1 | 1 | | | | | | 7 |
| RGP | James Paget University Hospitals NHS Foundation Trust | N/A | 3 | 0 | 3 | 0 | 0 | 1 | 3 | | | | | | 10 |
| RC9 | Luton & Dunstable Hospital NHS Foundation Trust | N/A | 0 | 0 | 0 | 1 | 2 | 1 | 0 | | | | | | 4 |
| RQ8 | Mid Essex Hospital Services NHS Trust | N/A | 1 | 1 | 2 | 2 | 0 | 3 | 2 | | | | | | 11 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | N/A | 2 | 2 | 1 | 2 | 2 | 4 | 4 | | | | | | 17 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | N/A | 3 | 1 | 3 | 4 | 1 | 0 | 2 | | | | | | 14 |
| RGN | North West Anglia NHS Foundation Trust | N/A | 0 | 1 | 1 | 2 | 1 | 2 | 2 | | | | | | 9 |
| RGM | Papworth Hospital NHS Foundation Trust | N/A | 1 | 2 | 0 | 0 | 1 | 2 | 1 | | | | | | 7 |
| RQW | Princess Alexandra Hospital NHS Trust | N/A | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | | | 1 |
| RAJ | Southend University Hospital NHS Foundation Trust | N/A | 1 | 2 | 0 | 1 | 1 | 1 | 1 | | | | | | 7 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | N/A | 0 | 1 | 2 | 1 | 2 | 1 | 1 | | | | | | 8 |
| RWG | West Hertfordshire Hospitals NHS Trust | N/A | 3 | 3 | 1 | 1 | 1 | 1 | 1 | | | | | | 11 |
| RGR | West Suffolk Hospitals NHS Trust | N/A | 0 | 1 | 1 | 0 | 1 | 1 | 0 | | | | | | 4 |
| | **East of England Total** | **N/A** | **21** | **20** | **25** | **21** | **21** | **26** | **23** | | | | | | **157** |
| | **England Total** | **N/A** | **255** | **295** | **264** | **248** | **270** | **252** | **290** | | | | | | **1874** |

**Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)**

| Trust Code | Acute Trust Name | Trajectory | 2017 | | | | | | | | | 2018 | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | |
| RDD | Basildon & Thurrock University Hospitals NHS Foundation Trust | N/A | 5.39 | 10.44 | 21.58 | 5.22 | 5.22 | 5.39 | 10.44 | | | | | | 9.08 |
| RC1 | Bedford Hospitals NHS Trust | N/A | 0.00 | 0.00 | 9.11 | 8.82 | 0.00 | 9.11 | 0.00 | | | | | | 3.83 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | N/A | 7.78 | 0.00 | 3.89 | 0.00 | 3.76 | 19.44 | 7.53 | | | | | | 6.00 |
| RDE | Colchester Hospitals University NHS Foundation Trust | N/A | 6.47 | 12.53 | 12.95 | 12.53 | 12.53 | 6.47 | 0.00 | | | | | | 9.08 |
| RWH | East & North Hertfordshire NHS Trust | N/A | 12.02 | 11.63 | 6.01 | 17.44 | 11.63 | 0.00 | 5.81 | | | | | | 9.27 |
| RGQ | Ipswich Hospital NHS Trust | N/A | 6.09 | 0.00 | 6.09 | 0.00 | 17.67 | 6.09 | 5.89 | | | | | | 5.97 |
| RGP | James Paget University Hospitals NHS Foundation Trust | N/A | 27.99 | 0.00 | 27.99 | 0.00 | 0.00 | 9.33 | 27.09 | | | | | | 13.08 |
| RC9 | Luton & Dunstable Hospital NHS Foundation Trust | N/A | 0.00 | 0.00 | 0.00 | 5.79 | 11.59 | 5.99 | 0.00 | | | | | | 3.36 |
| RQ8 | Mid Essex Hospital Services NHS Trust | N/A | 7.03 | 6.81 | 14.07 | 13.62 | 0.00 | 21.10 | 13.62 | | | | | | 10.85 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | N/A | 15.89 | 15.38 | 7.95 | 15.38 | 15.38 | 31.79 | 30.76 | | | | | | 18.94 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | N/A | 11.09 | 3.58 | 11.09 | 14.31 | 3.58 | 0.00 | 7.15 | | | | | | 7.25 |
| RGN | North West Anglia NHS Foundation Trust | N/A | 0.00 | 4.74 | 4.90 | 9.49 | 4.74 | 9.81 | 9.49 | | | | | | 6.19 |
| RGM | Papworth Hospital NHS Foundation Trust | N/A | 18.96 | 36.70 | 0.00 | 0.00 | 18.35 | 37.92 | 18.35 | | | | | | 18.61 |
| RQW | Princess Alexandra Hospital NHS Trust | N/A | 0.00 | 0.00 | 7.65 | 0.00 | 0.00 | 0.00 | 0.00 | | | | | | 1.07 |
| RAJ | Southend University Hospital NHS Foundation Trust | N/A | 7.17 | 13.88 | 0.00 | 6.94 | 6.94 | 7.17 | 6.94 | | | | | | 7.04 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | N/A | 0.00 | 8.46 | 17.48 | 8.46 | 16.92 | 8.74 | 8.46 | | | | | | 9.80 |
| RWG | West Hertfordshire Hospitals NHS Trust | N/A | 15.99 | 15.47 | 5.33 | 5.16 | 5.16 | 5.33 | 5.16 | | | | | | 8.22 |
| RGR | West Suffolk Hospitals NHS Trust | N/A | 0.00 | 8.16 | 8.43 | 0.00 | 8.16 | 8.43 | 0.00 | | | | | | 4.73 |
| | **East of England Total** | **N/A** | **7.51** | **6.92** | **8.94** | **7.26** | **7.26** | **9.29** | **7.96** | | | | | | **7.87** |
| | **England Total** | **N/A** | **7.21** | **8.35** | **7.47** | **7.02** | **7.64** | **7.13** | **8.20** | | | | | | **7.57** |

# CLOSTRIDIUM DIFFICILE – HOSPITAL ACQUIRED




**Post 72 hr Clostridium Difficile by Division**

| Division | 2016-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2017-18 YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| Medicine | 14 | 2 | 1 | 3 | 3 | 0 | 2 | 1 | 0 | | | | | 12 |
| Surgical | 8 | 0 | 1 | 0 | 1 | 2 | 0 | 1 | 1 | | | | | 6 |
| Women & Children | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| MVCC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | | | | 1 |
| Grand Total | 22 | 2 | 2 | 3 | 4 | 2 | 2 | 2 | 2 | | | | | 19 |

Summary of reviews of the 19 Trust allocated cases to end November:

- 9 cases have been provisionally accepted by the Appeals Panel for exemption from financial sanctions as there were no identified gaps in practice.
- Further cases to date will be submitted to the next Appeals Panel
- 4 cases to date had an avoidable delay in sending a stool sample and will not be appealed
- 1 further case to date will not be appealed due to documentation gaps
- In 1 of the above non-appealable cases antibiotics were inappropriately prescribed, and in 2 cases there was no documented review of antibiotics after 72hrs.

## C.DIFFICILE – PHE Benchmarking Data (October 2017)

Public Health England

# Clostridium difficile

**Count of acute trust apportioned cases per month**

| Trust Code | Acute Trust Name | Trajectory | 2017 April | May | June | July | Aug | Sept | Oct | Nov | Dec | 2018 Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RDD | Basildon & Thurrock University Hospitals NHS Foundation Trust | 31 | 5 | 1 | 2 | 1 | 1 | 2 | 1 | | | | | | 13 |
| RC1 | Bedford Hospitals NHS Trust | 10 | 0 | 1 | 1 | 0 | 1 | 2 | 0 | | | | | | 5 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | 49 | 1 | 11 | 4 | 7 | 5 | 8 | 5 | | | | | | 41 |
| RDE | Colchester Hospitals University NHS Foundation Trust | 18 | 0 | 3 | 3 | 1 | 1 | 2 | 0 | | | | | | 10 |
| RWH | East & North Hertfordshire NHS Trust | 11 | 2 | 2 | 2* | 4 | 2 | 2 | 2 | | | | | | 16* |
| RGQ | Ipswich Hospital NHS Trust | 18 | 1 | 3 | 1 | 8 | 2 | 1 | 1 | | | | | | 17 |
| RGP | James Paget University Hospitals NHS Foundation Trust | 17 | 0 | 2 | 3 | 3 | 1 | 0 | 2 | | | | | | 11 |
| RC9 | Luton & Dunstable Hospital NHS Foundation Trust | 6 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | | | | | | 8 |
| RQ8 | Mid Essex Hospital Services NHS Trust | 13 | 8 | 3 | 2 | 5 | 7 | 3 | 2 | | | | | | 30 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | 39 | 1 | 0 | 0 | 1 | 3 | 0 | 1 | | | | | | 6 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | 49 | 2 | 1 | 6 | 3 | 3 | 3 | 4 | | | | | | 22 |
| RGN | North West Anglia NHS Foundation Trust | 40 | 7 | 4 | 4 | 4 | 3 | 8 | 2 | | | | | | 32 |
| RGM | Papworth Hospital NHS Foundation Trust | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | | | | | | 2 |
| RQW | Princess Alexandra Hospital NHS Trust | 10 | 1 | 0 | 1 | 4 | 0 | 3 | 0 | | | | | | 9 |
| RAJ | Southend University Hospital NHS Foundation Trust | 30 | 5 | 2 | 4 | 1 | 3 | 2 | 0 | | | | | | 17 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | 53 | 2 | 3 | 4 | 5 | 3 | 5 | 5 | | | | | | 27 |
| RWG | West Hertfordshire Hospitals NHS Trust | 23 | 1 | 1 | 4 | 0 | 0 | 0 | 3 | | | | | | 9 |
| RGR | West Suffolk Hospitals NHS Trust | 16 | 3 | 0 | 0 | 1 | 0 | 2 | 6 | | | | | | 12 |
| | **East of England Total** | **413** | **40** | **39** | **42** | **49** | **36** | **44** | **37** | | | | | | **287** |
| | **England Total** | **4483** | **346** | **372** | **411** | **467** | **402** | **410** | **407** | | | | | | **2815** |

*** Figures shown for ENHT excludes 1 case in June which does not meet PHE criteria for inclusion but which is Trust associated**

**Monthly rate per 100,000 occupied bed days (acute trust apportioned cases only)**

| Trust Code | Acute Trust Name | Trajectory | 2017 April | May | June | July | Aug | Sept | Oct | Nov | Dec | 2018 Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RDD | Basildon & Thurrock University Hospitals NHS Foundation Trust | 13.60 | 26.97 | 5.22 | 10.79 | 5.22 | 5.22 | 10.79 | 5.22 | | | | | | 9.83 |
| RC1 | Bedford Hospitals NHS Trust | 8.30 | 0.00 | 8.82 | 9.11 | 0.00 | 8.82 | 18.22 | 0.00 | | | | | | 6.39 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | 15.60 | 3.89 | 41.40 | 15.56 | 26.34 | 18.82 | 31.11 | 18.82 | | | | | | 22.35 |
| RDE | Colchester Hospitals University NHS Foundation Trust | 9.10 | 0.00 | 18.80 | 19.42 | 6.27 | 6.27 | 12.95 | 0.00 | | | | | | 9.08 |
| RWH | East & North Hertfordshire NHS Trust | 4.90 | 12.02 | 11.63 | 12.02* | 23.26 | 11.63 | 12.02 | 11.62 | | | | | | 13.46* |
| RGQ | Ipswich Hospital NHS Trust | 9.40 | 6.09 | 17.67 | 6.09 | 47.11 | 11.78 | 6.09 | 5.89 | | | | | | 14.50 |
| RGP | James Paget University Hospitals NHS Foundation Trust | 13.10 | 0.00 | 18.06 | 27.99 | 27.09 | 9.03 | 0.00 | 18.06 | | | | | | 14.39 |
| RC9 | Luton & Dunstable Hospital NHS Foundation Trust | 3.10 | 5.99 | 11.59 | 5.99 | 5.79 | 5.79 | 5.99 | 5.79 | | | | | | 6.72 |
| RQ8 | Mid Essex Hospital Services NHS Trust | 7.30 | 56.28 | 20.42 | 14.07 | 34.04 | 47.65 | 21.10 | 13.62 | | | | | | 29.59 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | 25.80 | 7.95 | 0.00 | 0.00 | 7.69 | 23.07 | 0.00 | 7.69 | | | | | | 6.68 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | 25.80 | 7.39 | 3.58 | 22.18 | 10.73 | 10.73 | 11.09 | 14.31 | | | | | | 11.40 |
| RGN | North West Anglia NHS Foundation Trust | tbc | 34.32 | 18.98 | 19.61 | 18.98 | 14.23 | 39.23 | 9.49 | | | | | | 22.00 |
| RGM | Papworth Hospital NHS Foundation Trust | 7.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 36.70 | | | | | | 5.32 |
| RQW | Princess Alexandra Hospital NHS Trust | 6.50 | 7.65 | 0.00 | 7.65 | 29.62 | 0.00 | 22.96 | 0.00 | | | | | | 9.66 |
| RAJ | Southend University Hospital NHS Foundation Trust | 17.30 | 35.87 | 13.88 | 28.70 | 6.94 | 20.83 | 14.35 | 0.00 | | | | | | 17.10 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | 38.00 | 17.48 | 25.37 | 34.96 | 42.29 | 25.37 | 43.70 | 42.29 | | | | | | 33.08 |
| RWG | West Hertfordshire Hospitals NHS Trust | 10.90 | 5.33 | 5.16 | 21.31 | 0.00 | 0.00 | 0.00 | 15.47 | | | | | | 6.72 |
| RGR | West Suffolk Hospitals NHS Trust | 12.50 | 25.30 | 0.00 | 0.00 | 8.16 | 0.00 | 16.87 | 48.97 | | | | | | 14.19 |
| | **East of England Total** | **13.70** | **14.30** | **13.49** | **15.01** | **16.95** | **12.45** | **15.73** | **12.45** | | | | | | **14.33** |
| | **England Total** | **13.13** | **9.79** | **10.52** | **11.63** | **13.21** | **11.37** | **11.60** | **11.49** | | | | | | **11.37** |

*** Figures shown for ENHT excludes 1 case in June which does not meet PHE criteria for inclusion but which is Trust associated**

## CARBAPENEMASE-PRODUCING ORGANISMS (CPO)

Carbapenems are a class of broad spectrum intravenous antibiotics which are reserved for serious infections or when other therapeutic options have failed. One of the most concerning groups of Carbapenem Resistant Enterobacteriaceae (CRE) are those organisms which carry a carbapenemase enzyme that breaks down carbapenem antibiotics. This type of organism is called Carbapenemase Producing Enterobacteriaceae (CPE) and is the type which spreads most easily and has caused most outbreaks worldwide.

In accordance with PHE guidance, a screening programme was introduced in the Trust in June 2014 to identify patients at high risk of CPE/CPO carriage. This screening policy has now been expanded to include patients who have been admitted to any hospital during the past 12 months (UK or abroad) or undergone significant healthcare procedures, eg renal dialysis, abroad. Any such patients are then tested and patients are isolated until confirmed negative if they have had an overnight stay in any hospital in London, North West England or abroad, or received significant healthcare abroad. An enhanced screening programme for the Renal patient population has also been implemented as that patient group is in the highest risk category for CPE/CPO.

**Carbapenemase-Producing Organisms - 2017-18**

| Division/Dept | | 2016-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | YTD 2017-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| INPATIENTS | Renal Ward - Lister | 3 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | | | | 1 |
| | Medicine | 3 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 1 |
| | Surgery | 7 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | | | | | 4 |
| | W&C | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | | | | 1 |
| | MVCC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| RENAL DIALYSIS UNITS | Lister | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | L&D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | Harlow | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | St Albans | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | Bedford | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| OUTPATIENTS | Lister | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | | | | | 2 |
| | QEII | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | HCH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| | MVCC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | | | | 1 |
| TOTAL (TRUST PATIENTS) | | 15 | 1 | 2 | 1 | 1 | 1 | 2 | 2 | 0 | | | | | 10 |

**The above figures do not differentiate between Trust-associated and Community-associated cases.**

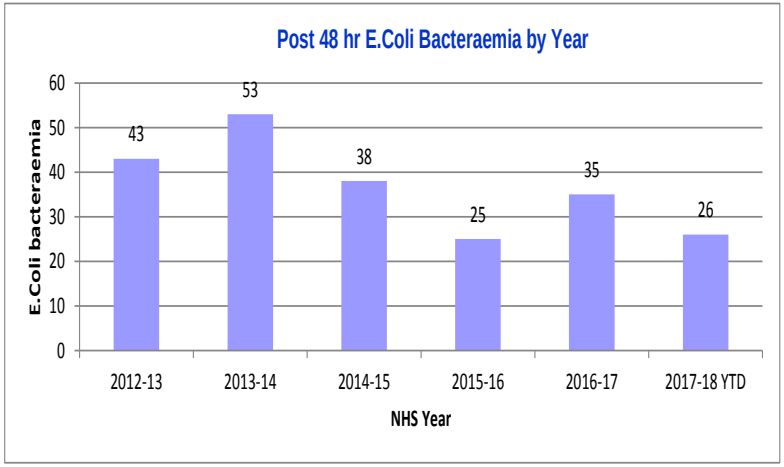
| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GP Patient Specimens (Not Trust Patients) | Not recorded | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | | | | | 2 |

## E.COLI BACTERAEMIA – POST 48 HRS

A new Quality Premium was introduced in July for a 10% reduction in E.coli bacteraemias attributed to each CCG, measured against 2016 performance data. Mandatory reporting of *Klebsiella species & Pseudominas aeruginosa* bacteraemias has also been introduced as part of a national requirement for a 50% reduction in gram negative bacteraemias by the beginning of 2021. The Trust does not have specific reduction targets at present, and Trust-associated cases make up less than 20% of reported cases. However, a number of strategies are being introduced in the Trust to minimise cases, including initiatives to reduce hospital acquired pneumonias (HAP) and catheter associated urinary tract infections (CAUTI).

### Hospital acquired E.Coli Bacteraemia by Division

| Division | 2016-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | 2017-18 YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Cancer | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| Medicine | 16 | 3 | 3 | 2 | 2 | 1 | 2 | 2 | 0 | | | | | 15 |
| Surgical | 16 | 1 | 2 | 1 | 1 | 0 | 2 | 1 | 0 | | | | | 8 |
| Women & Children | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | | | | | 3 |
| MVCC | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | | 0 |
| Grand Total | 35 | 4 | 7 | 3 | 3 | 1 | 4 | 3 | 1 | 0 | 0 | 0 | 0 | 26 |




Public Health England

### Escherichia coli

**Note: PHE figures for E.coli are not split between hospital-acquired and community-acquired cases**

| Trust Code | Acute Trust Name | Trajectory | 2017 April | May | June | July | Aug | Sept | Oct | Nov | Dec | 2018 Jan | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RDD | Basildon & Thurrock University Hospitals NHS Foundation Trust | N/A | 18 | 22 | 19 | 16 | 23 | 33 | 30 | | | | | | 161 |
| RC1 | Bedford Hospitals NHS Trust | N/A | 12 | 12 | 12 | 13 | 15 | 11 | 18 | | | | | | 93 |
| RGT | Cambridge University Hospitals NHS Foundation Trust | N/A | 32 | 22 | 33 | 32 | 35 | 30 | 31 | | | | | | 215 |
| RDE | Colchester Hospitals University NHS Foundation Trust | N/A | 16 | 25 | 27 | 26 | 38 | 28 | 28 | | | | | | 188 |
| RWH | East & North Hertfordshire NHS Trust | N/A | 23 | 27 | 18 | 24 | 30 | 29 | 24 | | | | | | 175 |
| RGQ | Ipswich Hospital NHS Trust | N/A | 27 | 21 | 23 | 12 | 17 | 13 | 14 | | | | | | 127 |
| RGP | James Paget University Hospitals NHS Foundation Trust | N/A | 19 | 23 | 20 | 11 | 18 | 16 | 27 | | | | | | 134 |
| RC9 | Luton & Dunstable Hospital NHS Foundation Trust | N/A | 13 | 12 | 22 | 13 | 23 | 13 | 20 | | | | | | 116 |
| RQ8 | Mid Essex Hospital Services NHS Trust | N/A | 16 | 17 | 18 | 21 | 22 | 19 | 18 | | | | | | 131 |
| RD8 | Milton Keynes Hospital NHS Foundation Trust | N/A | 21 | 13 | 12 | 27 | 21 | 23 | 11 | | | | | | 128 |
| RM1 | Norfolk & Norwich University Hospitals NHS Foundation Trust | N/A | 29 | 24 | 36 | 27 | 29 | 43 | 35 | | | | | | 223 |
| RGN | North West Anglia NHS Foundation Trust | N/A | 25 | 25 | 25 | 36 | 37 | 29 | 38 | | | | | | 215 |
| RGM | Papworth Hospital NHS Foundation Trust | N/A | 0 | 1 | 0 | 2 | 0 | 1 | 2 | | | | | | 6 |
| RQW | Princess Alexandra Hospital NHS Trust | N/A | 13 | 10 | 13 | 11 | 25 | 13 | 15 | | | | | | 100 |
| RAJ | Southend University Hospital NHS Foundation Trust | N/A | 19 | 21 | 23 | 26 | 18 | 25 | 32 | | | | | | 164 |
| RCX | The Queen Elizabeth Hospital King's Lynn NHS Trust | N/A | 18 | 18 | 20 | 17 | 17 | 18 | 19 | | | | | | 127 |
| RWG | West Hertfordshire Hospitals NHS Trust | N/A | 18 | 14 | 26 | 28 | 24 | 24 | 16 | | | | | | 150 |
| RGR | West Suffolk Hospitals NHS Trust | N/A | 12 | 11 | 16 | 15 | 11 | 17 | 13 | | | | | | 95 |
| | **East of England Total** | **N/A** | **331** | **318** | **363** | **357** | **403** | **385** | **391** | | | | | | **2548** |
| | **England Total** | **N/A** | **3290** | **3391** | **3503** | **3728** | **3781** | **3523** | **3593** | | | | | | **24809** |

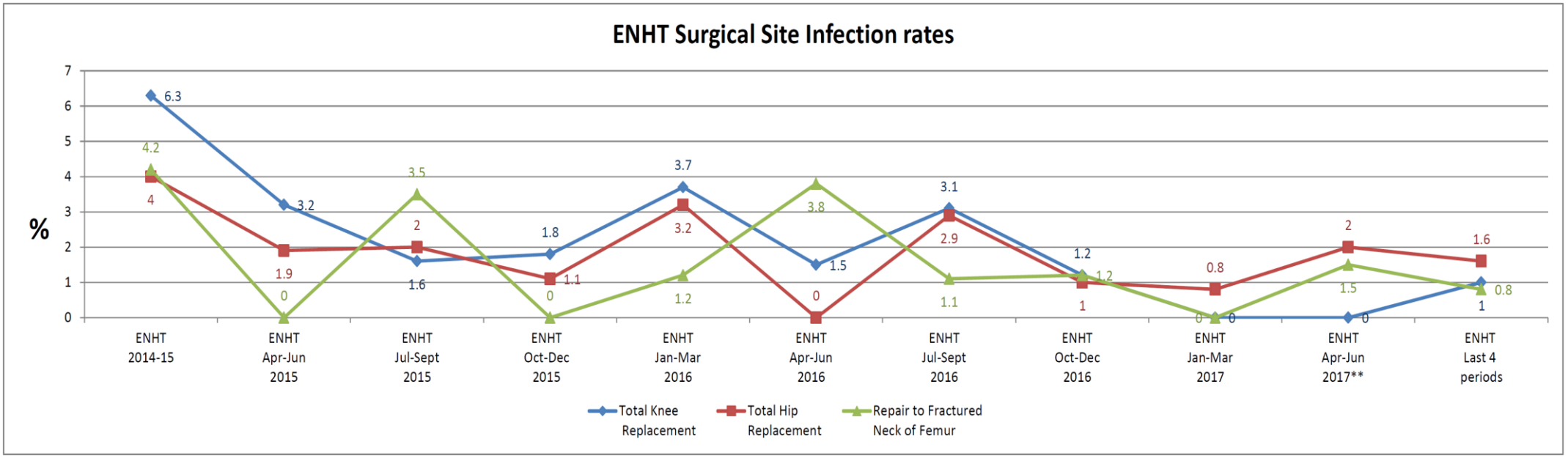
## Surgical Site Infection Rates

SSI figures over the last 4 periods (Jul 2016 – Jun 2017) show an overall reduction in infection rates in all three categories monitored (Total Knee Replacement, Total Hip Replacement & Repair of Fractured Neck of Femur), compared to the 2014-15 figures. However, the Trust remains a high outlier for Total Knee Replacement (TKR) and Total Hip Replacement (THR). The Surgical Site Infection Working Group is implementing the revised Surgical Site Infection Action Plan and is now using a national assessment toolkit.

| Category / Quarter | Oct-Dec 14 ENHT | Apr-Jun 15 ENHT | Jul-Sept 15 ENHT | Oct-Dec 15 ENHT | Jan-Mar 16 ENHT | Apr-Jun 16 ENHT | Jul-Sept 16 ENHT | Oct-Dec 16 ENHT | Jan-Mar 17 ENHT | Apr-Jun 17 **ENHT | * Last 4 periods ENHT | 2012-2016 National Benchmarks |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total Knee Replacement** | **6.3%** | **3.2%** | **1.6%** | **1.8%** | **3.7%** | **1.5%** | **3.1%** | **1.2%** | **0%** | **0%** | **1%** | **0.6%** |
| TKR infections/ops | 5 / 80 | 2 / 63 | 1 / 64 | 1 / 57 | 2 / 54 | 1 / 66 | 2 / 65 | 1 / 85 | 0 / 77 | 0 / 60 | 3 / 287 | |
| **Total Hip Replacement** | **4%** | **1.9%** | **2%** | **1.1%** | **3.2%** | **0%** | **2.9%** | **1%** | **0.8%** | **2%** | **1.6%** | **0.7%** |
| THR infections/ops | 4 / 101 | 2 / 103 | 2 / 100 | 1 / 89 | 3 / 94 | 0 / 94 | 3 / 105 | 1 / 99 | 1 / 129 | 2 / 98 | 7 / 431 | |
| **Repair Fractured Neck of Femur** | **4.2%** | **0%** | **3.5%** | **0%** | **1.2%** | **3.8%** | **1.1%** | **1.2%** | **0%** | **1.5%** | **0.8%** | **1.3%** |
| #NOF infections/ops | 5 / 118 | 0 / 93 | 3 / 86 | 0 / 99 | 1 / 81 | 3 / 80 | 1 / 87 | 1 / 82 | 0 / 116 | 1 / 68 | 3 / 353 | |

* The last 4 quarters for which data has been collected are considered the most useful for identifying trends, due to the comparatively small number of operations per quarter

** Apr-June 2017 reported case for Repair Fractured Neck of Femur is to be removed as later identified that it does not meet the criteria for inclusion as an infection



## High Impact Intervention Audit Scores

| High Impact Interventions | 2016-17 | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | YTD 2017-18 | RAG rate (Month on Month) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hand Hygiene | 96.48% | 96.48% | 96.80% | 96.44% | 92.02% | 94.89% | 96.42% | 95.49% | 93.03% | | | | | 95.24% | ▼ |
| Surgical Site Observation | 93.13% | 94.57% | 96.46% | 97.87% | 97.49% | 96.57% | 95.85% | 95.74% | 96.68% | | | | | 96.46% | ▲ |
| Intravascular Devices (Insertion) | 93.58% | 95.44% | 96.16% | 95.16% | 96.05% | 93.93% | 94.63% | 95.38% | 95.00% | | | | | 95.24% | ▼ |
| Intravascular Devices (Continuing Care) | 91.65% | 93.29% | 94.26% | 95.27% | 94.42% | 95.04% | 95.97% | 95.37% | 96.23% | | | | | 94.95% | ▲ |
| Urinary Catheter (Insertion) | 96.39% | 94.26% | 99.31% | 96.60% | 97.14% | 95.86% | 96.85% | 95.56% | 95.04% | | | | | 96.37% | ▼ |
| Urinary Catheter (Continuing Care) | 93.82% | 88.00% | 98.63% | 93.92% | 97.83% | 98.57% | 97.56% | 97.79% | 95.71% | | | | | 96.08% | ▼ |
| Renal Dialysis (Continuing Care) | 96.70% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 99.67% | 100.00% | 100.00% | | | | | 99.96% | ◆ |
| Ventilator (Continuing Care) | 97.00% | 100.00% | 81.48% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 96.77% | | | | | 96.67% | ▼ |
| Environment (Inpatients) | 96.70% | 96.54% | 97.25% | 96.74% | 96.46% | 95.63% | 95.63% | 97.04% | 95.97% | | | | | 96.42% | ▼ |
| Environment (Outpatients) | 97.17% | 96.96% | 96.50% | 97.62% | 96.85% | 96.29% | 96.32% | 95.98% | 96.79% | | | | | 96.65% | ▲ |
| Environment (Renal Dialysis) | 89.24% | 91.18% | 93.56% | 91.07% | 90.39% | 85.60% | 86.81% | 89.96% | 90.84% | | | | | 89.97% | ▲ |
| MRSA Screening Compliance | 96.42% | 90.25% | 97.09% | 95.61% | 98.03% | 95.69% | 93.93% | 97.78% | 96.94% | | | | | 95.63% | ▼ |

Compliance scores are extracted from the Meridian database of Trust-wide fortnightly peer audits undertaken by nursing staff in their own departments